Richmond Health Services: HSDA Pandemic Response Plan

HEALTH CARE FACILITIES

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Long-Term Care Facilities: Development of Pandemic Plan

Process

Managers of LTC facilities should:

- Develop pandemic response plans for their facilities. Use the **VCH Pandemic Response Planning Checklist for Long Term Care Facilities** to assist you.
- Identify an area where closer monitoring and more intensive nursing care can be provided and where parenteral therapy and oxygen therapy may be given to patients requiring heavier care.
- Work with the VCH **Emergency Co-ordinator** to assess capacity to increase bed capacity to create alternate care sites.

The **Emergency Co-ordinator** should:

- Work with the **Director, Community Care Network** and with LTC facilities to ensure that each LTC facility has a pandemic plan.
- Work with LTC facilities to identify areas where bed capacity may be increased to create alternate care capacity.
- Update LTC bed capacity information annually, as the plan is exercised.

References & Resources

For information on the **management of patients in long-term care facilities** during a pandemic see: VCH Pandemic Influenza Plan, Chapter 7, Clinical Management & Health Care Facilities, section 2. http://www.vch.ca/pandemic/docs/ch07_medical_management.pdf

Tools

VCH Pandemic Response Planning Checklist for Long Term Care Facilities:
http://www.vch.ca/pandemic/docs/long_term_checklist.pdf

HEALTH CARE FACILITIES

Long-Term Care Facilities: Bed Capacity

Note

During a pandemic, it will be necessary to manage patients within the long-term care (LTC) facility rather than transfer them to an acute care facility. An area for acute care may need to be designated, within the long-term care facility, where closer monitoring and more intensive nursing care can be provided and where parenteral therapy and oxygen therapy may be given.

Long-Term Care Facility Bed Capacity in Richmond HSDA

Richmond Facilities	Number of Beds of Type:				Comments (additional staff and bed space)
	Regular	Oxygen	Suction	Extra	
Rosewood Manor	121	0	0	1	Casual staff available (if funding allows); 2 portable suctions
Richmond Lions Manor	132	0	0	0	Casual staff available with conditions
Minoru Residence	250	4	?	0	Seasonally variable availability of casual/overtime staff
Fraserview	89	0	0	13	13 privately paid staff may be available
Pinegrove Place	75	0	0	0	Ability to add additional staff if funding is available
Courtyard Gardens					Did not respond
TOTAL	**417**	**4**	**0**	**14**	

Long-Term Care Facilities: Infection & Environmental Control – Physical Setting

Note

Influenza is a major cause of illness and death in residents of long term care facilities because the resident's advanced age and underlying illness increase the risk of serious complications and because institutional living increases the risk of influenza outbreaks. It is reasonable to anticipate that pandemic influenza would have the same impact in long term care settings.

Process

When a pandemic has been declared, **Facility Managers** should:

- Post signs at all entrances informing patients, residents, clients, visitors, volunteers and staff of appropriate actions to be taken before or upon entering the facility
- Provide education to all staff
- Implement the organization's Occupational Health Plan for Managing Pandemic Influenza.

HEALTH CARE FACILITIES

Long-Term Care Facilities: Infection & Environmental Control

Routine Practices

Process

During a pandemic, **Long-Term Care Facilities** should:

- Adhere to the previously established policies and procedures for routine infection control practices or refer to Health Canada Infection Control Guidelines: *Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care*.

Additional Precautions

Basic Hygiene Measures

Strategically placed alcohol-based hand sanitizers and boxes of tissues may enhance personal hygiene practices.

Process

Managers of LTC facilities should:

- Encourage residents, staff and visitors to minimize potential influenza transmission through hygienic measures; e.g., use disposable, single-use tissues for wiping noses; cover nose and mouth when sneezing and coughing; hand washing/hand hygiene after coughing, sneezing or using tissues.
- Reinforce the importance of keeping hands away from the mucous membranes of the eyes and nose.

Hand Hygiene

Waterless alcohol-based hand sanitizers can be used as a substitute for hand washing. They are especially useful when access to sinks or warm, running water is limited.

Process

Managers of LTC facilities should:

- Remind staff, residents and visitors that hand washing/hand hygiene is the most important procedure in preventing and controlling the spread of infection. Meticulous hand hygiene will inactivate the virus.

HEALTH CARE FACILITIES

Long-term Care Facilities: Infection & Environmental Control

Caregivers should:

- Perform hand hygiene after direct contact with individuals with suspected or confirmed influenza and after contact with their personal articles or their immediate environment.

Tools

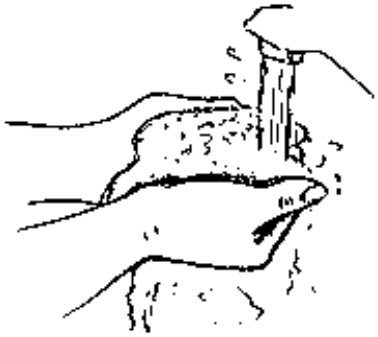
Hand Hygiene Poster: Soap and Water
Hand Hygiene Poster: Hand Sanitizer

References & Resources

For information on **infection and environmental control** in long-term care settings, see: VCH Pandemic Influenza Plan, Chapter 4, section 3.
http://www.vch.ca/pandemic/docs/ch04_infection_control.pdf

Hand Hygiene with Soap and Water

1. Remove jewelry. Wet hands with warm water



2. Add soap to palms

3. Rub hands together to create a lather

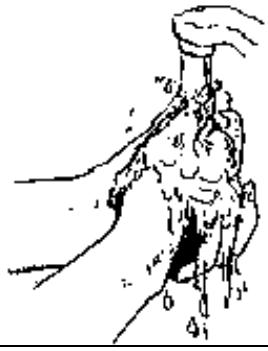
4. Cover all surfaces of the hands and fingers

5. Clean knuckles, back of hands and fingers

6. Clean the space between the thumb and index finger

7. Work the finger tips into the palms to clean under the nails

8. Rinse well under warm running water



9. Dry with a single-use towel and then use towel to turn off the tap

Minimum wash time 10-20 seconds.

Hand Hygiene with Alcohol-based Hand Sanitizer

1. Remove jewelry. Apply enough product to open palms.** 	**2. Rub hands together palms to palms** 	**3. Rub in between and around fingers** 
4. Cover all surfaces of the hands and fingers 	**5. Rub backs of hands and fingers. Rub each thumb.** 	**6. Rub fingertips of each hand in opposite palm** 

7. Keep rubbing until hands are dry.

****The volume required to be effective varies from product to product. Enough product to keep hands moist for <u>15 seconds</u> should be applied.**

Do not use these products with water. Do not use paper towels to dry hands.

Note: Wash hands with soap and water if hands are visibly dirty or contaminated with blood or other body fluids. Certain manufacturers recommend washing hands with soap and water after 5-10 applications of gel.

Personal Protective Equipment

Masks/Eye Protection

Masks (surgical/procedure) to minimize transmission of influenza may be helpful when having face-to-face contact with individuals suspected of having influenza during the early pandemic period, especially when immunization and chemoprophylaxis is not available. The use of masks may not be practical or helpful when transmission is widespread in a facility or a community.

Process

Health Care Workers should:

- ❑ Wear masks, eye protection or face shields to prevent exposure during procedures likely to generate sprays of blood or contact with body secretions or excretions.
- ❑ Avoid touching their eyes with their hands to prevent self-contamination with pathogens.

Gloves

Gloves are not required for the routine care of patients suspected or confirmed to have influenza. Gloves should be used as an additional measure. They are not a substitute for hand washing. Single-use gloves should not be re-used or washed.

Process

Health Care Workers should:

- ❑ Wear clean, non-sterile gloves for:
  - Contact with blood, body fluids, secretions, excretions, mucous membranes and non-intact skin
  - Handling items visibly soiled with blood, body fluids, secretions or excretions.

Gowns

Gowns are not required for the routine care of patients suspected or confirmed to have influenza.

Process

Health Care Workers should:

- ❑ Wear gowns to protect uncovered skin and prevent soiling of clothing, during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions.
- ❑ Ensure any open skin areas or lesions on forearms or exposed skin are covered as appropriate.
- ❑ Wash intact skin that has been contaminated with blood, body fluids, secretions or excretions as soon as possible.

Long-Term Care Facilities: Infection & Environmental Control

Cleaning, Disinfection and Sterilization of Patient Care Equipment

Process

During a pandemic **Long-Term Care Facilities** should:

- Adhere to previously established policies and procedures for the cleaning, disinfection and sterilization of patient care equipment.

Environmental Control (housekeeping, laundry, waste)

Note

Special handling of linen or waste contaminated with secretions from residents suspected or confirmed to have influenza is not required.

Process

During a pandemic **Long-Term Care Facilities** should:

- Adhere to the previously established policies and procedures for housekeeping, laundry and waste disposal, including regular garbage and biomedical waste.
- Enhance housekeeping, such as cleaning of hard surfaces, door knobs, railings, as required and resources permit.

Admission/Re-Admission

Note

Patients, from acute care who have recovered from pandemic influenza or who are immunized against the pandemic influenza strain, may be admitted into the LTC facility without restrictions.

Residents, who were transferred to acute care or other facility and who have recovered from pandemic influenza or who have been immunized against the pandemic influenza strain, may be re-admitted into the LTC facility without restrictions.

LTC facilities that have already had pandemic influenza through their facility, may admit individuals from the community or acute care without restrictions.

Admission/Re-Admission (cont'd.)

LTC facilities that have remained "influenza free" may admit patients from acute care or the community who have been potentially exposed to influenza. For patients in this category,

Process

Long-Term Care Facilities should:

- ❑ Manage such residents using droplet precautions.
- ❑ Maintain one meter of spatial separation.
- ❑ Use face protection (mask, goggles or face shield), if within one meter of the resident.
- ❑ Emphasize proper hand hygiene.

Cohorting

Note

Cohorting resident groups; i.e., confirmed/suspected influenza, exposed/not exposed to influenza, is not a feasible measure to control pandemic influenza in a LTC facility.

When influenza has been identified in one area of the LTC facility (via residents, staff or visitors) it can be assumed that the facility has been exposed.

Process

During a pandemic, **Long-Term Care Facilities** should:

- ❑ Encourage ill residents to stay in their rooms.
- ❑ Serve meals in resident's rooms, as resources permit.
- ❑ Cancel group outings and group activities, such as bingo, teas, choir, going to hairdresser, etc.
- ❑ Cancel resident appointments or medical procedures if possible until the outbreak is over.

Long-Term Care Facilities: Infection & Environmental Control

Visitor Restrictions

Note

There are no restrictions for asymptomatic visitors who have recovered from pandemic influenza or who have been immunized against the pandemic strain of influenza, at least two weeks previously.

Process

During a pandemic **Long-Term Care Facilities** should:

- Discourage visitors with ILI until they are asymptomatic. Close relatives of terminally ill residents may be exempted, but should put a mask on upon entry into the facility and their visit should be restricted to that patient only.
- Inform visitors when the long-term care facility has influenza activity. . It is only useful for the visitor to wear a mask, upon entry to the facility, if there is no influenza in the community.
- Discourage visits by those who have not yet had the pandemic strain of influenza or who have not been immunized against the pandemic strain. Close relatives of terminally ill residents may be exempted, but they should restrict their visit to that individual only and they should wash their hands on exit from the patient's room.

Long-Term Care Facilities: Providing Advanced Medical Care in Residential Facilities

Note

During a pandemic, it will be necessary to manage patients within the long-term care (LTC) facility rather than transfer them to an acute care facility. An area for advanced care may need to be designated, within the long-term care facility, where closer monitoring and more intensive nursing care can be provided and where parenteral therapy, oxygen therapy and end of life care may be given.

Process

In the interpandemic period, the **Director, Community Care Network,** should:

- ❑ Assess the need for education of LTC facility staff in providing advanced medical care to residents; e.g., starting IV's, end of life care.
- ❑ Develop and implement, with assistance from Home Care staff, educational programs to train LTC staff in the provision of advanced medical care.

Note

Provincial working groups are addressing the need for explicit, province-wide policies to address:

- reduction or suspension of services;
- identification of specific conditions that would require transfer to acute care facilities;
- stockpiling of supplies for residential facilities;
- standardized messages to address family expectations or demands for patient transfer to acute care.

Process

As policies are enunciated, the **Emergency Co-ordinator** should:

- ❑ Update the plan to include new information.

Acute Care Facilities: Development of a Pandemic Plan

Process

Management of Acute Care Facilities should:

- Develop pandemic response plans for their facilities.
- Incorporate regionally developed guidelines and protocols, as appropriate.
- Work with the VCH **Emergency Co-ordinator** to assess capacity to increase bed capacity to create alternate care sites.

The **Emergency Co-ordinator** should:

- Work with acute care facilities to ensure that each facility has a pandemic plan.
- Work with acute care facilities to identify areas in the facility where additional, temporary beds may be located to create surge capacity.
- Update acute care bed capacity information annually, as the plan is exercised.

References & Resources

For information on the **management of patients in acute care facilities** during a pandemic see: VCH Pandemic Influenza Plan, Chapter 7, Clinical Management & Health Care Facilities, section 2. http://www.vch.ca/pandemic/docs/ch07_medical_management.pdf

A useful tool for the **development of plans for acute care facilities** is Pandemic Influenza Planning Guidelines, developed by the Toronto Academic Health Sciences Network, available online at: http://www.baycrest.org/Family_Information/Pandemic_Information/TAHSNGuidelines.pdf

HEALTH CARE FACILITIES

ACUTE CARE FACILITIES: OPTIMIZING HOSPITAL CAPACITY

Developing Surge Capacity

To be able to meet pandemic demands, hospitals must develop a phased approach to surge capacity, including deferral of non-influenza care and dynamic use of influenza triage and admission/discharge criteria constantly adjusted to hospital capacity. Recent reviews of emergency response arrangements in the US suggest that 20% surge capacity is the maximum upper limit to an hospital "surge in place" response during major emergencies. This will vary according to local hospital resources.[1]

Table 1 outlines approaches to optimizing hospital capacity and capability that, pending further advice from clinical experts and the Ministry of Health, are suggested for use in VCH planning for pandemic response.

Table 1: Approaches to Optimizing Hospital capacity in VCH

Capacity	Activity
Physical Capacity	Defer any services for conditions that are not life-threatening, where no adverse health consequences are expected from the delay.
	Discharge Alternate Level of care patients to Long-Term care facilities immediately beds are available
	Discharge acute patients to home support when care can be provided safely in that environment
	Discharge acute patients to family and self-care when care can be provided safely in that environment
	Create "flex beds" from reserved beds or recently closed beds.
	Use ventilator capacity anywhere in the hospital where sufficient oxygen capacity exists; e.g., ER, post-anaesthetic care units, cohort infectious patients and non-infectious patients
	Deploy freed-up beds for influenza patients
Hospital Staffing	Redeploy clinical staff from deferred services
	Defer staff holidays and leaves of absence until pandemic ends
	For staff willing to work extra hours, establish 12-hour shifts up to the maximum recommended number of days per staff member
	Train non-clinical staff to provide support services such as meals, personal care patient movement for treatment, site cleaning and support for health care workers and their families (child care, pet care) so health care workers can do their jobs
	Recruit clinical agency staff in co-ordination with other hospitals in the Region
	Encourage members of the public to take home health care courses before the pandemic so they know how to prevent infection and provide supportive care for family members who are ill; train family members of hospital patients to provide home health care
	Cross-train clinical staff for influenza care and other essential services during a pandemic and other large-scale emergencies
Clinical Practices	Adopt clinical practices to optimize hospital capacity, pending further development of clinical guidelines

[1] Adapted from Ontario Health Pandemic Influenza Plan, 2005

HEALTH CARE FACILITIES

Acute Care Facilities: Optimizing Hospital Capacity

Table 2 outlines strategies that hospitals and their community partners can use to respond to the need for surge capacity.

Table 2: Strategies to Enhance Surge Capacity

Surge Levels During an Influenza Pandemic	Surge Strategies		Response Level	ICS Command Function
Pre-Surge	Basic	▪ Staffed and operational beds open	Intra-facility	Hospital
Minor Surge 5% - 10%	Enhanced	▪ Open approved ICU and ventilator-supported beds as staff redeployment/recruitment permits ▪ Defer elective surgery up to 72 hours as per routine surge protocols ▪ Cohort/isolate influenza patients in ER, acute units and ICU/ventilator units	Intra-facility	Hospital
Moderate Surge 11% - 15%	Augmented	▪ Establish early discharges; home support transfers; ALC transfers to LTC facilities ▪ Open more ICU/ventilator beds where oxygen available; e.g., operating rooms or post-anaesthetic care units ▪ Defer some treatment for non-life threatening conditions if no severe adverse health consequence anticipated from the delay	Intra-facility	Hospital
Major Surge 16%-20%	Optimum	▪ Defer all treatment for non-life threatening conditions where no severe adverse health consequences are anticipated from the delay	Inter-facility	Region
Large Scale Emergency >20%	Over capacity	▪ No more beds available ▪ Maintain services for life-threatening conditions ▪ Triage for all treatment ▪ Mass emergency care	Inter-facility	Region/Province

Mass Emergency Care

After hospital surge capacity and other health system resources have been exhausted, mass emergency care will be declared in order to ensure the fair and equitable allocation of scarce resources and maximize the benefit to the population at large. This approach is consistent with federal and provincial goals of pandemic influenza planning: to minimize serious illness and overall deaths.

Since there are substantial political, legal, regulatory and logistical implications to declaring the shift to mass emergency care, further advice will be sought from clinical experts and the Ministry of health about the criteria for mass emergency care and guidelines for implementing that care once hospital surge capacity is exhausted.

HEALTH CARE FACILITIES

Acute Care Facilities: Optimizing Hospital Capacity

Deferral of Non-Influenza Services

When a pandemic is declared, hospitals will begin a phased deferral or scale-back of certain non-influenza services; e.g., elective surgeries, outpatient procedures, in order to ensure that essential services are there for both influenza and other care. By using a phased approach hospitals will avoid unnecessary deferral of services before the full impact of the pandemic is known, but will be able to act quickly to defer services as the pandemic impact increases.

Process

When making decisions to defer services, **Managers in Acute Care** should:

- Establish a senior, multidisciplinary team to make decisions and seek support from ethical and legal experts
- Apply an ethical framework for decision making
- Use consistent criteria that are flexible enough to allow local responses based on local demands and resources
- Ensure their decisions are transparent.

Note

All hospital service deferrals should be based on a careful and compassionate clinical assessment of each patient's health condition, prognosis, risk of infection during acute hospital care.

Acute Care Facilities: Optimizing Hospital Capacity

Table 3 lists criteria and indicator conditions for hospitals to use to identify services that can be deferred and those that are essential and must be maintained. These criteria will be refined based on advice from clinical experts and the Ministry of Health.

Table 3: Criteria and Indicator Conditions for Deferring Hospital Services

Site of Care	Level 1 Defer services for non-life threatening conditions immediately if no severe adverse health consequences anticipated by the delay	Level 2 Maintain services for non-life threatening conditions as long as resources are available, if severe adverse consequences are anticipated from delay	Level 3 Maintain services for life-threatening conditions throughout the influenza pandemic
Hospital inpatient Surgery or Procedure	▪ Elective abdominal aortic surgery ▪ Cholecystectomy ▪ Hip/knee replacement ▪ Prostate transurethral resection	▪ Carotid endarterectomy ▪ Colectomy ▪ Thoracotomy ▪ Total prostatectomy ▪ Lumpectomy/mastectomy	▪ Initiation of mechanical ventilation
Hospital Outpatient Surgery or Procedures	▪ Vasectomy ▪ Myringotomy ▪ Carpal tunnel syndrome ▪ Cataract surgery	▪ Breast biopsy ▪ Chemotherapy ▪ Percutaneous coronary intervention (PCI) ▪ Cardiac catheterization	
Hospital Emergency Department Care	▪ Superficial injuries ▪ Back or neck pain ▪ Extremity strain	▪ Severe cuts ▪ Upper/lower respiratory infection ▪ OTITIS MEDIA	▪ Initiation of mechanical ventilation

Notes to Table 3:

1. These criteria are based in the three health care urgency categories developed by the Institute for Clinical Evaluative Sciences (ICES) to asses the impact of SARS on health services utilization.
2. If the spread of influenza is gradual, a scale-back may be time-sensitive, with some services deferred earlier than others according to the assessed impact from the delay.
3. These recommendations mirror the Alberta Clinical Subcommittee report (2003, page 21) which states that the exact details of rationing health care resources cannot be anticipated in advance by algorithm or list of trade-offs.
4. The report recommends a step-wise process, starting with decisions about elective surgery by the Chiefs of Surgery, Neurosurgery and Medicine, followed with shared decision-making among attending physicians, health care workers, senior physicians, the head of nursing, an ethicist and the Chief executive Officer, for all other treatment.

HEALTH CARE FACILITIES

Acute Care Facilities: Bed Capacity/Ventilator Capacity

Accurate counts of beds and ventilators are a necessary element of pandemic planning in the acute care sector.

Process

The **Emergency Co-ordinator** should:

- Work with **acute care management** to develop accurate bed capacity and ventilator capacity counts for all acute care facilities in the HSDA.

Tools

Ventilator Capacity at Richmond Hospital

Type of Ventilator	Intensive Care (ICU)	Coronary Care (CCU)	CSICU	Recovery Room (PAR)	Operating Room (OR)	Emergency Department	Storage	In Repair	Sleep Study Laboratory	Physiotherapy	Other
LP6							1				
Evita	5										
Home Vents (Legendaire)							2				
Transport LTV's	1					1					
Siemens 300				1			5				1*
Siemens 900C											
High Frequency Oscillator	1										
Non-invasive Ventilators (BiPAP)	4					2	9				
Non-Invasive Vents (CPAP)									6		
Totals	11			1		3	17		6		1
TOTAL NUMBER OF VENTILATORS	**39**										

* Special Care Nursery

Acute Care Facilities: Bed Capacity/Ventilator Capacity

Tools

For the following tools see: VCH Pandemic Influenza Plan, Chapter 7, Clinical Management & Health Care Facilities, section 8.
http://www.vch.ca/pandemic/docs/ch07_medical_management.pdf

Emergency Ventilator Capacity Considerations Worksheet
Inventory of Ventilators Worksheet

References & Resources

For information on the **assessment of bed and ventilator capacity in acute care facilities** see: VCH Pandemic Influenza Plan, Chapter 7, Clinical Management & Health Care Facilities, section 4.
http://www.vch.ca/pandemic/docs/ch07_medical_management.pdf

Note

For information on the **clinical management of influenza** see: VCH Pandemic Response Plan, Chapter 7, section 1. http://www.vch.ca/pandemic/docs/ch07_medical_management.pdf

HEALTH CARE FACILITIES

Acute Care Facilities: Infection & Environmental Control – Physical Setting

Note

Acute care settings group patients together, who have a high risk of developing serious, sometimes fatal complications related to influenza. In addition, morbidity and mortality related to nosocomial; i.e., hospital-acquired, infections is much greater in acute care populations than in other populations.

Process

When a pandemic is declared, **Acute Care Facilities** should:

- Open triage settings in acute care hospitals.
- Open cohort areas or units in hospital.
- Post signs at all entrances informing patients, residents, clients, visitors, volunteers and staff of appropriate actions to be taken before or upon entering the facility.
- Provide education to all staff.

Acute Care Facilities: Infection & Environmental Control

Routine Practices

Process

During a pandemic, **Acute Care Facilities** should:

- Adhere to the previously established policies and procedures they have in place for routine infection control practices.

Additional Precautions

Note

Although droplet and contact precautions are recommended in preventing the transmission of influenza during an inter-pandemic period, these precautions may not be achievable or practical as the pandemic spreads and resources become scarce. Infection control resources may need to be prioritized to the acute care settings where the complexity of patient care is greatest.

Process

During a pandemic, **Acute Care Facilities** should:

- Adhere to the previously established policies and procedures for using additional infection control precautions, when routine practices are not sufficient to prevent transmission.

Hand Hygiene

Waterless alcohol-based hand sanitizers can be used as a substitute for hand washing. They are especially useful when access to sinks or warm, running water is limited.

Process

Managers of acute care facilities should:

- Remind staff, patients and visitors that hand washing/hand hygiene is the most important procedure in preventing and controlling the spread of infection. Meticulous hand hygiene will inactivate the virus.

Health Care Workers should:

- Perform hand hygiene after direct contact with individuals with suspected or confirmed influenza and after contact with their personal articles or their immediate environment.

HEALTH CARE FACILITIES

Acute Care Facilities: Infection & Environmental Control

Basic Hygiene Measures

Note

Strategically placed alcohol-based hand sanitizers and boxes of tissues may enhance personal hygiene practices.

Process

Acute Care Facilities should:

- Remind patients, staff and visitors to minimize potential influenza transmission through hygienic measures; e.g., use disposable, single-use tissues for wiping noses; covering nose and mouth when sneezing and coughing; hand washing/hand hygiene after coughing, sneezing or using tissues.
- Emphasize the importance of keeping hands away from the mucous membranes of the eyes and nose.

Personal Protective Equipment

Masks/Eye Protection

Note

Masks (surgical/procedure) to minimize transmission of influenza may be helpful when having face-to-face contact with individuals suspected of having influenza during the early pandemic period, especially when immunization and chemoprophylaxis is not available. The use of masks may not be practical or helpful when transmission is widespread in a facility or a community.

Process

Health Care Workers should:

- Wear masks, eye protection or face shields to prevent exposure to sprays of blood, body secretions or excretions.
- Wear a fitted particulate respirator (N95 mask) during:
  - Contact with patients who have an undiagnosed cough that may be caused by an organism that is spread by the airborne route e.g. TB, chickenpox, and measles.
  - Aerosolizing procedures with a patient suspected or known to have an organism spread by droplet transmission.
- Avoid touching their eyes with their hands to prevent self-contamination with pathogens.

Personal Protective Equipment (cont'd.)

Gloves

Note

Gloves are not required for the routine care of patients suspected or confirmed to have influenza. Gloves should be used as an additional measure. They are not a substitute for hand washing. Single-use gloves should not be re-used or washed.

Process

Health Care Workers should:

- ❑ Wear clean, non-sterile gloves for:
  - Contact with blood, body fluids, secretions, excretions, mucous membranes and non-intact skin
  - Handling items visibly soiled with blood, body fluids, secretions or excretions.

Gowns

Gowns are not required for the routine care of patients suspected or confirmed to have influenza.

Process

Health Care Workers should:

- ❑ Wear gowns to protect uncovered skin and prevent soiling of clothing, during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions.
- ❑ Ensure any open skin areas or lesions on forearms or exposed skin are covered as appropriate.
- ❑ Wash intact skin that has been contaminated with blood, body fluids, secretions or excretions as soon as possible.

Acute Care Facilities: Infection & Environmental Control

Cleaning, Disinfection and Sterilization of Patient Care Equipment

Process

When a pandemic is declared, **Acute Care Facilities** should:

- ❑ Adhere to previously established policies and procedures for the cleaning, disinfection and sterilization of patient care equipment.

Environmental Control (housekeeping, laundry, waste)

Note

Special handling of linen or waste contaminated with secretions from patients suspected or confirmed to have influenza is not required.

Process

When a pandemic is declared, **Acute Care Facilities** should:

- ❑ Adhere to previously established policies and procedures for housekeeping, laundry and waste disposal, including regular garbage and biomedical waste.
- ❑ Enhance cleaning and disinfection of common touch surfaces (handrails, door knobs, sink/toilet), as resources permit.

Patient Accommodation or Placement

Process

When a pandemic is declared, **Acute Care Facilities** should:

- ❑ Limit single rooms in acute care settings to patients suspected or confirmed to have airborne infections; e.g., tuberculosis, measles, varicella and disseminated zoster, or for patients who visibly soil the environment or for whom appropriate hygiene cannot be maintained.
- ❑ Minimize crowding; i.e., maintain at least a one meter spatial separation between patients, visitors and staff, whenever possible.

Patient Triage or Cohorting

Process

When a pandemic is declared, **Acute Care Facilities** should:

- ❑ Open the following cohort areas:
  - Influenza-Like-Illness (ILI) Assessment Area;
  - Non ILI Assessment Area;
  - Suspected/Exposed to ILI inpatient units;
  - Not Exposed/Immune to Influenza, inpatient Units;
  - Not exposed to ILI but at very high risk of complications, inpatient units.

Patient Admission

Process

When a pandemic has been declared, **Acute Care Facilities** should:

- ❑ Priorize medical and surgical acute care hospital admissions, according to pre-established guidelines.
- ❑ Move patients who have recovered from influenza into the "Non Influenza" cohort areas, after the period of communicability of the pandemic strain has passed.
- ❑ As the pandemic progresses, merge the "Suspect/Exposed" cohort and the "Confirmed Influenza" cohort, as necessary to accommodate surge in demand.
- ❑ Maintain cohort principles, until the pandemic wave has been declared over.

Patient Activity Restrictions

Process

When a pandemic has been declared, **Acute Care Facilities** should:

- Enhance triage and admission processes.
- Limit patient movement and activities, including transfers within the hospital, unless the patient has recovered from pandemic influenza.
- Allow patients with ILI, who are coughing, to leave their rooms only for urgent, necessary procedures.
- Consider the need for and scheduling of procedures so that patients who do not have influenza are not exposed to those with influenza.
- Cancel group activities. One-on-one activities, such as physiotherapy, are desirable if the patient feels well enough.
- Put a surgical or procedure mask on patients with ILI who are coughing whenever they need to be out of their room until the period of communicability of the pandemic strain has passed.

References & Resources

For information on the **management of patients in acute care facilities** during a pandemic see: VCH Pandemic Influenza Plan, Chapter 7, Clinical Management & Health Care Facilities, section 2. http://www.vch.ca/pandemic/docs/ch07_medical_management.pdf

Visitor Restrictions

There are no restrictions for asymptomatic visitors who have recovered from pandemic influenza or who have been immunized against the pandemic strain of influenza, at least two weeks previously.

Process

During a pandemic **Acute Care Facilities** should:

- Discourage visitors with ILI until they are asymptomatic. Close relatives of terminally ill residents may be exempted, but should put a mask on upon entry into the facility and their visit should be restricted to that patient only.
- Inform visitors when the acute care facility has influenza activity. Wearing a mask upon entry to the facility is only useful if there is no influenza in the community.
- Discourage visits by those who have not yet had the pandemic strain of influenza or who have not been immunized against the pandemic strain. Close relatives of terminally ill residents may be exempted, but they should restrict their visit to that individual only and they should wash their hands on exit from the patient's room.

Management of Patients in the Community

Note

For case definitions, common clinical presentations and instructions for the assessment, triage, care and discharge of influenza patients, refer to the VCH Pandemic Response Plan, Chapter 7, section 1, Clinical Management of Influenza: http://www.vch.ca/pandemic/docs/ch07_medical_management.pdf

Discharge and Follow-up

During a pandemic, a shortage of hospital beds is anticipated; therefore identification of patients who can be discharged to an alternate care facility or to care at home must be timely.

Patients who are deemed clinically stable may be considered for transfer out of acute care to an alternate care facility or to care at home. The use of an alternative centre of care should be considered, if more prolonged observation is necessary for patients with pneumonia, co-morbidities or for those who are not functionally independent.

Clinically stable patients, receiving care in acute care facilities for conditions other than influenza, may also be considered for early discharge, in order to free up bed capacity.

Process

In the interpandemic period, the **Emergency Co-ordinator** should:

- Work with the **Transition Services Team** to identify and document local capacity to provide at-home care.
- Update the capacity assessment annually when the pandemic plan is exercised.

Physical Setting

Note

These guidelines may be used for any health care provided in the home setting.

Process

When a pandemic is declared, H**ome Care Providers** should:

- ❑ Cancel or postpone non-essential visits.
- ❑ Provide education to all staff.

Routine Practices

Process

During a pandemic, **Home Care Workers** should:

- ❑ Adhere to the previously established policies and procedures in place for routine infection control practices or to the Health Canada Infection Control Guidelines: *Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care*.

Additional Precautions

Note

Although droplet and contact precautions are recommended in preventing the transmission of influenza during the interpandemic period, these precautions may not be achievable or practical as the pandemic spreads and as resources become scarce. Adherence to routine practices is achievable.

Hand Hygiene

Waterless alcohol-based hand sanitizers can be used as a substitute for hand washing. They are especially useful when access to sinks or warm, running water is limited.

Process

Home Care Providers should:

- Remind home care workers, clients and household members that hand washing/hand hygiene is the most important procedure in preventing and controlling the spread of infection. Meticulous hand hygiene will inactivate the virus on the hands.

Home Care Workers should:

- Perform hand hygiene after direct contact with individuals with suspected or confirmed influenza and after contact with their personal articles or their immediate environment.

Basic Hygiene Measures

Note

Strategically placed alcohol-based hand sanitizers and boxes of tissues may enhance personal hygiene practices.

Process

Home Care Providers should:

- Encourage home care workers and their clients to minimize potential influenza transmission through hygienic measures.

Home Care Workers and their **clients** should:

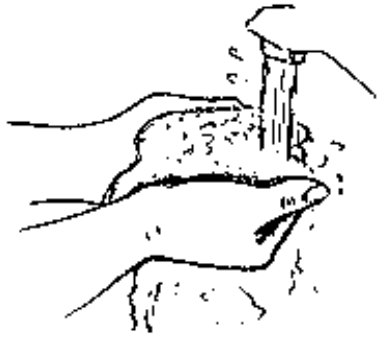
- Use disposable, single-use tissues for wiping noses.
- Cover nose and mouth when sneezing and coughing.
- Wash hands/hand hygiene after coughing, sneezing or using tissues.
- Keep hands away from the mucous membranes of the eyes and nose.

Tools

Hand Hygiene Poster: Soap and Water
Hand Hygiene Poster: Hand Sanitizer

Hand Hygiene with Soap and Water

1. Remove jewelry. Wet hands with warm water



2. Add soap to palms

3. Rub hands together to create a lather

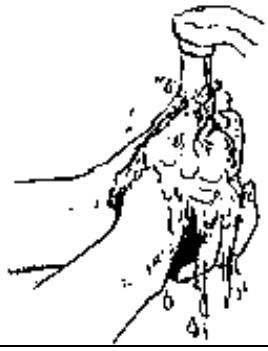
4. Cover all surfaces of the hands and fingers

5. Clean knuckles, back of hands and fingers

6. Clean the space between the thumb and index finger

7. Work the finger tips into the palms to clean under the nails

8. Rinse well under warm running water



9. Dry with a single-use towel and then use towel to turn off the tap

Minimum wash time 10-20 seconds.

Hand Hygiene with Alcohol-based Hand Sanitizer

1. Remove jewelry. Apply enough product to open palms.** 	**2. Rub hands together palms to palms** 	**3. Rub in between and around fingers** 
4. Cover all surfaces of the hands and fingers 	**5. Rub backs of hands and fingers. Rub each thumb.** 	**6. Rub fingertips of each hand in opposite palm** 

7. Keep rubbing until hands are dry.

****The volume required to be effective varies from product to product. Enough product to keep hands moist for <u>15 seconds</u> should be applied.**

Do not use these products with water. Do not use paper towels to dry hands.

Note: Wash hands with soap and water if hands are visibly dirty or contaminated with blood or other body fluids. Certain manufacturers recommend washing hands with soap and water after 5-10 applications of gel.

Masks/Eye Protection

Masks (surgical/procedure) to minimize transmission of influenza may be helpful when having face-to-face contact with individuals suspected of having influenza during the early pandemic period, especially when immunization and chemoprophylaxis are not available. The use of masks may not be practical or helpful when transmission is widespread in the community.

Process

Home Care Workers should:

- ❑ Wear masks, eye protection or face shields to prevent exposure during procedures likely to generate sprays of blood or contact with body secretions or excretions.
- ❑ Avoid touching their eyes with their hands to prevent self-contamination with pathogens.

Gloves

Gloves are not required for the routine care of patients suspected or confirmed to have influenza. Gloves should be used as an additional measure. They are not a substitute for hand washing. Single-use gloves should not be re-used or washed.

Process

Home Care Workers should:

- ❑ Wear clean, non-sterile gloves for:
  - Contact with blood, body fluids, secretions, excretions, mucous membranes and non-intact skin
  - Handling items visibly soiled with blood, body fluids, secretions or excretions.

Gowns

Gowns are not required for the routine care of patients suspected or confirmed to have influenza.

Process

Home Care Workers should:

- ❑ Wear gowns to protect uncovered skin and prevent soiling of clothing, during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions.
- ❑ Ensure any open skin areas or lesions on forearms or exposed skin are covered as appropriate.
- ❑ Wash intact skin that has been contaminated with blood, body fluids, secretions or excretions as soon as possible.

Cleaning, Disinfection and Sterilization of Patient Care Equipment

Process

During a pandemic, **Home Care Workers** should:

- Adhere to previously established policies and procedures for the cleaning, disinfection and sterilization of patient care equipment.
- Find alternative means of cleaning and disinfecting equipment for home use, as supplies become scarce.

Environmental Control (housekeeping, laundry, waste)

Note

Special handling of linen or waste contaminated with secretions from residents suspected or confirmed to have influenza is not required.

Process

During a pandemic, **Home Care Workers** should:

- Adhere to previously established guidelines for the management of linen, environmental cleaning and waste disposal or adhere to Health Canada Infection Control Guidelines: *Hand Washing, Cleaning, Disinfection and Sterilization In Health Care.*

Triage

Process

During a pandemic and prior to an appointment or before entering the home, **Home Care Workers** should:

- Perform a telephone assessment for influenza-like illness (ILI) among clients and their household contacts.
- Assess the risk of influenza in clients or household contacts.
- Provide clients and family members with information regarding influenza symptoms and self-care guidelines.
- Ask clients to notify home care staff if an ILI develops.

Visitors

Note

Severely immunocompromised clients; e.g., transplant recipients, haematology/oncology patients, are at risk of serious complication if infected with influenza.

Only well (asymptomatic or unexposed) visitors should visit severely immunocompromised patients at home during a pandemic.

Visitors for terminally ill clients may be exempted but, should put on a mask before entering the home and restrict the length of time spent with the patient, if possible.

References & Resources

For information on self care during a pandemic, see VCH Pandemic Influenza Response Plan, Chapter 5: http://www.vch.ca/pandemic/docs/ch05_self_care.pdf.

Alternate Care Facilities (ACF's): Designation of Sites

Alternate care facilities will augment services provided by traditional medical care facilities to patients affected by pandemic influenza. Alternate care facilities will be considered secondary sites and will assist residential and home care institutions, social services and hospitals, in meeting the surge in demand for services.

Process

The **Emergency Co-ordinator**, under the guidance of the **MHO**, will:

- Identify potential ACF sites.
- Assess potential sites, using the ACF Assessment Checklist.
- Work with **Medical Health Officer** to identify one or more potential ACF sites, based on compliance with criteria as detailed on the assessment tool.
- Negotiate memorandum of understanding with the appropriate authority; refer to VCH Legal Affairs and Risk Management for advice on terms for memorandum of understanding.

Note

The capacity to add beds to existing facilities, such as LTC facilities or acute care facilities should be explored before turning to outside resources. Cafeterias, meeting rooms and other common areas that may not be used, during a pandemic (in order to increase social distance) can, perhaps, be converted to patient care areas.

References & Resources

http://www.vch.ca/pandemic/docs/ch07_medical_management.pdf

Tools

Alternate Care Facility Assessment Checklist (see following)

Alternate Care Facility Assessment Checklist
Face Page

Alternate care facilities (ACF) are intended to augment services provided by traditional medical care facilities to patients affected by pandemic influenza. These facilities should be located in close proximity to an emergency department (ED) of a hospital. Alternate care facilities will be considered secondary sites. ACF's can provide care beyond basic first aid but are not intended for patients who are self-sufficient and are able to take care of daily personal needs. However, ambulatory patients may be sent to the ACF for care. ACF's will assist residential and home care institutions, social services and hospitals.

Facility name:	
Address:	
Contact name:	
Position title:	
Telephone #:	
Fax #:	
E-mail address:	

	Yes	No
Memorandum of Understanding (MoU) negotiated?		
Signed copy of MoU appended?		
Facility complies with CSA regulations?		

Criteria for Selection of Alternate Care Facilities (ACF's)

- ACF's should be located in a well-known geographic location, close to a hospital and major roads, be wheelchair accessible, have several entrances and exits and have adequate parking space.
- The building must be structurally sound, have large rooms on the ground floor, have toilet and shower facilities and food preparation and service facilities.
- The building should be (preferably) gas-heated and equipped with a power generator.
- The facility must comply with the regulations of the Canadian Securities Administrators (CSA).
- The layout should include areas to be allocated for registration, triage, treatment, ambulatory and non-ambulatory services, secured areas, food areas and pharmacy.
- Examples of inventory needs include cots, bedding, food, water, intravenous supplies, medications, biohazard supplies, clothing, specimen and trash bags, urinary health supplies, linens and patient gowns, janitorial and logistical supplies and respiratory supplies.
- All alternate care facilities need an Emergency Operations Centre for incoming information and co-ordination with other response resources. The choice of location should depend on safety considerations and the capacity to install and operate a variety of communications equipment.

Alternate Care Facility Assessment Checklist

Location:			
Proximity to Hospital:			
	Yes	**No**	**Comments**
Easily located by public?			
External Facilities:			
Parking?			
Proximity to transit?			
Off-loading facilities? Ramps?			
Internal Facilities:			
Washroom facilities: (M/F), sinks			
Kitchen: food prep area? Dishes? Dishwashing capability? Refrigeration?			
Secure space for patient records/admin?			
Adequate space for reception, waiting, patient care, patient/family education?			
Area for counselling & support services?			
Secure storage for pharmacy? Medical supplies?			
Mortuary space?			
Critical Support Systems:			
Adequate ventilation, heat, air conditioning, air flow?			
Power for lighting, sterilizers, refrigeration, food services?			
Back-up power?			
Adequate electrical outlets?			
Sanitation: adequate toilet bathing/shower and laundry facilities?			

Alternate Care Facility Assessment Checklist

Essential Support Services: Advance planning for provision of essential services to alternate care sites should consider the necessity to provide the following essential support services. Questions to consider: what facilities are available in-house? how will external services be supplied? by whom? what agreements can be negotiated now?			
	Yes	**No**	**Comments**
Security			
Communication Capability			
Building maintenance			
Laundry			
Environmental cleaning services			
Sterilization services			
Pharmaceutical services			
Medical waste disposal/storage			
Food services			
Facilities for staff lodging/eating			

Facility Assessment Checklist completed by:

Name: _____

Date: _____

Identify Triggers for Implementation of an Alternate Care (AC) Site

Since it is likely that a pandemic will not start in Canada, the first trigger for the consideration of establishment of AC sites may be reports of the severity and epidemiology of the pandemic from other countries. This is likely to be the first indicator of potential demand on traditional health care services when the pandemic reaches Canada.

It will be important to monitor the availability of resources in local acute care facilities and project when capacity may be exceeded (especially if there will be free-standing sites). Therefore, potential triggers include:

- The proportion of emergency room visits attributable to influenza
- The proportion of influenza cases requiring hospitalization
- The capacity of the hospital to accommodate influenza cases
- The proportion of cases who normally live with high-risk individuals or who have no support at home and cannot care for themselves.

Other triggers may include reports from sentinel physician or walk-in clinics that they cannot accommodate all patients requesting appointments for influenza-like-illness.

An increase in ambulance re-routings due to full emergency rooms may serve as another trigger for further implementation of plans for AC sites.