Provincial Long Term Care/Personal Care Home Pandemic Plan

This document has been produced with the input of representatives of Manitoba's Health System Service Delivery Organizations (Shared Health, Northern Regional Health Authority, Prairie Mountain Health, Interlake-Eastern Regional Health Authority, Southern Health-Santé Sud, and Winnipeg Regional Health Authority), Manitoba Health, and Revera. Technical expertise and professional advice have also been incorporated from provincial Infection Prevention and Control, the Provincial Redeployment and Recruitment Team and Shared Health Emergency Response Services-Emergency and Continuity Management.

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Acronyms

ABHR	Alcohol-based Hand Rub
ACP	Advanced Care Plan
AIA	Alternative Isolation Accommodation
BCP	Business Continuity Plan
CED	Communications and Engagement Division Manitoba*
CMA	Canadian Medical Association
CNPHI	Canadian Network for Public Health Intelligence
CPL	Cadham Provincial Lab
CPPHO	Chief Provincial Public Health Officer
CPR	Cardiopulmonary resuscitation
DC	Designated Caregiver
ED	Emergency Department
EFT	Equivalent Full Time
EMR	Electronic Medical Record
ER	Emergency Room
ERS	Emergency Response Services
FAQ	Frequently Asked Questions
GI	Gastrointestinal
HCA	Health Care Aid
HCW	Health Care Worker
IAP	Incident Action Plan
ICP	Infection Control Professional
ICR	Incident Command Reporting
ICS	Incident Command System
ICSA	Infection Control Support Associate
ICU	Intensive Care Unit
IMS	Incident Management Structure
IP&C	Infection Prevention & Control
JAS	Job Action Sheets
LMS	Learning Management System
LTC	Long Term Care
LTCAM	Long Term Care Association of Manitoba
MAC	Medical Advisory Council
MAR	Medical Administration Record
MD	Medical Doctor
MOH	Medical Officer of Health
NP	Nurse Practitioner
OCME	Office of the Chief Medical Officer
OESH	Occupational and Environmental Safety and Health
OMT	Outbreak Management Team
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PA	Physician Assistant

PCH	Personal Care Home
PCN	Position Control Number
PH	Public Health
PHIA	Personal Health Information Act
PPE	Personal Protective Equipment
POA	Power of Attorney**
PRRT	Pandemic Recruitment and Redeployment Team
QMR	Quarterly Medication Review
R	Resuscitation
RHA	Regional Health Authority
RN	Registered Nurse
SAP	System Applications and Products
SCMSS	Supply Chain Management Shared Services
SDM	Substitute Decision Maker***
SDO	Service Delivery Organization
SH	Shared Health
TC	Transitional Care
TCC	Transitional Care Centre
VTE	Venous Thromboembolism
WHIMIS	Workplace Hazardous Materials Information System

**Formerly Communications Services Manitoba.*

*** Is the legal authority contained in a written document that allows someone else to manage a person's legal and financial affairs.*

****Substitute decision maker has been used throughout this document to refer to the following legal representatives (a)* ***a proxy*** *appointed by a resident under The Health Care Directives Act, to the extent of the proxy's powers under the health care directive; (b)* ***a committee*** *appointed for a resident under The Mental Health Act, to the extent of the committee's powers under the appointment; (c) a* ***substitute decision maker*** *for personal care appointed for a resident under The Vulnerable Persons Living with a Mental Disability Act, to the extent of the substitute decision maker's powers under the appointment.*

Section I - Provincial Long-Term Care/Personal Care Home Pandemic Plan

Introduction

Building on the learnings of the COVID-19 pandemic, and pandemic-associated outbreaks across multiple Personal Care Homes (PCHs), this provincial pandemic plan will serve as a guide to assist with future pandemics that may be experienced within the province of Manitoba. This plan will be implemented upon the advice of the Chief Provincial Public Health Officer (CPPHO) and will be revised, altered, and changed as required based on current Public Health guidance and Infection Prevention and Control standards. Discontinued use of the plan will be on the advice of the CPPHO.

Confusion exists between the language of outbreak, epidemic and pandemic therefore it is important to understand their meanings to prevent confusion in planning.

- An outbreak is “a sudden rise in the incidence of a disease” and typically is confined to a localized area or a specific group of people.
- An epidemic is an unexpected increase in the number of disease cases above what is normally expected within a community, population, or region.
- A pandemic is an endemic that has spread over several countries or continents and affects many people.
- Should an outbreak become more severe and less localized, it may be characterized as an epidemic. It if broadens further and affects a significant portion of the population, the disease may be characterized as a pandemic.

A pandemic occurs when an organism, to which most humans have little or no immunity, acquires the ability to cause sustained human-to-human transmission that leads to a rapid worldwide spread. The organism may arise through genetic re-assortment (animal and human influenza genes mix) or genetic mutation (when genes in an animal virus change), allowing the virus to easily infect humans. When exposed to the new organism, most people will become ill, as they have no immunity to the newly mutated strain. If the new organism causes severe disease, it can lead to a substantial number of hospitalizations and deaths causing social and economic disruption. Pandemics can last anywhere from 12 to 18 months or longer.

Early recognition and prompt reporting in response to unusual clusters of illness are essential for effective management of outbreaks. When appropriate infection prevention and control measures are implemented in a timely manner, outbreaks are generally controlled quickly. For more detailed information about outbreak management, please consult your site Infection Control Support Associate (ICSA) and Infection Control Professional (ICP). In the event of an outbreak or threat of an outbreak of an unusual infectious disease, such as a newly emerging respiratory virus or any other infrequent infectious disease, direction for outbreak management of emerging pathogens will be provided by Public Health (PH), Infection Prevention and Control (IP&C), the Medical Officer of Health (MOH), Occupational and Environmental Safety and Health (OESH) and will extend beyond this document.

Purpose

This plan has been designed to provide direction in pandemic-associated outbreak response preparedness; improving the capacity to respond to potential and actual pandemic-associated outbreaks of an evolving organism. Each Service Delivery Organization (SDO) is responsible for the creation of a pandemic response governance structure which includes PCH Operators that support an overall pandemic unified Incident Command Structure.

Service Delivery Organizations and PCHs will use the provincial pandemic plan to develop site working documents to ensure they have an up-to-date pandemic plan that is reviewed annually and will support resident care and prepare staff to maintain a safe, healthy, and caring environment during a pandemic-associated outbreak.

Roles and Responsibilities

Key leaders within the SDO have responsibility to ensure all facilities within the organization are supported before, during and post pandemic-associated outbreak. Leaders are responsible for ensuring that there is regular site communication and being responsive to specific resource requests (e.g., education, staffing, supplies).

Effective outbreak management requires a multidisciplinary approach and involves individuals with different responsibilities. All staff and leadership have a role to play in outbreak prevention and management and a coordinated team approach is essential when managing outbreaks.

The facility plan will include task sheets for all clinical and non-clinical departments to guide the day-to-day workflow during an outbreak. Role clarity is key to ensure tasks are not duplicated, and all staff clearly understand their responsibilities during an outbreak as well as post outbreak.

A more detailed outline of specific roles and responsibilities within an Incident Command structure is presented in Section II.

Communications

Timely and up-to-date communication is a vital component of any pandemic and outbreak plan. Each facility regardless of site outbreak status, should have a communication process that allows for up-to-date information to be shared with management, physicians, staff, and residents/families of the facility and the SDO has a process in place to contact the appropriate individual at the Provincial level.

The SDO or site will designate a Communications Officer who will be responsible for communications during a pandemic-associated outbreak to ensure information is appropriately and effectively communicated to OESH, SDO leadership, IP&C, PH, staff, residents, families, the public and that there is a process is in place to handle media inquiries. Facilities will follow the direction provided by SDO senior leaders. The process of communication will be detailed within the site-specific plan. The facility plan will identify contact information for OESH, SDO leadership, IP&C, and Public Health, families, staff, and the communications team.

Types of Communication

Refer to Section II for further detail regarding communication.

General Updates

General updates refer to communication for the larger community (staff, residents, families, and union representatives) and include information on visitor protocols, outbreak information, measures being taken by the facility, and activities. This information is subject to media interest, so it is important to be prepared. To ensure accuracy and consistency, scripts and public messaging will need to be reviewed by site lead or designate. Sites may choose to provide general updates through mass email, newsletters, dedicated website with consideration for families who do not have access to technology (e.g., recorded message, phone tree, mail out). It is important to refer to original sources of information (e.g., Shared Health, Manitoba government) to ensure up to date information and to prevent misinformation from circulating.

Should the facility decide to host an information session with all families/residents such as a town hall, prepare to follow up with individuals after the session for resident-specific concerns. It is also important to contact families to understand whether their communications needs are being met.

Health Status Updates

The most important concern for families is to have health updates on their family member(s) living in the personal care home. Prepare for multiple enquiries from families. As this type of communication is resource intensive, facilities may wish to establish and communicate expectations for communication with the family designate(s), and provide scheduled updates, as well as family-initiated updates.

Communication with family must occur when there is a change to a resident's health status (e.g., decreased fluid intake, poor oral intake, behaviour change), whether they have been identified as positive for the organism, a close contact to a positive case, are showing symptoms, have been tested, waiting for testing, or have been cohorted. If possible, facilities should consider using virtual options to provide updates to involve the resident and give families a visual check-in of the resident.

It is ideal if clinical staff directly involved with caring for the resident provide the health status updates to family. Staff who have not been working with the resident may be called in to assist as this is resource intensive and staffing numbers may be impacted by the outbreak. The person providing updates will need to have access to clinical staff/resident records to provide updates such as resident's fluid intake, eating, behaviour, and mood.

Family-Initiated Communications

When a clinical team member cannot respond immediately to family-initiated communication, it is imperative for a staff member to call the family with a status update (at minimum), and an estimated call back time from the clinical team.

Contact Tracing

During a pandemic-associated outbreak, contact tracing can be a very intensive process. Each facility will outline the people responsible to complete this task. Although contact tracing is primarily the role of IP&C, during an outbreak, other support persons may be identified and trained to assist with this work. Additional COVID-19 specific information can be found at the Provincial COVID-19 resources for health-care providers and staff Shared Health website.

The site ICSA has responsibility to complete contract tracing for PCH residents. OESH, PH and facility leads will determine need to complete contract tracing for staff and visitors depending on exposure location and the nature of the infectious organism.

Infection Prevention & Control (IP&C)

Implementation of comprehensive IP&C strategies will help prevent transmission of microorganisms with or without the availability of vaccines and antivirals. IP&C measures are fundamental in every aspect of pandemic and response planning.

Increased volumes and prevalence of symptomatic individuals will require diligent attention to Routine Practices and Additional Precautions, health care worker and resident exposure prevention, and facility cleaning and disinfection standards.

The SDO will refer to existing outbreak policies and protocols for management of respiratory and Gastrointestinal (GI) outbreaks.

Identification and Management of Ill Residents

Early detection and timely response to illness is critical in mitigating transmission. Regular monitoring of PCH residents' health status will help to identify any changes early and will allow for early case/suspect detection and quick implementation of additional preventative measures.

Healthcare providers are encouraged to act with an abundance of caution as a proactive measure with any suspect cases.

Confirmation of a positive case in a pandemic-associated outbreak requires immediate action both within the PCH and the SDO. Promptly informing site and SDO leadership of a case is required to ensure timely implementation of a response plan.

A process must be in place to monitor each residents' health status during each shift and staff must be made aware of the importance of reporting any changes in health status, inclusive of atypical changes. Frequency of monitoring recommendations may change over the course of the pandemic-associated outbreak.

A resident showing any symptoms that could be associated to the pandemic or other unknown organism will be immediately placed on additional precautions as outlined by IP&C. The additional precautions required may change once the organism has been confirmed.

Notification of any positive case will require immediate IP&C consultation for direction in implementing a case management plan as well as implementation of necessary additional IP&C precautions. IP&C will seek consult from the MOH if required.

Preparation for a Pandemic-Associated Outbreak

Communications

The Communication Officer will be responsible for communication with relevant SDO leadership, public health officials, residents, families, staff, and the public in the event of a pandemic-associated outbreak. The Communications Officer will ensure a communication team is established to support communication responsibilities. It is important to establish a backup to the Communication Officer. It will also be critical to have a clinical staff person to support communications, especially if the Officer does not have a clinical background.

The site-specific plan will establish communication team member(s) and their responsibilities for types of communication.

In preparation for outbreak associated communication, the facility will need to obtain updated contacts for SDO senior leaders, IP&C, local public health officials, staff, residents, and their families. The contact lists are to be maintained and updated regularly.

First Contact/Family Designate

While updating the contact list of family members, staff will need to clarify with residents and families who is the first contact (e.g., family designate, next of kin, emergency contact**)** for health care updates as well as their preferred method of communication (telephone, virtual, email). It is not a requirement for a resident to have a health care directive and proxy in place; however, it is important to have these conversations with families/residents prior to an outbreak.

During a pandemic-associated outbreak, the first contact/family designate will receive updates on the resident's health condition, status, and changes. If the resident has a legal representative (proxy/substitute decision maker/committee), and is unable to make their own decision, the proxy/substitute decision maker/committee would be consulted for making health care decisions.

In addition, staff will need to update contact information for the Designated Caregivers (DC). It is essential to establish an understanding with families and residents regarding the role of the DC, the first contact/family designate and legal representative (proxy/substitute decision maker/committee). The first contact/family designate will be relied on to communicate health status changes or other essential information with the larger family network. It may be necessary to have more than one family contact to receive updates.

Designated Caregivers and Visitors

Each PCH resident, in collaboration with PCH staff, will identify designated caregivers (DCs) as permitted in provincial guidance. They will be supported to continue their involvement in providing active care and support to the resident's emotional wellbeing, health, and quality of life. The designated caregivers' information will be documented in the resident' health record.

It is important to distinguish between DCs and visitors. DCs are active and essential partners in care for their family member residing in a PCH. They are a

key support and are the voice of the vulnerable resident who cannot always speak for themselves. They may help with physical tasks like feeding, social and emotional support, as well as connection to the larger family. DC and visitor definitions can be found here: http://sharedhealthmb.ca/files/expanded-visitation-acute-and-pch.pdf

A process will be developed to allow for rapid problem solving related to concerns brought forward from residents/family. This will allow issues to be addressed in a timely manner.

Human Resource Planning

Refer to Section IV for further direction.

Human Resource planning is a critical component of pandemic planning and pandemic management. Planning should consider a variety of factors including Union collective agreements, staff availability, and system demands. During a pandemic, it is necessary to have sufficient staffing to meet resident care needs safely, adhere to Manitoba PCH Standards, and provide a safe and supportive environment for residents, family, staff, and volunteers.

Care in place strategies may be required potentially increasing the acuity and/or complexity of resident care while a reduction of staff can be anticipated due to illness or isolation requirements.

The facility pandemic plan will address staffing requirements, and SDO identified triggers and strategies to secure additional staffing in the event of a pandemic-associated outbreak in the PCH. Provincial Incident Command can be consulted if required.

Staffing needs will be informed by identifying critical and non-essential services (based on residents' health and functional status) and essential facility operations. In the event of a site's inability to secure additional staffing in a timely manner, critical resident care needs should be prioritized. As an example, this could be achieved through cross training all available staff/volunteers in feeding and swallowing to ensure nutrition and hydration needs of the residents are met.

Consideration must be given to providing staff with applicable resources and supports for preparation, planning and response. An increase in acuity and/or the number of positive residents will require adjusting the staffing model/ratio and an increase in human resources. Monitoring the wellbeing of staff is a key component of outbreak management.

Human resource contingency planning should consider the following:

- Compliance (as applicable) with Public Health Orders, single site staffing orders and other legislation affecting movement of staff.
- Adjustment of baseline staffing.
- Optimization of staffing rotations.
- Collective Agreement provisions providing for the movement of staff. Memoranda of Agreement may need to be negotiated with bargaining agents if Collective Agreement provisions do not address staffing changes and/or movement of staff that is required.

- Staffing mix and models. Plan staffing mixes for various scenarios keeping resident care needs in mind. For example, during the COVID-19 pandemic, there was a greater need for nurses to manage residents in place who were sick and required frequent nursing assessments and interventions such as medication administration.
- Consideration to adjust staffing ratios include:
    - Size of the facility
    - Number of ill residents
    - Acuity of ill residents
    - Extent of the outbreak
    - Geographical location of the outbreak and the facility
- Identify when to seek assistance from external staffing support including Redeployment Teams and other expedited hiring sources.
- Plan for implementing orientation, education, and training for re-assigned or redeployed staff, agency staff, volunteers, and family caregivers.
- Cross training of staff
- SDO available virtual education options
- Contingency planning should take into consideration option for delegates for all positions including leadership roles, clinical care roles and facility support roles.
- Consideration will be given to adjusting baseline staffing complements to meet increased staffing workload and increased resident service/care needs. Examples include but not limited to:
    - residents isolated in their rooms,
    - increased usage of personal protective equipment (PPE) with donning and doffing to enter and exit rooms,
    - delivery of meal trays,
    - bed bathing versus tub baths,
    - increase in resident falls,
    - increase in need for resident supervision or constant care,
    - residents being cared for in alternate facilities.
- Monitoring the wellbeing of staff is a key component of outbreak management and a responsibility of site leadership and Human Resources
- Tracking of hours worked for the purposes of payment of special premiums/benefits that may be in place.

Mental Health and Wellness

Mental health and wellness are an important part of overall health and wellbeing. It affects how we think, feel, and act. It also affects how we handle stress, relate to others, and make choices during an emergency.

It is imperative that each SDO have a staff member assigned to lead Mental Health and Wellness initiatives for staff, residents, and families during a pandemic-associated outbreak.

Each SDO must also have a plan for accessing Critical Incident Stress Management/Response (CISM/CISR) resources for PCH and SDO staff who experience Critical Incidents.

Orientation and Training

Should the need arise for external staff to support the PCH to provide resident care, applicable training and orientation will be required based on the health care providers experience and individual competencies. The SDO will develop orientation resources to ensure safe quality care continues to be provided to all residents during an outbreak.

The orientation and training plan will contain at a minimum:

- Health care providers practicing within their usual scope of practice will require a brief orientation.
- Health care providers adding additional skills to their practice will require additional training.
- Balanced approach for timing of training, particularly for those new to the environment is key. A refresher may be required when a gap in time exists between training and ability to apply learning.

During a Pandemic-Associated Outbreak

Admissions & Interfacility Transportation

During a pandemic and potential associated outbreak at a PCH site, direction will be provided by Provincial Incident Command regarding the process of admissions and interfacility transportation. Admissions may be halted during an outbreak (exceptions may be considered depending on the circumstances) which will impact the health system, families, and caregivers.

Service Delivery Organizations and Manitoba Health will determine what additional resources need to be put in place to support the health system and the individuals affected.

Communications

Communication Process for Outbreak Declaration

Once a pandemic-associated outbreak has been declared the PCH and SDO will notify stakeholders as per their current process. Stakeholders who may be notified include, but are not limited to:

- Manitoba Government
- Communications and Engagement Division (CED) Manitoba
- Chief Provincial Public Health Officer, Shared Health
- Communications
- Chief Provincial Nursing Officer
- Provincial Incident Commander, Service Delivery Organization
- Communicable Disease Coordinator,
- IP&C Lead
- Site Medical Leadership
- OESH
- SDO LTC Lead

Once the outbreak has been confirmed by SDO IP&C, the PCH will notify residents, families, resident designates, and staff using provincially approved

scripts/letters to ensure consistent messaging. Scripts and letters can be found here.

The PCH will remind staff of the site/SDO policies related to media and social media. Staff should be reminded to direct all media inquiries to the appropriate communications department as per established SDO process.

Communication with Families

Communication with families/residents and staff should be daily during a pandemic-associated outbreak.

- Ensure scheduled check-ins with the first contact/family designate.
- Ensure regular updates on visitor protocols, outbreak information and any changes at the site due to PH announcements.
- Facilitate virtual or window visiting options for residents and visitors during an outbreak. There are many benefits to arranging visits prior to care conferences/rounds to allow families to "see" residents and be able to ask questions of care providers.
- For residents who are isolated as suspect or confirmed, families should receive a daily call from the clinical team; or, more frequently if their health status has changed.

Communication with Staff

Maintaining communication and providing updates to staff members is important. Staff will require updates on the contact tracing process, protocols, visitation restrictions, the importance of confidentiality and who to contact if they have questions. Updates can be provided through huddles, email, scheduled calls or other PCH identified communication channels. Consider posting staff communication on a static communication board to provide staff a consistent location to access the updated information.

Communication with the Public

There will be a process in place for media enquiries within the SDO for PCHs. Please contact them if you have media queries. It is recommended that proactive messaging is provided to the wider community (families, residents, resident/family council and staff) to ensure they receive information on transmission, outbreaks and/or infections/deaths as appropriate, before government news broadcasts/releases. Proactive communication reduces misinformation and builds trust.

Cohorting

The priority of preventing or limiting the spread of an organism within the PCH will be supported by cohorting strategies. The intent is to keep confirmed (positive), suspected and negative cases apart to minimize further transmission. Cohorting plans need to be reviewed with SDO IP&C regularly. Cohorting recommendations may change depending on current state of outbreak, infrastructure, and resident behaviour (e.g., cognitive impairment).

Cohort areas should be separate and well ventilated, ideally with a separate entrance and located away from high traffic areas. Cohort areas should also have consideration

given to functionality, physical distancing, dining area capacity, cleaning/disinfection, storage, etc. Special consideration is needed for residents with cognitive impairment who are ambulatory.

Staff members should ideally work with only one cohort of residents. If staff are required to work with multiple cohorts, they should move from the lowest risk to the highest risk cohort to minimize risk of transmission. (i.e., from well to ill residents).

The facility specific plan will contain details for cohorting options within the facility in consultation with management and IP&C. The PCH floor plan will be reviewed during the planning to identify appropriate cohorting locations within the site and will form part of the plan. The current status of the pandemic and residents' status within the site (related to the pandemic organism), also guide cohorting plans. Cohorting recommendations may change through the course of the pandemic depending on these factors.

During the COVID-19 pandemic, Shared Health provided SDO's cohorting guidelines. The SDO and facility may develop cohort plans based on these guidelines understanding that they may change depending on organism type.

Visitor Restrictions

Visitation principles will be communicated to the SDO by the Operations Section of the Provincial Health Incident Command Structure for managing the pandemic and subsequent outbreak response.

Should visitation be restricted, visiting supports and virtual visitation will be essential in assisting DCs, visitors and residents with maintaining connections. Sites will support regular communication and visitation from DCs and visitors through virtual, indoor, and outdoor visits in alignment with PH orders and the pandemic visitation guidance. The facility may consider designating a staff or volunteer to help with virtual visiting options and addressing technology questions. Visitation principles may change over the course of a pandemic depending on severity and transmission concerns.

Information on site visits will be provided to DCs and visitors, and will include instructions regarding Routine Practices, PPE requirements, required precautions, and additional IP&C measures.

A system to facilitate contact tracing of visitors will be put in place if needed. *More information is presented under Contact Tracing.*

Physician/Nurse Practitioner Services

Refer to Section V for further direction.

Daily on-site physician and/or NP rounds will need to immediately be put in place once a pandemic-associated outbreak has been declared. Long Term Care Medical Leads in consultation with Public Health and SDO/site incident command, will provide direction to Physicians/NPs regarding the most appropriate approach to managing suspect and positive cases.

Refer to the Shared Health Including Medical Staff Rules and Regulations document for further outbreak management guidance. Please find it on the Shared Health LTC and PCH website.

Security and Screening

The facility in consultation with SDO Leaders will determine the need to implement or increase Security and Screening personnel.

Security Services may be required to ensure safe storage and prevent theft of high demand supplies, to facilitate a calming presence and manage restricted access to the building, should additional visitor restrictions be implemented. Facilities that do not have Security staff on site may consider strategies including but not limited to the use of minimal entry, exits, lock down or hiring outside agencies.

Screening staff may be required to assist with enhanced screening of visitors and staff and accept deliveries.

Supply Chain Management

Supply use during a pandemic-associated outbreak will increase and there will be a continued need to closely monitor supply levels and product demand across various departments to ensure timely response in procurement. A facility level contact(s) should be identified that will monitor stock levels and usage regularly across all departments (with support of department Leads) in a non-outbreak status as well as monitor stock levels at least daily during an outbreak.

Minimally, the following must be monitored:

- Appropriate inventory of PPE, meeting the minimum specifications and standards required (e.g., N95 respirators, level 3 procedure masks, level 1 isolation gowns. Gloves, over bed tables, etc.) Supply Chain Management Shared Services (SCMSS) maintains a list of minimum specifications and standards as per the PPE guidelines.
- Isolation Carts
- Storage containers
- Alcohol-based Hand Rub (ABHR) for hand hygiene
- Soap and paper towels for hand washing
- Appropriate inventory of approved cleaning and disinfecting supplies
- Appropriate numbers of waste receptacles
- Laundry carts
- Appropriate inventory of specimen collecting supplies
- Signage such as; additional precaution signage, screening signage, visitor restriction signage
- Staff should be aware of where all supplies are stored, how to access, and who to notify if stock levels are reaching a minimum quantity.

Post Pandemic-Associated Outbreak

Ongoing monitoring for a re-emergence of symptoms or complications is necessary during the pandemic-associated outbreak and once it has been declared over.

Following the active pandemic-associated outbreak's termination, the facility will have a plan for the safe restoration of infrastructure, services, and programs. Scaling down of monitoring to normal operations will be planned to ensure the facility can maintain current staffing support.

Section II - Emergency and Continuity Management Manitoba Personal Care Home Pandemic Preparedness

Objectives

Objectives have been established to ensure that Manitoba Personal Care Homes maintain the ongoing operations of the organization through a coordinated pandemic response.

Objectives are as follows:

- To develop a plan that ensures Manitoba PCH facilities have the tools, supplies, and resources necessary to effectively respond to a pandemic.
- To achieve public confidence that PCH facilities are well positioned to effectively respond, manage, and recover from a pandemic.
- To ensure optimal coordination between the PCH facilities, Service Delivery Organizations, Shared Health, and Manitoba Health.
- To ensure health care providers have access to the appropriate training, education, infection prevention and control practices, equipment, and other supports to protect themselves and PCH residents from exposure to a novel virus.
- To ensure the continuity of services with minimal disruption.
- To ensure minimal disruption and impact on our staff and the population we serve.
- To ensure collaborative work with all external partners through established communications processes.
- To consider communities wide range in culture, historical, and geographical needs, including those of First Nations.
- To ensure there is a staffing complement that can be deployed and quickly accessed during an emergency.
- To ensure the Provincial LTC/PCH Pandemic Plan is reviewed annually or when major changes to protocols, process, or procedures occur.
- To decrease the number of individuals exposed to a pandemic organism.
- To reduce morbidity and mortality in PCHs associated with pandemics.
- To ensure the implementation, and utilization of an Incident Command System (ICS) to effectively manage a pandemic.
- To return PCH's to a state of normalcy post pandemic and enhance the effectiveness of recovery objectives.

These objectives are consistent with Public Health Agency of Canada's Canadian Pandemic Influenza Plan for the Health Sector, which recommends organizations:

- Initiate an Incident Command Structure in the earliest stages of the pandemic to coordinate response activities and communication. Due to the lengthy duration of a pandemic, use of a modified Incident Command System (ICS) model is recommended.

- Maintain program and service processes with as little disruption as possible.
- Prioritize service delivery based on resource availability.

Pandemic Planning Principles and Assumptions

The threat of a new pandemic is considered an 'inevitable event'. The impact on the health system as well as societal disruption is considered high. Lessons learned from any pandemic experiences will be incorporated in future revisions of the provincial pandemic plan.

Although a pandemic is an inevitable event, the timing and epidemiology of the next pandemic is unpredictable. Planning is based on the following assumptions:

Absenteeism

The magnitude of a pandemic will create concerns related to workplace absenteeism. As a healthcare industry, PCH's will plan for a total workplace absenteeism rate of between 20% and 25% during the peak period of approximately two weeks.

These prudent planning assumptions are based on modeling conducted by the Provincial Pandemic Recruitment and Redeployment team (PRRT) which was established under the Manitoba Health/Shared Health Unified COVID-19 Provincial Incident Command in the Spring of 2020 to support the COVID-19 pandemic. A similar team may be required to be established in future pandemics. These planning assumptions reflect normal absenteeism, peak illness and care-giving absenteeism and has accounted for heterogeneous effects across work units, possible workplace-avoidance absenteeism and absenteeism stemming from public health measures such as school and daycare closures.

Immunization

It is unlikely a vaccine will be available at the start of pandemic activity in Canada.

Manitoba Health in collaboration with Shared Health will manage pandemic vaccine supply when a vaccine is available, as well as the supply and distribution of antiviral drugs contained within the National Antiviral Stockpile.

When enough vaccine is available, immunizations will occur; increasing the demand on staff human resources required to operationalize immunization programs.

Ethical and Legal Considerations

Pandemics pose various implications for human rights, access to health care, and obligations of and to health-care workers, and of countries and intergovernmental organizations. Given that a pandemic is a global concern, coordinated efforts at all levels of government are required. The enforcement of applicable by-laws and legislation related to Public Health orders are the responsibility of local, provincial, and federal governments.

Manitoba Health and SDOs will engage Legal Counsel and Ethics expertise to inform response to issues resulting from the pandemic response.

The *COVID-19 Shared Health Ethics Framework* is available to assist staff with ethical decision making while leveraging the concepts of freedom of liberty, privacy, equity, duty of care and trust.

Human Resources

In a pandemic, staffing, labour, and human resource issues must be addressed. A Provincial Pandemic Recruitment and Redeployment Team was established under the Manitoba Health/Shared Health Unified COVID-19 Provincial Incident Command in the Spring of 2020 to support the response to the COVID-19 pandemic to assist in guiding and supporting the organization with variety of staffing issues including a provincial redeployment plan. Provincial Health Labour Relations Services, working with the SDO HR Leads and Occupational Workplace Safety and Health, must lead and direct labour/human resource issues that will need to be addressed during a pandemic.

Such issues include but are not limited to:

- Declaration of an emergency
- Principles of redeploying staff
- Principles of reassigning staff
- Workplace Safety & Health – right to refuse
- Vaccinations
- Training for alternate functions
- Resiliency in the workforce
- Volunteers

Equipment and Supplies

Supply Chain Management is responsible for central purchasing, storing, distributing, securing, and transporting equipment and supplies for use across Manitoba's healthcare system. Supplies may be any product, including but not limited to N95 Respirators, gloves, procedure masks, gowns, etc. Working in collaboration with clinical experts, Supply Chain Management will advise on the appropriate types and quantities of supplies operators will be required to maintain on site.

The government of Manitoba will be responsible for maintaining an emergency stockpile of supplies.

Incident Command System

An Incident Command System (ICS) is internationally accepted best practices and principles that are based on and agreed to by the Federal/Provincial/Territorial Network on Emergency Preparedness and Response. ICS is an organizational planning system that defines the roles and responsibilities to be assumed by personnel, and the operating procedures to be used in the management and direction of emergency incidents.

The purpose of ICS is to ensure the rapid decision-making and action necessary in an emergency is properly informed, resourced, implemented, communicated, and documented.

Incident Command System Objectives

- Managing and coordinating emergency operations at a Site level, service level, corporate level, and provincial level.

- Liaising with appropriate Federal, Provincial, and Municipal government departments, partners, key stakeholders, and private sector organizations.
- Managing the acquisition and allocation of resources, supplies, and other supports.
- Establishing priorities and adjudicating conflicting demands for resources and/or support.
- Coordinating inter-jurisdictional mutual aid.
- Activating and using communication systems.
- Preparing and disseminating emergency public information and community warnings. Collecting, evaluating, and disseminating information and essential data.
- Responding to requests for human resources and other support.
- Restoring essential health services.
- Recovering from the incident as an organization.

Each PCH site must have a pandemic response governance structure supported by an ICS structure at the SDO level. These structures ensure pandemic information is effectively communicated with staff, clients, and the public.

The ICS may be fully or partially activated depending on what resources and functions are needed to support the response. The ICS may also be activated in a "virtual" format, at least initially, whereby the coordination of the pandemic response is conducted in a virtual/on-line environment.

Incident Command System Positions – Job Action Sheets

Job Action Sheets (JAS) are used by staff assigned a position within the ICS. The JAS provides direction to staff of what their role and responsibilities are.

Concept of Operations –Pandemic Incident Command Structures

Manitoba's pandemic response is led and coordinated at the site, SDO and provincial levels:

- Provincially by Shared Health and Manitoba Health Public Health using a unified ICS.
- Each SDO can activate their own ICS, which will report to the Command section of Provincial ICS.
- PCHs are aligned within the Operations section of the SDO ICS structure.

Incident Command Structures

- Provincial Incident Command Structure
- Organizational Incident Command Structure
- PCH Incident Command Structure

Assigning Staff to ICS Positions

As the workload can be extensive and the response time urgent, it is recommended that staff be assigned to ICS positions in advance of a pandemic-associated outbreak. Assignment of a primary and alternate staff for each ICS role is recommended.

Assignments must be approved in advance by each staff's respective manager.

Staff assigned to ICS positions will have received ICS orientation and training in advance of any ICS activation. This will ensure staff are comfortable with the scope of their duties and competent in carrying out their roles.

When ICS is activated, it will be necessary to release individuals assigned to these roles from their day-to-day work responsibilities.

Replacement and delegation planning should be carried out for any duties and responsibilities that cannot be postponed.

Training/Exercises

Shared Health Emergency and Continuity Management, in collaboration with SDO Emergency Management Leads will coordinate an annual training and exercise programme to enhance the health systems' overall state of preparedness for future pandemic events.

Incident command System Canada certified training will be offered to staff assigned to ICS positions.

Pandemic exercises enhance education, experience, and provide an opportunity to evaluate the pandemic response plan. Exercises can also aid in identifying gaps in plans, validating assumptions, enhancing awareness, improving understanding of the plan and expectations, and building better relationships between internal and external stakeholders.

Exercises shall occur annually with staff.

Communications Considerations

Operators must work with SDO Communications to develop a plan to keep staff, residents, families, stakeholders, and the public informed. Refer to the Emergency Communications Framework.

The SDOs Communications Lead is required to notify the Provincial Lead, Strategic Communications and Stakeholder Relations – Shared Health. The current Provincial Lead, Strategic Communications and Stakeholder Relations can be found here.

Formal Escalation Structure and Process

Each SDO must establish a written escalation structure and processes. This must be shared with PCH operators to support rapid decision-making and to ensure appropriate support is provided to PCHs in need.

Support requests may include:

- controlling outbreaks,
- completing infection prevention and control assessments,
- ensuring appropriate staffing levels,
- accessing PPE,
- meeting basic resident needs, etc.

Operators must keep SDOs informed of any emerging issues and are expected to request assistance as required. As outlined in further detail in the Pandemic / Outbreak Staffing Plan, key triggers requiring escalation to SDOs include:

- Any reduction in staffing levels by 5-10% - As outlined in the Pandemic/Outbreak Staffing Plan, PCH operators, in consultation with SDO PCH Leadership will assess the priority areas of service and engage in planning and responding with appropriate support.
- Any spike in resident illness where more than 10 per cent of residents are ill at the same time, a pandemic-associated outbreak or other any other identified situation where the potential for management at the site level is a concern. Additional factors for consideration are outlined in the Pandemic Staffing Plan.

RACI Chart

Also known as a responsibility assignment matrix, a RACI chart is a simple roles and responsibilities matrix used in project management. A RACI chart defines whether the people involved in a project activity will be Responsible, Accountable, Consulted, or Informed for the corresponding task, milestone, or decision.

Refer to Appendix A for the completed RACI Matrix.

Annual Plan Review

Shared Health Emergency and Continuity Management will coordinate an annual review of this plan. This review will include PCH/LTC stakeholders and Leaders of Manitoba Health, Public Health, and Shared Health. This review will ensure that the plan is current, and ready to be utilized in the event of a pandemic outbreak.

Section III - Pandemic Staffing Plan

Objectives

It is important to have a pandemic staffing plan that can be implemented quickly in a pandemic. The plan must address:

Initial	

	How staff are made available.
	• The process to identify those staff that have availability due to service reductions in their areas of work – whether partially or fully.
	• Identify process to determine what movement can occur within a site/program to maximize resources and identifying the staff that:
	  ○ Could be reassigned and where.
	  ○ What staff are not required at that site/program in the context of the pandemic.
	• Identify extenders, volunteers, families, and other non-traditional resources that could be utilized in areas of need.
	• Expedited hiring of staff during the pandemic.
	• Resources from other jurisdictions, i.e., federal resources.

	Where the staff come from.
	• Reassigned within the site/program.
	• Redeployed from other areas.
	• New hires (deployments from Pandemic Resource Pool - expedited hiring process utilized in a pandemic).
	• Training:
	  ○ Identifying training and orientation requirements for staff being reassigned.
	  ○ Use of micro-credentials.
	• Collaboration with educational facilities to:
	  ○ Obtain access to students who may be willing and able to assist.
	  ○ Develop required training such as micro-credentials.
	• Collaboration with regulatory bodies to:
	  ○ Obtain access to members who may be willing and able to assist.
	  ○ Assist with expediting temporary registration for retired professionals.
	  ○ Identify scope of practice for existing and new required roles, i.e., who can conduct nasopharyngeal swabbing, who can immunize, etc. The scope of practice may change based on the organism.
	• Media relations – call outs to the public including, but not limited to, retired professionals.

A pandemic staffing team must be set up to assist with pandemic staffing response. This can be modelled on the PRRT that was set up in the Spring of 2020 in response to

COVID-19. Specific references to the existing process could be easily tailored for future pandemic situations. For ease of reference, the current pandemic staffing team – PRRT – and exiting processes are referenced throughout.

Requesting Resources

If a site/unit/program/region requires resources, they contact the PRRT. Resources are requested using the resource request form, which is then sent to COVID19Recruitment@sharedhealthmb.ca.

The resource request form is a simple and easy to use tool that could be utilized for future pandemics. This form provides the information required to identify the classification, required skill sets, the number required, where, when, and other information required to fill a resource need. This can be utilized for commonly used classifications such as RNs, HCAs, OTs, etc. as well as more specific requirements such as Infection Control Professionals (ICP), Intensive Care Unit (ICU) Nurses, Medical Lab Technologists, or classifications that did not exist pre-pandemic, i.e., classifications used at testing sites, immunization clinics, etc. It reduces the need for follow-up questions if other means to request resources are used thereby expediting the ability to meet resource requests.

Identifying Available Resources

Redeployment

Staffing resources are finite. Where resources are required to meet needs in a specific area(s), services may need to be eliminated or reduced in other areas to free up those resources. This is a decision made by Provincial Incident Command in collaboration with SDOs and other stakeholders. Provincial ICS, with programs/sites/units/SDOs are to work in collaboration to determine which services can be reduced, while considering the impact in the SDO and/or province. Criteria is to be applied consistently to ensure standardization of staffing ratios. Once reductions are approved, the programs/sites/units identify the staff impacted (eligible for redeployment) because of the approved service reductions.

Exceptions may be made if OESH has a documented medical condition for an employee that prevents them from being redeployed to meet needs in a specific area(s). Considerations must also be given to employees that identify a medical or other reason that would prevent a redeployment. For example, there may be family considerations that would make redeployment challenging for the staff member.

Programs/sites/units give the PRRT the list of employees or positions eligible for redeployment using the following spreadsheet. The redeployment spreadsheet is sent to: COVID19Recruitment@sharedhealthmb.ca.

The COVID19Recruitment email box is monitored by the PRRT Intake team. The information is tracked for monitoring and reporting purposes. Members of the PRRT Recruitment and Deployment teams have access to this information required to fill resource requests.

The redeployment spreadsheet was created to identify employees impacted by a service reduction and includes detailed information with respect to each employee

including but not limited to name, classification, EFT, location of work, union, manager, skill set, other positions held and contact information. The redeployment spreadsheet provides all information required to identify if an employee(s) can be redeployed to area(s) of identified need and the information required to affect the redeployment.

In collaboration with Provincial ICS and clinical leadership, the PRRT reviews the redeployment spreadsheet for the appropriate skill set to meet the resource needs. Where there is a match between available resources and identified needs, the PRRT sends the Redeployment Notification to the Receiving and Sending Sites. This includes all information required to process the redeployment including the Redeployment Checklist for the Receiving Site which identifies the steps to take to determine the rotation(s) required to fill resource needs, identifies site specific onboarding activities, and contains a checklist of what the Receiving Site needs to consider: site access, parking, site/unit specific orientation, who the redeployed staff will report to, specific access the employee will require (building, units, med room, EMR, PYXIS, computer, etc.) and requests the name and contact information for the timekeeper and the cost centre this will be charged to.

PRRTs role

This listing is not all inclusive of PRRTs role.

- Ensure all required information is included in the spreadsheet
- Check to see if employee has alternate employment if not noted on the spreadsheet
- Notify manager where employee has alternate employment and obtain information regarding schedule to avoid unintended impacts to the unit/site/program
- Ensure communication flow between receiving and sending sites
- Assist with any staffing issues that arise
- Provide required information to affected sites; ensure process is followed for appropriate tracking, pay, and reporting
- Coordinate return of redeployed employees from receiving site

Summary of Process

- PRRT sends the sending site HR Director and the receiving site HR Director a contact list of employees eligible for redeployment.
- Sending site HR Director connects with the receiving site HR Director to obtain schedule.
- Sending site HR Director connects with redeployed employee's manager and discusses the redeployment.
- Sending site HR Director connects with employees eligible for redeployment requesting volunteers first. If insufficient volunteers, employee(s) can be redeployed without agreement. It should be noted that future pandemics may require agreement with the applicable unions to redeploy employees involuntarily.
- Sending site HR Director informs receiving site HR Director and PRRT.
- Sending site HR Director informs applicable union(s) of employees that have been redeployed.

- Receiving site HR Director tracks hours worked by redeployed employees and provides to the sending site HR Director so the sending site can accurately pay salary.
- There is no interview. The receiving site cannot decline the contact if qualifications/skill set are met.
- Employees can be partially redeployed. This can be done in several ways:

Example 1	50% reduction in work, one staff. A 1.0 EFT can be redeployed for 0.5 of their EFT.
Example 2	50% reduction in work, two staff; both 1.0 EFTs doing required work. Where operationally feasible, duties can be bundled and reassigned so that only one of the 1.0 EFTs is doing the required work previously done by both and the other 1.0 EFT is redeployed.
Example 3	50% reduction in work, ten staff. Bundle/reassign the work so five staff can be redeployed for their full EFT rather than redeploying 50% of the EFT of all the staff.

NOTE: Provincial ICS determines what classification of resources can be redeployed and where they are required. Incident Command determines when services resume/increase. PRRT working in collaboration with Provincial ICS and the sending and receiving sites, coordinates the process.

Once staff have been identified for redeployment from the sending site to the receiving site, the PRRT will send a Redeployment Notification to the receiving and sending Sites which includes the information they need to manage their redeployed staff.

When redeployed staff are being returned to the sending site, communication occurs between the sending and receiving site to facilitate the return of the redeployed staff. The PRRT is informed to ensure appropriate tracking. If the receiving site still has a need for resources, the PRRT would review the redeployment list to obtain suitable alternate resources.

Expedited Hiring Process

It is not possible to meet all staffing needs through the redeployment process. An expedited hiring process is required to attract additional resources. For COVID-19, an expedited hiring process was established for recruitment and hiring of staff to the Shared Health COVID-19 Resource Pool.

Mass postings or individual postings are done. Mass postings allow for the posting of multiple positions in a single posting, not specifying a site, to develop a pool of applicants for recruitment (e.g., call for HCAs). Postings can also be site specific e.g., Alternative Isolation Accommodation (AIA). Qualifications do not need to be limited to a specific classification, e.g., LPN, RN, OT, PT, etc. and identify that the successful applicant would be paid at their classification rate of pay and come under the applicable Shared Health Collective Agreement for their classification.

Communications to educational institutions and regulatory bodies are sent advising of available opportunities and for dissemination through mailouts and newsletters to

students, former students, and members. Information on prioritized needs and the means to express interest in them are provided.

Before a position can be filled, a position must be created in System Applications and Products (SAP). Compensation Services and Organizational Management use existing Job Profiles for these positions. If a new Resource Pool resource category which does not currently exist is required, Compensation Services and Organizational Management will, with PRRT input, create the job description, job posting and create a salary scale if one does not exist. A Job Code (classification) is created. This will determine the Personnel Area or Site and Personnel Sub Area or Union Grouping. Once these are established, this information is provided to Finance with the request that Position Control Numbers (PCN) be created.

Some positions may require a streamlined telephone interview to determine suitability regarding qualifications and skillset while others do not (e.g., interviews are not required for Entry Point Staff Screeners). Positions requiring current registration with an applicant's regulatory body are checked prior to an offer, e.g., RNs must be registered to work as RNs.

The Pandemic Recruitment and Redeployment team makes the decision to hire, verbally offers the position to the applicant(s), and completes the Position Budget Request spreadsheet for the selected applicants for expedited load of employee information into SAP. This is the information submitted to Human Resources Shared Services (HRSS) to hire applicants and includes: legal name, address, date of birth, social insurance number, PCN, salary, start date.

Human Resources Shared Services creates the offer letter using the Resource Pool standard offer letter. The offer letter that they receive and sign attests that they do not have a criminal record and are not on the Child Abuse or Adult Abuse Registries. If the applicant has a criminal record, this is escalated to the PRRT Director or designate. The PRRT would not proceed with the hire of an applicant on the Child Abuse or Adult Abuse Registries. The offer letter also requests verification of educational qualifications. Human Resources Shared Services sends out the onboarding information to the new hire. Resource Pool Employment Preparation Steps are sent to the Resource Pool Employee with their Resource Pool offer letter. This includes:

- When/how to expect/obtain their login credentials.
- How to obtain their photo ID badge.
- Required Learning Management System (LMS) courses. The new Resource Pool staff are paid for 2.50 hours to complete these required courses.:
    - Fire Safety Code Red (30 minutes)
    - Hand Hygiene (15 minutes)
    - PHIA (45-60 minutes)
    - WHMIS (30 minutes)
    - Personal Protective Equipment (15 minutes)
- Notification that online onboarding is required and to expect further instructions from healthcarecareers@wrha.mb.ca. This is all completed online, including providing an electronic signature on the forms. The employee is asked to do the following before the first day of work:
    - Complete benefit enrollment forms and tax forms.
    - Provide payroll deposit information.

- Read key regional policies.

The Pandemic Recruitment and Redeployment team requests the network credentials for the Resource Pool staff and emails the new Resource Pool staff their network ID with a reminder to complete the LMS training. PRRT checks the new hire's progress with completing the LMS training.

The Pandemic Recruitment and Redeployment team sends a customized Deployment Notification to the receiving site:

- PRRT inserts the appropriate Notification content for Resource Pool hires. For example, these staff may not have a set schedule. Note: term positions have a set rotation/schedule.
- Resource Pool staff are Shared Health staff (on SAP).
- Employee Welcome information has been gathered from the receiving site that contains location, receiving site contact, when and where to report to for work. The receiving site contact may be asked to connect directly with the Resource Pool employee and review what is required for their first day.
- If the employee has not completed their LMS training, PRRT includes information for the receiving site to ensure the training is completed on their first shift.
- If the employee has completed their LMS training, PRRT advises the receiving site that they will see this reflected on the timesheet.
- PRRT provides the receiving site with the timesheet for the new hire, inserting employee name, ID number, receiving site contact information for invoicing, and sending site Timekeeper contact information. Please email Covid-19CentralTimekeeping@sharedhealthmb.ca\ for further information.
- PRRT reminds receiving site that timesheets are to be submitted weekly to the sending site (link above).

Prioritizing Requests

During a pandemic, the requests for resources can far exceed the available supply. Given finite staffing resources, it is important for requests to be prioritized. This must be determined with HIC with a clear mechanism to identify when this situation occurs, the impacts, and provide a means of addressing it.

Process

1. Summary of resource requests sent by PRRT to Provincial ICS Operations Chief including:
    - Number of overall resource requests.
    - Number of overall resources requested:
        - By classification.
        - Skill set.
        - Sector.
        - SDO/Site/Unit(s).
2. Summary of available resources available through redeployment:
    - By classification.
    - Skill set.
    - Sector.
    - SDO/Site/Unit(s).

3. Summary of available resources in the Resource Pool.
    - By classification.
    - Skill set.
    - Sector.
    - SDO/Site/Unit(s).
4. Provincial ICS to provide guidance and direction on which requests are priority.

The Pandemic Recruitment and Redeployment team must also communicate with resource requestors to indicate what resources may be available and provide an estimate of how quickly and to what extent they can be met.

Triggers for Prioritizing PCH Requests

The staffing plan sets out three situations/scenarios/levels which set out progressively more challenging staffing situations, the service delivery options and the staffing strategies to address each situation. It is acknowledged that a situation can change very quickly requiring a flexible proactive approach.

Medical and IP&C triggers are included in the service delivery information in the scenarios.

Triggers for Enhanced MD/NP Presence in a Declared PCH/LTC Pandemic-Associated Outbreak

Enhanced presence of MD/NP in a PCH will occur if/when:

- One resident (not staff) is confirmed as a positive case at which time on site MD/NP presence will increase to three times / week
- Three or more residents (not staff) are confirmed as positive cases at which time on site MD/NP presence will increase to daily visits.

Refer to the Shared Health Including Medical Staff Rules and Regulations document for further outbreak management guidance. Please find it on the Shared Health LTC and PCH website.

To achieve this level of rapid response to changing needs in the PCH, there will need to be a coordinated and integrated approach between the provincial PCH/LTC Leads (administrative and medical), the SDO PCH/LTC Leads (administrative and medical) and the Site PCH/LTC Leads (administrative and medical). Other potential triggers to enhance MD/NP presence in the PCH may be considered through the provincial, regional, site Leads, and the respective incident command structures developed to coordinate care.

The ramping up of services will be defined as below. The ramping down of services will be dependent on multiple factors determined by provincial, SDO and site leadership.

Triggers for Enhanced Infection Prevention and Control Presence in a Declared PCH/LTC Pandemic-Associated Outbreak

Regular presence of the site-based Infection Control Support Associates (ICSAs) on the units in their facility is a basic expectation, as is an increased presence on units affected by cases of communicable diseases and outbreak activity. In accordance with current

staffing models and staffing levels, the regular presence of ICSAs in PCH/LTC facilities is the standard. Priorities are set according to need, based on factors including site and SDO IP&C capacity, nature of the outbreak and degree of control.

With sufficient regional resources in place, enhanced IP&C presence in a PCH/LTC site will occur if/when:

- One resident (not staff) is confirmed as a positive case at which time on site and affected unit ISCA presence will increase to daily presence with a three times per week minimum. Consultation with SDO IP&C shall occur. One resident case may/may not require SDO IP&C onsite presence; assessment of the situation is required to determine the need. An after-hours support structure is triggered via the Site PCH/LTC Leads to the SDO PCH/LTC Leads. SDO PCH/LTC Operational Leads/designates facilitate after hours IP&C support coordinated/identified in advance via the SDO.
- There are two or more confirmed resident cases (not staff). On site and affected unit ICSA presence to increase to required daily visits. Consultation with SDO IP&C shall occur; assessment of the situation is required to determine the need for onsite SDO IP&C presence.
- An after-hours support structure is triggered via the Site PCH/LTC Leads to the SDO PCH/LTC Leads. SDO PCH/LTC Operational Leads/designates facilitate after hours IP&C support coordinated/identified in advance via the SDO.

To ensure the appropriate level of support and rapid response to changing needs in the PCH/LTC facilities, a coordinated and integrated approach between SDO PCH/LTC Leadership (administrative and medical) and the Site PCH/LTC Leads (administrative and medical) is required. Other potential triggers to enhance IP&C presence in the PCH/LTC facilities may be considered through the provincial, regional, site Leads, and the respective incident command structures developed to coordinate care.

The ramping up of services will be defined as below. The ramping down of services will be dependent on multiple factors determined by the provincial, regional and site Leadership in consultation with relevant levels of IP&C.

NOTE: The scenarios below are intended as a general guide; other factors need to be considered. Each scenario identified below must be viewed with the following factors in mind which may alter the staffing strategies requiring elevation of the need to meet the staffing challenges. If other factors identified below exist, a 5% vacancy may require response at a scenario level higher than 1.

Factors

Factors to consider when reviewing staffing triggers:

- The size of the PCH. A smaller PCH may have the same impacts at a 5% staffing vacancy that a large PCH would not have until they are at 10% or more.
- Geography. Remoteness and accessibility to a PCH will exacerbate staffing challenges and may increase challenges in obtaining required resources.
- Staffing vacancies include all staff: Managers, Nurses, HCAs, Allied Health, Support Staff (Dietary, Housekeeping, etc.). Vacancies in any classification will impact the overall functioning of the PCH.

- Vacancies include vacancies regardless of cause: personal or family illness due to the pandemic or any other cause, personal isolation, child/elder care, leave of absence, unfilled vacant positions.
- Number of staff currently sick due to the pandemic and/or increasing volume of sick calls, including review of close contacts and those awaiting test results.
- PH and MOH direction for all staff to undergo asymptomatic testing, which may result in additional staff testing positive and having to isolate.
- IP&C and/or PH/MOH direction for asymptomatic resident testing, which may result in additional residents testing positive, increased resident care requirements and additional donning and doffing PPE requirements.
- Any reduction in staffing levels that cannot be resolved using normal processes (e.g., overtime, agency staff, PRRT).
- Level of overtime and/or mandating.
- Staff to resident care ratio (e.g., required hours of care per resident day are not met).
- Inability to schedule staff to meet minimal staffing guidelines or meet outbreak requirements within any department (e.g., enhanced infection prevention and control requirements, increased housekeeping requirements; isolation requirements for residents; increasing reporting requirements).
- Acuity of the residents within the facility.
- Outstanding pandemic causative agent resident swabs (waiting on number of tests/swabs pending).
- Point in disease trajectory.
- Number of reported cases in surrounding community.
- Staff reporting or demonstrating feelings/expression of fatigue, feeling overwhelmed, etc.
- Ability to access designated caregivers for support.
- Ability to access volunteers.
- Ability to support regular communication with families and DCs.

Scenario	Examples of Scenario	Service Delivery	Staffing Strategies
1	• Staffing challenges and/or staffing impacts such as gaps in schedules combined with inability to fill some vacant positions. Site working short, increase in overtime. Reduction in staffing levels under 5%. May have a site with 1 or 2 possible positive residents or staff.	• PCHs must provide as much regular care and resident services as possible including nursing, allied health, recreation, medical care, personal care supports, housekeeping and laundry. • Enhanced presence of MD/NP in a PCH will occur if/when one resident (not staff) is confirmed as a positive case at which time on site MD/NP presence will increase to three times/week. • One resident (not staff) is confirmed as a positive case at which time on site and affected unit ICSA presence will preferably increase to daily presence with three times per week minimum. Consultation with SDO IP&C shall occur. One resident case may or may not require SDO IP&C onsite presence; assessment of the situation is required to determine the need. • An after-hours support structure is triggered via the Site PCH/LTC Leads to the SDO PCH/LTC Leads. SDO PCH/LTC Operational Leads/designate facilitates after hours IP&C support	• Offering additional shifts to part time staff. • Offering additional shifts to casual staff. • Offering additional shifts for a longer period (e.g., 3 months instead of 6 weeks). • Offering overtime. • Mandating overtime. • Underfilling shifts (e.g., two HCAs for vacant nurse shift). • Utilizing work short protocols. • Combining low EFTs. • Offering higher EFTs (EFT Increase Form). • Changing shift descriptions for hard to fill shifts (e.g., changing N shift to D/E or D/N where feasible). • Overscheduling during high sick call shifts. • Standby staffing for peak periods – can have combination of 8-hour shifts and 12-hour shifts. • Building stats into the rotation. • Recruiting into existing vacancies. • Utilizing agency staff. • PCH reaches out to its previously retired staff willing to work. • Utilizing voluntary redeployment of nurses and HCAs. • Filling vacant roles from the pandemic Resource Pool. • To achieve enhanced rapid response presence of MD/NP/IP&C to changing needs in the PCH, there will need to be a

Scenario	Examples of Scenario	Service Delivery	Staffing Strategies
		coordinated/identified in advance via the region.	coordinated and integrated approach between the provincial PCH/LTC Leads (administrative and medical), the SDO PCH/LTC Leads (administrative and medical) and the Site PCH/LTC Leads (administrative and medical). • Other potential triggers to enhance MD/NP/IP&C presence in the PCH may be considered through these provincial, regional, site Leads, and the respective incident command structures developed to coordinate care. • The ramping down of services will be dependent on multiple factors determined by the provincial, regional and site Leadership in consultation with relevant stakeholders.

2	• Increased staffing challenges and/or staffing impacts due to 1-5 positive staff and/or residents in 1-5 PCHs in a given region. Reduction in staffing levels by 5-10%. Difficulty staffing those PCHs due to staff required to self-isolate, increased sick calls, and increased reluctance of staff from pandemic Resource	• PCHs must provide as much regular care and resident services as possible, identifying which services can potentially be cancelled, postponed, or reduced based on available resources and resident needs. Visitor restrictions in place. Affected PCHs at Level Red.
		• May modify (reduce/ cancel) social and recreational activities, rehabilitation services, other programming (e.g., support with virtual visits etc.) and reassign staff to assist with other necessary care.
			• Utilize staffing strategies identified in Scenario 1 and:
			  ○ Where activities/services are reduced or cancelled, reassign those staff to areas of need (e.g., Recreation staff can assist HCAs).
			  ▪ Provide training as required.
			• Utilize clinical management staff.
			• Utilizing voluntary redeployment of nurses and HCAs.
			• Filling vacant roles from pandemic Resource Pool
			• Outreach to educational institutions.

Scenario	Examples of Scenario	Service Delivery	Staffing Strategies
	Pool to accept assignments in the impacted PCHs. PCH working short, increase in mandated overtime. • PCH Operators in consultation with regional PCH Leadership will assess the priority areas of services and engage in planning and responding with appropriate support.	• PCH respites and admissions are suspended. • There are two or more confirmed resident cases (not staff). On site and affected unit ICSA presence to increase to required daily visits. Consultation with SDO IP&C shall occur; assessment of the situation is required to determine the need for onsite SDO IP&C presence. • An after-hours support structure is triggered via the Site PCH/LTC Leads to the SDO PCH/LTC Leads. SDO PCH/LTC Operational Leads/designate facilitates after hours IP&C support coordinated/identified in advance via the SDO. • If three or more residents (not staff) are confirmed as positive cases at which time on site MD/NP presence will increase to daily visits.	
3	• Increased staffing challenges and/or staffing impacts due to 6-15 positive staff and/or residents in 6-15 PCHs in each SDO. May have resident death(s). May be outbreaks in another SDO(s). Reduction in	• PCHs will need to continue to prioritize services and determine which additional services will need to be cancelled, postponed, or reduced based on available resources and resident needs. Visitor restrictions in place. Affected PCHs at Level Red. Utilize strategies in Scenario 2 and: ○ Linens may be changed only when wet or soiled at a	• Utilize staffing strategies identified in Scenario 2 and: ○ Seek exemption from 14-day restriction (that was put in place for COVID-19) between working at PCHs to redeploy staff from one PCH to another (e.g., Site A with sufficient staffing, redeploys staff to positive site B).

Scenario	Examples of Scenario	Service Delivery	Staffing Strategies
	staffing levels by 10-20%. Increased difficulty safely staffing those PCHs due to staff required to self-isolate, increased sick calls, and minimal or no ability to provide staff from the pandemic Resource Pool due to reluctance to accept assignments in the impacted PCHs and/or lack of available qualified staff. Increase in mandated overtime. • PCH Operators in consultation with regional health system Leadership will assess the priority areas of services and engage in planning and responding with appropriate support. Collaboration between different sectors in the region (Acute Care, Community, PCH etc.) is required	minimum of every x (e.g.,10) days. ○ Beds would be clean, however not necessarily be "made" as per usual expectations. ○ Resident personal clothing will be worn for 2 days unless wet or soiled prior to sending for laundering. ○ Prioritize housekeeping services for resident areas. Administrative areas will be cleaned by housekeeping less frequently or not at all except in units with high prevalence of dementia where all surfaces including staff areas should be considered high touch. ○ Tub baths may be suspended, and residents only provided with sponge baths. ○ Dietary may resort to an Emergency Plan meals and menu. ○ Communication with family may change or decrease in frequency. i.e., general e-mail update, and resident specific updates only as required or resident condition changes.	• Utilizing voluntary redeployment including alternate care providers in addition to nurses and HCAs. • Call out to SDOs identifying areas of current and anticipated need and request list of staff available for redeployment. • Mandatory redeployment within the region. • Fill vacant roles with alternate care providers from Resource Pool. • Outreach to educational institutions.

Scenario	Examples of Scenario	Service Delivery	Staffing Strategies

4	• Staffing Crisis (staffing levels reduced by 20-30%) during an outbreak; multiple sites may be impacted.
	• Increased staffing challenges and/or staffing impacts due to more than 15 positive staff and/or residents in 15 or more PCHs. Resident death(s). Outbreak in another region(s). Inability to safely staff the impacted PCHs due to staff required to self-isolate, increased sick calls, and inability to provide staff from Resource Pool due to reluctance to accept assignments in the impacted PCHs and/or lack of available qualified staff.
		• PCHs will need to continue prioritizing services and cancel, postpone, or reduce non-essential services.
		• Personal Care Home Leaders in consultation with SDO health system Leadership will assess the priority areas of services and engage in planning and responding with appropriate support.
		• Collaboration and coordination on a provincial level required to assess the priority areas of services and engage in planning and responding with appropriate support.
		  ○ Where appropriate, implement Rapid Response/SWAT team concept – moving staff from other programs to PCHs to ensure sufficient staffing to provide safe care in PCHs.
		  ○ SDOs in consultation with HIC will assess the priority areas of services and staff across regions and sectors.
		  ○ Implement alternate models of care. Additional nurses will be required for nursing assessments and interventions that cannot be done by other disciplines.
			• Utilize strategies in Scenario 3 and:
			  ○ Mandatory redeployment within the region.
			  ▪ Consider staff incentives to go to remote areas (accommodation, travel, additional compensation). Voluntary redeployment across regions.
			  ○ Call outs for former health care workers in the community/region/province.
			  ○ Accessing other providers: ERS, medical offices, dental offices etc. where feasible and provide training.
			  ○ Call out for volunteers to assist with functions requiring minimal training, i.e., housekeeping, laundry.

Scenario	Examples of Scenario	Service Delivery	Staffing Strategies
		○ If nursing services are reduced to those necessary to prevent adverse consequences to the residents and which can only be done by a nurse, it is necessary to identify who can do the non-essential nursing services. Some may be done by HCAs, some by Recreation, Allied Health etc. ○ Provide education and training for staff where scope of practice is enhanced including professional and support staff e.g., Allied Health and Health Care Aides. ○ Canvas with families the possibility of taking healthy residents' home with Home Care, ensure they understand the risks and ability to manage at home. ○ Consider utilizing volunteers to assist with functions requiring minimal training, i.e., housekeeping, laundry. Ensure volunteers receive proper orientation and training including IP&C training.	

Scenario	Examples of Scenario	Service Delivery	Staffing Strategies
5	• Staffing crisis (staffing levels reduced by more than 30%) during an outbreak; multiple sites may be impacted. Increased staffing challenges and/or staffing impacts due to more than 15 positive staff and/or residents in 15 or more PCHs in multiple SDOs. Resident deaths in multiple PCHs. Inability to safely staff the impacted PCHs.	• Collaboration and coordination on a provincial level required. ○ Implement Rapid Response/SWAT team concept – moving staff from other programs to PCHs to ensure sufficient staffing to provide safe care in PCHs. ○ SDOs in consultation with HIC will assess the priority areas of services and staff across regions and sectors. ○ Government may consider issuing an Emergency Order granting temporary amendments to the relevant legislation and suspending collective agreements so that SDOs are able to take all reasonable steps necessary to address the staffing issues which may arise in PCHs due to the pandemic.	• Utilize strategies in Scenario 4 and: ○ Mandatory redeployment across regions. ○ May require military assistance.

Section IV - Roles & Responsibilities of Medical Leadership & Medical Staff during a Pandemic-Associated Outbreak

Roles and Responsibilities

PCH/LTC SDO Medical Lead (or designate)

The role of the PCH/LTC SDO Medical Lead during a pandemic-associated outbreak:

- Works with provincial and regional counterparts and leads to plan for a coordinated and standardized approach to a pandemic-associated outbreak.
- Works closely with Provincial and SDO Medical Officers of Health/Public Health, IP&C, OESH and SH to develop supporting processes, guidelines, and communication across the PCH/LTC continuum as information changes during a pandemic.
- Liaise with all PCH/LTC sites in the SDO to support a coordinated approach to the outbreak if needed.
- Work with the appropriate PCH/LTC leadership in the SDO and participate in SDO Incident Command meetings.
- Meet and support LTC/PCH Site Medical Leads as well as LTC/PCH Administrative Leads on a regular basis during a pandemic. This may be most efficiently done by attendance at the Site Incident Command meetings.
- Is available (or designate) 24/7 to answer questions from medical staff (MD/NP) from sites experiencing an outbreak.
- Supports the development of, along with provincial IP&C medical and program leads, an integrated IP&C Program for Long-Term Care for the region, while standardizing IC&P practices, where appropriate, in the Province of Manitoba.
- Supports the maintenance and implementation of an integrated IP&C Long-Term Care Program encompassing PCH Site Medical Leadership; PCH Medical Staff, SDO IP&C and ICSAs.
- Supports Site PCH/LTC Medical Leads in addressing infection, prevention and control specific issues and connects SDO and site level medical leads to provincial IP&C Leads where appropriate.
- With the SDO Medical/Specialty Leadership team help establish and maintain an IP&C medical organization structure consistent with the SH Provincial Medical specialty governance structure.

PCH/LTC Site Medical Leads

The role of the PCH/LTC Site Medical Lead during a pandemic-associated outbreak:

- Develop a schedule, based on pandemic/outbreak guidelines and policies, for medical staff presence (physicians/NPs) within the LTC/PCH setting to meet the needs of the residents, until such time as the outbreak is declared over.

- Attend Site Incident Command meetings and work with the LTC/PCH Site Administrator in coordinating the needs of the LTC/PCH residents during a serious pandemic outbreak.
- Support LTC/PCH physicians/NPs on a regular basis during a serious outbreak/pandemic for the purposes of staying in touch and informed as well as offering teaching/learning opportunities.
- May participate in an on call medical leadership group (along with the LTC/PCH Regional Medical Lead to be available 24/7 to answer questions from medical staff (MD/NP) from sites experiencing an outbreak.
- Act as a resource and leader for the assigned PCH and guide the staff of physicians and nurse practitioners who provide the care on site.

Pandemic-Associated Outbreak Escalation Triggers

With the first positive resident of an outbreak, on site visitation by MD/NP is expected to increase to 3x/week. If there are more than 3 residents affected, then daily visits are expected.

Refer to the Shared Health Including Medical Staff Rules and Regulations document for further outbreak management guidance. Please find it on the Shared Health LTC and PCH website.

LTC/PCH Site Medical Lead Pandemic-Associated Outbreak Checklists

The following checklists are meant to provide a review of current practice and expectations for the PCH/LTC Site Medical Lead.

CHECKLIST 1 – PCH/LTC Site Medical Lead as a Resource to the PCH	
Initial	
	Keep up to date on current Infection Prevention & Control Measures in LTC.
	Encourage current fit testing for N95s.
	Encourage vaccination (if applicable) of all staff including MDs/NPs.
	Speak to your LTC/PCH Site Administrative Lead to determine your involvement in the Pandemic-associated outbreak planning: • Does your site have the ability to do hypodermoclysis? • How will you be notified when an outbreak occurs? • How is your LTC/PCH managing outbreaks (e.g., cohorting)? • Is there a clear written contingency plan if there are physician/clinician coverage issues expected?

CHECKLIST 2 – PCH/LTC Site Medical Lead as a Leader to the Attending MDs/NPs	
Initial	
	Speak to every MD/NP that works at your site. • Do they have barriers or risks that would prevent them from attending in person in the event of an outbreak? • What is their time commitment to the LTC/PCH in the event of an outbreak?
	Plan for MD/NP coverage • With the first positive resident of an outbreak, on site visitation by MD/NP is expected to increase to 3x/week. • If there are more than 3 residents affected, then daily visits are expected. • Is there an explicit plan for a handover of care after a period not longer than 14 days of onsite care? A "ramp down" strategy?
	Plan for additional MD/NP resources if have an outbreak.
	Discuss/prepare with the LTC/PCH Regional Medical Lead so contingency planning can be prepared in advance.
	If you have MDs/NPs who are unable to assist with outbreak response, you will (circle your selection): • reduce their workload, or • temporarily replace them, or • they can support the clinical demands of the medical staff providing on-site care.
	Discuss and identify gaps with the LTC/PCH Regional Medical Lead so recruitment planning can occur.
	Work with the MDs/NPs to have the staff focus on tasks that assist in streamlining resident care during an outbreak: • QMRs with a focus on de-prescribing and simplifying medication passes and medication frequency regimens • Discuss advanced care plan (ACP) status with residents/POA. • Review current status and resident's healthcare directive in the event the resident gets seriously ill. Involve family where appropriate. • Get clear understanding of level of care: ○ Do they want to transfer to hospital if declining due to (outbreak identifier)? ○ Do they prefer to maximize on site management and transition to palliation if not improving? ○ Do they want intubation or Cardiopulmonary resuscitation (CPR) if declining?
	If possible, cohort individual MD/NP's clinical work to a unit/floor rather than throughout multiple floors/units in a PCH. This encourages better teamwork and less movement between multiple units for each MD/NP.
	Consider going to a single on-call provider per PCH after-hours call model. Rather than all MDs/NPs taking calls afterhours for their own residents, move to a model where one provider is on call for all PCHs. This reduces on-call burnout and provides a single clear contact for on-call issues.

	Ensure all MDs/NPs continue to contact their associated Emergency Department for any transfers out from the PCH. Discuss these at SDO Incident Command meetings if time allows (i.e., not delay the timely provision of care).

Pandemic-Associated Outbreak Management Information

LTC/PCH Medical Staff (MD, NP, PA) - Pandemic-Associated Outbreak Information

This information has been prepared to be provided to MDs, NPs, and PAs at the time they are participating in care at a PCH in a pandemic-associated outbreak situation.

OESH Contact Information	
Please contact the physician OESH resource as per SDO/provincial protocol.	
Contact OESH for contact tracing, and direction whether your need to be tested or isolate related to the pandemic-associated outbreak at the personal care home. This includes weekends and holidays if necessary.	
Name	
Title	
Work phone	
Cell phone (text or call)	
Email	

ICSA Contact Information	
Please contact the ICSA contact person as per SDO/provincial protocol.	
Name	
Title	
Work phone	
Cell phone (text or call)	
Email	

SDO IP&C Contact Information	
Please contact the IP&C contact person as per SDO/provincial protocol.	
Name	
Title	
Work phone	
Cell phone (text or call)	
Email	

MOH/PH Contact Information	
Please contact the MOH/PH contact person as per SDO/provincial protocol.	
Name	
Title	

Work phone	
Cell phone (text or call)	
Email	

Outbreak Communication

Incident Command Committee Meetings: There is a formal site committee structure immediately convened to coordinate the site level and regional response to pandemic-associated outbreaks at PCHs. MDs, NPs, and PAs responsibilities include:

- An invite to the Site level Incident Command Meetings to help identify issues/areas of concern brought up at the site level that require escalation through the LTC/PCH site leadership (LTC/PCH Site Medical Lead or Site Administrator).
- During a pandemic-associated outbreak, involvement through regular site meetings will be essential.
- Where available, the outbreak specific Outbreak Management Team Meeting Template will outline the roles and an agenda for these meetings.
- If not able to attend an Incident Command Meeting please contact the LTC/PCH Site Medical Lead or the LTC/PCH Site Administrator regarding items to report and review the minutes following the meeting.

Email: Email is the primary mode of communication for invitations to Incident Command Committee meetings, meeting minutes and copies of communications with staff and families.

- **Important:** Please provide the LTC/PCH Site Administrator with the email address you check regularly, including after hours. ***Where applicable, the use of an SDO approved email is the preferred mode of communication as per the Rules & Regulations 7.5.1***

Virtual Meetings: The incident command meetings usually occur by Microsoft Teams (or other) application. It is helpful to have a microphone and webcam. The Microsoft Teams (or other) application will need to be downloaded to phones and tablets to use.

Payment: Renumeration for participation in the Incident Command Meetings depends on the payment model. There is a medical remuneration form to fill out with the 2023 rate. Alternatively, contact Medical Administration/Services Department (insert email) to discuss the appropriate payment process.

PCH/LTC Medical Lead Contact Information:

PCH/LTC SDO Medical Lead Contact Information	
Name	
Title	
Work phone	
Cell phone (text or call)	
Email	

PCH/LTC Site Medical Lead Contact Information	
Name	
Title	
Work phone	
Cell phone (text or call)	
Email	

General Outbreak Management

Resident symptom surveillance and testing guidance: The guidance for symptoms suggestive for (outbreak identifier) in the LTC/PCH setting is broader than that for the public.

- An outbreak code may be required to be included on the requisition sent with the swab.

Outbreak checklists: Refer to the appropriate guiding checklist for the outbreak in question at the LTC/PCH.

On site medical care: When there is a surge in residents with (outbreak identifier), an increase in on site medical care is needed (daily during the outbreak).

- Special Pandemic/Outbreak tariffs may be available for the increased presence on site. Check with your SDO Medical Administration Services (insert email) for the details including the remuneration form.
- It is strongly recommended a plan for handover of on-site medical coverage be scheduled at approximately day 14, if not sooner.
- In the case of an unexpected absence from site due to symptoms requiring isolation at short notice dialogue with local colleagues and the LTC/PCH Site Medical Lead should occur to discuss coverage.
- If there are any concerns that coverage is not available with local providers, please contact the LTC/PCH Site Medical Lead as soon as possible so alternatives can be explored.

PPE donning and doffing: The personal care home will supply appropriate PPE.

- Where staff are required to wear a N95 respirator, they must have been fit-tested within the prior 2 years. Name tags may indicate the brand of respirator for which an individual has been tested.
- Ensure the brand of respirator(s) needed are on hand (discuss with LTC/PCH Site Administrator)
- Staff are encouraged to ask someone to buddy with them for donning and doffing of PPE.
- IP&C suggested the following videos during the COVID-19 pandemic for review of donning and doffing. IP&C direction may change based on the pandemic organism.
    - Donning
    - Doffing
    - Point of care risk assessment

Education

See Appendix C for further information.

MD/NP Wellness: Providing care to residents living in a PCH during a pandemic-associated outbreak is an intense experience. Resident needs can increase quickly and unpredictably. Strains associated with this important work can be on top of the existing challenges the pandemic has presented. Seek out regional peer support resources**.** In addition, please consider accessing these resources from Doctors Manitoba and the CMA.

Physician and Family Support Program: For all Doctors Manitoba members and anyone living in their household. Accessible 24/7 at 1-844-436-2762 (register using DOCSMB as company ID). Masters prepared counsellors are available for counselling in person, by telephone or video, and referrals to other services as needed.

Physician Wellness Hub: A virtual, safe space where physicians can gather to discuss shared experiences, get support, seek advice, and help each other. Visit here.

Review of Goals of Care: Transfer to Hospital and Intensive Care

Educational material to support Goals of Care Conversations in the context of a pandemic-associated outbreak identifier can be found at: https://www.youtube.com/watch?v=-3LfeaJWS8A

Site staff should be able to provide you with a list of residents who have previously expressed a wish for active medical management including transfer to hospital and anyone who has an Advanced Care Plan that includes Resuscitation (R).

For residents wanting hospital and intensive care treatment, the goals of care need to be reviewed at the time a pandemic-associated outbreak is declared and with changes in clinical status. This is essential to understand the resident wishes in more detail. Changes in status triggering review include but are not limited to the resident testing positive for (pandemic-associated outbreak identifier) and developing symptoms requiring (oxygen therapy, rehydration).

If a resident and/or their substitute decision maker has indicated, they want intensive treatments it is important to state and document these options require telephone consultation with an intensive care specialist and/or the hospital admitting physician. These consultants may decide, at the time the resident will not benefit from those treatments and those intensive interventions should not be offered. This is dependent on the resident's underlying comorbidities and frailty as well as their clinical status at the time off site treatment is being discussed.

Pandemic/Outbreak Template for Standard Orders

See Appendix C for a completed example.

Pandemic-Associated Standing Orders
Confirmed Medication Standing Orders:
Medication Orders:
Supplemental O2:
IV and subcutaneous fluid for treatment of dehydration:
Protected Code Blue PCH:
Cohorting guideline:
IP&C discontinuation of precautions:
Medication streamlining:
Death of a suspect/confirmed PCH Resident:
Education:
Physician Wellness:

Section V - Personal Care Home/Transitional Care Centre Pandemic-Associated Outbreak Facility Plan

Insert PCH Site Here

Purpose

The PCH/TCC will populate the facility plan template to ensure site readiness in the event of a pandemic-associated outbreak. This plan will be used in conjunction with existing SDO policies, SH guidance and other SDO outbreak plans e.g., respiratory outbreak.

This facility plan outlines minimum expectations and considerations in the event of a pandemic-associated outbreak in PCH/TCC/LTC. Facilities are expected to populate the plan and develop task sheets to assign actions for all clinical and non-clinical staff. The completion of a site-specific plan will identify strengths of each site to meet challenges ahead and weaknesses that can be reviewed and addressed to enhance preparedness. Planning and preparedness will support resident care and prepare staff to maintain a safe, healthy, and caring environment in challenging circumstances.

Outbreaks are continually changing and evolving; therefore protocols, policies and resources are subject to change in response to this and will be communicated to site leadership.

The pandemic plan will be reviewed annually, and changes will be made based on written input from multiple stakeholders within the province. These stakeholders include but are not limited to SDO PCH/LTC leadership, First Nations representatives, PCH Operators, IP&C, Communications, Long Term and Continuing Care Association of Manitoba (LTCAM) and others as required.

Note: The attached plan has been populated with key actions to consider in planning. The action items are to assist the site in populating their plan. Actions may be added, changed, altered based on the facility structure and existing directions provided by SDO leadership.

Documents to include in Pandemic Response Binders/Kit

- Pandemic Plan
- Testing and collection,
- Reporting tools (line lists)
- PPE
- Staff resources (Mental Health and Wellness, EAP, OESH)

- Contact listings
- Resident nutrition and hydration
- Staff and visitor screening tools
- Resident screening tools (e.g., Stop and Watch Early Warning Tool)
- Provincial outbreak posters and signage
- Provincial Cough Etiquette and Hand Hygiene posters
- Visitor signage
- Audit tools (e.g., PPE, Hand Hygiene)
- Facility floorplan/layout
- Employee screening
- Communications scripts

PCH Profile

PCH/TCC name			**# of beds**	
PCH/TCC physical address			**# of units and beds/unit**	
Phone number			**# of double occupancy rooms**	
Fax number			**# rooms sharing a bathroom**	
Juxtaposed	*(Yes/No)*	**To what facility/building:**		

Key List Locations

Facility	
Title	**Location**
Facility contact list *Site Lead, Administrative Assistant, Resident Services Manager, Clinical Resource Nurse, Unit Clerk, Chief of Staff, Medical Clinic (Physicians/NPs/PAs), ICSA, Environmental Services Manager (& leads for housekeeping/laundry, maintenance), Food Services Manager, LTC pharmacy, Materiels Management, Public Health*	
Service Delivery Organization (SDO) contact list *Medical Office of Health (MOH), MOH on-call (after hours and weekends), SDO Infection Control Professional (weekday & weekends from 8:00-16:00), IP&C (after-hours), Senior Leader/Administrator on-call (after hours),*	

pharmacy contact (after hours), media intake line	
Staff contact list	
Staff schedules (nursing, housekeeping, dietary, laundry, other)	
Resident family contact list	
Current resident list	
Designated caregiver contact list	
First Contact/ Family designate	
Legal decision maker (Proxy/SDM/Committee)	
Power of Attorney	

Appropriate Levels of Supplies

Consider: The type of organism, PPE, alcohol-based hand rub, soap and paper towels, specimen collection supplies, cleaning and disinfecting supplies, oxygen cylinders, concentrators, isolation carts, etc. Each site should have ONE CONCENTRATOR per resident prescribed 02, and 1-3 spare concentrators depending on size of facility.

Type of Supply	Location(s)	Minimum Quantity

**Required supplies will be determined by the organism contributing to the pandemic-associated outbreak.*

Infection Prevention and Control

The IP&C checklists have been removed from the Provincial LTC Pandemic Plan as they are updated on a more frequent basis dependent upon the type of infection/outbreak. Updated information can be found on the Shared Health IP&C website.

Pandemic-Associated Outbreak Task Sheets

Senior Administrative Pandemic-Associated Outbreak Task Sheet

Senior Administrative Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
OUTBREAK MEASURES		
		CEO to notify Deputy Minister of Outbreak
		Coordinate a communication plan
		Establish outbreak team with appropriate members and assigning functions
		Advocate for appropriate human, logistical and financial resource requirements
		Provide frequent leadership presence, communication, direction, and support to staff
		Ensure debriefing and evaluation of outbreak occurs
		Designate Communication Lead and back up person responsible for communication to families.

Nursing Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
INITIAL OUTBREAK NOTIFICATION		
		Site specific process to take place to notify residents and family/visitors of outbreak.
		Outbreak signage to be posted upon entry to unit/facility
OUTBREAK MEASURES		
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines which include the following recommendations: ○ Additional Precautions (Implementation and Discontinuation) ○ Testing and Specimen Collection ○ Antiviral Treatment and Prophylaxis (if recommended) ○ OESH ○ Cohorting Residents and Staff ○ Environmental and Equipment Cleaning/Disinfection/Management ○ Laundry/Dishes/Garbage ○ Nutrition Services ○ Admission Recommendations ○ Transfers ○ Visitation ○ Activities • Contact tracing for residents – recommendations will be provided by IP&C dependent of type of outbreak (also considering causative organism)
		Clinical Management: • Review upcoming resident appointments and cancel any non-urgent appointments • Review physician binder and suspend rounds for any non-urgent issues (in collaboration with physician and management) • Care plan/quarterly review-attendance at these will be dependent on availability of staff and workload • Facilitate frequent check-ins and additional fluid intake and monitor for any signs of dehydration ○ Consider implementing 24-hour fluid balance record or a fluid/nutrition monitoring process for residents

		• Exercise/mobilization • Contact management including documented resident assessment
		Communication: • Provide regular updates to residents on unit regarding status of outbreak • Provide regular updates to family regarding status of outbreak • Inform management of concerns during outbreak • Provide updates to Social Worker/designate and administrative staff so they can help in facilitating family communication • Provide updates to communication lead/designate so they can help in facilitating family communication. Clinical staff should be contacting infected resident's families proactively and regularly. If this is not possible, work with management /communication lead to bring in supports to assist with this communication • Direct media requests to: _____
		If cohort areas are planned, must ensure it meets the current Cohorting guidelines by consulting management and IP&C.
ONCE OUTBREAK TERMINATED		
		Site specific process to ensure residents and family are aware
		Outbreak signage removed post appropriate cleaning/disinfection of outbreak area
		Continued heightened surveillance
		Complete the IP&C outbreak evaluation tool and submit to manager.

Health Care Aide Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
OUTBREAK MEASURES		
		Notify nursing staff of residents who have developed pandemic-associated symptoms
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		Inform management of concerns during pandemic-associated outbreak
		Direct media requests to: _____
ONCE OUTBREAK TERMINATED		
		Site specific process to ensure residents and family are aware
		Outbreak signage removed post appropriate cleaning/disinfection of outbreak area
		Continued heightened surveillance
		Complete outbreak evaluation tool and submit to manager. Found here: https://healthproviders.sharedhealthmb.ca/files/ipc-outbreak-management-ltc-evaluation.pdf

Management Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Delegation of tasks is at the discretion of management.		
Date/Time	Initial	Task
UPON INITIAL OUTBREAK NOTIFICATION		
		Manager receives notification of pandemic-associated outbreak declaration from IC&P/designate. Manager then notifies: • Director (SDO Lead) • Physician lead of site • Manager leads of site (i.e., environmental services, nutritional services, maintenance, activities, lab/diagnostics, pharmacy, materiel's management etc.) • Staff at site, following site-specific process regarding call out to all staff

		Schedule staff huddle to review initial pandemic-associated outbreak measures:
		• Outbreak signage posted upon entry to unit/facility
		• Implementation of additional precautions
		• Specimen collection and identification of outbreak code on requisition
		• Screening residents for symptoms
		• Communication plan to residents, family, and visitors
		• Personal Protective Equipment auditing plan
		• Hand Hygiene
		  ○ Review 4 moments of hand hygiene for staff
		  ○ Remind staff to assist residents with hand hygiene before meals and after using bathroom if unable to manage independently
		• Review plan for admissions/transfers
		• Review visitation plan
		• Review plan for activities on unit/facility
		• Reinforce importance of equipment cleaning
		• Reinforce where to direct media calls

		Resident care communication: • Take a photo of each resident (if not taken during annual planning), print copies for identification purposes. Replace photo on Medical Administration

		Record (MAR), Care Plan, and in all other locations where resident photo is required. • Review and update care plans • Ensure communication boards are up to date. Include 1 photo of the residents on the outbreak door poster and one photo in a visible location in the resident room.
		Provide orientation for all new staff to the facility. Including: • HCA and volunteers • Nursing staff • Allied Health roles • Additional housekeeping support • Security staff • All new staff to facility
ONGOING OUTBREAK MEASURES		
		Recommendations for resident contact tracing will be provided by SDO IP&C dependent on type of pandemic-associated and causative organism
		Collaborate with SDO IP&C and ISCA through the course of the pandemic-associated outbreak
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		Communication: • Delegate the release of communication scripts for families and staff to communication lead/delegate via email/phone calls – Communication scripts. • Encourage family that want updates to connect with communication lead/designate • Ensure clinical staff are contacting infected residents' families proactively and regularly. If this is not possible, work with communication lead to bring in supports to assist with this communication. • If staff case, delegate communication lead to send off positive staff member communication script email to all staff and families.
		Staffing: • Consider increasing staff complement to care for acutely ill residents • Cohort staff to specific units or patient assignments, if possible ○ If unable to dedicate staff, move workflow from non-infected to infected residents ensuring adherence to Routine Practices • Restrict staff movement in the daily assignments from pandemic-associated outbreak affected areas to non-

		affected areas, if possible • Consider 1:1 supervision for residents who are unable to comply with IP&C measures • Monitor staffing and redirect non-clinical staff to support clinical tasks as needed • Assess need for security
		Supplies: • Ensure process in place to monitor need for supplies. i.e., oxygen cylinders/concentrators
		OESH: • Liaise with OESH/designate when there are symptomatic staff • Discuss with the Outbreak Management Team (OMT) regarding implementation of active staff screening.
		PPE: • Assist with monitoring of PPE supply use. • Assess HCW fit testing (as required)
		Preparation for cohorting (if required): • In consultation with IP&C/designate, review the need to establish a cohort area • Housekeeping and maintenance staff to be coordinated to assist with moving patient/furniture and preparing the cohort area. • All resident belongings labelled before moving • Nurse, HCAs, and Housekeeper dedicated specifically to cohort area • All other staff are to avoid walking thru area as much as possible. • Two-way radios provided to staff in cohort area to communicate with other staff. • Ensure a charting/documentation table is set up • Provide all resident meals in their rooms in cohort area. • Work with scheduling to ensure nursing staff, housekeeping staff and HCAs are assigned to cohort area
		Audits: • Monitor staff compliance with PPE use and hand hygiene • Monitor staff screening – give consideration for reimplementation of in-person staff screener
		Mental Health resources for staff: • Delegate administration staff to send out mental health resources to staff via email
		Huddles:

		• Have regularly scheduled staff huddles throughout pandemic-associated outbreak to reinforce outbreak measures (i.e., additional precautions, hand hygiene, visitation principles)
		Visitation/External Service Providers: • Review with SDO leadership and IP&C regarding the need to suspend visitation. If visitation cancelled, have communication lead/administrative staff assist with notifying families. • Review suspension of external care providers • Review physician visits to site • Plan for acquisition of additional hand-held devices for virtual family and physician check ins
		Complete Incident Command Reporting (IRC) daily and submit to Regional Lead Community & Continuing Care, PCH-Operators, IP&C providers, and Human Resources
ONCE OUTBREAK TERMINATED		
		Site specific process to ensure residents and family are aware
		Outbreak signage removed post appropriate cleaning/disinfection of outbreak area
		Continue enhanced surveillance for resident suspect cases on unit and/or facility
		Arrange for outbreak debriefing

Dietary/Nutrition Services Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
ONGOING OUTBREAK MEASURES		
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		Prepare separate meal cart, as those residents on Additional Precautions will be served in their rooms.
		If cohort areas implemented at site: • Meals delivered to cohort areas via cart by dietary staff- will be picked up at the cohort area. Trays will be distributed, collected, and placed back on the cart in the cohort area by nursing staff. • Ensure additional dietary supplies (i.e., water, and snacks (are provided to cohort areas as well
		Ensure tables are set just prior to mealtimes to decrease risk of contamination
		Work with management to stagger mealtimes as needed
		Implement modified/simplified menu as needed including premade meals
		Be prepared to assist residents in the dining room with their meals as well other tasks such as preparing toast, cutting up items etc.
		Consider suspending staff meal service in consultation with management if workload is exceeding staff capacity.
		Be prepared to take on additional care tasks as needed/directed by management (i.e., staff screening)

Maintenance Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
ONGOING OUTBREAK MEASURES		
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		If cohorting implemented: • Assist staff in setting up cohort area for ill residents as needed • Assist with posting appropriate signage in cohort area and to limit staff movement • Plan for additional long-term external storage e.g., portable lockable containers for personal effects of residents
		Assist with procurement/movement of supplies in the building (i.e., portable 02 tanks, monitoring 02 use at the hospital etc.)
		Plan for increased waste management including increased number of waste receptacles, disposal of waste, etc.
		Be prepared to take on additional care tasks as needed/directed by management (i.e., staff screening)

Activities/Recreation Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
ONGOING OUTBREAK MEASURES		
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		If direction from management is received to suspend all visitation: • Ensure visitation cancellations are communicated to families • Assist residents in utilizing virtual means to communicate with family (i.e., tablet and telephone)
		Isolation Care Plans: • Ensure isolation care plans are up to date • Prepare items for isolation care plans and place in resident rooms who are on Additional Precautions
		Assist with resident socialization, virtual and 1:1 visits
		Assist in other care tasks as directed by manager
		Cancel external programs during an outbreak as directed by management

Primary Care Provider/Physician/Nurse Practitioner/ Physician Assistant Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
ONGOING OUTBREAK MEASURES		
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		Order laboratory testing as indicated and as directed during a pandemic-associated outbreak
		Consult with MOH/IP&C physician as required
		Order antiviral treatment or supportive therapies as required
		Order antiviral prophylaxis using pre-calculated antiviral dosages (if applicable).
		Depending on causative organism and extent of pandemic-associated outbreak, physician compliment to determine physician/NP/PA who will make in-person daily visits to PCH. • Other physicians/NP/PA to utilize virtual means (i.e., phone conference, face time) to be on call for support
		Review daily line lists and complete medication reviews for acutely ill residents
		Assist in discussions with resident and family regarding Advanced Care Plan, goals of care and expressed wishes.
		Assist nursing staff in communicating resident's health status
		Discuss with OMT regarding continuation of Scheduled Medication Reviews during outbreak

Social Worker Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
ONGOING OUTBREAK MEASURES		
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		Participate in nursing shift report and staff huddles to assist in communication with families.
		General family inquiries will be directed first to Social Worker/designate and SW/designate will seek out additional individuals to communicate with families as needed
		Be prepared to provide emotional/end of life support to families as needed
		Assist in ongoing care planning, and annual reviews virtually as able.
		Assist in the facilitation of virtual visits and 1:1 visits with families/residents

Administration Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
ONGOING OUTBREAK MEASURES		
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		Assist with distribution of communication scripts to resident families as directed by management/communication lead
		Assist with distributing Mental Health Resources information to staff via email/phone calls as directed by management/communication lead
		Review all upcoming scheduled meetings and cancel/defer meetings
		Assist with communication of changes to visitation guidelines as directed by management/communication lead
		Assist with Visitor Screening as directed by management
		Assist with posting signage to identify outbreak, cohort area, and limiting staff movement
		Assist with cleaning/disinfecting high touch items in other areas as directed by management
		Complete daily inventory of PPE stock and ensure ordering as required
		Ensure that PPE order sheet is up to date and administration office/staff are aware of where it is located.
		Communicate any anticipated shortages of supplies with management as soon as possible.
		Be prepared to take on additional care tasks as needed/directed by management (i.e., staff screening)
		Finance: • Ensure any additional expenses are coded as directed by management
		Scheduler: • Work with management to ensure communication of any potential staffing vacancies as soon as possible, priorities for replacement, and expected staffing gaps. • Be prepared to assist in distribution of communication scripts to staff members.

Environmental Services/Housekeeping Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
ONGOING OUTBREAK MEASURES		
		Infection Prevention and Control Management: • Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		If cohort areas in place: • Staff to be specifically dedicated to cohort area ○ If unable to dedicate staff workflow should move from non-infected to infected residents ensuring adherence to Routine Practices and Additional Precautions. • Be prepared to assist with moving residents as needed to cohort area.
		Clean and disinfect all high touch surfaces in outbreak affected area(s) at least twice day. This includes: • High-touch surfaces (e.g., handrails, tap handles, faucets, door handles, soap dispensers, furniture, phones, computer keyboards etc.) • Care areas and communal areas such as dining/activity areas and lounges
		In consultation with management suspend tasks that can be delayed/ suspended (i.e., project cleaning, annual cleaning etc.)
		Priorities for laundry are reusable isolation gowns, cleaning supplies, and resident linen • Residents have a 7-day supply of clothing; - personal laundry can be deferred if needed to accommodate priority wash items
		Continue to use Routine Practices for dietary, laundry, and waste management; no special precautions are required. Direction may change based on the pandemic organism.
		Be prepared to take on additional care tasks as needed/directed by management

Infection Prevention and Control (Site and/or SDO) Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
IDENTIFICATION AND CONFIRMATION OF OUTBREAK		
		Determine if pandemic-associated outbreak is present: • Review data being reported to determine if there is a potential outbreak. • If clinical findings indicate the outbreak definition has been met, review information to confirm outbreak status as per SDO process.
ONCE OUTBREAK DECLARED		
		Obtain an outbreak code from Cadham Provincial Laboratory (CPL) as per established SDO processes. ○ Cadham Lab # (204)945-7473 or # (204)945-7311
		Ensure appropriate IP&C measures are implemented in a timely manner.
		Notify, in collaboration with manager, all appropriate stakeholders and departments there is a pandemic-associated outbreak; include all pertinent information.
		Determine the number of specimens to be performed.
		Refer to the Respiratory Illness and Gastrointestinal Illness Outbreak Management Guidelines.
		Site and SDO IP&C to communicate daily during outbreak.
		Direct outbreak control strategies appropriate to the type and scope of outbreak.
		Provide guidance on contact tracing as required.
		ICSA notify MHSC of the outbreak by completing an outbreak summary using the Canadian Network for Public Health Intelligence (CNPHI) reporting system.
		Ensure increased auditing, as required, for hand hygiene, PPE use and equipment cleaning and disinfection in collaboration with site leadership.
		Ensure outbreak control strategies are maintained until the outbreak is declared over and appropriate cleaning and disinfection of pandemic-associated outbreak area has occurred, following outlined SDO processes.

		Escalate IP&C risk issues for awareness and collaborative problem solving.
		Report as required by legislation and regional policies. Report deaths per Public Health Act, Reporting of Diseases & Conditions Regulation.
		Site Visit(s) During Outbreak: • ICSA to communicate daily with SDO IP&C. If questions/concerns or request from site, SDO IC&P to visit site. • Further site visits assessed on an as needed basis.
		Redeployment of SDO IP&C to pandemic-associated outbreak site may be needed: • If ICSA is redeployed or absent for extended period, • If outbreak is not controlled, • If deemed appropriate by SDO IP&C program, or • On as needed basis in consultation with OMT.
OUTBREAK TERMINATION		
		Declare outbreak as per SDO process.
		Notify site/manager of outbreak termination.
		Complete outbreak evaluation tool and share with manager.
		Receive collated site outbreak evaluation information from manager.
		Complete and finalize CNPHI Report.
		Complete and submit Outbreak Summary Report Template to OMT.

Pharmacy Pandemic-Associated Outbreak Task Sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
ONCE OUTBREAK DECLARED		
		Notify the PCH pharmacist about the outbreak and include: • Confirmed or suspected organism. • Location of cases (e.g., unit, building.). • Number of resident cases and symptoms.
		Medication Orders: • Confirm applicable medications have been initiated for resident cases (E.g., Regional LTC COVID-19 medication orders for Influenza, oseltamivir treatment) • Follow-up with the prescriber before the end of the medication treatment course for applicable medications.
		Wardstock/Stat Box: • Discuss with the pharmacist medications that may require temporary addition to the PCH stat box during the pandemic-associated outbreak with approval from the PCH Pharmacy Manager (E.g., For COVID-19, dexamethasone 2 mg x 10 tabs; dexamethasone 4 mg x 10 tabs; dalteparin 5,000 units pre-filled syringes x 10; site-specific: dexamethasone 4 mg/mL (5 mL vials) x 3) • Discuss with the pharmacist the wardstock/stat box medications expected to have increased use during the pandemic-associated outbreak, check quantities and reorder at the start of the pandemic-associated outbreak. • Identify a dedicated PCH individual to do daily monitoring of the medications expected to have increased use during the pandemic-associated outbreak.
		Medication Deliveries: • Reassess the frequency of medication deliveries and transportation system (e.g., front reception versus at the resident units) • Reassess the location for medication deliveries.
		Communication: • Establish a communication plan between the pharmacist and the PCH prioritizing a detailed review of preparations on Thursdays for the weekend.

		• Pharmacist participates in the PCH Incident Command meetings as required/available. • Establish a process where the pharmacist is notified about new resident cases when deemed necessary. • If resident cohorting is occurring, review with nursing a plan to update pharmacy on changes to room numbers.
		Medication Streamlining: • Pharmacist connects with the prescriber to review opportunities for streamlining medications with a focus on decreasing medication pass times.
		Pharmacy Onsite PCH Visits: • Pharmacist to provide a list of scheduled onsite PCH visits.
		Quarterly medication reviews (QMRs): • QMRs should proceed as scheduled. • Pharmacist and PCH to discuss if QMRs can be conducted onsite or completed virtually with consideration given to: ○ Where is the pandemic-associated outbreak? ○ How many cases? ○ Where are the QMRs conducted? A location outside the outbreak resident units is recommended. ○ Can virtual QMRs be supported? ○ Is nursing available to participate? QMRs can proceed with only prescriber and pharmacist if nursing resources are short.
		Medication room audits: • Pharmacist and PCH to discuss scheduled medication room audits during the outbreak with consideration given to: ○ Should the medication room audits be postponed until the outbreak is resolved? ○ Do all the medication room audits need to be postponed or just the affected unit(s)? ○ When can medication room audits be rescheduled? ○ Can nursing perform a medication room audit in the interim to remove any expired products? ○ Implications for Manitoba Health PCH Standards?
		Pharmacy and Therapeutics (P&T)/Medical Advisory Council (MAC) Meetings: • PCH to consider scheduled P&T/MAC meetings with consideration given to: ○ Can the meeting proceed in a space outside the resident units?

		○ Should the meeting be postponed until the PCH outbreak is resolved? ○ Can the meeting be held virtually (e.g., Zoom, Microsoft Teams)? ○ Implications for Manitoba Health PCH Standards.
		Pharmacy education in-services: • PCH to consider pharmacy education in-services with consideration given to: ○ Can the in-service proceed in a space outside the resident units? ○ Should the in-service be postponed until the PCH outbreak is resolved? ○ Can the in-service be held virtually? (e.g., Zoom, Microsoft Teams)

Communications Lead Pandemic-Associated Outbreak Task sheet		
Ensure case(s) have been reviewed with the SDO IC&P/designate to **confirm** the outbreak case definition has been met and to declare a pandemic-related outbreak.		
Date/Time	Initial	Task
ONCE OUTBREAK DECLARED		
		Identify a communication lead to communicate with families (this may be more than one person/one person assigned to multiple residents).
		Direct general family inquiries first to the communication lead. The communication lead will seek out additional individuals to communicate with families as needed.
		Ideally, clinical staff should be contacting infected resident's/families proactively and regularly. If this is not possible, work with management/ nursing staff to help with this communication, such as updates from nursing staff on individuals' well-being. Ensure participation in nursing shift report to assist in this communication with families.
		Determine the process for how the communication lead designate will proactively provide updates to families, including: • When & how often they will be contacted (i.e., once per week on Mondays between 3 to 5). • How they will be contacted (phone, email, etc.). • What information they will receive.
		Determine the process for how family members can contact the communication lead/designate for updates: • When the designate is available (i.e., Tuesdays from 3-5 p.m.). • How they can be contacted (phone, email, etc.). • What information they can provide.
		Identify an administrative staff member to provide regular updates on the facility, current public health orders, and any other site-wide information.
		Determine the process for providing site-wide updates: • When & how often they will be provided (i.e., once per week on Mondays at 5 p.m.). • How they will be provided (email, website, virtual town hall, etc.). • What information will be provided.
		Develop key messages regarding communication with families.

		Provide communication scripts with key messages to administration staff to assist in handling calls from family members looking for updates.
		Update website with details of communications processes.
		Contact families to inform them of communications processes.

Appendix A - RACI Matrix

R- Responsible (Do the work or assign the work to get the task completed) **A** - Accountable (Ultimate answerable for the task being completed) **C** - Consulted (Their opinions are sought) **I** - Informed (They are kept up to date on the progress)	**PCH Site Leadership (Operator / Executive Director/CEO/Site Manager)**	**SDO CEO/ Regional Lead**	**Provincial PCH Liaison**	**Operations Chief, Pandemic Unified Incident Management**	**Planning, Community and Continuing Care Director**	**Communications**		**Infection Prevention & Control**			**Human Resources**		
Pandemic-associated Outbreak Preparation During Pandemic-associated Outbreak						**Shared Health Lead**	**SDO**	**Prov.**	**SDO**	**Site**	**PRRT**	**SDO**	**Site**
Implementation of Pandemic Plan													
Sets strategic direction for the province and for PCHs regarding specific actions required relevant to the disease.		I	I/C	R/A	C	C		C					
Development of strategic guidelines and directives for the PCH sector.	C/I	C/I	C	C	R/A	C		C			I		
Identifies pandemic response implementation and communication strategy for all SDO, owned, operated and its service partners (licensed affiliated and private PCH Operators).	C/I	R/A	C		I				I/C		I		
Coordinates the pandemic response implementation strategy for SDO owned, operated and its service partners (licensed affiliate and private PCH Operators).	C/I	R/A	C		I				I/C				
Reviews infection prevention and control direction, disease- specific actions required and strategic guidelines with SDOs.		I	I		C			R/A	C				
Reviews direction and disease-specific actions required with PCHs.	I	R/A	I						R/C	I			
Reviews direction and disease- specific actions required with First Nations PCHs.			R/A	I									
Operationalizes and implements the strategic guidelines as identified by Unified Incident Command, including any disease-specific actions required.	R/A	I	I							C			

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Pandemic-associated Outbreak Preparation						**Shared Health Lead**	**SDO**	**Prov.**	**SDO**	**Site**	**PRRT**	**SDO**	**Site**
During Pandemic-associated Outbreak													
Development and formatting of strategic and/or templated operational documents for use across SDOs.	I/C	I/C	C	R/A	C	R/A		C	I				
Supports the development of operational documents for use across an SDO.	C/I	R/A	C/I				R/C		I/C	I			
Distributes provincial documentation to SDOs.			I/C	R/A	R/A	R							
Distributes provincial documentation to PCHs.		R/A	I/C										
Distributes provincial documentation to First Nations PCHs.			R/A	I									
Identifies site individuals responsible for implementing key tasks as outlined in the pandemic plan. Tasks may be specific to key areas, such as contact tracing, communication, human resources, supply management. Establishing priorities and reassigning duties may be required.	R/A	I	I							I	I		
Develops a site communication strategy in relation to a pandemic response to inform staff, clients, family and public. This may include identifying and assigning this task to an individual.	R/A	I	I				I						
Communicates and provides information to PCH Staff and Families.	R	A	I										
Communication of provincial Visitation principles for visitors and designated family caregivers.	R	A	I										

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Pandemic-associated Outbreak Preparation During Pandemic-associated Outbreak						**Shared Health Lead**	**SDO**	**Prov.**	**SDO**	**Site**	**PRRT**	**SDO**	**Site**
Proactively identifies needs/issues and develops provincial level strategies to manage human resources, resident care, supply/resources, education and training, and infection prevention and control.	I	I	I/C	R/A/C	R/A/C			C			C		
Identify provincial level risks associated with pandemic response.	I	I	I/C	R/A/C	R/A/C			C			C		
Proactively identifies needs/issues and develops regional level strategies to manage human resources, resident care, supply/resources, education and training, and infection prevention and control.	I/C	R/A	I/C	I	I/C				C		I	C	
Identify regional level risks associated with pandemic response.	I	R/A	I/C	I	I/C				C		I	C	
Proactively identifies needs/issues and develops site level strategies to manage human resources, resident care, supply/resources, education and training, and infection prevention and control.	R/A	I/C	I/C	I						C			C
Identifies site level risks associated with pandemic response.	R/A	I	I	I					I	C			C
Identifies and reviews site level triggers which would require escalation.	R	A/C	I/C							C			
Completes required site level pandemic plan audits and acts on results.	R/A	A/I	I/C	I					I/C	I/C			
Monitors audit results and actions.	R/A	I	I/C	I						R			
Develops tasks sheets for all clinical and non-clinical departments to guide the day-to-day workflow in an outbreak (See examples).	R/A	I	I/C										
Provides pandemic response training to all staff and volunteers at the site.	R/A	I	I/C							I/C	I		

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Pandemic-associated Outbreak Preparation During Pandemic-associated Outbreak						**Shared Health Lead**	**SDO**	**Prov.**	**SDO**	**Site**	**PRRT**	**SDO**	**Site**
Establishes site-based mechanisms to review and inform implementation of IP&C measures. (e.g., Audit)	A	I	I						I	R			
Completes IP&C audits.	R/A	I/C							I	I/C			
Identifies and provides recommendations for IP&C risks.	A	I	I						C	R			
Monitors residents' health status and reports atypical changes.	R/A	I	I						I	I/C			
Establishes physician coverage for PCHS in collaboration with SDO and PCH Medical Directors.	I/C	R/A	I	I									
At a provincial level, identifies service priorities and what services can be reduced.		C	I/C	R/A	R/A						C/I		
At a regional level, identifies services or portions of service that can be reduced.	I/C	R/A	I	I	I						I	C/I	
At a site level, identifies services or portions of service that can be reduced, including identification of critical and nonessential services based on resident's health and functional status.	R/A	I/C	I/C	I/C	I/C						I	C/I	R
Action staffing shifts at the site based on the priorities identified provincially, regionally and at the site level.	R/A	I	I/C	I								I	R
Identifies regional staff impacted by service reductions including classification, skill set, EFT available for redeployment.		R/A									I	C	
Identifies site staff impacted by service reductions including classification, skill set, EFT available for redeployment.	R/A	I	I/C								I		R

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Pandemic-associated Outbreak Preparation During Pandemic-associated Outbreak						**Shared Health Lead**	**SDO**	**Prov.**	**SDO**	**Site**	**PRRT**	**SDO**	**Site**
Coordinates the assignment of redeployed staff from a provincial perspective.		C	C	C	C/I						R		
Coordinates the assignment of redeployed staff from a regional perspective.											R	R	
Assist with coordination of redeployed staff - as a sending site.	R/A	I	I/C								R		R
Tracks expenses related to pandemic response (e.g., staffing, overtime, equipment, supplies).	R/A/I	R/A/I	I										
Identification and communication of a positive case(s).	R/A	I	I	I					I	I/C			
Declaration of an outbreak, in consultation with IP&C / Designate.	I/C	I	I					I	R/A	C			
Implements Site Level Incident Command Meetings. Meeting frequency is determined by severity of outbreak; recommended daily.	R/A	I/A	I	I					I	C			
Implements Regional Level Incident Command Meetings. Meeting frequency is determined by severity of outbreak; recommended daily.		R/A	I	I	I			I	C				
Uses approved provincial scripts to communicate with staff and families.	R/A	I	I	I							I	I	R
Measures and monitors identified site level triggers.	R/A	I/C/A	I/C	I						I			
Ensure and implement plans to meet client care needs during outbreak.	R/A	I	I/C	I									
Implements site level strategies to address any identified issues.	R/A	I	I/C										
Assist with coordination of redeployed staff - as a receiving site.	R/A	I/C	I/C	I							R		

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Pandemic-associated Outbreak Preparation						**Shared Health Lead**	**SDO**	**Prov.**	**SDO**	**Site**	**PRRT**	**SDO**	**Site**
During Pandemic-associated Outbreak													
Orientation and training of staff redeployed to the site.	A	A									I	R	R
Maintenance of time sheet for staff redeployed to the site, including submitting time sheet as per processes to ensure payment.	A											I	R/A
Manages case contacts and outbreak.	A	I	I/C	I					R	R			
Monitors residents' health status and reports atypical changes.	R/A								I/C	I			
Identifies and provides recommendations for IP&C risks.	A	I/A	I/C						R/C	R			
Continually review of critical and nonessential services based on resident's health and functional status.	R/A	I/A	I	I						I			
Escalation During an Outbreak													
HR issues identified.	R/A	C/I	C/I	I							I	I	R
Site level strategies to address HR issues implemented.	R/A	I/A	I									I	R
Regional level strategies to address HR issues implemented.	I/C	R/A	I	I	I						I	R	C
Provincial level strategies to address HR issues implemented.	I	I/C	I/C	R/A	R/A						R	C	C
Resident Care issues identified.	R/A	C/I	C/I	I									
Site level strategies to address Resident Care issues implemented.	R/A	I/A	I/C										
Regional level strategies to address Resident Care issues implemented.	I/C	R/A	I										
Provincial level strategies to address Resident Care issues implemented.	I	I/C	I/C	R/A	R/A								

R- Responsible (Do the work or assign the work to get the task completed) **A** - Accountable (Ultimate answerable for the task being completed) **C** - Consulted (Their opinions are sought) **I** - Informed (They are kept up to date on the progress)	**PCH Site Leadership (Operator / Executive Director/CEO/Site Manager)**	**SDO CEO/ Regional Lead**	**Provincial PCH Liaison**	**Operations Chief, Pandemic Unified Incident Management**	**Planning, Community and Continuing Care Director**	**Communications**		**Infection Prevention & Control**			**Human Resources**		
Pandemic-associated Outbreak Preparation						**Shared Health Lead**	**SDO**	**Prov.**	**SDO**	**Site**	**PRRT**	**SDO**	**Site**
During Pandemic-associated Outbreak													
Supply and resource issues identified.	R/A	C/I/A	C/I	I									
Site level strategies to address Supply and Resource issues implemented.	R/A	I/A	I/C										
Regional Level Strategies to address Supply and Resource issues implemented.	I/C	R/A	I										
Provincial Level Strategies to address Supply and Resource issues implemented.	I	I/C	I/C	R/A	R/A								
IP&C issues identified.	A	C/I	C/I	I				I/C	I/C	R			
Site level strategies to address IP&C issues implemented.	A	I/A	I/C						I/C	R			
Regional level strategies to address IP&C issues implemented.	I/C	R/A	I						R	I/C			
Provincial level strategies to address IP&C issues implemented.	I	I/C	I/C	R/A	R/A			R	C	I			
Financial issues identified.	R/A	C/I/A	C/I	I									
Site level strategies to address financial issues implemented.	R/A	I/C/A	I										
Regional level strategies to address financial issues implemented.	I/C	R/A/C	I										
Provincial level strategies to address financial issues implemented.	I/C	I/C	C/I	R/A	R/A								

Appendix B – Links

Canadian Medical Association Physician Wellness Hub	https://www.cma.ca/physician-wellness-hub/wellness-connection
COVID-19 Doffing	https://www.youtube.com/embed/p4ulnM6Ua7c?wmode=transparent&hd=0&autoplay=0&controls=1&fs=1&autohide=2&theme=dark&rel=0&showinfo=1&iv_load_policy=3
COVID-19 Donning	https://www.youtube.com/embed/KeNlxl6hm3Q?wmode=transparent&hd=0&autoplay=0&controls=1&fs=1&autohide=2&theme=dark&rel=0&showinfo=1&iv_load_policy=3
Incident Command Structure - Organizational	https://sharedhealthmb.ca/wp-content/uploads/sdo-and-site-stanadard-org-structure.pdf
Incident Command Structure – PCH	https://sharedhealthmb.ca/wp-content/uploads/pch-and-other-org-structure.pdf
Incident Command Structure - Provincial	https://sharedhealthmb.ca/wp-content/uploads/provincial-ics-structure.pdf
IP&C Outbreak Evaluation Tool	https://healthproviders.sharedhealthmb.ca/files/ipc-outbreak-management-ltc-evaluation.pdf
IP&C Outbreak Management Guidelines - Respiratory (including Influenza and COVID-19) and Gastrointestinal	https://healthproviders.sharedhealthmb.ca/files/outbreak-management-guidelines-resp-and-gi.pdf
IP&C Shared Health website	https://healthproviders.sharedhealthmb.ca/services/ipc/#outbreaks
LTC and PCH Shared Health website	https://sharedhealthmb.ca/covid19/providers/ltc-and-pch-resources/
LTC COVID-19 Goals of Care Conversations	https://www.youtube.com/watch?v=-3LfeaJWS8A
Outbreak Management Team Meeting Template	https://healthproviders.sharedhealthmb.ca/files/outbreak-management-team-meeting-template.pdf
Position Budget Request Form	https://wrhasp.manitoba-ehealth.ca/dlc/c19prrt/_layouts/15/AccessDenied.aspx?Source=https%3A%2F%2Fwrhasp%2Emanitoba%2Dehealth%2Eca%2Fdlc%2Fc19prrt%2FShared%20Documents%2FTemplates%20and%20Forms%2FPosition%20Budget%20Request%20%2D%20COVID%20Casual%20Pool%2Exls&Type=item&name=32fcf214%2D15f2%2D4a24%2Da726%2Dc7ae318371e9&listItemId=82
Provincial COVID-19 resources for health-care providers and staff	https://sharedhealthmb.ca/covid19/providers/
Public Health Agency of Canada - Canadian Pandemic Influenza Preparedness: Planning Guidance for the Health Sector	https://www.canada.ca/en/public-health/services/flu-influenza/canadian-pandemic-influenza-preparedness-planning-guidance-health-sector.html
Resource Support Request Form	https://sharedhealthmb.ca/files/covid-19-resource-request-form.xlsx
Routine Practices Protocol	https://healthproviders.sharedhealthmb.ca/files/routine-practices-protocol.pdf
Shared Health Ethics Framework	https://sharedhealthmb.ca/files/covid-19-shared-health-ethics-framework.pdf
Shared Health Executive	https://sharedhealthmb.ca/about/organizational-structure/executive/
Staff Eligible for Redeployment Spreadsheet	https://sharedhealthmb.ca/files/covid-19-staff-eligible-for-redeployment.xlsx

Appendix C - Example of a Pandemic-Associated Outbreak Standing Orders

Pandemic-Associated Standing Orders

Confirmed Medication Standing Orders:

- There is an existing medication standing order set for PCH residents who are confirmed to be positive. This is intended to support clinical judgement.
- Most residents will not require antibiotics for bacterial co-infection.
- VTE prophylaxis should be considered for residents with any decrease in ambulation. If VTE prophylaxis is not in keeping with goals of care, the same should be indicated on the order form.

Medication Orders:

- There is an existing LTC Medications Order Form for PCH residents who are confirmed to be positive. This is intended to support clinical judgement.
- For Influenza, oseltamivir prophylaxis orders are included in the PCH Medication Standing Orders
- For other outbreaks, prescribers, pharmacists, and IP&C should be consulted to determine treatment recommendations

Supplemental O2:

- O2 therapy is not on the Standing Orders. Instead, it is on the PCH Medication Standing Orders stating oxygen should be titrated to “O2 sat greater than 90% or their normal baseline”.
- Oxygen is provided using concentrators. There are limits to the flow of oxygen that can be sustained at the PCH (5L/min). Oxygen by non-rebreather requires flows of 10 – 15 L/min, which cannot be provided using a concentrator.
- If oxygen at higher flow rates may provide clinical benefit and a transfer to acute care is in keeping with the goals of care, this may need to be discussed with the resident and/or substitute decision maker and then the hospitalist or provincial ICU consultant.

IV and subcutaneous fluid for treatment of dehydration:

Note: IV therapy is not a standard part of PCH care in the absence of an outbreak.

- During an outbreak, staffing levels are adjusted based on the needs at the time. Redeployed staff may be able to establish IV and/or support the use of subcutaneous access.
- There are no pumps being used in PCH. Staff is educated to convert infusion rates into gravity fed drops/minute. The use of gravity fed intravenous fluid increases the risk of a large volume of fluid being accidentally administered if it is not closely supervised. Prescribers should inquire about the presence of staff competent in parenteral fluid and medication administration if considering orders and order fluid infusions as small volume boluses.
- More intensive IV or subcutaneous fluid can be provided in hospital. If there might be clinical benefit and transfer to acute care is in keeping with the goals of care, this would need to be discussed with the resident and/or the substitute decision maker and then the hospitalist or provincial ICU consultant.

Protected Code Blue PCH: There is an updated document that outlines the procedure for a Protected Code Blue in a PCH.

Cohorting guideline: If multiple residents in a PCH are found to be positive you may be involved in decisions about room changes, otherwise known as cohorting. There is a detailed document that summarizes specific considerations relevant during these discussions.

IP&C discontinuation of precautions: Physicians and nurse practitioners should not be asked to discontinue additional precautions, even when swabs come back negative for PCH residents. This is done in collaboration with IP&C.

Medication streamlining: Deprescribing should be an ongoing focus for prescribers, pharmacists, and nurses as a proactive measure for pandemics-associated outbreaks. When safe for residents, decreases in medication frequency to twice daily will decrease nursing time and PPE use.

Death of a suspect/confirmed PCH Resident:

- PCH staff should report deaths by fax.
- The Office of the Chief Medical Examiner (OCME) has jurisdiction over all deaths in an outbreak therefore the Practitioner of Record **DOES NOT need to sign the death certificate**. Please send the original death certificate to the OCME by mail for completion by the Medical Examiner.
- All deaths from a respiratory or febrile illness must have a nasopharyngeal swab taken. **If this has not been completed insure a post-mortem Nasopharyngeal swab is taken.**

Education: There are a total of 8 locally produced presentations, that have been archived in several formats, specific to practicing in the PCH setting during the COVID-19 pandemic. The most recent is an update on medical care of PCH residents with COVID-19 https://www.cpd-umanitoba.com/covid-19-resources/ (on the bottom right of page).

- Seven of these are accredited to be reviewed by registering through the U of M CPD: https://www.cpd-umanitoba.com/online-learning/. PDFs for the seven presentations are available by going to this same link. Seven of the presentations can be viewed on YouTube.
    - Clinical Frailty Scale
    - Goals of Care
    - Symptom Management
    - Chronic care of residents residing in PCHs
    - Delirium in the PCH during COVID-19
    - Mental health and BPSD
    - What to expect during COVID-19 outbreak in PCH

Physician Wellness: Providing care to residents living in a PCH during a pandemic-associated outbreak is an intense experience. Resident needs can increase quickly and unpredictably. Strains associated with this important work can be on top of the existing challenges the pandemic has presented. There are SDO and/or provincial peer support resources. Contact the PCH/LTC Site Medical Lead or PCH/LTC SDO Medical Lead for further information. In addition, please consider accessing these resources from Doctors Manitoba and the CMA:

- Physician and Family Support Program:
    - Accessible 24/7 at 1-844-436-2762 (register using DOCSMB as company ID). For all Doctors Manitoba members and anyone living in their household.
    - Masters prepared counsellors are available for counselling in person, by telephone or video, and referrals to other services as needed.
- Physician Wellness Hub: https://www.cma.ca/physician-health-and-wellness/wellness-connection