STRATHMERE LODGE

Emergency Management Program

INFECTIOUS DISEASE OUTBREAK, EPIDEMIC & PANDEMIC EMERGENCY RESPONSE PLAN

Original Date: May 2015
Reviewed/Revised: Sept. 4, 2026

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1.0 PURPOSE

The purpose of this Plan is to establish a coordinated response to:

- outbreaks of a communicable disease;
- outbreaks of a disease of public health significance;
- epidemics; and
- pandemics

that affect or may affect Strathmere Lodge.

The Plan is intended to:

- protect residents, staff and others from transmission of infectious disease;
- ensure early identification and response;
- establish clear lines of authority;
- provide for resident isolation and cohorting;
- provide for staff cohorting and management of symptomatic or exposed staff;
- establish the Lodge Outbreak Management Team (OMT);
- maintain essential resident care and required programs;
- ensure appropriate communication and reporting;
- coordinate the Home's response with the Middlesex-London Health Unit (MLHU); and
- support recovery and return to normal operations.

This Plan supplements, rather than replaces, The Lodge’s Infection Prevention and Control (IPAC) policies and procedures.

2.0 SCOPE AND DEFINITIONS

This Plan applies to infectious disease events ranging from a suspected outbreak affecting one Resident Home Area (RHA) to a widespread epidemic or pandemic affecting the entire Home and surrounding community.

For purposes of this Plan:

Outbreak means an occurrence of disease above the normally expected level or an occurrence meeting applicable Public Health outbreak criteria.

Communicable Disease means a disease capable of transmission from one person to another, directly or indirectly.

Disease of Public Health Significance means a disease designated as such under applicable Ontario public health legislation.

Epidemic means disease occurring in a community or region at levels significantly above those normally expected.

Pandemic means an epidemic occurring across multiple countries or continents, potentially resulting in widespread illness and significant disruption to health care, staffing, supplies and community services.

Disease-specific definitions, case definitions and outbreak thresholds shall be based upon **current MLHU, Ministry of Health, Chief Medical Officer of Health and other applicable provincial direction**, rather than permanently prescribed within this emergency response plan.

3.0 REGULATORY AND PUBLIC HEALTH FRAMEWORK

Provincial long-term care legislation (O. Reg. 246/22) requires the Home's emergency plan for infectious disease outbreaks, epidemics and pandemics to specifically address:

- an area for isolating residents;
- resident and staff cohorting;
- staffing contingencies for required programs;
- management of staff who may have been exposed;
- management of symptomatic residents and staff; and
- an Outbreak Management Team, including its membership, roles and responsibilities.

The Home's IPAC program also requires infection surveillance on every shift, recording of symptoms, immediate action to reduce transmission/isolate/cohort as required, daily analysis for evidence of infection, and an outbreak management system and written outbreak response plan.

Current Public Health and provincial requirements and direction shall prevail where they establish more specific requirements than this Plan.

4.0 PREVENTION, SURVEILLANCE AND EARLY DETECTION

Prevention and early identification are the first lines of defence against an outbreak.

Staff shall:

- apply Routine Practices and Additional Precautions as required;
- perform appropriate hand hygiene;
- use personal protective equipment (PPE) according to the assessed risk and current requirements;
- monitor residents for signs and symptoms of infection;
- report suspected infection promptly;
- document symptoms and observations;
- notify the registered nursing staff/IPAC Lead as appropriate; and
- take immediate measures to reduce potential transmission.

Resident symptoms indicating possible infection shall be monitored **on every shift**.

Surveillance information shall be reviewed and analyzed in accordance with the Home's IPAC program.

The IPAC Lead shall monitor relevant:

- MLHU notifications;
- provincial health alerts;
- respiratory virus activity;
- outbreak trends;
- emerging infectious diseases; and
- changes in Public Health/IPAC guidance.

MLHU maintains current outbreak control resources specifically for long-term care homes, including respiratory and enteric outbreak control measures, symptomatic resident guidance and line lists.

5.0 ACTIVATION AND ESCALATION

This Plan may be activated when:

- an outbreak is suspected;
- MLHU declares an outbreak;
- an unusual cluster of illness is identified;
- a disease of public health significance presents a threat to the Home;
- an epidemic or pandemic creates a significant risk to residents or operations;
- significant infectious disease transmission occurs within the Home; or
- Public Health or another competent authority directs emergency measures.

Response Sequence

SURVEILLANCE → SUSPECT → ISOLATE/PRECAUTIONS → NOTIFY IPAC → CONTACT MLHU → LODGE OUTBREAK MANAGEMENT TEAM (OMT) → COHORT/CONTROL → MONITOR → MLHU DECLARES OVER → RECOVERY

Measures shall be proportionate to the nature, extent and transmission risk of the disease.

6.0 INCIDENT COMMAND AND LINES OF AUTHORITY

The **Administrator** has overall administrative responsibility for the Home's emergency response.

The **IPAC Lead** provides technical leadership for outbreak prevention and control and coordinates the Home's outbreak management activities.

The **Director of Resident Care (DRC)** provides clinical/nursing leadership.

After hours, the **Charge Nurse (RN)** shall initiate immediate measures and assume initial operational coordination until the Administrator/designate and/or IPAC Lead assumes the applicable leadership functions.

An outbreak does not need to await the arrival or authorization of a manager before staff initiate necessary resident isolation, precautions or other immediate infection control measures within their authority.

7.0 OUTBREAK MANAGEMENT TEAM

A Lodge **Outbreak Management Team (OMT)** shall be established when an outbreak is declared and may be convened earlier when circumstances warrant.

Core OMT Membership

Position	Primary Responsibility
IPAC Lead	Outbreak coordination, surveillance, Public Health liaison, IPAC measures
Administrator	Overall operations, resources, external/organizational coordination

Position	Primary Responsibility
Director of Resident Care	Clinical/nursing operations
Assistant Director of Resident Care	Clinical support, staffing/resident care coordination
Environmental Services Manager	Environmental cleaning, disinfection, laundry/waste
Food Services Manager	Dietary operations, food/fluid continuity
Office Supervisor	Administrative/communication support
Manager of Programs	Resident programming and activity modifications

Additional participants may include the Medical Director/attending physicians, Nurse Practitioner, Pharmacy, MLHU/Public Health, laboratory resources and other persons required by the circumstances.

LODGE OUTBREAK MANAGEMENT TEAM (OMT)

Responsibilities

The OMT shall:

- review outbreak status and epidemiological information;
- establish/adjust control measures;
- review affected resident home areas (RHAs);
- review resident and staff cohorting;
- assess staffing;
- review PPE and essential supplies;
- review symptomatic residents/staff;
- coordinate testing as applicable;
- address admissions/transfers/absences/visitation;
- coordinate communications;
- identify emerging risks;
- document decisions; and
- plan recovery.

Meeting frequency shall reflect outbreak severity and Public Health direction.

8.0 PUBLIC HEALTH NOTIFICATION AND COORDINATION

The **Middlesex-London Health Unit (MLHU)** is the primary Public Health partner for institutional outbreak management.

Where an outbreak is suspected, the IPAC Lead/designate shall contact MLHU in accordance with current reporting requirements.

MLHU currently identifies respiratory and gastroenteritis institutional outbreaks as reportable to the Medical Officer of Health and provides both regular-hours and after-hours outbreak reporting processes.

The Lodge shall follow MLHU direction regarding:

- outbreak assessment/declaration;
- case definitions;
- testing/specimen collection;
- isolation/additional precautions;
- cohorting;
- outbreak control measures;
- admissions/transfers/absences as applicable;
- visitor measures;
- surveillance;
- communication requirements; and
- declaration that the outbreak is over.

MLHU ultimately determines when an outbreak is declared and when it is declared over.

9.0 IMMEDIATE RESPONSE TO A SUSPECTED OUTBREAK

Upon identifying a suspected outbreak:

1. Assess affected resident(s).
2. Initiate appropriate precautions without delay.
3. Isolate symptomatic residents as appropriate.
4. Notify the IPAC Lead/designate.
5. Begin/update applicable surveillance and line listing.
6. Identify potentially affected residents/staff.

7. Contact MLHU as required.
8. Obtain specimens/testing as directed or clinically indicated.
9. Review PPE and supplies.
10. Increase environmental cleaning as appropriate.
11. Consider cohorting.
12. Convene the OMT as warranted.
13. Implement MLHU-directed outbreak control measures.

Staff shall **not wait for laboratory confirmation** before implementing reasonable infection control precautions where an infectious illness is suspected.

10.0 RESIDENT ISOLATION

At Strathmere Lodge, the **resident's own room is the primary area used for isolation**.

Where required, additional rooms or areas may be designated according to:

- type of infection;
- mode of transmission;
- number of affected residents;
- resident needs;
- room configuration;
- outbreak epidemiology; and
- MLHU/IPAC direction.

Residents shall continue to receive appropriate:

- nursing/personal care;
- medications;
- food and fluids;
- physician/Nurse Practitioner (NP) services;
- psychosocial support;
- meaningful engagement; and
- essential services

while isolated.

Isolation measures shall be implemented in the least restrictive manner consistent with resident and public safety and current requirements.

11.0 RESIDENT COHORTING

Residents shall be cohorted **by Resident Home Area (RHA) where feasible**.

Depending upon the outbreak, further cohorting may distinguish between residents who are:

- symptomatic/confirmed;
- exposed;
- recovered; and
- unaffected.

Dedicated areas, equipment, staff and workflows may be established where appropriate.

Resident movement between/among affected and unaffected RHAs shall be minimized where required.

Cohorting arrangements shall be continually reassessed as the outbreak evolves.

12.0 STAFF COHORTING

Where feasible and appropriate, staff shall be assigned to specific RHAs/cohorts to reduce transmission between/among affected and unaffected areas.

Measures may include:

- limiting cross-RHA assignments;
- assigning designated staff to affected residents;
- establishing workflows that minimize movement of staff, equipment and supplies between/among affected and unaffected residents or areas;
- restricting unnecessary staff movement;
- adjusting break locations;
- modifying schedules/assignments.

Absolute staff cohorting may not always be operationally possible. Decisions shall balance infection control risk with the requirement to provide safe resident care.

13.0 SYMPTOMATIC RESIDENTS

A resident who develops symptoms potentially associated with communicable disease shall be:

ASSESSED → PRECAUTIONS/ISOLATION → DOCUMENTED → REPORTED → MONITORED → TESTED/TREATED AS APPROPRIATE

Clinical assessment shall consider:

- symptoms;
- vital signs;
- hydration/nutrition;
- respiratory status where applicable;
- change in cognition/function;
- underlying conditions;
- potential complications.

Physicians/NP shall be notified where clinically indicated.

Emergency medical care/911 shall not be delayed because the Home is in outbreak.

Resident goals of care and treatment preferences shall continue to be respected.

14.0 SYMPTOMATIC OR EXPOSED STAFF

Staff shall report infectious disease symptoms or relevant exposures according to current Home policy.

Symptomatic/exposed staff shall be managed according to:

- applicable occupational health requirements;
- current Public Health/provincial guidance;
- nature of the disease/exposure;
- work restrictions where applicable; and
- fitness-to-work considerations.

The emergency response plan shall **not establish permanent disease-specific exclusion periods**.

Return-to-work requirements shall reflect the current requirements applicable at the time of the outbreak.

15.0 PPE AND ADDITIONAL PRECAUTIONS

PPE shall be selected according to:

- Routine Practices;
- Additional Precautions;
- point-of-care risk assessment;
- organism/mode of transmission;
- current Public Health/provincial requirements.

Required PPE shall be readily available at the point of care.

Signage shall be posted as appropriate.

The IPAC Lead/designate shall monitor:

- PPE consumption;
- available inventory;
- anticipated duration;
- burn rate;
- supply chain risk.

Additional supplies shall be ordered **before critical inventory levels are reached**.

16.0 RESPIRATORY OUTBREAK

Potential respiratory outbreaks may include influenza, COVID-19, RSV and other respiratory pathogens.

Response may include:

- resident isolation;
- appropriate respiratory precautions;
- testing/specimen collection;
- line listing;
- resident/staff cohorting;
- enhanced surveillance;
- environmental cleaning;

- treatment/antiviral measures where prescribed;
- modified activities/dining;
- visitor/access measures where applicable.

Specific case definitions and outbreak control measures shall follow **current MLHU/provincial direction**.

17.0 ENTERIC OUTBREAK

Potential enteric outbreaks may include norovirus and other infectious gastroenteritis.

Response may include:

- isolation/contact precautions;
- enhanced hand hygiene;
- appropriate PPE;
- line listing;
- specimen collection;
- enhanced environmental cleaning/disinfection;
- resident/staff cohorting;
- modification of communal dining/programming;
- food service precautions;
- exclusion of symptomatic staff according to current requirements.

Current MLHU enteric outbreak control measures shall guide organism-specific response.

18.0 OTHER COMMUNICABLE DISEASES / DISEASES OF PUBLIC HEALTH SIGNIFICANCE

This Plan applies equally to other infectious diseases that may require emergency response.

The Home shall not assume that respiratory or enteric measures are appropriate for every disease.

The IPAC Lead shall determine required precautions in consultation with MLHU and other appropriate clinical/Public Health resources.

Response may require disease-specific:

- isolation;
- contact tracing;
- testing;
- prophylaxis/treatment;
- vaccination;
- environmental measures;
- staff restrictions;
- resident/staff surveillance;
- reporting.

19.0 EPIDEMIC OR PANDEMIC RESPONSE

A widespread epidemic or pandemic may create challenges beyond a conventional outbreak, including:

- multiple affected RHAs;
- widespread staff illness/absence;
- community health system pressure;
- hospital capacity constraints;
- medication/supply shortages;
- PPE shortages;
- food/supplier disruption;
- laboratory/testing constraints;
- transportation disruption;
- significant family/public concern.

The Home shall progressively escalate its emergency response according to operational impact.

The Administrator may expand the Home's Incident Management structure and increase the frequency of OMT/leadership meetings.

Priority shall be:

LIFE SAFETY → INFECTION CONTROL → ESSENTIAL RESIDENT CARE → STAFFING → MEDICATIONS/FOOD/WATER → ESSENTIAL OPERATIONS → OTHER SERVICES

20.0 STAFFING CONTINGENCY

Staffing contingency planning shall address **all programs required under the Fixing Long-Term Care Act and Ont. Regulation 246/22**, s. 269.

The Administrator/DRC and managers shall monitor absenteeism and staffing capacity.

Escalating measures may include:

Normal staffing → overtime/call-in → redeployment/reassignment → management/supervisory assistance within competence → modified schedules → prioritization of essential services → external staffing/resources where available.

No employee shall be assigned duties beyond their lawful scope, competence or training.

Resident safety and essential care shall be prioritized.

21.0 MEDICATIONS, MEDICAL SUPPLIES AND EQUIPMENT

The Lodge shall maintain continuity of:

- prescribed medications;
- emergency medications;
- oxygen/respiratory support;
- treatment supplies;
- infection control supplies;
- PPE;
- other essential clinical equipment.

The Lodge's Pharmacy provider shall be contacted early where medication supply disruption is anticipated.

Emergency medication and pharmacy contingency procedures shall be implemented as required.

22.0 FOOD, FLUIDS AND DIETARY SERVICES

Food and fluid requirements shall continue during an outbreak, epidemic or pandemic.

The Food Services Manager shall assess:

- staffing;
- food inventory;
- supplier disruption;
- resident nutritional needs;
- modified dining arrangements;
- infection control requirements.

Menus may be modified where necessary due to staffing or supply constraints while maintaining appropriate resident nutrition and hydration.

23.0 ENVIRONMENTAL SERVICES, LAUNDRY AND WASTE

Environmental Services shall implement cleaning and disinfection appropriate to the organism and transmission route.

Measures may include:

- increased high-touch cleaning;
- enhanced affected room cleaning;
- appropriate disinfectant/contact time;
- dedicated cleaning equipment;
- management of contaminated laundry;
- safe waste handling;
- terminal cleaning following discontinuation of precautions.

Cleaning practices shall follow current IPAC/Public Health guidance.

24.0 PROGRAMS, DINING AND RESIDENT MOVEMENT

Restrictions shall **not automatically be applied Home-wide simply because an outbreak exists on one RHA.**

The OMT/IPAC Lead shall determine appropriate modifications based on transmission risk and Public Health direction.

Measures may include:

- RHA-specific programming;
- smaller group activities;
- in-room programming;
- modified communal dining;
- suspension of cross-RHA programs;
- virtual/individual engagement.

Resident quality of life and psychosocial well-being shall be considered when implementing infection control measures.

25.0 ADMISSIONS, TRANSFERS AND ABSENCES

Admissions, transfers, hospital returns and resident absences shall be managed according to:

- current Public Health/provincial requirements;
- outbreak status;
- resident clinical needs;
- transmission risk;
- receiving facility requirements.

Urgent medical transfers shall not be delayed because of outbreak status.

Receiving health care providers shall be advised of applicable precautions/outbreak status.

26.0 VISITORS, CAREGIVERS AND BUILDING ACCESS

Visitor measures shall comply with the Home's Visitor Policy and current applicable law/Public Health direction.

Measures may include:

- outbreak notification;
- signage;
- PPE;
- hand hygiene;
- education regarding risk;
- limiting access to affected areas where legally permissible/required.

Ontario's Long Term Care regulation 246/22 specifically requires essential visitors to continue to have access during an outbreak, epidemic or pandemic, subject to applicable law.

27.0 COMMUNICATIONS

The Home shall provide timely and ongoing communication appropriate to the emergency.

Communications may include:

- residents;
- Substitute Decision Makers (SDMs)/families;
- staff;
- volunteers;
- students;
- caregivers;
- Residents' Council;
- Family Council;
- MLHU;
- Ministry of Long-Term Care;
- physicians/Nurse Practitioner;
- Pharmacy;
- suppliers/community partners.

Communication shall occur:

- when the emergency/outbreak begins;
- when significant changes occur; and
- when the emergency/outbreak ends.

The Lodge will use OneCallNow broadcast message software as a primary communication vehicle.

Information shall protect resident confidentiality.

The Administrator/designate shall coordinate external/media communication.

28.0 MINISTRY OF LONG-TERM CARE/ CRITICAL INCIDENT REPORTING

An outbreak of a disease of public health significance or communicable disease is an **immediately reportable Critical Incident** to the Ministry Director under O. Reg. 246/22, s. 115.

Accordingly:

MLHU/Public Health notification does not replace Ministry of Long-term Care reporting.

The appropriate Ministry of Long-term Care reporting process shall be initiated promptly upon outbreak declaration/when the reporting obligation is triggered.

29.0 BUSINESS CONTINUITY

During a prolonged epidemic/pandemic, managers shall assess the ability to maintain:

- nursing and personal care;
- physician/Nurse Practitioner services;
- medications;
- Dietary;
- Environmental Services;
- Laundry;
- resident programming;
- administrative services;
- building operations;
- supplies;
- communications.

Non-essential functions may be modified where necessary to maintain essential resident services.

30.0 OUTBREAK RESOLUTION AND RECOVERY

MLHU/Public Health shall determine when the outbreak is declared over.

Following declaration that the outbreak has ended:

- communicate outbreak resolution;
- discontinue outbreak measures as directed;
- restore normal resident activities/dining;
- restore normal staffing assignments;
- complete required environmental cleaning;
- replenish PPE/supplies;
- reconcile outbreak documentation;
- review resident outcomes;
- support residents/staff affected by the event;
- complete debriefing;
- identify lessons learned.

Return to normal operations should be **planned rather than instantaneous** where significant operational disruption has occurred.

31.0 DEBRIEFING AND EVALUATION

Following an emergency activation, The Lodge shall provide for debriefing as required.

The Lodge Outbreak Management Team (OMT) shall review:

- what occurred;
- effectiveness of control measures;
- resident outcomes;
- staff impact;
- staffing adequacy;
- PPE/supply adequacy;
- communication;
- Public Health coordination;
- operational challenges;
- required corrective actions.

Lessons learned shall inform revisions to this Plan and related IPAC procedures.

32.0 DOCUMENTATION

Records shall include, as applicable:

- outbreak declaration;
- affected RHA(s);
- line lists/surveillance;
- OMT meetings/decisions;
- Public Health communications/directions;
- resident/staff cohorting;
- staffing contingency actions;
- communications;
- supply issues;
- Ministry reporting;
- outbreak resolution;
- debriefing;
- corrective actions.

33.0 TRAINING, TESTING, EVALUATION AND REVIEW

Staff, volunteers and students shall receive emergency plan training:

- before performing their responsibilities; and
- at least annually thereafter.

Training shall be appropriate to the individual's responsibilities.

The **IPAC Lead shall participate in developing, updating, evaluating, testing and reviewing this Plan.**

The **Medical Officer of Health/designate shall be invited to participate** in developing, updating, testing, evaluating and reviewing the Plan, as required by s. 269 of Ont. Reg. 246/22.

The Plan shall be tested **at least annually**.

Recommended Annual Exercise

A particularly useful scenario for The Lodge might be:

At 10:00 a.m., the IPAC Lead identifies four residents with new respiratory symptoms on one RHA. By noon, two employees from that RHA report similar symptoms. MLHU is contacted and subsequently declares an outbreak. By the following morning, three additional employees have called in sick and one resident on another RHA develops symptoms.

The exercise would test: **surveillance → isolation → MLHU notification → OMT activation → resident/staff cohorting → PPE → staffing contingency → communication → Ministry of Long-Term Care reporting → spread to another RHA**.

APPENDIX A – OUTBREAK QUICK RESPONSE GUIDE

Step	Action
1. IDENTIFY	Recognize symptoms/cluster through surveillance
2. PROTECT	Isolate symptomatic resident; initiate precautions
3. NOTIFY	Registered staff → IPAC Lead/designate
4. TRACK	Document symptoms; initiate/update line list
5. PUBLIC HEALTH	Contact MLHU as required
6. ACTIVATE	Convene Lodge Outbreak Management Team
7. CONTROL	PPE • cohorting • cleaning • testing • resident/staff management
8. CONTINUE CARE	Staffing • medications • food/fluids • essential programs
9. REPORT	Ministry of Long-Term Care Critical Incident and other required reporting
10. COMMUNICATE	Residents • families/SDMs • staff • others
11. MONITOR	Review cases, staffing, supplies and transmission daily
12. RECOVER	MLHU declares over → restore → replenish → debrief → review

APPENDIX B – LODGE OUTBREAK MANAGEMENT TEAM (OMT) QUICK CHECKLIST

At each OMT meeting, review:

Area	Review
Epidemiology	New cases, recovered cases, affected RHAs, transmission pattern
Residents	Symptoms, isolation, testing, treatment, hospital transfers
Staff	Illness, exposures, absenteeism, work restrictions
Cohorting	Resident and staff assignments
PPE	Requirements, compliance, inventory/burn rate
Environment	Cleaning/disinfection, laundry, waste
Staffing	Current/next 24–72 hours, contingency measures
Dietary	Dining arrangements, staffing, food supply
Programs	Activities, resident movement, psychosocial needs
Visitors	Current measures/communications
Supplies	Clinical, PPE, continence, cleaning, food
Public Health	MLHU direction/outstanding actions
Reporting	Ministry/other reporting
Communication	Residents, families, staff
Next Steps	Decisions, responsible person, deadline

APPENDIX C – RESPONSE ESCALATION MATRIX

Situation	Response
Single symptomatic resident	Assess + precautions/isolate + surveillance
Several epidemiologically linked cases	IPAC assessment + line list + MLHU
Outbreak declared on one resident home area (RHA)	OMT + RHA cohorting/control measures
Multiple RHAs affected	Enhanced OMT/Incident Management System + expanded cohorting
Significant staff absenteeism	Staffing Contingency Plan
PPE/supply disruption	Emergency procurement/conservation consistent with requirements
Hospital/system pressures	Enhanced resident clinical management + system coordination
Community epidemic/pandemic	Home-wide preparedness/business continuity
Concurrent utility/service failure	Activate Essential Services emergency response plan
Outbreak resolved	MLHU declaration → recovery/debrief

APPENDIX D

STAFFING CONTINGENCY – ESSENTIAL SERVICES PRIORITIZATION MATRIX

1. Purpose

During an infectious disease outbreak, epidemic or pandemic, staff absenteeism may significantly affect Strathmere Lodge's ability to maintain normal operations.

This Appendix establishes a framework to:

- maintain resident health, safety and well-being;
- maintain programs and services required under applicable legislation;
- identify essential functions that must continue;
- establish priorities when staffing resources become limited;
- guide staff reassignment and redeployment;
- identify functions that may be modified, deferred or delivered differently; and
- support timely escalation before staffing reaches an unsafe level.

A staffing shortage does not automatically permit a required program or service to be discontinued. Where normal service delivery cannot be maintained, The Lodge shall determine how the required outcome can continue to be achieved safely using available staffing, reassignment, modified workflows and external resources where available.

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2. Guiding Principles

During significant staff shortages:

RESIDENT LIFE SAFETY → ESSENTIAL CLINICAL/PERSONAL CARE → FOOD/FLUIDS/MEDICATIONS → INFECTION CONTROL → ESSENTIAL BUILDING SERVICES → OTHER REQUIRED PROGRAMS → ROUTINE/NON-URGENT FUNCTIONS

Decisions shall consider:

- resident acuity and care needs;
- outbreak location and transmission risk;
- staffing numbers and skill mix;
- professional scope of practice;
- employee competence and training;
- resident and staff cohorting requirements;

- anticipated duration of the shortage;
- availability of external resources.

Employees shall not be assigned duties beyond their lawful scope of practice, competence or training.

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3. Staffing Escalation

Staffing capacity shall be continually assessed during a significant outbreak, epidemic or pandemic.

Level	Staffing Situation	Response
Level 1 – Manageable	Absences can be managed through normal staffing processes	Normal replacement procedures; overtime/call-in as necessary; monitor trends
Level 2 – Significant	Vacancies becoming difficult to replace or multiple departments affected	Management review; enhanced call-in/overtime; modify assignments; restrict non-essential work; consider staff redeployment
Level 3 – Critical	Staffing shortage threatens ability to maintain required resident care/services	Activate staffing contingency; prioritize essential functions; management/supervisory staff assist within competence; modified schedules/workflows; seek external staffing/resources
Level 4 – Emergency	Available staffing cannot safely maintain essential resident care/services	Administrator/DRC Incident Management response; immediate external assistance; notify/consult appropriate authorities; consider extraordinary service delivery arrangements and, if necessary, resident relocation/evacuation

No fixed percentage of staff absence automatically determines the level. A 15% absence involving critical nursing positions may have greater operational impact than a larger absence distributed across several departments.

4. Essential Services Prioritization Matrix

Program / Service	Functions That Must Be Maintained	Potential Contingency Measures
Registered Nursing	Clinical assessment; medications; treatments; changes in condition; physician/NP communication; emergency response; infection surveillance; documentation	Overtime/call-in; reassignment; management nursing support where qualified; prioritize time-sensitive clinical functions; external nursing resources
Personal Support / Resident Care (PSWs)	Activities of Daily Living (ADLs); continence; repositioning; transfers; mobility; hydration; feeding assistance; resident safety	Overtime/call-in; modify assignments; cohort staff by RHA where feasible; cross-department assistance with appropriate non-clinical tasks; prioritize high-risk residents
IPAC	Surveillance; outbreak management; PPE/precautions; line lists; cohorting; MLHU liaison; staff/resident education	IPAC Lead prioritizes outbreak functions; designate trained alternate if applicable; distribute defined surveillance/data tasks; management support
Medical / Nurse Practitioner (NP) Services	Urgent assessment; changes in condition; prescribing/treatment; outbreak-related clinical management	Telephone/virtual consultation where appropriate; prioritize urgent needs; alternate physician/NP coverage arrangements
Pharmacy / Medication Supply	Medication availability; emergency medications; medication system support	Early pharmacy contact; emergency delivery arrangements; medication inventory review; alternate delivery/access arrangements
Food and Nutrition	Safe meals; therapeutic diets; hydration; feeding assistance; food safety	Simplified/emergency menu; modify meal production; prioritize resident nutrition/hydration; alternate suppliers; redeploy appropriate staff for non-specialized support

Program / Service	Functions That Must Be Maintained	Potential Contingency Measures
Housekeeping / Environmental Cleaning	Outbreak cleaning/disinfection; high-touch surfaces; resident rooms; washrooms; spill response	Prioritize affected areas/high-touch surfaces; redeploy trained staff; modify lower-priority cleaning schedules; external resources where available
Laundry	Essential resident clothing, linens and infection control laundry requirements	Prioritize essential loads; adjust schedules; maintain separation/handling requirements; external laundry service if necessary
Maintenance / Building Operations	Heating/cooling; electrical systems; water; elevators; life-safety systems; generator; urgent repairs	Prioritize life-safety/essential systems; on-call contractors; defer routine/non-urgent maintenance
Recreation / Programs	Resident psychosocial well-being, meaningful engagement and required programming	RHA-based programming; individual/in-room activities; smaller groups; redeploy program staff to appropriate resident-support functions
Social Work / Resident Support (incl. BSO)	Urgent psychosocial needs; resident/family support; significant behavioural/emotional concerns	Prioritize urgent residents/families; telephone/virtual contact where appropriate; defer routine administrative work
Administration / Clerical / Ward Clerks	Emergency communications; staffing support; records; essential payroll/purchasing; reception/access control	Cross-train administrative staff; remote work where feasible; prioritize emergency functions; defer non-urgent administrative projects
Resident/Family Communications	Outbreak status; significant changes; required emergency communications	Centralized communication; mass communication systems; designated spokesperson; scheduled updates
Supply / Procurement	PPE; clinical supplies; food; continence products; cleaning supplies; essential equipment	Monitor inventory/burn rate; order early; alternate suppliers; prioritize essential supplies
Waste Management	Safe removal of general and outbreak-related waste	Prioritize resident care/outbreak areas; external contractor

Program / Service	Functions That Must Be Maintained	Potential Contingency Measures
		coordination; adjust collection schedules
Other Required Programs	Functions necessary for resident safety, health, well-being and regulatory compliance	Modify method/frequency where legally permissible; redeploy resources; prioritize highest-risk resident needs

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5. Redeployment Principles

Where staffing shortages require reassignment of employees, managers shall consider:

Competence → Training → Scope → Resident Need → Infection Risk → Cohorting

Staff may be reassigned to **appropriate duties they are capable of safely performing**.

Examples may include:

- Programs staff assisting with resident engagement on RHAs;
- administrative staff assisting with communications, supply distribution or other non-clinical functions;
- managers assisting operational departments within their competence;
- appropriately trained employees assisting with meal service;
- staff performing logistical/support duties so clinical employees can concentrate on resident care.

Redeployment shall **not** result in an employee performing regulated clinical functions for which they are not authorized or competent.

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6. Functions That May Be Modified or Deferred

During a severe staffing shortage, certain activities may be modified, rescheduled or temporarily deferred **where doing so does not compromise resident safety or violate an applicable legal requirement.**

Examples include:

- non-urgent meetings;
- non-essential administrative projects;
- routine audits that can lawfully be deferred;
- non-urgent maintenance;
- discretionary education;
- non-essential external appointments where clinically appropriate;
- large-group programming where individual/RHA-based alternatives can be provided;
- non-essential internal reporting.

The decision to defer work shall be made by the responsible manager in consultation with the Incident Commander/Administrator as appropriate.

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7. Protecting Resident Care During Staff Shortage

Staffing contingency measures shall **not result in blanket cancellation of basic resident care.**

Managers shall identify residents requiring particular priority because of:

- feeding assistance;
- high risk of falls;
- pressure injury risk;
- complex transfers;
- responsive behaviours;
- oxygen/respiratory needs;
- complex medications/treatments;
- end-of-life care;
- acute illness;
- other significant clinical risks.

Care delivery may be reorganized, but residents' immediate health, safety and essential needs remain the priority.

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8. Staffing Contingency and Cohorting

Staffing contingency decisions shall be coordinated with outbreak cohorting.

Where feasible:

- employees should remain assigned to their designated RHA/cohort;
- unnecessary movement between affected and unaffected RHAs should be minimized;
- relief staff should be assigned strategically;
- shared staff should follow appropriate PPE, hand hygiene and other IPAC measures.

Cohorting shall not be maintained to the point that an RHA is left without sufficient staffing to provide safe resident care.

Where the Home must choose between ideal cohorting and immediate resident safety, the OMT/IPAC Lead shall determine appropriate mitigating precautions.

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9. External Staffing and Assistance

Where internal measures are insufficient, the Administrator/DRC may seek:

- agency staff;
- available external nursing/PSW resources;
- County resources where available;
- Health system/community partners;
- staffing assistance available through emergency measures;
- other resources authorized during a provincial or community emergency.

External personnel shall receive appropriate orientation regarding:

- outbreak status;
- assigned RHA/cohort;
- PPE;
- Additional Precautions;
- emergency procedures;
- resident care responsibilities;
- reporting structure.

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10. Management Responsibilities

Each Department Manager shall:

1. identify the minimum functions that must continue;
2. monitor absenteeism;
3. identify staffing gaps for the next operational period;
4. identify available staff;

5. identify functions that may be modified;
6. identify employees who may be safely redeployed;
7. advise the Administrator/DRC of emerging staffing risks;
8. maintain appropriate documentation.

The **Administrator/DRC shall assess staffing capacity across the entire Home**, rather than allowing individual departments to manage severe shortages independently.

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11. Staffing Situation Report

During Level 2–4 staffing pressures, each manager should be able to report:

Question	Status
How many employees are scheduled?	
How many are absent/unavailable?	
What positions/skills are missing?	
Can today's essential functions be maintained?	**YES / AT RISK / NO**
Can the next shift be safely staffed?	**YES / AT RISK / NO**
What work can be modified/deferred?	
What internal staff can be redeployed?	
What external resources are required?	
Are outbreak cohorting arrangements sustainable?	
What is the greatest resident safety risk?	

This can be reviewed at each OMT meeting during significant staffing pressures.

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12. Escalation Where Essential Care Cannot Be Maintained

If the Home determines that available staffing may become insufficient to safely maintain essential resident care:

DO NOT WAIT FOR THE NEXT SHIFT TO FAIL.

The Administrator/DRC shall:

ASSESS → ESCALATE → SEEK RESOURCES → PRIORITIZE CARE → NOTIFY APPROPRIATE AUTHORITIES/PARTNERS → REASSESS

If safe resident care cannot reasonably be maintained despite contingency measures, The Lodge shall seek assistance from appropriate health system/emergency authorities and consider whether **temporary resident relocation or evacuation** is necessary.

Activation of the **Evacuation Emergency Response Plan** shall be considered where continued operation presents an unacceptable risk to residents.