REIMAGINING CARE FOR OLDER ADULTS

Next Steps in COVID-19 Response in Long-Term Care and Retirement Homes

What We Heard

July 2020

Canadian Foundation for Healthcare Improvement
Fondation canadienne pour l'amélioration des services de santé

cpsi icsp
Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

About the Canadian Foundation for Healthcare Improvement

The Canadian Foundation for Healthcare Improvement (CFHI) works shoulder-to-shoulder with partners to accelerate the identification, spread and scale of proven healthcare innovations. Together, we're delivering lasting improvement in patient experience, work life of healthcare providers, value for money and the health of everyone in Canada.

Canadian Foundation for Healthcare Improvement
150 Kent Street, Suite 200
Ottawa, ON K1P 0E4

General Inquiries: info@cfhi-fcass.ca | (613) 728-2238

About the Canadian Patient Safety Institute

Established by Health Canada in 2003, the Canadian Patient Safety Institute (CPSI) works with governments, health organizations, leaders, and healthcare providers to inspire extraordinary improvement in patient safety and quality.

Canadian Patient Safety Institute
102A Tower, 10025 102A Ave NW #1400,
Edmonton, AB T5J 2Z2

General Inquiries: info@cpsi-icsp.ca | (780) 409-8090

Disclaimer

Because of its limitations, this Discussion Paper should not be used as the sole source of information when assessing the requirements for change in Long-Term Care (LTC) and Retirement Homes. This Discussion Paper should be read and considered as a part of a more comprehensive review of the LTC and Retirement Home landscape in addressing the challenges posed by COVID-19.

Unless explicitly indicated otherwise, all opinions expressed in this report are the opinions of the interviewee(s) and may not reflect the beliefs or opinions of the CFHI or the CPSI.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

About 8 in 10 COVID-19-related deaths in Canada are in long-term care (LTC), double the OECD average.[1] By July 7, 2020, the National Institute of Ageing reported more than 18,000 cases and 6,851 deaths among residents of long-term care (LTC) and retirement homes (RH) in Canada, as well as almost 10,000 staff cases and 16 deaths; however the majority of deaths have been in LTC.[2] Reports in the press, by the Canadian Armed Forces and elsewhere have highlighted the pandemic's devastating effects in some homes.

This report focuses on steps we can take now to ensure that settings that care for older adults are better prepared for future waves of the pandemic, potentially coinciding with seasonal influenza. It is intended for front-line teams, policy-makers, and others who are spending long hours managing tough situations now, while also trying to look ahead.

What Happened Between March and May in Long-term Care and Retirement Homes in Canada

The first questions we asked interviewees were about contributing factors to COVID-19 outbreaks: What happened and why? What are the key issues that need to be addressed in the next 3-6 months?

They noted that the COVID-19 pandemic has surfaced long-standing systemic vulnerabilities in LTC homes. Examples include chronic under-resourcing, rising needs of residents, infrastructure/facility risks, staffing challenges, underlying demographics, high numbers of people coming into homes, insufficient infection prevention and control training and practice, and uneven clinical leadership. Some but not all of these issues also apply to other settings such as retirement homes where older adults live communally. Interviewees noted that these challenges did not develop in weeks or months and will not all be solved quickly.

Many also told us that:

- Initial pandemic preparations focused on acute care hospitals.
- Personal protective equipment and infection prevention and control expertise was not shared across the health system early in the pandemic.
- A regional focus helped to coordinate resource allocation and pandemic response.
- Reporting and testing have been uneven across the country.
- LTC homes that were overwhelmed seem to follow a consistent pattern to reach a tipping point.
- Homes in full outbreak require a major team response.

APPROACH

This report is primarily based on more than 40 interviews with family partners in care and health system leaders across Canada, undertaken mostly over a three-week period in late May and early June, 2020. Where possible, we have also reflected up-to-date data, published reports and expert commentaries. We are respectful that the insights reflected in this report come from very difficult learned experiences this spring and deeply appreciate the generosity of those who shared them with us.

The interviews focused on:

- Contributing factors to COVID-19 outbreaks in LTC and other places where older adults live in congregate settings
- Promising practices with the potential for short-term spread and scale
- Maintaining essential non-COVID-19 care for older adults through 2020 and beyond.

The interviews were designed to represent a range of perspectives but those we spoke with were invited to contribute their personal thoughts and expertise, not to represent specific organizations or communities. They were intended to provide rapid feedback to suggest directions for further exploration, rather than to produce definitive conclusions and so should not be the sole source of information when assessing opportunities for improvement in this sector.

Promising Practices and Policy Options

Hard-won lessons from LTC homes that experienced outbreaks – alongside lessons learned in Canada and internationally from those less affected in the first wave of the pandemic – point to a range of promising practices that have the potential to offer significant value in the short-term. Based on what we heard, there are six main types of practices that could reduce the risk of another wave of outbreaks or mitigate its effects.* They can be translated into a series of questions to ask when assessing preparedness and response:

1. PREPARATION:

- Have LTC homes updated implementation of Infection Prevention and Control (IPAC) standards and training?
- Have homes met with regional partners to co-design response plans for different outbreak scenarios (e.g. using tabletop simulations)?
- Have homes and/or others secured Personal Protective Equipment (PPE) supply and management arrangements?
- Are third-party assessment and guidance to ensure adherence to IPAC protocols being leveraged?

2. PREVENTION:

- Are homes regularly and systematically testing, even those without symptoms? Do homes have rigorous contact tracing protocols in place?
- Have homes implemented universal masking and other IPAC precautions?
- Have homes worked with partners to optimize care models, to reduce the number of outside care providers coming into the home and to manage how often residents need to leave for care (e.g. using virtual care, strong primary care, and on-site services where appropriate)?
- Are approaches in place (e.g. via intensive home and community care supports) to reduce the number of people who are waiting in hospital for other types of care and/or who need long-term care?

3. PEOPLE IN THE WORKFORCE:

- Have homes stabilized and reinforced staffing, as well as working conditions and psychological health and safety?
- Are staff limited to working in only 1 higher risk environment and are supports in place to make this possible?
- Are there plans to increase capacity through training and recruitment as required?
- Are the community-transmission risks that staff and their families may face understood and mitigated where possible?

4. PANDEMIC RESPONSE AND SURGE CAPACITY:

- Do homes have formal, clear, and well-communicated plans of where they will turn for assistance if there is an outbreak?
- Is there a pre-agreed plan for surge support for every home if needed that will ensure a robust response?
- Are surveillance methods in place (e.g. data/dashboards) to proactively identify where surge capacity may be needed?
- How will homes reduce the risk of cross-infection in the case of an outbreak involving residents (e.g. testing before cohorting residents who are or are not infected)?

* While our focus is on actions specific to the care of older adults, homes were more likely to have outbreaks if more cases were circulating in the community. The effectiveness of broader pandemic response matters greatly. For instance, we heard about communities with managed entry who provided hotels and food to help people entering the community to self-isolate. Likewise, broad-based public health messaging, testing, and contact tracing can reduce the risk of infection among staff.

5. PLAN FOR COVID-19 AND NON-COVID-19 CARE

- Have homes stabilized clinical leadership (e.g. medical director) and ensured back-up?
- Do all residents have access to high quality primary health care that does not require them to leave the home during an outbreak?
- Have arrangements for access to needed specialty care been put in place?
- Do all residents have up-to-date, person-centred, integrated care plans in place?
- Have palliative approaches to care been embedded in the home's processes and culture?

6. PRESENCE OF FAMILY

- Do homes recognize and support family caregivers as essential partners in care?
- Have policies regarding family presence been revisited with resident/family representatives at the table?
- Have harm reduction approaches been considered to support family presence (in-person and/or virtually) and are appropriate infrastructure, supplies, and policies in place?
- If family caregivers are not permitted in the home, what are the alternate plans for ensuring that the care and services (e.g. assistance with eating, translation) that they normally provide are not compromised?

These questions and the observations that follow are presented to Canadian stakeholders in an effort to spread and scale promising practices as we prepare for potential future waves of the pandemic. They are intended to complement work being undertaken by others regarding broader policy and system change.

APPROACH AND METHOD

A British Columbia (BC) man in his 80s was the first Canadian to die in early March.[3] Since then, about 8 in 10 COVID-related deaths in Canada have been in LTC homes, the highest rate among countries studied by the International Long-Term Care Policy Network.[4] A recent report by the Canadian Institute for Health Information (CIHI) published in June 2020 has also identified Canada as having the highest death rate in LTC compared to OECD countries.[5] While most long-term care and retirement homes† have not had an outbreak, reports in the press and from the Canadian Armed Forces[6] have highlighted the pandemic's particularly devastating impact in some LTC homes.

TABLE 1: National Institute of Ageing Long-Term Care COVID-19 Tracker, developed in a partnership between the National Institute of Ageing at Ryerson University, Empower Health, and the NIA Long-Term Care COVID-19 Tracker Open Data Working Group (as of July 7, 2020).[7]

Jurisdiction	Total cases	Total deaths	Total homes	Total affected	% of homes affected	Resident Cases	Staff cases	% of all cases	Resident deaths	Staff deaths	% of all deaths
Alberta	7,851	154	350	58	17%	558	304	11%	117	0	76%
British Columbia	2,869	173	392	39	10%	320	184	18%	97	0	76%
Manitoba	316	7	261	5	2%	4	2	2%	2	0	56%
New Brunswick	165	2	468	2	0%	16	10	16%	2	0	29%
Newfoundland & Labrador	261	3	125	1	1%	1	0	0%	0	0	0%
Northwest Territories	5	0	9	0	0%	0	0	0%	0	0	0%
Nova Scotia	1,061	63	134	13	10%	265	123	37%	57	0	90%
Nunavut	0	0	0	0	0%	0	0	0%	0	0	0
Ontario	35,920	2,689	1,396	436	31%	6,576	3,275	27%	2,052	8	76%
Prince Edward Island	27	0	39	0	0%	0	0	0%	0	0	0%
Quebec	55,079	5,448	2,215	568	26%	10,275	6,079	30%	4,455	8	82%
Saskatchewan	759	13	402	3	1%	4	4	1%	2	0	15%
Yukon	11	0	5	0	0%	0	0	0%	0	0	0%
CANADA	104,337	8,552	5,801	1,125	19%	18,019	9,981	27%	6,784	16	79%

† Across Canada, a variety of facilities provide long-term accommodation for people who require on-site support, including health and personal care services. What these facilities are called (e.g. long-term care, nursing homes, residential care, continuing care, and retirement homes), the level and type of care offered, and how facilities are owned and governed varies. For the purposes of this report, we have generally used the umbrella term "home" to describe this range of settings as a key characteristic they share is that they are residents' homes. That said, there are important differences in experiences to date during the pandemic, both across the country and for different types of care.

This report focuses on steps we can take now to ensure that we are better prepared for a potential future wave of the pandemic. Or, stated differently: What can we learn from the first wave, including where Canadian health systems and long-term care operators got things right and how do we spread and scale promising practices quickly across the country? It neither is – nor is it intended to be – a full review of the sector's response.

Over a three-week period in late May and early June, the Canadian Foundation for Healthcare Improvement (CFHI) reviewed data and conducted over 40 interviews with family partners in care and health system leaders[‡] to understand issues related to pandemic response in congregate settings where approximately seven percent of older Canadians live.[§] These rapid interviews were leveraged to identify and share promising practices, with a view to the potential for spreading and scaling key practices across jurisdictions.

The interviews focused on three areas (See Appendix 2 for the Interview Guide):

1. Contributing factors to current outbreaks: What happened and why? What are the key issues that need to be addressed in the next 3-6 months?
2. Promising practices in response to the COVID-19 pandemic.
3. Organizing non-COVID care for older adults through 2020 (and beyond).

These interviews were designed to be representative not representational. They were intended to provide rapid feedback for operators, other practitioners and policy makers to suggest directions for further exploration, rather than to produce definitive conclusions. This rapid process has many limitations, including:

- Interviewees shared their lived experiences and personal perspectives related to a fast-evolving situation, including a range of facts and observations that it has not been possible to validate.
- Generalization from a relatively small sample of about 40 interviewees.
- Lightly covering a broad series of topics that will require deeper analysis.
- Addressing a rapidly evolving situation, where circumstances differ across the country, and by region, and are changing over time as new evidence emerges.

We also recognize that gaps in care for older adults with complex health and social needs have been well-documented for some time. There are reports from many provinces and territories outlining issues and how they might be addressed, including a list of 35 reports and recommendations compiled by the Registered Nurses of Ontario (RNAO) dating back 20 years.[8] While the pandemic magnified existing vulnerabilities in some cases, these challenges did not develop in weeks or months and will not all be solved in the short-term. Others have and will discuss in great detail in the coming months how we can correct those broader shortcomings and address the longer-term issues (e.g. C.D. Howe Institute, The Conference Board of Canada, Canadian Nurses Association, Estabrooks et al., Royal Society of Canada). We have not attempted to duplicate this important work in this report.

‡ The list of family partners and health system leaders who were interviewed is included in Appendix 1.

§ The list of interviewees and the interview guide are included as Appendix 1 and Appendix 2 respectively. Note: This report reflects a summary of what we heard from interviewees. While we circulated the draft report to interviewees for review, the summary should not be interpreted as representing the views of everyone individually.

WHAT HAPPENED IN MARCH TO MAY 2020 IN LTC AND RETIREMENT HOMES IN CANADA?

1) The pandemic has highlighted a number of long-standing vulnerabilities in LTC homes, according to interviewees.

Some, but not all, of these vulnerabilities apply to other congregate living settings for older adults. Examples include:

1. **Chronic under-resourcing**: For instance, staff working on multiple units within one home, inability to dedicate staff to COVID-19 units and Non-COVID-19 units, not enough housekeeping staff to enhance cleaning protocols, and lack of infection prevention and control expertise within many homes.
2. **Rising acuity of residents**: Residential care for older adults has slowly and gradually become a provider of more complex health services, especially a dominant and rising prevalence of comorbid dementia.
3. **Infrastructure/facility risks**: Over 80% of interviewees pointed to multi-bed rooms, poorly designed hallways, shared bathrooms (in some cases, this was reported as an issue for both residents and staff), lack of air conditioning, and similar infrastructure challenges as important aggravating factors in many "breakdown" situations, including the ability to properly isolate residents infected with COVID-19 in separate units within the homes. Recent research (June 2020) from the University of Toronto and McMaster University reports that structural considerations account for a portion of the difference in deaths between LTC and RH.
4. **Staffing challenges**: Many staff in this sector have relatively low pay and minimal benefits, which can contribute to high turnover and staffing shortages. Part-time work, often for multiple employers, has become the norm in many parts of the long-term care and home care sectors.
5. **Underlying demographics**: The majority of people working in this sector are women. Many are racialized and/or new to Canada. Crowded living conditions and income security, which may reflect a variety of systematic factors including racism, may also have played a role in the spread of COVID-19.
6. **High numbers of people coming into homes with limited infection control measures**: The number of health and social services care providers, suppliers, visitors, and others coming into homes on a daily basis was high pre-pandemic. Access was often not tracked in a way that supports contact tracing. Personal protective equipment (PPE) was often not available or in limited supply.
7. **Insufficient infection prevention and control (IPAC) training and practices**: High turnover and dated or inadequate protocols in some homes mean that this has been a long-term challenge, according to interviewees. Many staff have little or no experience applying pandemic level infection prevention and control practices in LTC. Many homes were left to procure PPE themselves. Some homes lacked the clinical leadership to proactively manage IPAC practices effectively.
8. **Uneven medical direction practices and responsibilities**: Many homes that experienced breakdowns had little medical presence and poor medical back-up plans.

These long-term vulnerabilities will require long-term solutions, although several potential short-term initiatives undertaken in some cases during the pandemic (e.g. arbitrarily higher pay, decanting residents to field hospitals and hotels, stopping LTC admissions or readmissions, families pulling residents out of homes) may influence longer-term reforms.

2) Initial pandemic preparations focused on acute care hospitals.

"We were all watching what was going on in Italy, Spain and later in New York." Based on the news from other countries in January and February 2020, interviewees told us that shoring up acute care system intensive care unit (ICU) capacity was the understandable focus in many parts of the country. "We tried to 'Flatten the Curve' so that our hospitals and ICUs wouldn't be overwhelmed and downloaded many ALC [alternative level of care] patients to long-term care." One interviewee put that number at 1,600 patients in Ontario alone, with similar transfers happening in some other jurisdictions. Another indicated that, in Quebec, only 170 older adults were waiting for placement on June 11, 2020, compared to 500 in October of 2019; a number that has remained fairly stable for the last 5 years.

Most felt that "we missed it." One exception was the systematic involvement of long-term care partners pre-March in a "Table Top" preparation exercise at Kingston FLA Public Health Unit. In this process, hospitals, care homes, and other providers stepped through an outbreak scenario and discussed possible responses in August 2019. At the time of the interview, they had had one case in LTC/RH and no deaths across their 3,000 residents. They also provide yearly intensive education on influenza preparedness and response providing support on IPAC, outbreak management and immunization strategies.

Many LTC home leaders we spoke with felt that they had been talked down to by health system leaders during the early phases and received communications that were often confused, unclear and conflicting. For instance, testing in the early stages of the pandemic was rationed, and rules for LTC homes were sometimes unclear. Many interviewees reported a lack of public reporting and of timely reporting of laboratory tests, with delays in reporting at times more than a week. They said that there was a lack of direction on single employers, use of PPE, dedicated entry points into the homes and cohorting residents. Gaps in assessment and protection of vulnerable populations in LTC homes continued until the risk of outbreaks in homes became clear, at which point resources and attention began to shift from acute care to long-term care. This was reported to have happened swiftly in some jurisdictions (e.g. British Columbia) but others said that this response was very slow, and even in the face of orders to hospitals from the provinces, resources were provided very reluctantly by some hospitals. When staff resources were provided, we heard that many had little experience working with older people, particularly those with dementia, as staff in some cases were redeployed from pediatrics and operating room settings.

While rates of infection have been significantly lower in retirement homes, some interviewees felt that they and other congregate adult settings still require additional attention and are surviving this wave primarily because of better facilities, including single rooms. Many also felt there are continuing vulnerabilities in the home care sector, with it being viewed as "non-essential" and outside of broader health system planning. Those who raised this issue pointed out that, in some jurisdictions, home care services were significantly reduced at the beginning of the pandemic and there are still not plans to open up home care services fully. They pointed out that this is a cognitive disconnect with messages that citizens across Canada (and the world) are getting – i.e. that "home" is the safest place you can be right now. Interviewees indicated that this will likely cause a serious problem for other parts of the healthcare system which depend on home care services being available.

3) PPE and IPAC expertise was not shared across the health system early in the pandemic.

Canada faced general shortages of PPE in the early days of the pandemic, including in LTC, retirement homes and home care settings. We heard that available supplies were often concentrated in hospitals (some of which leveraged their foundation and community partners to raise funds and run far-reaching PPE drives and campaigns), and that smaller providers often had difficulties in procuring needed supplies. There were differing opinions about what caused these shortages, which no doubt broader reviews will explore. In general, however, those we spoke with felt that Canada's provinces overall were late to move to universal masking of healthcare workers in congregate living settings. Some examples of opinions expressed:

1. "We have the regulations and standards. They weren't properly followed and enforced."
2. "Public health is always two weeks behind."
3. "We went to universal masking on March 29th (provincial directive was on April 9th) and were widely criticized (for fear-mongering) when we delivered 10,000 masks to our homes."
4. "We asked for help from [our big academic neighbour] and they told us they needed their PPE and staff for their ICUs."
5. "Someone delivered masks to us when we announced the outbreak. I never found out who, but I suspect that [an agency] leader just did the right thing."
6. "We were lucky because we saw what happened in British Columbia and so we were better prepared."
7. "Thank goodness for the citizen-led and rogue efforts by ICU docs on this."
8. "We created our own buying cooperative for PPE (CAPES) because we couldn't get a response from provincial authorities."
9. "We stockpiled our own PPE so that our (home care) workers would have a supply. I am pleased to say that we have only had one health care worker who has had COVID."
10. "We had to make our own clinical decisions on appropriate use of PPE for our front line workers in home care as we couldn't wait for LHINs (Local Health Integration Network) to inform us of best practices. This was a risk financially, but well worth it as the impact has been zero deaths in home care and very low infection rates for our staff, much less than 1 percent."
11. "Early universal masking (in March); with 2 masks per day per staff at all times greatly reduced the number of positive cases."

4) A regional focus helped to coordinate resource allocation and pandemic response.

Interviewees repeatedly pointed to a lack of formal links between many homes and other parts of the health system as a major aggravating factor in managing outbreaks in the early days of the pandemic. Many homes did not have the capacity to manage outbreaks of this nature given a lack of infection prevention and control specialists or the resource depth themselves to turn around a situation once a tipping point had been reached. A designated responsible back-up facility was not in place in areas of the country in March, April and even early May.

Where strong regional relationships existed, the early response was reported to be more effective. For instance, British Columbia, Saskatchewan, the maritime provinces, Kingston (Ontario), and some parts of Alberta were held up as positive examples by those interviewed. In particular, we heard that British Columbia was able to respond well to even the early outbreaks via its regional health authorities. There and elsewhere, interviewees indicated that regional authorities or a provincial/territorial authority tended to be able to move resources to homes more quickly for either protection or response. Where public health was outside of the health authority, we heard that there was sometimes a communication problem in the early days of the pandemic as the response was operationalized.

In Quebec and Ontario, interviewees reported that regional responses and acute care support were initially mostly voluntary. They noted that in these provinces, there tends to be an organizational/reporting break between the acute and LTC sectors. This separation was seen to be particularly challenging in Toronto and Montreal where major academic centres are not typically part of regional structures. Most homes with early outbreaks managed them on their own. In a few cases, local teams and/or the Canadian Armed Forces were deployed.

A system of support was formalized and centralized later in April in Ontario and Quebec. Hospitals were brought in to address acute staffing shortages in a minority of homes in outbreak in both provinces. In Ontario, for example, the Incident Management System (IMS) Table is composed of four acute care hospital Chief Executive Officers (CEOs), an LTC/RH chain CEO, two Deputies, the Chief Coroner, the Chief Medical Officer and the CEO of Ontario Health. Interviewees reported that it now coordinates a strong response (typically hospital-led) to outbreaks and, during May and June, has brought order to Ontario's response. Likewise, systems of mutual support and rapid access to clinical expertise have been developed in Quebec under the leadership of the ministerial response table.

5) Reporting and testing have been uneven across the country.

Interviewees also reported that regionalized systems appear to have been advantaged in terms of the organization of testing and reporting. There has been a steady improvement reported across all jurisdictions, but interviewees judged some as having done a poorer job in early days. Interviewees in Ontario were particularly critical of the fragmentation of messaging and responsibility among the 34 public health units and the lack of available testing. Some homes in Ontario had to advocate for mass testing so that they could properly cohort residents; and many homes brought testing in house in order to expedite their response. This was crucial given that early spread of the virus in LTC was sometimes attributed to asymptomatic staff and residents. Home care was generally not included in testing and left to individuals to access assessment centres if symptomatic. At times, we heard that they were either denied a test or waited for days. In New Brunswick, where up until late May there were no positive cases of COVID-19 in their LTC homes, they confirmed that lots of testing had taken place. That said, even in regionalized provinces such as Saskatchewan and Nova Scotia, data reporting was criticized by some as being not operational enough and at a level that was too aggregated to support local pandemic response. One interesting phenomenon during the pandemic has been the number of transparency efforts from academic and volunteer groups across the country. They worked with reporters and family members of residents to track what was happening in LTC homes across the country. These efforts were an important part of the response to the pandemic; we heard that attention to sustainability of these types of efforts is needed.

6) LTC homes that were overwhelmed seem to follow a consistent pattern to reach a tipping point.

Interviewees reported that management of homes that were overwhelmed were surprised with the asymptomatic nature of the virus – particularly in the early days. “We found out we had one case, then the next day it was several dozen cases. On the third day we had many staff out sick and more out with fear.” Lack of PPE, weak IPAC practice, and limited availability of early testing helped spread the virus among residents and staff. “We see homes reaching a tipping point where even good managers become overwhelmed or get sick themselves.” We heard that older facilities and shared rooms often made this situation worse, as did the part-time/itinerant nature of staff in some homes. Understandably, part-time and short-term staff may feel less loyal to a particular site, and interviewees reported that they were more likely to be afraid of the unknown, particularly in places where management teams were struggling or became ill themselves. “Some homes lost 50% of staff, but some lost none.” Once a home “tipped,” we heard that it was very difficult for the home’s local management team to right the operation on its own.

7) Homes in full outbreak require a major team response.

Few homes were able to turn around an overwhelming outbreak once established without outside assistance, according to the people interviewed. They repeatedly described the need to not activate a small-scale response and to cast a wider net in engaging a support program early. Interviewees suggested that “SWAT” teams of 5 to 20 led by a senior Registered Nurse (RN) (+/-Medical Doctor [MD]) dropped into outbreak situations appeared to be much more effective than adding a few solo staff to the existing team. These “SWAT Teams” were developed in regions (e.g. BC), provincial health authorities (e.g. Saskatchewan), individual hospitals (e.g. North York General Hospital, Michael Garron Hospital in Ontario), province-wide at the hospital level in Ontario (through IMS), the Canadian Armed Forces (in Ontario and Quebec), home care agencies and in the bigger long-term care/residential home chains. Interviewees consistently reported that this capacity has been created on a just-in-time basis over the past three months and we heard that it needs to be formalized as part of our public health response capability. The organization and formalization of these teams is well underway now across most jurisdictions. Interviewees emphasized that it will need to be funded appropriately and organized permanently for future waves of this pandemic and in anticipation of future pandemics.

PREPARING FOR THE NEXT WAVE(S): PROMISING PRACTICES AND POLICY OPTIONS AS OF MID-JUNE 2020

This section discusses promising practices and policy options as of mid-June 2020. These have been distilled from the interviews, analyses and discussions with stakeholders that the Canadian Foundation for Healthcare Improvement (CFHI) has undertaken in the past several weeks. As indicated earlier, we are attempting to rapidly understand better practices and feed them back to the front-line teams who are spending long hours managing these tough situations. We are very respectful that their insights are the result of some very difficult lived experiences this spring and deeply appreciate the generosity of those who shared them with us. Our hope is to support a helpful discussion as provinces and territories prepare for possible future waves, recognizing that many jurisdictions and homes have already, and continue to, actively innovate to strengthen pandemic preparations and response.

Note: Interviewees were clear that one of the best ways to protect homes is to keep the community transmission of COVID-19 low. Strategies for doing so are critically important but beyond the scope of this report.

Infection Prevention and Control (IPAC) – Preventing Future Outbreaks

The first priority in preventing future outbreaks is to keep the virus out of LTC homes. This requires early detection of carriers (symptomatic and asymptomatic) and isolating them before they transmit the virus to residents. Interviewees indicated that the key to doing this is routine surveillance testing of all staff, family caregivers, and some visitors to the homes. We heard about further study that is underway on the frequency and organization of this surveillance and is expected to be published in July, which should help inform decisions in this regard.

Interviewees noted that this strategy is proving successful in Ontario where surveillance testing has prevented over 50 outbreaks in recent weeks by detecting COVID-19 positive staff and isolating them before they introduce the virus to the home. Combined with universal masking, this approach will minimize future outbreaks, providing time to address other systemic weaknesses in LTC.

Universal masking is now reported to be the standard of care guideline in most LTC and retirement homes and will soon be for home care services and most physician practices. This is likely to continue for some time in areas where there is community spread of the virus. Interviewees told us that use of splash guards, isolation gowns, and gloves is also much more common. Cleaning routines have also been enhanced. This added layer of protections adds expense and can be time-consuming for staff who are already stretched. Interviewees estimated the total added costs for IPAC and other pandemic related costs as on the order of $50-$100 per resident per day. We heard that this added expense may also make other options to LTC more attractive for payers and encourage the introduction of home care alternatives.

Infection Prevention and Control – Practice and Training

Interviewees reported that Infection Prevention and Control (IPAC) in homes has moved forward a long way in the past three months. Standards have been strengthened and steps have been taken to ensure that standards are met, although this will require on-going focus. The government of Quebec recently announced that this will be a major focus for the province through the summer.

There are several groups that have stepped up to publish best practices and standards and to provide training resources across the country, including:

- Alberta Health Services
- British Columbia Centres for Disease Control and Prevention
- Centre for Learning and Research Innovation (CLRI)
- Comité sur les infections nosocomiales du Québec (CINQ)
- HSO/Accreditation Canada
- New Brunswick
- Nova Scotia
- Ontario Retirement Communities Association (ORCA)
- Ordre des infirmières du Québec
- Prince Edward Island
- Public Health Agency of Canada
- Saskatchewan
- Shared Health Manitoba
- The Michener Institute

Local health systems and standards-setting bodies have responsibility and authority for IPAC best practice. We heard from interviewees that this will be the focus for homes and their regulators and credentialing authorities through the late summer. Several interviewees spoke of an August/September inspection cycle for IPAC to prepare for the flu season, a possible future wave of COVID-19, and to plan for the possibility of both waves breaking at the same time. There is an opportunity to strengthen and develop supportive partnership models between regulators and LTC in preparation for the future waves of COVID-19.

Public Health Preparation Best Practices – Urban

Proactive preparation in homes, and with the broader health system, were key to avoiding outbreaks in urban settings, interviewees said. This included planning with health system partners, often coordinated on a regional basis. In some cases, training, PPE supplies, and other activities were provided across a province/territory or chain of homes.

> We heard that Kingston, Frontenac, Lennox and Addington (KFLA) Public Health Unit stands out amongst its peers as having exemplary results for a non-remote community. With more than 200,000 people, the city of Kingston, several universities and the TransCanada Highway, it had only 1 case in its 30 homes (11 LTC and 19 RH) as of May 25, 2020. KFLA recognized the seriousness of the coming pandemic and undertook a full set of inspections of IPAC readiness modelled upon their annual flu preparations. They augmented their team with restaurant inspectors and a public health nurse, and an inspector arrived in each home. The nurse had more of a coaching role. The inspector had an auditing role. Both were backed up by a Medical Officer of Health (MOH) willing to write up offences at penalties of $5,000 per day. Three of their checklists are attached in Appendix 3 through 5. This was also done for correctional facilities.
>
> The MOH Dr. Kieran Moore is also an emergency room doctor and made several other key points about readiness: 1) Public Health Units cannot wait to be told what to do; they need to be proactive and operational, 2) Relationships need to be developed with all institutional and community players (hospitals, homes, primary care), and 3) those relationships need to be tested using table-top exercises in which participants can see one another's likely responses and discuss them. The agenda describing KFLA's table-top exercise is attached as an Appendix 6. Another key strategy was early availability and accessibility of testing.
>
> As another interviewee said, "these relationships need to be built across the region before the crisis. It is very hard to do in the heat of the moment."
>
> It is noted that at the time of publication of this report, there have been several outbreaks identified in Kingston, Ontario; however, no outbreaks have been reported in LTC.

Accreditation standards include criteria related to emergency preparedness and planning. These criteria require that teams practice their response to fires, natural disasters and situations that require evacuations. Actual drills are best practice when possible, however table-top exercises and simulations can also achieve similar outcomes. We heard that there is an opportunity to spread the use of drills, simulations and/or table-top exercises related to pandemics more consistently and more systematically within organizations as they prepare for future waves of COVID-19.

Public Health Preparation Best Practices – Communities with Managed Entry

Communities that can control entry to their locales have advantages during a pandemic but may also face unique challenges as they may have fewer local response resources. By controlling access points, monitoring and quarantining travelers, and assessing commercial traffic, they may successfully keep COVID-19 out of their communities with an "iron ring" strategy. This, in turn, means that outbreaks are less likely in LTC. In Prince Edward Island (PEI), for instance, we heard that the bridge and airports were controlled, and travelers have been assessed and monitored.

Likewise, in the Yukon, the territorial government placed controls at the Whitehorse airport and the major highways. People travelling are placed in a hotel with food provided for a 14-day isolation period. These community-wide actions have been complemented with actions specific to LTC. For instance, we heard that all LTC homes are single rooms and a separate hotel has been set up to cohort and quarantine all COVID-19 cases. Staff in LTC homes are paid a "living wage" and are reported to be well-trained and prepared.

Pandemic Response and Response Planning – Communities with Managed Entry

While "iron ring" strategies can be successful for communities that can manage entries to their locales, considering how they will respond if an outbreak does occur is still quite important. Interviewees were clear that jurisdictions and communities that do not have the lived experience of responding to an outbreak would benefit from looking to parts of the country that have done so successfully. For instance, Saskatchewan managed three community outbreaks in three northern centres. One was centered at La Loche and included the LTC home and rural hospital. The outbreak was declared on April 17 and ended on May 16, 2020. The Saskatchewan Health Authority, Northern Intertribal Health Authority and the local Emergency Operations Centre collaborated to respond to COVID-19 in a culturally diverse northern and remote population. The outbreak highlighted several long-standing social determinants of health challenges in the community, including lack of adequate housing, overcrowding, vulnerable populations, language barriers, social inclusion, and challenges related to mental health and substance use. Responding required a prompt and coordinated public health response that leveraged existing relationships, as well as community strengths and partnerships. Complementing a robust community response, we heard that the Saskatchewan Health Authority recruited a team province-wide. They were sent in with appropriate PPE and IPAC training to assist local healthcare providers and partners.

Likewise, we heard that ready access to expert advice is particularly important when communities may have needs that go beyond local capacity. For instance, Infopoint is a new information sharing initiative developed for First Nations health managers by the First Nations Health Managers Association (FNHMA). We heard that it offers a help line where First Nations health managers can access reliable, credible resources and information on COVID-19. Weekly virtual town halls hosted by FNHMA also offer a venue for learning from other communities, including regarding pandemic preparations and response to support elders in First Nations communities.

Interviewees emphasized that all communities need to consider how they might have to manage a combined flu and COVID-19 outbreak. Importantly, they felt that given the first wave experience every LTC and retirement home (rural and urban) should have a clear understanding of where it will turn for assistance if there is an outbreak. These understandings should be formal, clear and articulated to the community in advance of the next wave.

Pandemic Response and Response Planning – Managing Provincial/Territorial and Regional Surge Capacity

Interviewees consistently said that clear back-up plans for LTC homes (and probably for all adult congregate living centers) are essential as we head into the fall. These plans need to be formal, clear and publicly articulated, reflecting existing capacity (e.g. few home operators can turn around a full outbreak without external support). As described above from interviews, a number of homes in March to May of 2020 reached a tipping point and their outbreaks could not easily be righted from within. We heard that surge capacity and ready response teams need to be organized in advance, coordinated at appropriate regional and provincial/territorial tables. Based on the interviews, regional authorities, provincial/territorial authorities, and provincial/territorial tables with delegated ministerial powers all appear to be workable models once they have been started and organized, although start-up time has generally been longer when functions are siloed and there are not clear regional systems already in place.

Much of Western Canada and Atlantic Canada are organized as regional health systems with existing linkages between acute hospitals and LTC homes at the regional or provincial/territorial level. While there are some notable differences among them, in general the response in all of the regionalized provinces was to move to a hospital-led or region-led (but often acute care hospital supplied) response team model. Public health was generally incorporated into this operational response after a period of time or was already in the regional governance. In each of these jurisdictions, regional response including public health now appears to be an established norm. We heard about regional systems to hold PPE, manage surge capacity and plan for various scenarios as future waves develop.

Elsewhere, a number of acute care and primary care partners also stepped up and brought staff and resources to bear to turn around the situation in local home(s) with outbreaks. We heard that effective response teams typically had seasoned RN/MD leadership, enough team members to make a meaningful difference, access to PPE and knowledge of effective IPAC procedures. Their arrival tended to immediately stabilize the situation and often reduced the fear factor that was leading to staff absenteeism. The sense of 'someone being there for me' was reported by multiple interviewees.

In a number of cases, response efforts appear to have begun at the local level before they were formalized at the regional or provincial level. For instance, one community hospital began providing masks to homes before the end of March and advised universal masking in its community. This was not supported at the time by public health. Their teams responded to 11 outbreaks, four of which were still live at the end of May. They also developed a dashboard that they use on a daily basis to monitor the LTC and retirement homes in their community.

Where hospitals moved early in their community, interviewees indicated that they seem to have done so because of prior relationships built up through community collaboration efforts across the country. In Ontario, for instance, these were often based on Ontario Health Teams that had been in discussion prior to 2020, but that are now being used to help organize the response. Likewise, partnerships that were in place prior to the pandemic were identified as a key facilitator for some homes in their response to COVID-19. We heard that strengthening these relationships should be part of wave 2 preparation.

We also heard about another set of response teams that existed and appear to have had some success within some larger and better-resourced chains and through home care agencies. It appears that dozens of LTC and retirement homes were responded to in this way. This was particularly true early in the pandemic. Interviewees noted that there is an important question about whether large chains should have a formal response capability and responsibility. This issue needs clarity because people we spoke with reported that several smaller operators (for profit and not for profit) did not have the capacity to deal with the pressure of an outbreak.

Every LTC and retirement home (indeed all adult congregate services) should have a clear understanding of where they will turn for assistance if there is an outbreak, according to interviewees. These understandings should be formal, clear and articulated to the community in advance of the next wave. There was consensus that formal surge capacity with professional leadership, PPE, IPAC training and resources needs to be organized and tested in every community in Canada prior to the fall influenza season.

Interviewees also advised that the Government of Canada should continue to backstop jurisdictions in wave two. This is currently being done by the Canadian Armed Forces and Rangers. We heard that there is an open question about how this national capability should be organized given the range of agencies departments and approaches available.

Regional and jurisdictional stockpiles and supply chain for PPE (and other essential items)

This was a major issue early in the pandemic, but interviewees reported that it had largely been addressed for acute care hospitals, LTC and retirement homes by June 2020. They also indicated that it has not been addressed fully at this time for physician offices, social services providers and home care agencies. We heard that best practice is provincial/territorial and regional stockpiling and a centrally managed supply chain. This was accomplished early in Alberta, Nova Scotia and some other jurisdictions. In larger provinces, interviewees felt that both provincial/territorial and regional stockpiling is needed to keep par levels manageable and keep costs down. There have been significant industry association efforts as well, both by individual companies and by retirement homes as a group through CAPES.

There is a palpable ongoing lack of trust among system participants on this issue that we heard still needs to be addressed by clearer guidelines and transparency of process and supply levels. Holding the surge capacity for PPE centrally should reduce the required emergency excess capacity held for the whole system. This was the conclusion of several reports after SARS. This makes good sense because holding many individual stockpiles at many individual sites can result in expiration of equipment and added inventory costs. In practice, however, implementing centralized stockpiles requires that system participants have trust in the system and its supply chain. Interviewees noted that trust needs to be reestablished after the last several months. Until it is, there will be local and industry association stockpiling for safety reasons. This is not selfish behavior; it is learned experience and conservatism in the face of very difficult circumstances. Many system participants have spent heavily to ensure that they never face shortages of the type they faced in March and April again.

It should be noted that a substantial volunteer and philanthropic fundraising effort was a crucial “stop-gap” measure for PPE in many jurisdictions. Interviewees emphasized that this is one of many areas where citizens’ and clinicians’ actions were critical to our response to the pandemic. But we were told that it also was another driver of inequity between those who have the marketing and philanthropic capacity, and those who are not so well resourced or connected.

Healthcare workers: Managing the Number of People Coming into Homes

Interviewees consistently reported that infection control has become an important lever in forcing a move towards better organization and scheduling of healthcare workers coming into homes. British Columbia’s Provincial Health Officer made relatively early decisions in this regard. In March, the province took control of nursing home staffing in the Lower Mainland for six months. Staff were restricted to work at a single location; pay and working conditions were also equalized. Action has also been taken locally. For instance, one Hamilton Ontario area retirement home that had previously seen 6 agencies with 38 different workers moving through in a single day to provide government-funded home care was able to consolidate to 1 agency with 8 healthcare workers. However, in Ontario it should be noted that consolidation like this of home care provision has only been recommended and not mandated. As a result, we heard that many of its 770 retirement homes have higher than optimal foot traffic from an infection prevention and control perspective. Interviewees suggested that best practice for both infection control and staff continuity would be to more tightly limit the number of healthcare workers who are serving any individual home. This includes staff and others providing services to residents, even if they are paid by others. Some interviewees advised that a home’s Executive Director should be given the right and responsibility to limit workers and to consolidate contracts for infection control reasons. Specifically, they felt that s/he should be given the authority to incorporate the spend into the jobs of existing staff members and/or to force limits on agencies where she/he deems it in the best interests of the IPAC for the home as it prepares for the next wave. Consistency and consolidation of roles is also reported to be a driver of job satisfaction for healthcare workers when implemented properly and so, in addition to infection control benefits, it may strengthen employment relationships among agencies, homes and healthcare workers.

Many interviewees suggested that there need to be formal controls and registration of all people coming into homes going forward, as well as an active plan by each home’s leadership to minimize total numbers and time spent while ensuring residents’ needs are met. This dovetails with PPE supply, use and training for all people coming into homes. There were three tracking systems mentioned as being widely in use. We heard that this would also help with contact tracing in preparation for potential future waves of COVID-19.

Revitalized clinical leadership and care reorganization for better infection control and for pandemic response

Strong clinical leadership was seen as a key factor in responding to outbreaks and in preventing them from becoming major outbreaks. It was also seen as an underused lever to do a better job of organizing care for residents. Many interviewees asked that a policy review of how medical directors are appointed and their relationship with their local health care partners (e.g. acute care hospital or health region) be considered and made much more comprehensive. In addition, interviewees noted that many health and social services for residents have been curtailed because of restrictions on care providers entering homes or residents leaving to receive care from outside services. They discussed the need to resume health and other services for residents in a coordinated way that takes into account overall harm reduction.

A few specific principles were suggested:

- One or more medical directors per LTC home (with backup), for infection control and response reasons.
- Clarity that clinical leadership from a medical director or a suitable replacement is available physically, on-site during an outbreak. Where this is difficult, other suitable arrangements to provide clinical leadership in a pandemic need to be in place and ready.
- Medical director credentialled by the same acute care hospital or regional authority responsible for providing back up to the home.
- Chief of Medical Staff (or a pre-designated alternative role or individual) of the hospital/regional authority responsible to backstop clinical leadership if s/he is unable to respond in a pandemic.
- Each resident should have ongoing access to strong primary health care.
- Concentration of specialty services to the extent possible, with a comprehensive plan to move services to virtual delivery as much as possible when infection control restrictions are in place. A consolidation of specialty services that are currently split among multiple hospitals and clinics is intended to create stronger linkages between a home and the clinical staff of the responsible hospital and related ambulatory care facilities.
- Up-to-date person-centred care plans for all residents and support to implement key elements of person-centred care (e.g. embedding palliative approaches to care).
- Move to a 7 day a week management strategy to ensure continued support and decision capability on site.

Family Caregivers: Striking a Balance

Blanket no visitor policies were introduced early in the pandemic in an effort to decrease the risk of outbreaks. While they noted that this was an understandable decision in the circumstances, interviewees spoke of the resulting unintended hardships inflicted on residents in homes during March to June of 2020, as well as moral distress experienced by health care workers. There is also growing evidence that the presence of family caregivers who are designated by the patient to partner in their care benefits care, experience, safety and outcomes.

The prohibition on family members and friends was almost universal in many jurisdictions, with limited exceptions, e.g. end of life. Those interviewed spoke of the hardship and suffering that this imposed on residents and their families because of loneliness, separation, and guilt. We heard that the collateral damage from restricted visitor policies during COVID-19, including in homes that have not had an outbreak, was substantial.

This approach also resulted in a sudden lack of access to the additional level of unpaid care and support being provided by these individuals. Several interviews spoke about the critical role of family care partners as ‘hidden’ members of the care team. There was a divided opinion on this acknowledged and important “hidden helper” role. Some felt that it was an inappropriate downloading to the family of a home’s responsibilities to provide care; others saw it as a life-enhancing support, particularly for individuals with later-stage dementia or those who did not speak the same language as their paid care providers. Family members who are partners in care family members indicated that it is not uncommon to spend twenty hours a week helping to improve their loved one’s quality of life. Removing such a support can be devastating for residents and contributed to the already constrained human resources in homes.

Many also noted the informal quality control and feedback loop of having family members actively involved in the care of a resident. In order to mitigate some of these restrictions, many homes put in place communication strategies with family councils and families and care partners in effort to increase transparency. In addition, one LTC home went so far as to give employment to five family caregivers so that they could receive IPAC training and PPE and still come in to help all residents at the home. Some homes purchased tablets in early March so that residents could interact virtually with their family and care partners. The province of Nova Scotia equipped all their LTC homes in late May. Others implemented window visits and permitted visits at end of life, but we were told that practices varied by home and technology was a challenge throughout. There were also mixed views looking forward. While some jurisdictions are revisiting early policies, at least one home we spoke with stated that they cannot envision how they would ever go back to an open-door policy for visitors. In addition, even in jurisdictions that have reopened with a single visitor policy (e.g. Saskatchewan), there are disturbing reports of individual homes still not allowing partners in care to enter.

There is no simple answer to this challenge, but even those who felt that broad-based restrictions were a correct response initially in wave one hesitate to suggest that continuing a full ban through the winter of 2020 makes sense from a health and happiness perspective. They noted that residents of long-term care are entitled to live their lives as well as possible. With an average length of stay of 20-24 months according to a recent publication on nursing home length of stay in three Canadian regions, interviewees felt strongly that we can't separate residents from their family for a full year.

CFHI recently discussed this situation with a Rapid Response Advisory Group. While the focus of this group was on the hospital context, much of their advice may also apply across the health system. The Advisory Group identified seven next steps for re-integration of family caregivers as partners in care during the pandemic:

- Ensure a foundation of patient and family partnered care
- Revisit policies on family presence with patient, family and caregiver partners at the table
- Distinguish between family caregivers who are essential partners in care and visitors
- Consider the needs of people who face specific risks without the presence of family caregivers as essential partners in care
- Take a comprehensive, balanced approach to assessing risk
- Establish a rapid appeal process
- Increase the evidence to guide decisions regarding family caregiver presence.

We heard that this needs to be an immediate policy priority for jurisdictions as we move into the summer.

Reorganizing Specialty and Chronic Care for Residents

Interviewees noted that very few homes have historically coordinated their residents' external care plans or visits. And few did so proactively in the context of the pandemic. Under current protocols, much care has been deferred. Some has been moved to virtual -- telephone, video or asynchronous. For instance, New Brunswick specifically provided tablets to support virtual care from physicians with residents.

There was a recognition among interviewees that maintenance of non-COVID-19 care and services is important to residents' health and quality of life, although this has not been a major focus for most to date. That said, there are those who are working with their Canadian scheduling software vendors (e.g. PointClickCare) to understand specialty visit volumes across residents and how to integrate those plans and records with their local acute care hospital. As with the organization of incoming healthcare workers, we heard that homes need to look at outgoing visits for diagnosis and treatment from an IPAC lens and be more proactive in coordinating where and how residents receive outside care to minimize risk. Some interviewees felt that active management by the executive director gives homes the opportunity to serve residents in a better and safer fashion. Items being considered by those interviewed included:

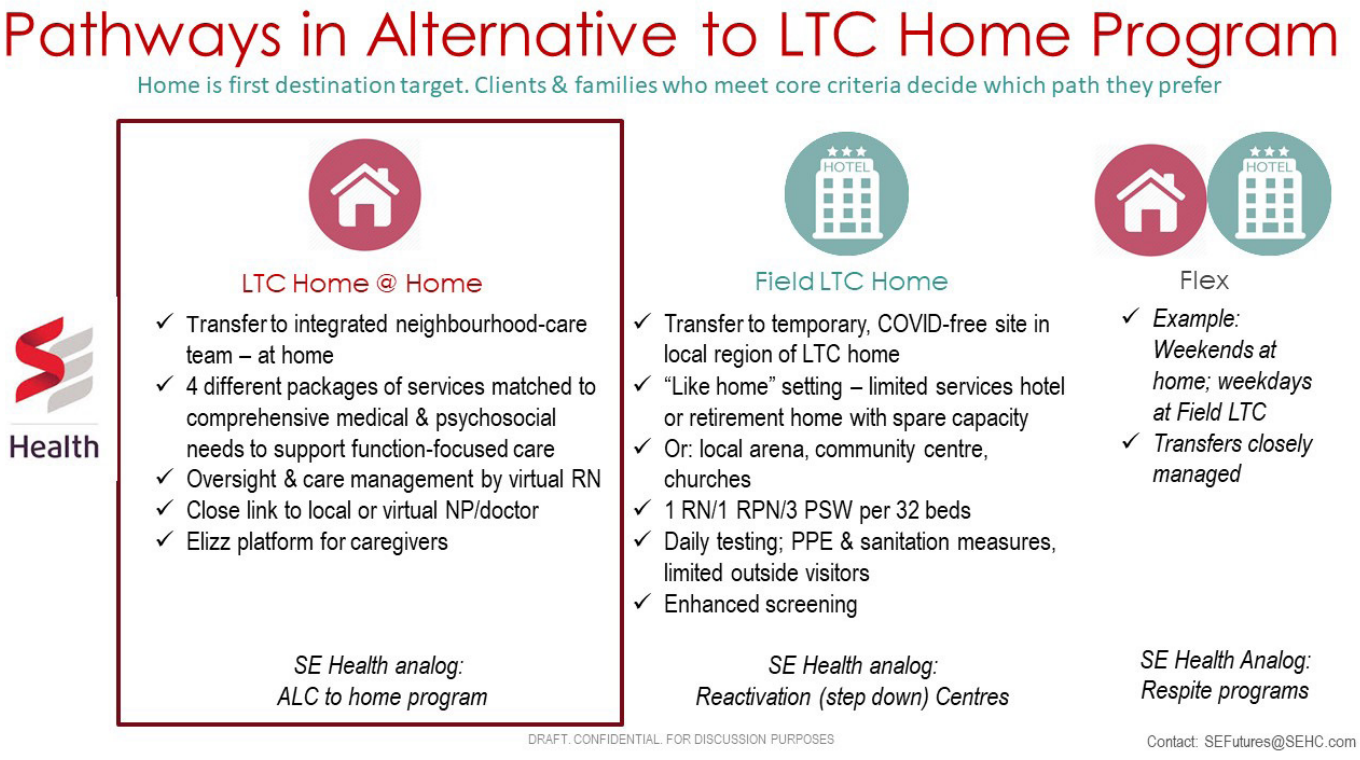
- Consolidating specialty services to a single hospital and single medical staff
- Virtual care for stable specialty follow-up visits, post-surgery wound inspections, and other monitoring services:
  - Sometimes using RN/RPN/PSW on site to assist with physical exam
- On site clinics for higher volume specialties (cardiology, ophthalmology, palliative care, and others) and other common services, e.g. ocular injections, perhaps using different healthcare providers (e.g. nurse practitioner, paramedic, or optometrist) to provide or facilitate care

- Embedding palliative approaches to care, including advanced care planning
- Clean site ambulatory visits as an option for larger general hospitals that have this capability.

This will be an important area for the remainder of 2020 as we look to provide medical services to long-term care home residents without putting older adults at undue risk for iatrogenic COVID-19 infection. For instance, interviewees mentioned outbreaks in regional dialysis centres as an example of these concerns. We heard that our health system has been a major disease vector in wave one of the pandemic; we need to take steps now to control iatrogenic COVID-19 in future waves.

Expand home care – short term

Canada has one of the highest rates of institutionalized older adult care in the western world.[9] Interviewees advised that robust home-based care options (beyond traditional home care as offered today in many parts of the country) may help alleviate pressure on both hospitals and long-term care homes during the pandemic. This could include support for those waiting for a long-term care bed in hospital, for those living in multi-bed LTC facilities where infection control is very challenging, and for those who can have services that can be provided at home even if they are usually offered in institutional settings (e.g. some dialysis, chemotherapy, and mechanical ventilation). Interviewees noted that doing so would require tailored models of care and funding matched to the specific medical, functional and social needs of the resident. For instance, the graphic below (courtesy of Saint Elizabeth (SE) Healthcare¶) talks about three alternative paths they have made available to families and organizations that are managing a LTC wait list, in both urban and rural settings.



¶ We have included an SE Healthcare specific example here with their permission. Several other home care organizations have similar offerings. Inclusion of this graphic is not intended as an endorsement of one specific organization but rather as a concrete example of what is being implemented.

Wage Subsidies, Training, and Other Supports

Interviewees noted that the conditions of work influence the quality of care. They flagged a number of long-standing, multi-faceted issues, some of which will require time to address. These range from wages and benefits to training and mental health supports.

Turnover is high among Health Care Aides/Assistants/, Resident Attendants/Care Aides/Care Workers, Personal Care Attendants and/or Personal Support Workers (PSWs) in the LTC and home care sector. Likewise, nurses are generally not at wage parity with their hospital counterparts, with the exception of jurisdictions such as Saskatchewan. Several jurisdictions (e.g. Alberta, Saskatchewan, Ontario, and Quebec) have made across-the-board increases in salaries or offered hazard pay bonuses to front-line staff during the pandemic. Alberta limited this pandemic pay supplement to Continuing Care (not home care). Federal government wage subsidies have also been used by a range of fee-for-service workers, including those working in home care agencies, who lost substantial income during the pandemic. The most comprehensive response was in British Columbia where the province took over employment contracts for all staff in LTC during the pandemic.[10] There have also been some changes in the mix of health workers. For instance, New Brunswick and Nova Scotia continue to expand a mid-level EMS Tech workforce that sits at a pay level between PSWs and RNs.

In addition to wage enhancements, there have been efforts to expand the number of health workers available or upgrade their skills. For instance, Quebec has announced a plan for an innovative educational program to train 10,000 new Healthcare Aides and has offered them full tuition and expense reimbursement ($22,000 per student) for their year of studies. In some jurisdictions, continuing education resources have also been developed to support those new to the care of older adults or to LTC settings. Some programs to support the psychological health and safety of health workers have also been introduced.

Many of these programs are currently time limited. Interviewees noted that it will be important to consider what comes next, including whether temporary measures will continue and/or become permanent. They also highlighted longer-term implications, such as pay parity, registration and professionalization of the workforce, continuing education, and full-time employment.

ENDNOTES

1. Canadian Institute for Health Information. Pandemic Experience in the Long-Term Care Sector: How Does Canada Compare With Other Countries?. Ottawa, ON: CIHI; 2020; accessed on June 25, 2020: https://www.cihi.ca/sites/default/files/document/covid-19-rapid-response-long-term-care-snapshot-en.pdf.
2. Ibid.
3. Hager M, Woo A. How the coronavirus took North Vancouver's Lynn Valley Care Centre; published March 21, 2020 https://www.theglobeandmail.com/canada/article-how-the-coronavirus-took-north-vancouvers-lynn-valley-care-centre/.
4. Comas-Herrera et al. Mortality associated with COVID-19 outbreaks in care homes: early international evidence. ltccovid.org; May 21, 2020. Accessed on May 21, 2020; at https://ltccovid.org/wp-content/uploads/2020/05/Mortality-associated-with-COVID-21-May-7.pdf.
5. Canadian Institute for Health Information. Pandemic Experience in the Long-Term Care Sector: How Does Canada Compare With Other Countries?. Ottawa, ON: CIHI; 2020; accessed on June 25, 2020: https://www.cihi.ca/sites/default/files/document/covid-19-rapid-response-long-term-care-snapshot-en.pdf.
6. Shanifa Nasser, Lucas Powers, CBC News and The Canadian Press. Ford faces blowback after military report reveals 'horrific' conditions at Ontario long-term care homes; published on May 26th, 2020. Accessed at: https://www.cbc.ca/news/canada/toronto/covid-19-coronavirus-ontario-update-may-26-1.5584665.
7. National Institute of Aging Long-Term Care COVID-19 Tracker, developed in a partnership between the National Institute of Ageing at Ryerson University, Empower Health, and the NIA Long-Term Care COVID-19 Tracker Open Data Working Group; accessed on July 7, 2020 at https://ltc-covid19-tracker.ca/.
8. Registered Nurses Association of Ontario (RNAO). Long Term Care Systemic Failings: Two Decades of Staffing and Funding Recommendations. June 5, 2020. Accessed at: https://rnao.ca/sites/rnao-ca/files/RNAO_LTC_System_Failings_June_2020_1.pdf.
9. Institut C.D.Howe Institute. Paying for the Boomers: Long-Term Care and Intergenerational Equity. Commentary # 415; September 2014. Accessed at: https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_415.pdf.
10. Kathleen Harris, Ashley Burke. The long-term care crisis: How B.C. controlled COVID-19 while Ontario, Quebec face disaster; published on May 28th, 2020. Accessed at: https://www.cbc.ca/news/politics/long-term-care-crisis-covid19-pandemic-1.5589097.

BIBLIOGRAPHY

Brown et al. Association Between Nursing Home Crowding and COVID-19 Infection and Mortality in Ontario, Canada. June 23, 2020. Accessed at: https://www.medrxiv.org/content/10.1101/2020.06.23.20137729v1.full.pdf.

Canadian Institute for Health Information. Pandemic Experience in the Long-Term Care Sector: How Does Canada Compare With Other Countries?. Ottawa, ON: CIHI; 2020; accessed on June 25, 2020: https://www.cihi.ca/sites/default/files/document/covid-19-rapid-response-long-term-care-snapshot-en.pdf.

Canadian Nurses Association. CNA calls on governments to redesign long-term care to address serious 'vulnerabilities'. May 27, 2020. Accessed at: https://www.cna-aiic.ca/en/news-room/news-releases/2020/cna-calls-on-governments-to-redesign-long-term-care-to-address-serious-vulnerabilities.

Comas-Herrera et al. Mortality associated with COVID-19 outbreaks in care homes: early international evidence. ltccovid.org; May 21, 2020. Accessed on May 21, 2020; at https://ltccovid.org/wp-content/uploads/2020/05/Mortality-associated-with-COVID-21-May-7.pdf.

Estabrooks et al., We must act now to prevent a second wave of long-term care deaths. Globe and Mail. June 10, 2020. Accessed at: https://www.theglobeandmail.com/opinion/article-we-must-act-now-to-prevent-a-second-wave-of-long-term-care-deaths/.

Estabrooks CA, Straus S, Flood, CM, Keefe J, Armstrong P, Donner G, Boscart V, Ducharme F, Silvius J, Wolfson M. Restoring trust: COVID-19 and the future of long-term care. Royal Society of Canada. 2020. Accessed at: https://rsc-src.ca/sites/default/files/LTC%20PB%20%2B%20ES_EN.pdf.

Hager M, Woo A. How the coronavirus took North Vancouver's Lynn Valley Care Centre; published March 21, 2020 https://www.theglobeandmail.com/canada/article-how-the-coronavirus-took-north-vancouvers-lynn-valley-care-centre/.

Harris, Kathleen; Ashley Burke. The long-term care crisis: How B.C. controlled COVID-19 while Ontario, Quebec face disaster; published on May 28th, 2020. Accessed at: https://www.cbc.ca/news/politics/long-term-care-crisis-covid19-pandemic-1.5589097.

Hoben et al. Nursing Home Length of Stay in 3 Canadian Health Regions: Temporal Trends, Jurisdictional Differences, and Associated Factors. J Am Med Dir Association. 2019 Sep;20(9):1121-1128. doi: 10.1016/j.jamda.2019.01.144. Epub 2019 Mar 14.

Hsu et al. Impact of COVID-19 on residents of Canada's long-term care homes – ongoing challenges and policy responses. ltccovid.org; May 10,2020. Accessed at: https://ltccovid.org/wp-content/uploads/2020/05/LTCcovid-country-reports_Canada_Hsu-et-al_May-10-2020-2.pdf.

Institut C.D.Howe Institute. COVID-19 Crisis Public Health and Emergency Measures Working Group. Communique # 4: A Tale of Two Epidemics: Why Seniors's Care in Canada was So Hard Hit; June 2, 2020. Accessed at: https://www.cdhowe.org/sites/default/files/attachments/communiques/mixed/CWGR_2020_0602.pdf.

Institut C.D.Howe Institute. Paying for the Boomers: Long-Term Care and Intergenerational Equity. Commentary # 415; September 2014. Accessed at: https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_415.pdf.

Nasser, Shanifa; Lucas Powers, CBC News and The Canadian Press. Ford faces blowback after military report reveals 'horrific' conditions at Ontario long-term care homes; published on May 26th, 2020. Accessed at: https://www.cbc.ca/news/canada/toronto/covid-19-coronavirus-ontario-update-may-26-1.5584665.

National Institute of Aging Long-Term Care COVID-19 Tracker, developed in a partnership between the National Institute of Ageing at Ryerson University, Empower Health, and the NIA Long-Term Care COVID-19 Tracker Open Data Working Group; accessed on July 7, 2020 at https://ltc-covid19-tracker.ca/.

Rapid Response Expert Advisory Group. Canadian Foundation for Healthcare Improvement. Better Together: Re-Integration of Family Caregivers as Essential Partners in Care in a Time of COVID-19. July 8, 2020. Accessed at: https://www.cfhi-fcass.ca/docs/default-source/itr/tools-and-resources/bt-re-integration-of-family-caregivers-as-essential-partners-covid-19-e.pdf?sfvrsn=5b3d8f3d_2.

Registered Nurses Association of Ontario (RNAO). Long Term Care Systemic Failings: Two Decades of Staffing and Funding Recommendations. June 5, 2020. Accessed at: https://rnao.ca/sites/rnao-ca/files/RNAO_LTC_System_Failings_June_2020_1.pdf.

Rozon M, Brophy E. The time to fix long-term care in Canada is now. The Conference Board of Canada. June 24, 2020. Accessed at: https://www.conferenceboard.ca/insights/blogs/the-time-to-fix-long-term-care-in-canada-is-now.

APPENDICES

Canadian Foundation for Healthcare Improvement
Fondation canadienne pour l'amélioration des services de santé

cpsi icsp
Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

APPENDIX 1: INTERVIEW LIST: REIMAGINING CARE FOR OLDER ADULTS: NEXT STEPS IN COVID-19 RESPONSE IN LONG-TERM CARE AND RETIREMENT HOMES

1. Zayna Khayat, Future Strategist, SE Health
2. Dennis Kendel, Health Sector Consultant
3. Cathy Hecimovich, CEO Ontario Retirement Communities Association (ORCA)
4. John Yip, President and Chief Executive Officer, Kensington Health
5. Azi Boloorchi, Vice President, Innovation, Data and Strategic Projects, Revera Inc.
6. Janet Davidson, O.C., Healthcare Consultant
7. Janet Daglish, National Director, Business Development and Government Relations, Bayshore HealthCare
8. Leighton McDonald, President & CEO, Closing the Gap Healthcare
9. Michael Guerriere, President & CEO, Extendicare
10. Stacey Daub, Vice President, Strategy, Integration and Digital Health, North York General Hospital
11. Kieran Moore, Medical Officer of Health and Laurie Conway, IPAC Nurse, Kingston, Frontenac, Lennox and Addington Public Health Unit
12. Karen Chan, Assistant Deputy Minister of Continuing Care, Government of Yukon
13. Mark Rochon, Associate, KPMG Global Healthcare Center of Excellence
14. John Bethel, National Health Care Leader, Ernst & Young
15. Erik Sande, President, Medavie Health Services
16. Adrian Schauer, Founder & CEO, AlayaCare Home Health Software
17. Jacques Ricard, médecin conseil, MSSS, responsable provincial démarche OPUS-AP
18. Group interview with Health Canada officials – Strategic Policy Branch:
    - Kendal Weber, Assistant Deputy Minister
    - Abby Hoffman, Assistant Deputy Minister
    - Marcel Saulnier, Associate Assistant Deputy Minister
    - Sharon Harper, Acting Director General
19. William Charnetski, EVP, Health System Solutions and Government Affairs, PointClickCare
20. Colin Busby, Research Director, IRPP
21. Petrina McGrath, Executive Director, Quality and Safety, Saskatchewan Health Authority
22. Mike Villeneuve, Chief Executive Officer, Canadian Nurses Association
23. Brendan Carr, President & CEO, Nova Scotia Health Authority
24. John Flood, President, Penumbra Press (Patient Partner)
25. Andrew MacDougall, Provincial Director of Long-Term Care, Health PEI
26. Jennifer Thornhill-Verma, Community Member, Bruyère Board of Directors
27. Leslee Thompson, CEO, HSO/Accreditation Canada
28. Saskatchewan Health Authority team meeting:
    - Dalene Newton, Executive Director, Continuing Care Saskatoon
    - Lisa Major, Executive Director Continuing Care Northeast SHA
    - Debbie Sinnett, Executive Director, Continuing Care Regina
    - Suzanne Mahaffey, Executive Director, Primary Health Care Saskatoon
    - Jennifer Hamel, Director Continuing Care Saskatoon Urban SHA
    - Bernene Cohen, Recreation Therapist/Case Manager
    - Christina Denysek, Executive Transition Lead, Strategy & Partnership
29. Group discussion with patient partners:
    - Dave Fasano, Family Caregiver, Ontario Health Patient and Family Advisory Council
    - Miriam Walker, Family Caregiver
    - Susan Mills, Family Caregiver
    - Jim Hutchinson, Family Caregiver and SHA Family Advisor
30. Sarah Downey, President & CEO and Wolf Klassen, Vice-President, Program Support, Michael Garron Hospital
31. Samir Sinha, Director of Geriatrics, Sinai Health System and the University Health Network; Director of Health Policy Research, National Institute on Ageing

In addition to these phone interviews, we are grateful to additional experts in British Columbia, Alberta, Ontario, and Quebec who reviewed and provided written comments on the draft report.

APPENDIX 2: CFHI COVID-19 HOMES INTERVIEW GUIDE

This interview guide is intended to prompt a rapid discussion of three key topics related to older adults with significant health and/or social needs, particularly those living in congregate settings:

1. **Contributing Factors to Current Outbreaks**: What happened and why? What are the key issues that need to be addressed in the next 3-6 months?
   - **Infrastructure/Facilities**: Did home design make some homes more vulnerable and/or less able to deal with COVID-19?
   - **Management/IC Practice**: To what extent did management (including staffing) and infection control practices and policies contribute to outbreaks?
   - **Systemic Issues**: What systemic and policy issues contributed to response failure? Size, integration into health system, ownership model, funding levels.
   - **Response to Outbreak**: Contrast good and poor responses to outbreak and infection control. What is leading practice?

2. **Best Practices in Response to the COVID-19 Outbreak**
   - **Reporting/ Monitoring**: Is there a commitment to full/open reporting of outbreak status & related data? Is testing available and timely? How would you improve reporting and monitoring?
   - **Response to Outbreaks**: Who is the responsible responder? How should response be organized/resourced?
   - **PPE and Staff Availability**: Where and how should surge capacity be organized and supplies held? How should they be mobilized in the months to come? How can we improve worklife and retention for staff?
   - **Person-Centred Care**: How have seniors, family and other partners in care, and front-line staff been engaged in response? How should they be? How are key needs of seniors (e.g. cognitive, palliative) being addressed?

3. **Organizing Non-COVID Care Through 2020 (and beyond)**
   - **Assessing and Organization**: Many seniors regularly receive care outside of their home, e.g. specialty care for chronic conditions or podiatry. Who should organize this care when minimizing physical contact (e.g. while Homes are closed)?
   - **Care Organization**: Do outside care providers (e.g. specialists) and homes have the capability to deliver services: safely in the care providers' office spaces/facilities; virtually (+/- PSW or RPN or other assist); safely in seniors' homes
   - **What are Leading Practices**: How can ambulatory care be best organized for congregate senior facilities during outbreaks? Who is doing this well? How?

These rapid interviews are intended to help inform work by CFHI and other partners in the short and medium-term, including beginning to identify leading practices and share them across jurisdictions. If something is missing, please tell us. At this point, our focus is on current year response to these challenging times, not major longer-term issues including funding levels, ownership structures, and health system organization. That said, these will undoubtedly arise and should as important areas for longer-term action by a range of partners.

Please feel free to send us any reference materials you think are relevant. If materials are confidential or proprietary, please indicate that.

APPENDIX 3: KINGSTON, FRONTENAC, LENNOX AND ADDINGTON PUBLIC HEALTH UNIT COVID-19 CHECKLIST FOR LONG-TERM CARE AND RETIREMENT HOMES

Date of Visit:	
Name of Facility/Practice:	
Address:	
Phone Number:	
Name of Contact:	
Email Address:	
Name of Public Health Inspector:	

The purpose of this checklist is to prepare long-term care and retirement home staff to identify and manage a person with suspected COVID-19.

Main Entrance(s) - Visitors	Yes	No	Resources and Notes
1. **Ministry signs are posted** at entrances			Provide signs. Also downloadable from KFL&A website.
2. **Alcohol-based hand rub (ABHR) with 60 – 90% alcohol, tissues, and procedure masks** are available at reception.			
3. **On arrival, all visitors are asked**: • Do you have a fever or cough or difficulty breathing? **If yes**, they are asked to leave and only return when their symptoms have resolved. **If they have no symptoms**, they are asked these questions: • Have you travelled outside Canada in the past 14 days? • Have you been in close contact with someone who has been tested for COVID-19? • Have you been in close contact with a person with acute respiratory illness who has travelled outside Canada? If yes to any of the questions, visitors are asked to leave and only return after 14 days from their exposure. They are advised to contact their health care provider or Telehealth Ontario.			Affected areas are updated daily
Care Area(s) – Residents	**Yes**	**No**	**Resources and Notes**
4. **New residents are assessed for respiratory symptoms** and potential exposures to COVID-19 on admission • Use the same 4 screening questions as above			
5. **Residents are monitored daily for respiratory symptoms** • A central record of monitoring is kept			
6. **Residents with acute respiratory illness or fever are immediately isolated** using droplet and contact precautions • Visitors are assisted to use the same PPE as staff			PHO's Routine Practices and Additional Precautions

Care Area(s) – Residents	Yes	No	Resources and Notes
7. **Alcohol-based hand rub (ABHR) is available at the point of care** • Wall-mounted, table-top, or free-standing units just inside or outside resident's rooms			
8. **Personal Protective Equipment (PPE) is available at the point of care for residents on additional precautions** • PPE includes disposable gowns, gloves, procedure masks, and eye protection. • Garbage bin and ABHR are available immediately outside the room			
9. PPE is available near the point of care for all residents • Staff don't have to walk very far to access PPE			
Staff	**Yes**	**No**	**Resources and Notes**
10. **Staff can demonstrate how to doff PPE correctly**.			PHO doffing video (1 minute)
11. **Staff can state what to do if they develop respiratory symptoms or fever** • Contact the facility's occupational health service • Remain off work until the period of peak symptoms has passed, and at least 24 hours after fever has resolved with no antipyretics (e.g., Tylenol, Advil)			
12. **Staff can state what to do if they return from travel outside Canada, or have been exposed to someone who has been tested for COVID-19** • Contact the facility's occupational health service • Contact their health care provider or Telehealth Ontario: 1-866-797-0000 or KFL&A Public Health 613-549-1232			
13. **Signs are posted at staff entrances and in the staff break room** reminding staff to monitor themselves for illness and stay home when they are sick			Instructions for How to Self-Monitor for COVID-19
14. **Staff can list at least 2 resources for reliable information about COVID-19**			KFLAPH / KFLAPH COVID-19 Call Centre: 613-549-1232, press 4 Ontario Ministry of Health website for health care providers PHO / PHAC
15. **Any suspected COVID-19 illness in residents or staff is reported to KFLAPH**			Daytime: COVID-19 Call Centre 613-549-1232 follow prompts to press 4 After hours: 613-549-1232 follow prompts to speak to the on-call manager

APPENDIX 4: COVID-19 CHECKLIST FOR LONG-TERM CARE AND RETIREMENT HOMES

The following checklists are taken from: Ontario Ministry of Health COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH), April 15, 2020.

ADMINISTRATION

- ◯ Substitute decision makers are identified for all residents.
- ◯ Advanced directives have been reviewed for each resident.
- ◯ Clear medical directives regarding DNR and ventilation are on each resident's chart.
- ◯ Staff and residents are kept informed about COVID-19.
- ◯ A protocol is in place to communicate with stakeholders about a COVID-19 outbreak, should one occur in the home.
  - ◯ A list of stakeholders is identified (e.g., staff, residents, families, community members).
  - ◯ A draft message to stakeholders is available.
  - ◯ Communication platforms have been identified (e.g., social media, email distribution lists, media outlets).
  - ◯ One or more persons in the home are prepared to reply to media inquiries.
- ◯ The dining room and activity areas have been reconfigured to ensure social distancing.
- ◯ Environmental cleaning protocols have been increased to twice daily for high touch surfaces.
- ◯ A protocol is in place to manage staff shortages.
  - ◯ The home has requested that ministry inspectors to be deployed to the home to function as support staff.
- ◯ A protocol is in place to manage staff who have been exposed to COVID-19.
- ◯ There is a designated room or area for one COVID-19 case.
- ◯ There is a designated expansion space for two or more COVID-19 cases.

VISITORS

- ◯ The home is closed to visitors except for essential visitors.
  - ◯ An essential visitor is a person performing essential support services (e.g., food delivery, maintenance, and other health care) or a person visiting a very ill or palliative resident.
  - ◯ There is a sign posted at each entrance.
- ◯ Entrances are controlled (e.g., people can only come in if someone allows them in).
  - ◯ On entry, essential visitors are asked screening questions and their temperature is taken.
  - ◯ Emergency first responders are permitted into the home without screening
  - ◯ Essential visitors who screen positive or have symptoms are denied entry.
  - ◯ Essential visitors are instructed to visit only one person.
  - ◯ Essential visitors wear a mask if visiting a resident without COVID-19.
  - ◯ Essential visitors to a resident on additional precautions for COVID-19 or other illness are supported in correctly donning and doffing appropriate PPE.
  - ◯ Accommodation is arranged for essential visitors.
  - ◯ Food and product deliveries are received in an identified area, and delivery personnel are screened.

STAFF

- ◯ Staff entering the building are asked screening questions and their temperature is taken.
- ◯ Staff temperatures are monitored a second time each day.
- ◯ Staff who screen positive or have symptoms are sent home and followed up by the home's occupational health staff.
  - ◯ Staff who have ARI symptoms are sent to a COVID-19 assessment centre for testing and are told to self-isolate.
  - ◯ Staff who have travelled outside of Canada within the last 14 days are told to self-isolate.
  - ◯ Staff who are contacts of a COVID-19 case are told to self-isolate.
  - ◯ Staff who have been in contact with a person with ARI who has travelled outside Canada are told to self-isolate.
- ◯ Staff stay 2 metres apart from other staff, visitors, and residents whenever possible.
- ◯ Staff confirm that they self-monitor for symptoms daily.
- ◯ Staff are able to state what they should do if they become symptomatic at home.
  - ◯ Self-isolate.
  - ◯ Seek assessment and testing for COVID-19.
  - ◯ Seek medical care by telephone, or by ambulance if needed.
  - ◯ Notify their occupational health service.
- ◯ Staff are able to state what they should do if they become symptomatic at work.
  - ◯ Immediately don a surgical mask and notify the manager.
- ◯ There is enough PPE available to the home to last 1 month.
  - ◯ PPE inventory is reported daily to the Ministry of Health
- ◯ Staff have been trained on the use of PPE, including
  - ◯ Point of care risk assessment
  - ◯ Location of PPE supplies
  - ◯ Donning
  - ◯ Doffing
- ◯ Staff can demonstrate proper donning and doffing of full PPE.
- ◯ Staff who work at the home have agreed not to work elsewhere.

TESTING

- ◯ The home has at least 4 respiratory test kits on hand, and they are not expired.
- ◯ Every symptomatic resident or staff member is tested for COVID-19.
  - ◯ Includes deceased residents who were symptomatic but not previously tested.
- ◯ Public Health is notified of any suspected case of COVID-19, including anyone who is tested.
- ◯ An outbreak number issued by Public Health is included on any COVID-19 test requisition.

RESIDENTS

- ◯ Residents are screened for symptoms twice daily, including temperature.
  - ◯ Residents with symptoms of COVID-19, including mild respiratory symptoms, are placed on droplet + contact precautions in a private room if possible, and tested for COVID-19.
- ◯ All new admissions are screened and put on droplet + contact precautions for 14 days.
- ◯ All re-admissions who have been out of the home more than 24 hours are screened and placed on contact + droplet precautions for 14 days.
- ◯ Non-essential scheduled appointments have been delayed or cancelled.
- ◯ Residents are not be permitted to leave the home for short-stay absences.
- ◯ Residents who go outside of the home are told they must remain on the home's property and practice social distancing.
- ◯ Residents maintain a physical distance of 2 metres from other residents and staff where possible.
- ◯ Nebulizer treatments have been changed to multidose inhalers (MDI) wherever possible.
- ◯ Use of CPAP machines has been discontinued wherever possible.
- ◯ Protocols are in place to limit the spread of airborne droplets during any aerosol generating medical procedure (e.g., nebulizers, CPAP, etc.)
  - ◯ The resident's door is kept closed.
  - ◯ The number of staff in the room is minimized.
  - ◯ Anyone in the room wears an N95 mask.

OUTBREAK

- ◯ Managers recognize that 1 resident or staff case of COVID-19 constitutes an outbreak.
  - ◯ Public Health is notified immediately of a suspected or confirmed COVID-19 case.
  - ◯ All symptomatic residents and staff are tested for COVID-19 during an outbreak.
- ◯ Residents who test positive for COVID-19 are placed on droplet + contact precautions in a single room if possible.
  - ◯ Public Health is consulted to determine who is a close contact and may have been exposed.
  - ◯ Residents who have had close contact with the case are placed on droplet + contact precautions for 14 days from their last exposure.
  - ◯ Staff who have had close contact with the case without PPE are excluded from work and self isolate for 14 days from their last exposure. If the staff member is critical to continuing operations, they may continue to work using PPE and undergoing regular symptom screening for 14 days.
  - ◯ Staff who have had close contact with the case while wearing PPE self-monitor for 14 days from their last exposure.
- ◯ Staff who test positive for COVID-19 are excluded from work and self isolate until cleared by Public Health to return to work.
  - ◯ Public Health is consulted to determine who is a close contact and may have been exposed.
  - ◯ Residents who have had close contact with the case are placed on droplet + contact precautions for 14 days from their last exposure.
  - ◯ Staff who have had close contact with the case are excluded from work and self isolate for 14 days from their last exposure.
- ◯ Control measures listed on the Respiratory Outbreak Control Measures Checklist are instituted, with added measures for COVID-19 as follows:
- ◯ Admissions are deferred until the outbreak is controlled.
- ◯ Re-admissions are deferred including those who are taken out by family.
- ◯ Residents who must leave the home for an out-patient visit are provided a mask and screened upon their return.
- ◯ All communal activities/gatherings and all non-essential activities are discontinued.
- ◯ All meals are trayed and served in residents' rooms.
- ◯ Pets residing at the home are assessed by a veterinarian and housed elsewhere.
- ◯ Residents are physically separated into three areas housing
  - ◯ 1: Lab confirmed COVID-19 positive cases.
  - ◯ 2: ARI symptomatic cases prior to lab confirmation.
  - ◯ 3: Asymptomatic residents.
- ◯ Units or smaller homes where it is impossible to isolate residents from each other are considered a single unit, where all residents are managed as if infected and staff use droplet + contact precautions for all residents and while in the affected area.
- ◯ Staff are assigned to care for either symptomatic or asymptomatic residents.
- ◯ Managers communicate with Public Health, Ministry of Labour, Ministry of Long-Term Care and/or the Ontario Long Term Care Association, and with local hospitals as necessary.

APPENDIX 5: KINGSTON, FRONTENAC, LENNOX AND ADDINGTON PUBLIC HEALTH UNIT COVID-19 LONG-TERM CARE OR RETIREMENT HOME VISIT

The following checklist is taken from: Ontario Ministry of Health COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH), April 15, 2020.

Date:	Facility:	PHN:	PHI:

		Yes	No	N/A	Notes
Entrance and Common Areas					
1	PHI/PHN is screened for symptoms and contacts on entry, including temperature				
2	PHI/PHN is told to mask for source control				
3	All employees are wearing procedure masks, unless on break				
	Physical distancing is maintained in the:				
4	TV room				
5	Dining room				
6	Staff lounge or break room				
Care Areas					
7	A PSW/RPN is assigned to care for either symptomatic or asymptomatic residents (i.e., staff cohorting)				
8	A PSW/RPN has worked only on this unit for the previous 3 shifts, not on other units				
	For AGMPs, staff wear fit tested N95 respirators and the room door is closed				
9	CPAP				
10	Nebulizers				
11	Open tracheostomy suctioning				
12	Staff perform hand hygiene for 15 seconds on room entry and exit:				
	Opportunity 1				
	Opportunity 2				
	Opportunity 3				
	Opportunity 4				
	Opportunity 5				
	Opportunity 6				
	Opportunity 7				
	Opportunity 8				
	Opportunity 9				
	Opportunity 10				

		Yes	No	N/A	Notes
Symptomatic Resident					
13	A symptomatic resident is on droplet + contact precautions				
14	The symptomatic resident been tested for COVID-19				
15	KFL&A PH was notified of the suspected case				
16	Any roommate of the symptomatic resident is on droplet + contact precautions				
17	Roommate has been tested for COVID-19				
Staff PPE Use					
	At the doorway to a droplet + contact room, the following is available:				
18	Gloves				
19	Gowns				
20	Procedure masks				
21	Eye shield or goggles				
22	ABHR				
23	Trash bin for doffing				
24	Recycle bin for masks				
25	Doffing instruction sign				
26	Staff demonstrate doffing correctly				
	Staff 1				
	Staff 2				
	Staff 3				
27	Used masks and eye protection are saved in separate, sealed, dated yellow bags for reprocessing				
Extended Use					
28	Staff are wearing the same PPE for multiple encounters with several residents				List items in extended use:
29	PPE is changed if moving from a symptomatic resident to an asymptomatic resident or vice versa				
30	PPE is removed before exiting the patient care area (e.g., to go to break or to a ‘clean’ area)				
31	PPE is changed if damaged, soiled or wet				
Re-Use					
32	Staff are removing PPE and putting it back on				List items in extended use:
33	PPE is changed if moving from a symptomatic resident to an asymptomatic resident or vice versa				
34	PPE is removed before exiting the resident care area (e.g., to go to break or to a ‘clean’ area)				
35	PPE is changed if damaged, soiled or wet				
36	PPE is doffed without self-contamination				
37	PPE is stored without contaminating the inner clean surface				
38	PPE is re-donned without self-contamination				

APPENDIX 6: KINGSTON, FRONTENAC, LENNOX AND ADDINGTON (KFLA) PUBLIC HEALTH UNIT TABLE TOP EXERCISE

Influenza Preparedness Day - August 16, 2019

9:00AM	Introduction, Australian flu season, goals of preparedness
9:20AM	Surveillance capacity and real-time monitoring
9:30AM - 12:00PM	Influenza preparedness scenarios-SECTORS (Roundtable discussions, presentations and feedback)
12:00 - 1:00PM	Lunch and networking
1:00 - 2:00PM	Best practices in infection prevention and control
2:00 - 4:00PM	Actions taken during peak flu activity-REGIONS (Roundtable discussions, presentations and feedback)
4:00PM	Closing remarks and next steps