

19. Long-Term Care Homes

Influenza almost always selects the weakest in society to kill, the very young and the very old. ... Pneumonia was even known as “the old man’s friend” for killing particularly the elderly, and doing so in a relatively painless and peaceful fashion that even allowed time to say good-bye.

The Great Influenza, John M. Barry

If an influenza pandemic does occur in Ontario, residents in long-term care homes (LTCHs) may be affected. Viruses can be introduced into LTCHs by staff and visitors, and they can spread easily in these closed communities. Because of their age and underlying medical conditions, most people living in LTCHs who develop influenza are at increased risk of complications. During seasonal influenza outbreaks in LTCHs, up to 70% of residents and staff may become infected. Based on an attack rate of 35% at the peak period of a pandemic wave, between 20 to 25% of LTCH home staff may fall ill and be unable to work for a period of time.

LTCHs across Ontario already have emergency plans and infection prevention and control programs in place to prevent and manage respiratory infection outbreaks, including seasonal influenza (see *A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes* at:

http://www.health.gov.on.ca/english/providers/pub/pubhealth/ltc_respoutbreak/ltc_respoutbreak.html.

This chapter, which is designed to supplement the guide, provides information on how to plan for specific issues that may arise during an influenza pandemic. If an influenza outbreak occurs in the home during the pandemic, LTCHs should use both the guide and the information in OHPIP.

19.1 Objectives

- To help long-term care homes prepare for a pandemic.
- To reduce the spread of pandemic influenza within LTCHs among residents, staff, family members and volunteers.
- To maintain essential care and services for residents during a pandemic in order to keep them in the LTCH.
- To make effective use of staff skills and knowledge during a pandemic.
- To identify services in LTCHs that can be reduced, modified or curtailed during a pandemic.
- To ensure that workplace health and safety standards are maintained to support staff, families and volunteers in meeting resident care and service needs.

19.2 Planning

To prepare for an influenza pandemic, LTCHs should develop their own plans and coordinate them with other health organizations in their community, public health unit area or Local Health Integration Network (LHIN).

Develop a Pandemic Influenza Plan

Every LTCH should establish a pandemic planning team and a coordinator responsible for pandemic planning. The planning team should include people with expertise in infection prevention and control, and develop plans in collaboration

with the LTCH's Joint Health and Safety Committee or Safety representative. The LTCH should also work closely with long-term care compliance inspectors in developing and implementing their pandemic plans. Inspectors are a valuable resource for planning.

The LTCH's pandemic plan should be reviewed and updated annually or more frequently if required. These plans should augment the LTCH's outbreak management and emergency plans.

Review and Update Emergency Plans

Because an influenza pandemic is likely to cause social disruption and affect critical services, LTCHs should review their emergency/business continuity plans to ensure they take into account the potential impact of an influenza pandemic.

Coordinate Planning with Other Health Organizations

Because an influenza pandemic will affect the whole community, LTCHs cannot plan in isolation. They should:

- connect with other health organizations in the community, including the public health unit (which has lead responsibility for local pandemic planning), other LTCHs, hospitals, community care access centres (CCACs), home care providers, primary care providers, emergency medical services (for resident transfers), laboratory services, pharmacies and regional infection control networks
- familiarize themselves with other organizations' plans and functions during a pandemic
- identify opportunities to collaborate/ share resources during a pandemic
- identify possible scenarios and how they would be handled by the system (e.g., if the hospital is unable to accept residents

from LTCHs how will LTCH provide care? Can well residents be moved to another site/level of care? How will the system make the best use of human resources?)

- identify agencies that could provide staff in the event of shortages (e.g., nursing agencies)
- identify volunteers or family members who could provide services or assistance in the event of a shortage of trained staff
- work with partners, such as acute care hospitals and CCACs, to determine how to apply provincial criteria (to be developed) for who will be admitted to hospital, cared for in a LTCH, and/or served by home care.

19.3 Options for Resident Care

LTCHs should assess residents' care needs in order to identify, in the event of pandemic influenza in the community or home:

- residents who could be discharged temporarily to family members
- residents who could be discharged temporarily home with home care services
- residents who must continue to be cared for in a LTCH.

This information will be particularly important if hospitals are overwhelmed and LTCH beds are needed for influenza patients convalescing, or in the event of staff shortages.

19.4 Services to be Reduced, Enhanced or Deferred

During a pandemic, LTCHs may reduce or delay some services to compensate for staff shortages, or to prevent the spread of influenza. Table 19.1 provides examples of

services that could be reduced, deferred or enhanced, based on severity of the pandemic and residents' needs.

Onsite adult day programs or childcare programs may be reduced or curtailed based on the capacity of the LTCH to staff them or due to public health measures implemented by the local Medical Officer of Health. As long as homes have enough staff, they can continue to provide these programs – unless instructed otherwise by the local public health unit. There should be no interaction between ill residents and program participants. Program participants should be screened for ILI before entering the home.

Decisions about which services to reduce, curtail or enhance should be made based on nursing and professional judgment, residents' needs, infection control and prevention guidelines, and advice from the public health unit. Plans to reduce services should be discussed with public health and compliance inspectors and the College of Nurses.

Note: some laboratory services may be curtailed during a pandemic, and this may affect the routine care and diagnosis services that LTCHs provide (see Chapter 14).

Managing a Potential Increase in Deaths

Depending on the severity of pandemic strain, LTCHs may see an increase in deaths. Most LTCHs do not have morgues or systems for storing or removing multiple bodies. For information on how to manage this situation, please see the Ministry of Community Safety and Correctional Services *Natural Death Surge Capacity Plan*. LTCHs can also contact their local public

health unit.

19.5 Surveillance

It is unlikely that the spread of a pandemic strain into Ontario will first be detected in a LTCH but, because residents are highly vulnerable, the pandemic virus could spread quickly and easily from the community into the long-term care environment.

Surveillance is a key component of detecting, preventing and managing the spread of pandemic influenza. Someone with training in infection prevention and control should be responsible for the home's surveillance program.

LTCHs already do regular surveillance for febrile respiratory infections. When pandemic activity has been reported in the community (phase 6), LTCHs should enhance their surveillance. During a pandemic, LTCHs should:

- continue to monitor residents for signs of FRI/ILI
- conduct active surveillance for FRI/ILI in visitors, students, staff and new residents
- continue to take nasal pharyngeal swabs during a respiratory infection outbreak during a pandemic, but not as many
- notify the local medical officer of health of any respiratory infection outbreak in the home
- continue to report daily line listings to the health unit, but submit the aggregate information electronically using the web portal (for more information, see Chapter 5: Surveillance).

Table 19.1: DRAFT FOR DISCUSSION ONLY: LTCH Services that Could be Maintained, Reduced or Enhanced During an Influenza Pandemic (adapted from Peel Long-Term Care Pandemic Influenza Plan)

Type of Service	Level of Care that Must be Maintained	Services that Could be Reduced	Services that May be Enhanced
Personal care	Face, hands and perineum washed twice daily and as needed to maintain skin integrity Active care that reduces risk of health complications	Bathing limited to baths/showers as needed	
Medications	Administered as prescribed		Antiviral administration
Personal hygiene and grooming		Modify depending on resident health needs, staff availability; defer care of fingernails and feet	
Oral Care	Twice daily		
Assessment of care needs	Ongoing	Frequency may be reduced	
Clothing and bedding changes		As needed	
Toileting and incontinence care	Maintain routine toileting and incontinence care Maintain routine catheter care as ordered		
Skin and wound care	Routine aseptic dressings, sterile dressings and colostomy care		
Assistance with eating	Provide as needed Maintain G-tube feeding		
Oxygen therapy	Maintain		
Repositioning bedridden residents		Once every 2 hours or as needed to promote comfort and prevent skin breakdown	
Communications with families/ decision makers	Maintain regular communications		May have to increase frequency or change method (e.g., website)
Non-urgent medical appointments		Reschedule	
Contract services	Determine whether services such as physiotherapy and psychiatry visits should continue	Defer hairdressing and foot care depending on resident needs (i.e., foot care not deferrable for residents with diabetes)	
Day programs		Defer and reschedule, depending on resident health needs, staff availability and severity of pandemic	
Social and recreational activities		Can be reduced or deferred	
Management of natural deaths			Will likely increase

19.6 Human Resource Planning

Human resources planning is key to maintaining services during a pandemic. LTCHs should work with the Medical Directors and attending physicians, nurse practitioners and others to plan for the delivery of critical or acute care technical services such as starting intravenous therapy, oxygen support and ordering laboratory tests (as outlined in chapter 14). To ensure continuity of physician services, some communities might establish a group of two or three physicians who will provide telephone support to all LTCHs or provide care to all residents in a certain number of LTCHs (i.e., doctors on wheels).

During a pandemic, LTCHs are likely to experience staff shortages, and may have to take extraordinary measures to continue to provide care for residents. OHPIP supports a skills-based approach (for more information, see competency evaluation tools in Chapter 8). As part of their planning, LTCHs should identify:

- the minimum skills required to meet residents' needs, including providing care for residents who develop influenza
- the direct care staff who have those skills or who could be trained to take on more responsibilities within their scope of practice in different roles
- strategies that could be used to increase capacity (e.g., contracting staff from external agencies, extending working hours, calling staff back to work)
- other staff (e.g., clerical, housekeeping) who could be trained to assist with care (e.g., feeding of residents who are not at high risk of choking)

- family members/volunteers who could be trained to help with care and daily living activities (e.g., how to give a bed bath and assist with feeding and toileting)
- staff /volunteers with skills to provide training to family members and volunteers
- other organizations in the community that might be able to provide workers with the appropriate skills
- any labour (i.e., union), insurance or liability issues the LTCH would have to address if it altered staff roles or used temporary workers and volunteers
- which staff will be responsible for supervising staff in different roles, family members or volunteers who participate in resident care delivery
- the supports that staff and other workers may need to be able to work (e.g., transportation, accommodation, assistance with child care and other family responsibilities).

LTCHs should engage members of the Occupational Health and Safety Committee and the union (i.e., the bargaining agent) in pandemic planning to ensure that their plans include appropriate practice, communication and education.

19.7 Infection Prevention and Control Measures

For Staff and Volunteers

Information on occupational health and safety and infection prevention and control is set out in detail in Chapter 7, and include both the hierarchy of controls approach to create a safer work environment, and the use of routine,

droplet and some airborne precautions. The type of personal protective equipment required is also described in that chapter.

The differences from usual practice in a LTCH during a pandemic include:

- the use of N95 respirators by everyone entering a room where there are residents with influenza-like illness
- the recommendation to cohort residents with pandemic influenza, depending on the capacity/structure of the home, the nature of the home's population (i.e., will moving people be too disruptive), and the severity and epidemiology of the pandemic strain
- if cohorting is not possible, separating residents who are particularly vulnerable to complications from influenza from residents with influenza
- restricting residents with influenza to their rooms as long as it does not cause the resident undue stress or agitation and can be done without applying restraints
- screening all new admissions to the home during a pandemic
- the importance of following the established transfer authorization process when transferring patients to hospital or to another health care facility – unless other arrangements have been made for transfers during a pandemic (i.e., Fax PTAC at 416-397-9061 for a transfer request, or use the web-based application if available. If approved, an authorization number will be issued immediately and faxed or issued on-line to the home)
- allowing ill staff, students and volunteers to return to work before they are completely recovered (if

required because of staff shortages), but restricting ill workers to non-direct care or to working with residents with symptoms of ILI if possible. Staff, students and volunteers should NOT be deployed to care for high risk, medically fragile patients

- there will be few restrictions on where staff are allowed to work because the virus will be widely circulating in the community. If there are significant staff shortages throughout the health care system, staff may work in many different settings.

Occupational Health and Safety Tip Box

Employers shall develop and implement appropriate measures, procedures and training for the protection of workers in consultation with Joint Health & Safety Committees (JHSC) or Health and Safety Representatives and Infection Prevention and Control resources. See measures in Chapter 7 for more information.

Some examples of controls in long-term care settings include:

- HVAC system
- hand hygiene and cough etiquette signage
- barriers (e.g., curtains, Plexiglas)
- education and training for workers and supervisors
- appropriate IPC housekeeping practices by trained workers
- personal protective equipment (based on risk assessment)

For more advice on identifying and implementing controls, see the following web sites: <http://www.labour.gov.on.ca>; <http://www.ricn.on.ca>; <http://www.osach.on.ca>; <http://www.whsc.on.ca>

For more information on Occupational Health and Safety Measures and Infection Prevention and Control in Health Care Settings consult the OHPIP Chapter 7.

For Volunteers

Visitors will likely not be restricted from the LTCH unless they are ill because they will be needed to assist with care. During a pandemic, visitors should be required to perform hand hygiene on arrival, before leaving the resident's room, and before leaving the LTCH, and use PPE as instructed by staff. Any restrictions on visitors should be based on the severity and epidemiology of the pandemic; however, not allowing visitors is not recommended, as it may cause emotional hardship to both the residents and the relatives. Notices should be posted on the doors of rooms of ill residents advising visitors to check at the nursing station before entering the room.

19.8 Outbreak Management

If an outbreak of influenza is detected in the LTCH during the pandemic, the LTCH should follow the recommendations of the Ministry of Health and Long-Term Care document: *A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes*. In addition, the LTCH should take into account the following:

- there are some differences in infection control (see 19.7), such as the use of N95 respirators
- antivirals will be used for all staff, volunteers and residents for outbreak control if pandemic vaccine is not yet available
- exclusion policies for unvaccinated staff will not apply if there is no vaccine available for the pandemic strain
- it is unlikely that public health units will be able to offer on-site assistance
- outbreak reporting has been streamlined and will use the web-

based surveillance system (see Chapter 5: Surveillance); however, line listings should still be sent to the public health unit

- the importance of reporting if an outbreak fails to come under control with the use of antivirals and taking additional swabs to check for antiviral resistance or other organisms.

19.9 Education and Staff Support

Preparedness should include ongoing education of staff, volunteers, residents and residents' families about influenza and the home's pandemic plan. A significant amount of education will focus on infection prevention and control practices and measures to protect the health of staff and residents (see Chapter 7). Education plans should be developed in collaboration with staff responsible for occupational health and safety. They should include:

- the education required for staff, including staff who do not routinely care for residents but might have to during a pandemic
- education for volunteers
- education required for residents, the Residents' Council, families and the Family Council, which may include training family members to assist with some aspects of care during a pandemic (e.g., bed baths, assisting with feeding and toileting)
- education for visitors
- approaches to training (e.g., team-based approaches that will ensure any temporary workers receive appropriate support and supervision, and cross-training to ensure staff are able to

- cover one another's duties, such as peritoneal dialysis)
- frequency of training (e.g., during orientation, then annually – or more frequently if threat of a pandemic is imminent)
- training resources (e.g., pamphlets, fact sheets, formal presentations, public awareness campaigns). Every effort should be made to ensure that education provided by the LTCH is consistent with that provided by other homes and other health care organizations in the community and province.

Education Programs

Education and training programs for all staff and residents should include (but not be limited to):

- the home's influenza pandemic plan
 - the importance of hand hygiene and proper hand hygiene technique
 - appropriate cleaning and disinfection of equipment (i.e., any equipment that is shared between residents must be cleaned and disinfected after each use)
 - appropriate use of PPE which includes application, removal and disposal of gloves, gowns, eye protection, surgical masks and N95 respirators
 - risks associated with infectious diseases such as febrile respiratory illnesses (FRI) – including influenza-like illness (ILI)
 - benefits of case finding/surveillance
 - principles and components of routine infection control practices
 - risks of transmission
 - procedures that are considered high risk and the reasons for that risk
- individual staff responsibility to keep other staff and residents safe
 - the employers' responsibility to protect workers health
 - any changes to staff exclusion policies during a pandemic and the reasons for those changes.

Supporting Staff

LTCHs should work with unions to identify supports that will help staff provide care during a pandemic such as:

- assistance with transportation
- accommodation and meals
- access to counselling and psychosocial support to help staff cope with job-related stress or with anxiety about the pandemic
- flexible scheduling that gives staff time to fulfill family responsibilities with family-related needs
- assistance with babysitting for children (i.e., if schools are closed or staff are working extra shifts), caring for elderly family members, and caring for pets.

See also Chapter 21, Psychosocial Support.

19.10 Antivirals and Vaccine

During a pandemic, LTCHs will be responsible for administering antivirals to residents and staff, for treatment and outbreak control. Once a vaccine is available, LTCHs will also be responsible for immunizing residents, staff and volunteers. The Ministry Emergency Operations Centre (MEOC) will be responsible for supplying and coordinating the distribution of antivirals to LTCHs, and the public health unit will be responsible for supplying and coordinating the distribution of vaccine.

Administration of Antivirals

Antivirals will be supplied to LTCHs as needed, based on available supplies and demand in the community. LTCHs may make arrangements (e.g., a service agreement) with the pharmacy affiliated with the LTCH to assist in dispensing and administering antivirals.

LTCHs must have the capacity to safely store antivirals and vaccine, including cold chain storage that meets public health guidelines (i.e., keeps vaccine at a temperature between 2 and 8° C) and maintain distribution records. LTCH pandemic plans should:

- identify the person responsible for receiving, storing and reporting on the use of antivirals and vaccine
- identify where antivirals and vaccine will be stored, and how the home's supply will be kept secure
- review security procedures to ensure they are adequate
- have a contingency plan in case of power failure or equipment malfunction
- set out the role of the pharmacy on contract with the LTCH in providing access to antivirals and backup services (if any)
- describe the mechanisms the LTCH will use to track who receives antivirals and vaccine, and to report any adverse reactions.

(For more information on the storage and distribution of antivirals and vaccine, see Chapter 9A: Ontario Emergency Mass Vaccination/Prophylaxis Plan.)

Prescribing and Administering Antivirals

To be most effective, antiviral treatment must be started as soon as possible after

onset of symptoms – preferably within 12 to 24 hours. Antivirals can be prescribed up to 48 hours after onset of symptoms, but they will be less effective. Treatment decisions are the responsibility of attending physicians but, because it may be difficult to reach attending physicians during an influenza pandemic, LTCHs should have medical directives and consent forms on file that allow them to administer antivirals to residents who are ill with ILI.

Use of Antivirals for Prophylaxis

A provincial policy for the use of antivirals during an influenza pandemic will be developed when national recommendations are complete. This section will be updated then.

19.11 Supplies and Supply Chains

As part of preparedness planning, LTCHs should identify the type and quantity of supplies (other than antivirals and vaccine) they will need, and purchase and maintain a one-month stockpile. MOHLTC will also maintain a one-month supply for LTCHs. See Chapter 10 for a supplies and equipment template developed by the Ministry of Health and Long-Term Care.

During a pandemic, traditional supply chains may be disrupted. For example, a supplier in another jurisdiction may have to give priority to local companies. During the preparedness phase, LTCHs should:

- talk to suppliers about their ability to deliver during a pandemic
- review systems in place to ensure adequate supplies (e.g., environmental cleaning supplies, food, medications, oxygen concentrators)

- establish relationships with alternative suppliers/sources, including: equipment suppliers, food suppliers, medical suppliers, pharmacies, oxygen suppliers, attending physicians and any other health care providers who provide contracted services to the home (e.g., physiotherapists, occupational therapists).

19.12 Communication

Most LTCHs will already have plans and procedures for communicating with residents, residents' families, staff, media and other organizations in the community (e.g. local public health units, the coroner's office, and funeral directors) in the event of an outbreak or emergency. These plans should be reviewed to ensure that they will be appropriate during a pandemic.

To provide effective communications, LTCHs should:

- maintain up-to-date contact lists for staff and residents' families/next of kin or caregivers
- use influenza fact sheets and other materials provided by the local public health unit or the MOHLTC, including Important Health Notices, so messages to the public are consistent
- have an alternate or backup system of communication
- post signs at all entrances indicating the situation (e.g., pandemic activity in the community and/or pandemic activity within the home), advising visitors of the potential risk of either introducing influenza into the home or acquiring influenza within the home, and of any visiting restrictions, if applicable

- use other communication systems as appropriate (e.g., website) to maintain communications with family members and visitors.

19.13 Review the Pandemic Response

When the pandemic wave is over, LTCHs should meet with local public health unit staff and other community partners to review the response to the pandemic in the home and in the community, identify what was handled well and what could be improved, and prepare for a possible next wave.

19.14 Next Steps

The MOHLTC and the long-term care sector will continue to address outstanding issues, including:

- developing provincial criteria to help communities determine which patients will be admitted to hospital, cared for in a LTCH, and served by home care during an influenza
- developing policies and agreements to ensure that residents who are discharged home or to the care of family members will not lose their LTCH bed and that any discharging of residents related to the pandemic will not have a negative effect on LTCHs' operating budgets.

References

1. Ontario Ministry of Health. Influenza Prevention and Surveillance Protocol for Ontario Long-Term Care Facilities. November 1999.
2. Ontario Ministry of Health and Long-Term Care. A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes at:

http://www.health.gov.on.ca/english/providers/pub/pubhealth/ltc_respoutbreak/ltc_respoutbreak.html.

3. National Advisory Committee on Immunization (NACI). Statement on influenza vaccination for the 2007-2008 season. An advisory committee statement.