Congregate Care Setting COVID-19 Preparedness Plan

TEMPLATE DOCUMENT

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Chapter 1: Introduction

British Columbia is facing a pandemic caused by a virus that spreads rapidly and causes high rates of illness and death. Unlike other public emergencies, a COVID-19 pandemic will impact multiple communities across the province and country. Health authorities must be prepared to respond in the context of uncertain availability of external resources and support. Although it is unknown how severe a COVID-19 pandemic may be, even a moderate event will strain the already taxed health care system of British Columbia. Therefore contingency planning is required to mitigate the impact of the pandemic.

It is anticipated that primary care practitioner's offices, community clinics, and emergency departments will be overwhelmed with the number of patients seeking and requiring care. Individuals living in health facility environments, such as long-term care, assisted living, or supportive housing will also be impacted, and different levels of care will be required to support these individuals when affected with COVID-19. Essential services will still need to be provided to those individuals who do not have COVID-19 but are critically ill and requiring hospitalization. This will further be compounded by the fact that a substantial proportion of the workforce will be absent due to illness in themselves and/or family members.

The key to the successful response for pandemic COVID-19 requires an integrated response that includes consideration of all IH services, communities, and Aboriginal communities/agencies within our geographical area. The Interior Health 2020 COVID-19 Preparedness Plan[1] provides direction on how our Region would care for the influx of patients with pandemic COVID-19. The Plan was developed to outline the roles of various sectors during the pandemic, including surveillance, infection control measures, human resources, and communications, with the goal of controlling spread of disease and mitigating the effects of a COVID-19 pandemic. Further instruction during a pandemic will be developed by key corporate leads and communicated across IH (i.e. additional infection control precautions once the nature of the virus is known).

This document builds on the IH COVID-19 pandemic plan, and outlines the response solutions and operational guidelines for Congregate Care settings. With a focus on patient care, this Plan acts as a guide in the event there is a need to defer some aspects of care and service, either due to the impact of the pandemic on staffing levels or in order to meet the demands of pandemic impacted patients.

It should be noted that this plan will need to be reviewed annually in view of the changing environment and emergence of new information.

Source: Interior Health Pandemic COVID-19 Preparedness Plan, 2020

[1] Revised and updated from the IH PIPP.

Chapter 2: Guide to Completing Pandemic Plans

In order to complete the Congregate Care Pandemic Plan, sites will fill out this template, following these steps:

1. Establish a Pandemic COVID-19 Planning Working Group (see Chapter 3)
2. Establish and identify an Incident Command Centre (see Chapter 5)
3. Identify Service Deferral Priorities and Capacity Planning (see Chapter 7)
4. Complete Site Business Continuity Plans (see Chapter 8)

The most current pandemic information and resources are available on the BC Ministry of Health Pandemic Plan. To reduce redundancies, site pandemic plans should not contain general information that has already been covered in these documents. Instead, site pandemic plans should focus on how the provision of health services will differ during a pandemic. They should be written from the frontline staff perspective, and should be clear on staff priorities and responsibilities during a pandemic.

Site Pandemic COVID-19 Planning Working Groups are responsible for creating site Pandemic Plans, and should consider the following principles when doing so:

- Collaboration and consultation with the rest of the health system in the geographic area
- Processes and systems to be utilized during pandemic should build on existing structures and linkages currently in use at the site
- All aspects of site plans must be aligned with Provincial Guidelines and the IH 2020 Pandemic COVID-19 Preparedness Plan. (i.e. sites should not create their own criteria for ventilator allocation or use of N95 masks)
- Instructions should focus on what is “different” during a pandemic (i.e. supplies, space allocation, reduction in care or service, public access), and how this will be achieved
- Site plans should be scalable depending on the scope and severity of the pandemic and able to deal with increased levels of illness and reduced staffing

Chapter 3: Working Group Membership

To assist in the creation of Pandemic Plans, a cross section of individuals from across the site should be invited to participate in a Working Group. Site administrators are responsible to identify a lead and co-lead for this work, and experience has shown that involving staff responsible for the hands-on delivery of care is essential to the successful development, implementation and use of pandemic planning tools. Equally important are the non-health care services that support healthcare professionals in their work, such as plant or facility operations, administration and safety personnel. While consideration should be given to these individuals and others, the specific composition of each site Pandemic COVID-19 Planning Working Group will vary based on the size of their facility.

An administrative lead and co-lead must be identified for this work, and physician representation should be requested where available and appropriate. Other suggested members for site working groups may include, depending on individual care needs and the service model, the following roles:

- Nurse practitioner and/or Physician;
- Care team members;
- Relevant programs and departments (Allied Health, Dietary, Housekeeping, Laboratory, etc.);
- Facility operations (Plant Services);
- Emergency Preparedness Coordinator;
- Clinical Nursing Educator or quality review coordinator;
- Pharmacy provider;
- Human Resources;
- Administration; and
- A member from the site's Joint Occupational Health & Safety Committee

Table 1: Site Pandemic COVID-19 Planning Working Group Members

NAME	POSITION

Chapter 4: Planning Considerations and Assumptions

Site pandemic plans are based on the BC Pandemic Planning Assumptions, and IH 2020 Pandemic COVID-19 Preparedness Plan, which provides a common basis for planning across all public and private sector organizations. Working to this common set of assumptions will avoid confusion and facilitate baseline planning across the BC and Health Authority Health System that should be flexible and scalable depending on the real time epidemiology and modeling during a future pandemic.

In the event of a pandemic, the healthcare system will be severely taxed, if not overwhelmed, due to the high percentage of illnesses and complications resulting from the pandemic COVID-19 strain, leading to a surge in the number of those requiring hospitalization and critical care.

As a result, current service delivery levels and expectations on the part of both healthcare workers and the public-at-large will not be provided during a severe pandemic.

Based on the decisions made by site-level Incident Command Centers and the IH Emergency Operations Centre (IHEOC), prioritization of existing community care resources may be necessary over the course of the pandemic to mitigate the intense shortages of human resources, space and equipment needs during the pandemic wave.

One of the most important mitigation strategies to manage the spread of pandemic COVID-19 will be the infection control practices during such an emergency. It is important that staff is aware of the Interior Health or BCCDC/PICNet Respiratory Infection outbreak guidelines, to ensure that they know how to protect themselves and patients during a pandemic. Please refer to the IH Pandemic COVID-19 Preparedness Plan for further details on Infection Prevention and Control during a pandemic.

The key to successful response for pandemic COVID-19 requires consideration of both planning at the site level and planning for an integrated response that includes consideration of all IH services, communities, and Aboriginal communities/agencies within our geographical area.

Planning Assumptions

General

- A substantial proportion of the workforce will not be able to work for some period of time due to illness in themselves or family members.
- Contingency plans will not include the use of other essential personnel such as RCMP or local police for transportation or security.
- Outbreaks will likely occur simultaneously or in a close sequence in multiple locations, which impacts the ability of one jurisdiction to assist another.
- All residential facilities are expected to be self-sufficient in managing their patients with COVID-19. This means that patients will be managed in Congregate Care settings with required treatment being provided by the facilities' employees and with their own resources.

- Due to volume and range of illness in the affected population different levels of care will be required, i.e. self-care [home], group care in the community [alternate care centres], and intense health care [those requiring inpatient acute care].

Acute Care

- Acute Care facilities are expected to provide services within their own catchment areas.
- The healthcare system will be severely taxed, if not overwhelmed due to the high percentage of illness and complications resulting from COVID-19, leading to a surge in the numbers of those requiring hospitalization and critical care.
- As a result, current service levels and expectation on the part of both healthcare workers and the public-at-large will not be provided during a pandemic.
- Acute Care sites will defer a range of services over the course of the pandemic to "free-up" both human resources and beds/space to meet the demands of pandemic COVID-19 patients.
- Staff and the service they provide will be redefined to ensure the highest numbers of staff are available to provide various levels of pandemic COVID-19 care.
- To limit the strain on Emergency Departments and to lessen the spread of infection in acute care sites, assessment centres may likely be established external to hospitals, to screen and triage the majority of pandemic COVID-19 cases.
- Alternate Care Centres will also be established to provide basic treatment services for those COVID-19 patients too sick to go home but not ill enough to require acute care.
- Interior Health has adopted a set of "Ethical Guidelines for Pandemic Planning" to assist in decision making before and during a pandemic. These guidelines were developed by the University of Toronto Joint Centre for Bio Ethics and may be supplemented by the Calgary Regional Health model.
- A standard Interior Health Triage Model will be used to manage the access of patients to treatment/care interventions, when resource levels are variable, during the various phases of the pandemic.
- Standardized Interior Health treatment protocols will be available to assist in the decision making process in allocating ventilators, management of patients with pneumonia and for expediting extubation of patients on ventilators.
- Standardized Interior Health treatment protocols will be available to assist in the decision making process in the rationalization of renal dialysis within the context of decreased staffing resources within the renal program.

Congregate Care

- Congregate Care agencies whether Interior Health owned or contracted may be called upon to provide care for COVID-19 patients who do not require hospitalization or for whom hospitalization is not possible because of overcapacity.

- There will be an increased risk in working in communities so workers will require sufficient personal protective equipment (PPE) to meet the risk.
- Education and training in pandemic precautions will be necessary so that staff members will be confident in providing care.
- Regular communication to clients is important to ensure that clients are receiving relevant, current and accurate information.
- Collaboration between the hospital, community, and other agencies will be essential so that all are aware of the available workforce and priority of the work for the Community Care staff.

Chapter 5: Emergency Response Management System

Interior Health's Emergency Response Management System (IH ERMS) is a comprehensive emergency management process that allows for a scalable, coordinated response to emergencies and disasters that impact, or that have the potential to adversely impact, the delivery of health services within IH. IH ERMS allows for a scaled response through the application of four basic operational levels. These operational levels are:

- Site / Facility Internal Incident;
- Portfolio Impact Event;
- Geographic Community Level – Multiple Site / Portfolio Impacts; and
- Multiple Community / IH Wide Level.

Site/Facility Level

At the site level, all sites/facilities are required to have Site Emergency Response Plans that address internal emergency/disasters. Response to Pandemic outbreaks should be no different as the incident management structure at a facility allows for a scalable response that expands or contracts as required to manage additional planning, coordination or resource requirements.

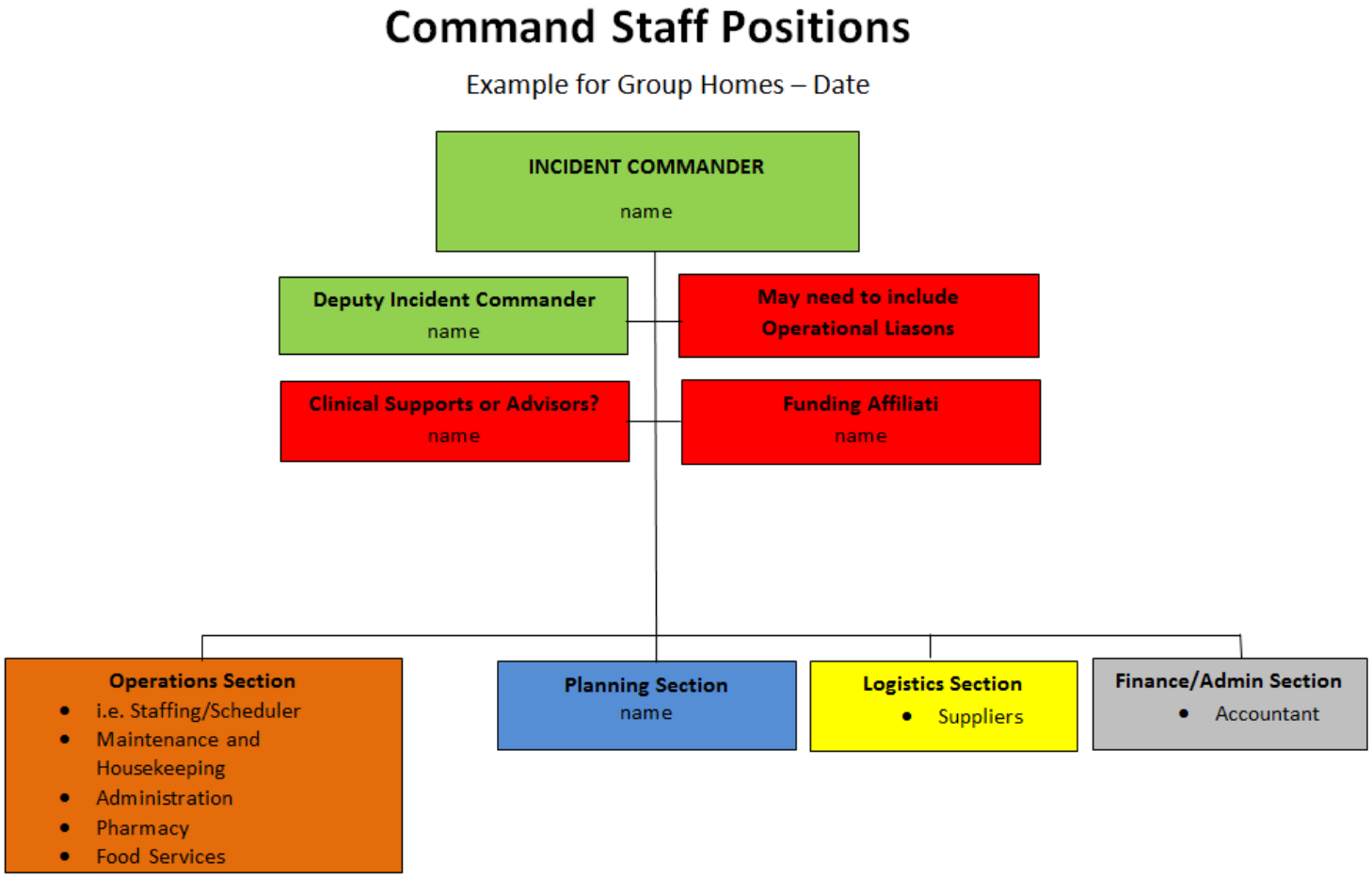
The Site/Facility emergency response typically has the following roles and responsibilities:

- Manage the response for the site or facility;
- Keep applicable operational contacts informed of events;
- Allow for liaison with local emergency first responders (Fire, Police, BCAS);
- Provide a Health Representative to a Municipal EOC as required; and
- If required, requests activation of the next level from the Portfolio EOC

A typical response model for a single event or single facility internal incident is identified on the following page.

To ensure a coordinated site response, and continued support in the event of a pandemic, all sites must identify an Incident Command Centre (ICC) for this purpose. Site ICCs must have an administrative lead (site manager level) and, where necessary, a Physician lead, and should have department leads as necessary to facilitate the operational response to a pandemic. Site ICCs are responsible to lead and coordinate site level implementation of pandemic response.

Figure 1: EXAMPLE: Site Incident Command centre



Chapter 6: Activation of Pandemic Plans

The Health Authority Level plan will be activated when:

- more than one of the health authority areas and/or other BC heath authorities are affected; and/or
- higher demands are placed upon the Interior Health's systems or staff, sufficient that there is significant impairment of the ability of Interior Health to conduct business or provide health services; and/or
- a pandemic outbreak has been declared by the Chief Medical Health Officer

After the Health Authority Level plan has been activated, Site Plans will then be activated, as appropriate, by their site Incident Command Centres.

Chapter 7: Service Deferral and Capacity Planning

Once a pandemic outbreak has been declared and the IH COVID-19 Plan is activated by the Chief Medical Health Officer, it is anticipated that an increasing number of patients will become ill and staffing levels will be impacted due to illness. Should either of these two factors substantially impact service delivery, site Incident Command Centers should begin to consider the scaling back of services to ensure the provision of emergent care.

Site Pandemic COVID-19 Planning Working groups must decide on key strategies for coping with increased patient needs as well as reduced staffing.

During a pandemic, the site Incident Command Centre will work closely with Clinical Operations and/or site leadership and/or the IHEOC, to ensure the appropriate strategies and their impacts are considered.

Chapter 8: Congregate Care Business Continuity Plan

Once a pandemic outbreak has been activated within Interior Health by the Chief Medical Health Officer and staffing levels have reached a critical threshold, the EOC Directors will activate the scaling back of service to provide prioritized care within the Congregate Care sector. The staffing resources in the areas where service is being deferred may be redeployed to other areas including but not limited to the alternate care site, community care, acute care, etc.

As part of the pandemic planning Managers are asked to define delivery of service when staffing levels were reduced to 65, 50 or 35 percent of normal staffing capacity.

In a pandemic, this information may be extremely valuable to an Incident Command Centre or health executive team responsible for the site or facility's pandemic response. By engaging departmental staff in this exercise, it will help in identifying the potential impacts of reduced staff numbers.

Percentage of Weekday FTE	Staff Positions FTE's Available	Prioritized Services
100%	**Manager: X** **Unit Clerk: X** **RN: X** **LPN: X** **RCA: X** **RT: X** **Aboriginal Worker: X** **Social Worker:** **List others** **Consider lab, etc.**	☐Hydration & Nutrition ☐Medication Management ☐Medical & Symptoms Monitoring ☐Specialized Care (Wound TX) ☐Personal Care ☐Inventory Maintenance ☐Therapeutic Services ☐Administration (EOC Function) ☐Respite Services ☐Other ☐Other
65%	**RN: X** **LPN: X** **RCA: X** **AW: X** **List others**	☐Hydration & Nutrition ☐Medication Management ☐Medical & Symptoms Monitoring ☐Specialized Care (Wound TX) ☐Personal Care ☐Inventory Maintenance ☐Therapeutic Services ☐Administration (EOC Function) ☐Respite Services ☐Other ☐Other

Percentage of Weekday FTE	Staff Positions FTE's Available	Prioritized Services
50%	**RN: X** **LPN: X** **RCA: X** **AW: X** **List others**	☐Hydration & Nutrition ☐Medication Management ☐Medical & Symptoms Monitoring ☐Personal Care ☐Inventory Maintenance ☐Therapeutic Services ☐Administration (EOC Function) ☐Respite Services ☐Other
35%	**LPN: X** **RCA: X** **List others**	☐Hydration & Nutrition ☐Medication Management ☐Medical & Symptoms Monitoring ☐Personal Care ☐Inventory Maintenance ☐Administration (EOC Function) ☐Other

8.1 Prioritization of Normally Provided Services

BOX A: TO BE COMPLETED - Prioritization of Normally Provided Services

ORDER OF PRIORITY (1 = highest)	SERVICES PROVIDED (Break down Services into separate tasks if necessary)
1.	Service _____
2.	Service _____
3.	Service _____
4.	Service _____
5.	Service _____
6.	Service _____
7.	Service _____
8.	Service _____

**(Please insert additional rows as is necessary.)*

8.2 Pandemic Staffing & Services Profile

BOX B: TO BE COMPLETED - Pandemic Staffing & Services Profile

Percentage of week-day FTE	STAFF POSITIONS And FTE available	PRIORITIZED DEPARTMENT PANDEMIC SERVICES
65%		❑ Service _____ ❑ Service _____ ❑ Service _____ ❑ Service _____ ❑ Service _____ ❑ Service _____ ❑ Service _____
50%		❑ Service _____ ❑ Service _____ ❑ Service _____ ❑ Service _____ ❑ Service _____
35%		❑ Service _____ ❑ Service _____ ❑ Service _____