Ontario Health

PREPAREDNESS ASSESSMENT

For Long-Term Care Homes

Version 3 – August 10, 2020

Purpose

The Ministry of Long Term Care and Ontario Health have established an ongoing provincial table (LTC Operations Committee) that will focus on providing guidance and solutions for all LTC homes, help support the work of regional tables, guide and support the preparedness planning for LTC home and stabilization of the sector.

Each Ontario Health regional is to establish an OH Regional planning table to work with LTC homes in the region and continue to build partnerships. One of the first steps is to conduct a preparedness assessment and planning exercise by the end of August.

This preparedness assessment for long-term care homes is intended to help homes identify, plan for, and take action on key areas of operational health for near-term stabilization and longer-term improvement, following wave one of the COVID-19 pandemic. This document can be used to help develop and guide policies, procedures, preparedness and response planning by the home, in collaboration with residents, families, the community, and network of health system partners. It can be used as a snapshot in time, but more importantly, as a way to check-in and guide ongoing improvement.

For this baseline assessment the completion of the by the LTC will assist in assessing planning contingencies. LTCHs may draw upon assistance from partners in Public Health, Hospital, Home and Community Care or others to seek input. Each LTCH is accountable to produce the finished assessment.

Alongside this work, the province has set out a commission in LTC to begin work on modernization of the sector.

Timelines

- Please complete and submit the preparedness assessment no later than **August 28, 2020 noon to Sheila. Stirling@lhins.on.ca**
- By the **September 10, 2020**, Ontario Health regions will roll up results and provide to the Ministry of Long-Term Care. Preparedness assessments may be conducted again in the future.

Preparedness At-A-Glance

Based on learnings to date there are three key factors of effective preparedness: 1) Human Resources, 2) Infection Prevention and Control, 3) Partnerships and Sustained Operations. Additional factors may be added to the assessment and/or plans as relevant for each LTC home.

Check the box that most closely aligns with the overall level of preparedness for each of the three key factors below (based on the responses on pages 3-20).

Key Factors for Preparedness:	Level 1	Level 2	Level 3	Level 4	Level 5
1. Human Resources	☐	☐	☐	☒	☐
2. Infection, Prevention and Control (IPAC)	☐	☐	☐	☒	☐
3. Partnerships and Sustained Operations	☐	☐	☐	☒	☐

Description of Levels

In each section below, you are asked to assess the current level of home preparedness on a scale of 1 to 5. Descriptions of levels 1, 3, and 5, as well as guiding questions, are provided for each key factor. Overall, the levels are meant to signify:

Level 1 = home is not prepared and significant improvement and support is needed

Level 3 = home is prepared to a basic level that creates a safe environment for residents and staff (with current resources – near-term stabilization will be reached)

Level 5 = home is highly prepared and connected to a responsive network of health system resources and supports (already at or on its way to "modernization")

Assumptions

When completing the preparedness assessment, assume that all emergency orders remain in effect and leverage existing direction and guidance. Please see the Government of Ontario website for a comprehensive summary of COVID-19 orders, directives, memorandums and other resources.

Helpful Resources

The following list is not exhaustive – other materials may be used/referenced, including guidance materials prepared by Ontario Health Regions.

- Government of Ontario - COVID-19 LTC Stakeholder Communications web page (also in French)
- Public Health Ontario - COVID-19: IPAC for Long-Term Care Homes and Retirement Homes Readiness Checklist (English version, French version)
- Provincial Infections Disease Advisory Committee – IPAC – Best Practices in IPAC Programs in Ontario (English version, French version)
- Province of Ontario, Ministry of Long-term Care- LTC covid 19 Commission

Ontario Health

Preparedness Assessment

Long-Term Care Home:	Tendercare Living Centre
Completed By (Name, Title, Organization):	Francis Martis, Executive Director, Marleys Shortte, Assistant DOC, ICP

To complete the assessment: Please review the descriptions of levels 1, 3, and 5 for each preparedness area and check the box for the level (1-5) that most closely aligns with the homes current status. Levels 2 and 4 are provided in case the home falls in between the described levels. Please describe why you selected this level and any additional information you would find helpful to document.

1. Human resources

Key Factor: Human Resources	Level 1	Level 2	Level 3	Level 4	Level 5
1A. LEADERSHIP **Appropriate level and capacity of leadership and management in place, including leadership recruitment, development, retention, and support (as relevant).** **Questions to think about:** 1. Has the home demonstrated strong leadership during the pandemic? Have there been changes to leadership? What is their administrative capacity? 2. Does the leadership reach out to local community leaders for support and mentorship? 3. Is there a cohesive culture and communication between leadership and front-line staff? 4. Does the leadership demonstrate empathy, vulnerability, and trust with their residents and staff? 5. Does the leadership demonstrate a growth mindset and foster a culture of distributed leadership and improvement? 6. Is the leadership well supported by the home owner or corporation?	• Vacancies exist in leadership positions • Lack of policies and procedures to support recruitment and retention of leadership • Lack of leadership performance standards and oversight • Little experience or training in leadership and management for the Executive Director. • Medical leadership is not visible in decision making of the organization • Little to no training in quality improvement		• No vacancies in leadership team • Governance (e.g., Board) is supportive and responsive to needed changes in leadership • Business continuity plans in place, including cross-training to support succession planning • Leadership development, recruitment and retention plans in place, with focus on appropriate skills or extensive training for existing and new leadership, leveraging mentorship from hospital • IMS structure in place • Medical Director is present at decision making and planning tables. • Staff identify a degree of trust in their leader • Experience in quality improvement		• Appropriate 360 performance review and oversight of leadership, tied to compliance audits as well as governance, staff, resident, and family feedback • Distributed leadership development and training programs in place, to enable greater leadership capacity and business continuity • Leadership is linked with local integrated care system / OHT planning table • Leadership development and recruitment plan is in place, and leverages mentorship from local partners, i.e., hospital • Communities of Practice: LTCH leadership all participate in sharing knowledge / resources amongst themselves (i.e., staff skills in areas such as cognitive impairment, behavioural support training, and palliative care) or contract ongoing with hospital • Continual quality improvement is evident • Staff report high degrees of trust in their leadership team • Business continuity plans are regularly

	• Director of care is not present on site • Unclear or inconsistent use of best practice standards		• Director of Care is present on site for shifts • Experience in best practice standards (ie: care for patients exhibiting behavioral issues, infection control)		updated • Direct of care is highly engaged and maintains high standards in training and auditing for best practise
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)
Tendercare has a strong and committed Leadership Team. Our experience during the current pandemic period was critical in keeping our residents and staff safe. We had two staff that tested positive and all residents have been COVID free to date. The Governing Board together with Extendicare is supportive and responsive to our needs.
IMS structure is in place. We hold regular staff meetings to keep staff informed and to seek input.
Executive Director, DOC and, 3 Assistant DOC's are present on the units supporting staff, residents and families.
Medical Director meets regularly with the Leadership Team and provides input on management of the pandemic.

Key Factor: Human Resources	Level 1	Level 2	Level 3	Level 4	Level 5
1B. HUMAN RESOURCE PLANNING **A health human resources plan in place to ensure staffing levels that are appropriate for full-service delivery, including plans for return to work and staffing shortages in the event of emergency and need.** **The M-LTC will action on decisions for prevention and containment funding, infrastructure and capital and enhance compliance/monitoring/inspections.** **Questions to think about:** 1. In the past, what have been the challenges for the home around staffing capacity? How have staffing shortages been managed? 2. Is there a staffing plan that addresses a potential future staffing shortage? 3. Does the home have the ability to draw on additional internal staff ("bench strength") to withstand a staffing emergency? 4. What back-up systems are in place? Does the home have strong relationships to the community to support emergency shortages? 5. Have innovative models or ways to influence the local staffing pool been explored?	• Current staffing shortages • High dependence of agency and part-time staff • Lack of relationships with staffing agencies • Lack of policies and procedures for return to work and work restoration • Limited forecasting of staffing schedule and demands • Staffing ratios are not meeting current standards • No plan in place to increase staffing ratios to accommodate added work during the pandemic (social distancing, in room care, acute medical needs) • No active recruitment is underway • Little to no support for staff regarding resilience building and wellness		• Robust HHR strategy and plan is developed to address staffing, retention, education, and wellness support; may include temporary staff placement from hospital • Plan for emergency staffing shortages has been developed, including strong relationships with external staffing agencies • Increased ratios to support new needs based on IPAC guidelines, i.e., in room feeding, individual exercise programs, deep and more intensive cleaning • Recruitment strategy underway (i.e., recruitment to new staffing ratios and to replace part-time with full-time staffing compliments) • Cross-training and orientation programs in place to support existing staff and new hires • Establishing return-to-work and work restoration program for LTC staff		• HHR plan that supports a single employer model and full time employment for staff • Modified staffing ratios in place for acuity of residents and care needs rather than occupancy • Most staff are full-time employees paid at competitive wages • Staff have benefits and support programs • Continuing education opportunities for skill development
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

We have agreement with 2 staffing agencies for PSW's and RPN's. Agency staff have been offered FT hours to prevent some working in other homes. We have an agreement with Scarborough Health Network for emergency staffing. We have managed our staffing needs without seeking SHN resources for staffing. All departments have contingency plans for adjusting staffing needs to respond to emergencies. We are in communication with staff on LOA to facilitate early return to work.

Key Factor: Human Resources	Level 1	Level 2	Level 3	Level 4	Level 5
1C. STAFFING SUPPORT **Appropriate occupational health, wellness and mental health supports in place for human resources' return to work, attraction and retention.** **Questions to think about:** 1. Does the home have dedicated occupational health resources that are communicated well and encouraged? 2. What is the culture like in the home? Have they had historical challenges with recruitment / retention? 3. Have staffing supports been extended to the home from health system partners? Is this model sustainable?	• Mental health and wellness resources not available • Lack of dedicated occupational health resources • Lack of policies and procedures for return to work • Lack of staff recruitment planning		• Established policies, procedures and program for occupational health and wellness • Access to mental health and wellness resources for staffing • Retention strategy developed including full-time employments, training, and competitive wages		• Occupational health program with policies and procedures in place • Effective communication of existing mental health and wellness resources and staff are using them • Retention strategy in place • Investments in longer-term skills training for in-house expertise and best practice skills (part of LTC HR processes going forward) • Staff training in areas such as compassion, communication, and bereavement available
Choose Your Preparedness Level:	☐	☐	☐	☐	☒

Comments: (Please describe why you chose the level above.)

We have an effective Health and Safety Team at Tendercare. We have an Employee Assistance Program and staff are encouraged to use the EAP program when needed.

We are continuously recruiting and have added Resident Support Aides, RN's and RPN to our staffing compliment. We are experiencing shortages of PSW's and Registered Practical Nurses. We have an agreement with Scarborough Health Network for staffing supports.

We have an on line Surge Education Program for all staff. IPAC training was provided by Scarborough Health Network and is ongoing.

Key Factor: Human Resources	Level 1	Level 2	Level 3	Level 4	Level 5
1D. MEDICAL LEADERSHIP **Reliable medical care that is accessible for on-site care.** **Questions to think about:** 1. How has the medical director historically supported the home? 2. Is there a strong partnership between the medical director and administrator / leadership team? 3. Is there a strong virtual plan in place, including trusted clinical relationships in the home to enable virtual care? 4. Is the Medical Director an effective leader for the home? How strongly are they connected to the community resources? Have they undergone leadership and management training? 5. Does the Medical Director maintain best practice training for themselves and the MRP physicians?	• Lack of medical care providers • Lack of plan for ongoing delivery of necessary on-site care • Lack of access to or use of virtual care platforms • Poor relationships between Medical Director and clinical on-site staff • Lack of knowledge and application of best practice standards • Little to no connection with medical leaders and partners in the community, such as hospital, public health		• LTC-Medical Director has virtual care program for specialists linked to Hospital in place (include virtual options and contact chart) • LTC-Medical Director has virtual care model in place to allow effective MRP care • LTC-Medical Director with LTC-Executive Director training staff for proper bedside assessment and SBAR to facilitate virtual care • Effective physician coverage in place for on-site daily presence of physicians- or being recruited for at this time • Effective communication with families and patients in place with LTC Medical Director • Care plans are up-to-date, including palliative care, order sets, and DNR status, including all necessary standing orders for swabbing and treatment • Best practice standards in key areas are up to date and enforced, such as infection prevention and control, palliative care, management of behavioural issues in dementia • Medical Director links in regularly with partners and medical leaders, such as hospitals and public health		• Implementing a LTC administrator (Executive Director) + Medical Director dyad leadership model, with daily onsite medical leadership presence • Demonstrated effective use of virtual care platforms • Staff are trained and capable of supporting virtual care with offsite physician • Dedicated (single home) medical care team with strong community / hospital clinical connections • Continuing medical education mandatory credits for MRPs in essential areas of care, such as infection prevention and control, palliative care, management of behavioural issues in dementia • Medical Director belongs to a community of practise
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

The Medical Director is very supportive and has been in the home throughout the pandemic to provide medical support. There is a strong partnership between the medical director, Director of Care, Administrator and other Attending Physicians in the home. The Medical Director and other MRP physicians are accessible for both onsite and virtual support.

Key Factor: Human Resources	Level 1	Level 2	Level 3	Level 4	Level 5
1E. RESIDENTS AND FAMILIES **Reunited residents with their families (visitations and family member as supporting caregivers).** **Questions to think about:** 1. What communication strategies were in place between the home and family members during wave one of the pandemic? 2. Were communications with residents and families timely, open, and transparent? 3. Does trust need to be restored between the home and families? 4. How involved are families and residents in the planning and implementation of these policies? 5. Is the home adequately resourced and prepared to implement visits that are safe?	• Strategy for visitation not in place or not aligned with the directives • Lack of communication with families and caregivers • Inactive/disengaged Resident and Family Council • Loss of trust between families and the home		• Visitation strategy in compliance with directives • Communication strategy in place for families and residents on policy requirements related to visiting policy • Mechanism in place for timely communications to residents and families, as well as managing concerns and complaints • Identified family members / caregivers for each resident and strategy to sustain visits/contact during wave 2 • Family/caregiver education strategy for PPE and IPAC developed • Plans, activities, and communications are developed in collaboration with residents and families that enable LTC to rebuild trust • Processes and awareness / understanding have been developed for residents and families to share feedback and escalate concerns to LTC leadership and MLTC		• Active/engaged Resident and Family Council involved in visitations • Implementation of regular communication strategy with family members/caregivers • Implementation of plans, activities, and communications in collaboration with residents and families that enable LTC to rebuild trust • Implementation of a virtual family visit model • Residents and families are engaged in co-design of new programs and processes for residents that provide a greater sense of purpose, quality of life, and connection to the community • Training and policies in place to allow for caregivers and families to continue to support care deliver during an outbreak, such as IPAC and PPE training, safety and reporting, liability waivers
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

We have been communicating with families regularly via emails and phone during the pandemic. We are in communication with our Family Council and Residents Council. Community Partners were updated on the pandemic situation. We have had no residents tested positive for COVID-19 to date. We have provided for indoor and outdoor visits as well as 'Face Time' and Essential Caregivers with input from our family council. Essential Caregivers were oriented on IPAC practices including hand hygiene and PPE use.

2. Infection, Prevention and Control (IPAC)

Key Factor: IPAC	Level 1	Level 2	Level 3	Level 4	Level 5
2A. IPAC LEADERSHIP **Dedicated onsite IPAC leads who are present 24/7 who can oversee, reinforce and support proper IPAC responsibilities, protocols and practices to all staff in the home (e.g., O. Reg. 79/10 requires designated lead for training and orientation, however, the lead may not be an IPAC specialist or may be a shared resource across multiple homes but has access to specialized resources in the local hospital, Public Health Ontario regional Communities of Practice and/or the local public health unit).** **Questions to think about:** 1. Are there dedicated, well-trained IPAC leads in place with culture of safety in the home? 2. Does the IPAC lead have the authority to enforce proper practices? 3. Is there a culture of improvement within the home to support sustainable practices?	• Lacking dedicated IPAC resource • Lack of IPAC training for lead and staff • Lack of IPAC policies and procedures • Lack of recognition for and authority of IPAC lead		• Dedicated in-house IPAC resource • Trained IPAC leads / champions onsite 24/7 • All staff trained on IPAC with clear policies and procedures • Relationship with external IPAC expertise including hospital and public health • Audit system in place, both internal and external; frequent internal audits led by onsite IPAC leads within the home, layered with less frequent external audits by IPAC experts provided by health system partners • Regular review of all aspects of the hierarchy of control to prevent outbreaks, including maximizing flu vaccination • Ongoing regular on-line and on-site training of staff on IPAC strategies		• IPAC education and training available 24/7 • IPAC Champions across organization • Strong connections to local response table and PHU • Demonstrate culture of Quality Improvement with capacity for sustained implementation of practices
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

` An ADOC currently serves as IPAC Lead and there is an IPAC Team in place. Education on the core competences of IPAC (hand hygiene, chain of infection, cleaning and disinfecting, and routine precautions) are provided to all staff as part of orientation and annually. Staff education is provided online and in person. Education is provided to staff on an ongoing basis during unit meetings, staff meetings, outbreak meetings and spot checks/audits. Hand hygiene audits are completed regularly. An average of 60 audits are done monthly. The average compliance rate for January - June 2020 is 91%. Internal IPAC audits are done monthly to ensure IPAC policies are being followed. Internal audits include PPE use, set up of isolation rooms, cleaning and disinfecting of shared and designated care equipment and high touch surfaces, hand hygiene, accessibility of PPEs, and cleanliness of clean and soiled utility rooms. Audits are done at least twice annually by Extendicare's National IPAC Consultant. National IPAC Consultant is also accessible to the home for training and quality support. The home is audited by the Ministry of Labor during outbreaks if staff become ill with outbreak related symptoms. These audits usually focus on PPE availability and use and staff education on routine precautions. There

is ongoing 24hr surveillance on all units, surveillance forms are reviewed daily by IPAC Lead or designate. Infection rates are tracked monthly and plans are put in place to address any negative trends noted. The home has a strong immunization program. Staff and Residents Flu Immunization rates are usually above 95% annually. The home works closely with TPH to minimize outbreaks. TPH Liaison is involved in Flu Campaign preparations, outbreak management and contributes to quarterly Professional Advisory Meetings. The IPAC Lead also uses PHO as a resource by attending Community of Practice events. PHO Best Practices and Guidance Documents are also used to support the IPAC Program.

Key Factor: IPAC	Level 1	Level 2	Level 3	Level 4	Level 5
2B. IPAC PROTOCOLS AND PRACTICES **Consistent, evidence-informed and verified IPAC protocols and practices in place.** **Questions to think about:** 1. Does this home have the policies/processes in place with demonstrated ability to implement/action them and sustain them throughout?	• Lack of verified IPAC protocols and practices in place.		• IPAC policies, procedures and programs in place, in compliance with relevant Directives • Demonstrated adherence to IPAC protocols and practices • Audit system in place		• Continued collaboration with hospital, PHU, PHO • Demonstrated capacity to sustain implementation of best practices • Dedicated Quality Improvement resources in the home • Demonstrated organizational commitment to safety in strategic plan
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

The home has IPAC Policies and Procedures based on PHO best practices and guidelines. IPAC Policies and Procedures are available online and in print. Policies and procedures are updated annually by Extendicare. Audits are done to ensure compliance to policies and procedures. There are 2 QI RPNs who assist in completing audits however the consistency and frequency of audits are affected by these RPNs being reassigned to replace RPNs on the units. There is commitment to safety within the home. The IPAC Team works with the Health & Safety Committee to ensure IPAC practices are in keeping with MOL regulations.

Key Factor: IPAC	Level 1	Level 2	Level 3	Level 4	Level 5
2C. PPE SUPPLY CHAIN **Sustainable supply of protective personal equipment (PPE) for staff and for residents and visitors where appropriate.** **Questions to think about:** 1. How connected is the home to a stable supply chain including local partnerships, i.e., hospital? 2. How effective is the communication and audit strategy to ensure sustainable best practices are in place?	• Lack of PPE supply in place • No demonstrated connection to effective supply chain • Purchasing of supplies is ad hoc versus anticipatory		• Demonstrated compliance with relevant guidelines on use and conservation appropriate for the work and community prevalence of disease • Demonstrated adequate PPE supply in place • Plan to ensure access to effective Supply Chain • Communication strategy to support PPE practices		• Collaboration with local integrated planning table/OHT • Demonstrated capacity to sustain effective PPE use • Shows knowledge in proper levels of PPE based on situation in the patient room, home and community
Choose Your Preparedness Level:	☐	☐	☐	☐	☒

Comments: (Please describe why you chose the level above.)

There are policies and procedures available for PPE use, inventory, and supply ordering including pandemic supplies. Extendicare has secured sustainable PPE supply source. The home has dedicated/preferred vendors for PPE supplies. Additional supplies are available through Extendicare and also Scarborough Health Network. PPEs are ordered weekly to ensure adequate supplies are maintained. Additionally, the home has separate supplies stored for use during pandemic in the event preferred vendors are not able to keep up with weekly orders. A minimum of 1 week's supply of PPEs are kept as pandemic supply.

Key Factor: IPAC	Level 1	Level 2	Level 3	Level 4	Level 5
2D. IPAC ASSESSMENTS **Regular on-site IPAC assessments.** **Questions to think about:** 1. Does the home have an invested, strong IPAC culture including dedicated trained resources and appropriate auditing processes?	• Lack of demonstrated IPAC assessments on site • No demonstrated capacity to complete IPAC assessments		• Regular IPAC assessments completed with follow up • Documentation to support practices • Audit strategy in place, both internal and external; frequent internal audits led by onsite IPAC leads within the home, layered with less frequent external audits by IPAC experts provided by health system partners		• Regular IPAC assessments completed with follow up • Documentation to support practice in place • Strong audit system in place 24/7 • On-site education provided regularly • Home demonstrates commitment to culture of safety- open communication, proper authority and accountability, demonstrated commitment in strategic plan
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

IPAC assessments are completed monthly by IPAC Lead and QI nurses. Extendicare IPAC Consultant performs IPAC audits annually and more often if needed. The IPAC program is audited using IPAC Foundational Audit Tool annually and an action plan developed to address identified gaps. IPAC Foundational Audit and Action plan are reviewed by the IPAC Consultant.

Key Factor: IPAC	Level 1	Level 2	Level 3	Level 4	Level 5
2E. IPAC TRAINING **Ensuring all staff in the home have "core" IPAC training (e.g., PIDAC Best Practices), and access to on-demand training on IPAC and PPE. Core training includes moments for hand hygiene and appropriate use of PPE for new staff as well as training refresh in donning and doffing of PPE with audits and feedback.** **Questions to think about:** 1. How is this home monitoring staff IPAC compliance and knowledge? 2. What is the culture for quality improvement in this home? Do they have the demonstrated ability to implement and embed practices across the home? How is excellence sustained?	• No demonstrated training practices in place		• Documentation of IPAC training for all staff available • Training regularly provided across the home (emphasis on in-person training, not virtual) • Strong orientation program in place for new hires		• Regular education and training opportunities • Dedicated IPAC champions across the home providing audit and education supports • Demonstrated commitment to excellence-ability to embed practices and sustain them • Dedicated Quality Improvement resources in the home
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

IPAC training is provided to all staff through Surge on-line learning as mandatory learning on hire and annually. The completion rate for 2020 is currently 71.5%. Hand hygiene and Donning & Doffing audits are done and staff are provided with on the spot education and feedback. Hand hygiene, cleaning and disinfecting and Routine Practices are standing agenda items in Unit Meetings and Nursing Practice Meetings.

Key Factor: IPAC	Level 1	Level 2	Level 3	Level 4	Level 5
2F. ENVIRONMENTAL CLEANING **Processes, resources and adequate equipment / supplies in place to train and implement best practices for regular environmental cleaning. Ensue an audit and feedback process is in place.** **Questions to think about:** 1. How well-resourced are the environment cleaning teams in the home? Do they feel supported? Do they have bench strength? 2. How does the home create a culture of cleanliness that everyone contributes to? 3. What is the culture of quality improvement to support sustained practices?	• Not compliant with environmental cleaning requirements		• Policies and procedures in place for environmental cleaning • Relationship with external partner to support emergency needs • Environmental cleaning audit in place • Demonstrated compliance • Modified staffing ratios (cleaning) to achieve compliance to new standards • Deep cleaning conducted when appropriate		• Cross-trained staff on environment cleaning practices for additional support • Culture of excellence in safety across the organization
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

Environmental cleaning policies and procedures guided by PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings are in place. Audits are done monthly with focus on shared and dedicated care equipment cleaning as well as general cleanliness of residents' home areas. Housekeeping Services are provided by a contracted company. Deep cleaning of residents' rooms is done monthly. Routine cleaning of rooms is done daily and is enhanced during outbreaks or when a resident is on additional precautions.

Key Factor: IPAC	Level 1	Level 2	Level 3	Level 4	Level 5
2G. PHYSICAL INFRASTRUCTURE, ADDITIONAL PRECAUTIONS, AND ALTERNATIVE BED CAPACITY • **Physical infrastructure that supports and enables IPAC standards and protocols.** • **Options/plan for additional precautions including single room allocation and cohorting that support IPAC practices.** • **Options for alternative bed capacity that protects resident safety and wellbeing and follows IPAC guidelines.** **The M-LTC will action on decisions for prevention and containment funding, infrastructure and capital and enhance compliance/monitoring/inspections.** **Questions to think about:** 1. Does this home's physical structure enable implementation of IPAC standards- if not, how have they mitigated those challenges? 2. What needs to be done further to support these challenges? 3. Does this home have the capacity to ensure proper isolation protocols are implemented? What about when responsive behaviours and wandering are a consideration? 4. Does this home have a strong plan to reduce/eliminate ward rooms? What more needs to be done? 5. Does the home have the ability to isolate, cohort, and maintain resident safety and quality of the life?	• Physical infrastructure does not enable IPAC standards and protocols and no risk mitigation plan is in place • No plan for isolation and cohorting requirements • No ability to support isolation or cohorting requirements • No plan for reduction of ward room beds		• Robust operational plan for IPAC standards and protocols implementation • Identified spaces for isolation and resident cohorting (e.g., beds left vacant) • Demonstrated compliance (e.g., with Directive #3) • Ongoing education and training for staff on physical infrastructure needed for IPAC implementation • Plan for isolation and cohorting requirements • Plan for supporting transition/ admission of COVID + and COVID – residents • Plan in place for reduction of occupancy/ward room beds		• Available isolation rooms / spaces • Demonstrated ability to isolate and cohort residents • Additional investment in new infrastructure, larger rooms, smaller resident "units" (e.g., on one floor, or small building unit), and dedicated staff; each unit would have all amenities – group dining and recreational activities) • Enhanced participation of family and caregivers in innovative visitation models that are IPAC compliant, enabled through physical infrastructure
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

The home is working towards eliminating 3 and 4 bed ward rooms. Residents are no longer admitted into rooms with more than 1 other resident. There is a redevelopment plan in place that will ensure total elimination of ward rooms. Staff cohorting practices are in place. Eight isolation beds are available for use in the event of COVID19 outbreak among residents. The isolation of residents who wander or are otherwise noncompliant with isolation remains an issue. Enhanced hand hygiene among residents, cleaning of high touched surfaces and providing ill residents with masks are

some of the measures that have been used to support residents' safety when isolation is not possible.

Key Factor: IPAC	Level 1	Level 2	Level 3	Level 4	Level 5
2H. TESTING **Process, capacity and adequate supply of swabs for regular staff surveillance testing in accordance with guidance issued by government** **Questions to think about:** 1. Is the culture in the home supportive of these surveillance strategies? If not, why not? 2. Does the home have the demonstrated capacity to support surveillance strategies?	• Lack of swab supply • Not participating in staff surveillance testing • Not in compliance with guidelines		• Swabbing policies, procedures and program in place for staff • Adherence to swabbing guidelines • Swabbing of staff and residents is conducted; screening and reporting for staff symptoms daily • Identified lead to comply with data reporting		• Strong connection to local / community response table • Demonstrated ability to manage swabbing protocols and program
Choose Your Preparedness Level:	☐	☐	☐	☐	☒

Comments: (Please describe why you chose the level above.)
Extendicare has initiated "Ride the Wave", a Team swabbing initiative that consist of weekly swabbing of staff. Swabs are ordered as per MOH direction. Staff are supportive of swabbing initiative and an average of 265/300 staff are tested weekly. Daily screening of staff and residents for symptoms remains in place.

Key Factor: IPAC	Level 1	Level 2	Level 3	Level 4	Level 5
2I. OUTBREAK MANAGEMENT **Process, protocol and appropriate human resources are in place to respond to, contain and manage an infectious disease outbreak.** **Questions to think about:** 1. Did the home demonstrate the capacity to manage an outbreak during wave one of the pandemic? 2. If the home hasn't had a previous outbreak, are their plans up-to-date? Are they connected to the local community response table? 3. What risks remain in the home should an outbreak occur?	• Lack of plan, processes and procedures to support outbreak management • Lack of in-house resources to support outbreak management requirements		• Established outbreak management plan in place • Timely compliance with case reporting and outbreak with PHU • Staff trained on early detection and identification of possible COVID-19 cases • Weekly self-audit completed • Identified lead to comply with data reporting • Relationship to local response/partnership table in place to together manage pathogen outbreaks in the home		• Plan and dedicated in-house resources to support stabilization / prevention of outbreak • Strong connection to community partnerships and external resources • Working with local partners to manage capacity and care as a local integrated system
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

The IPAC Lead or Designate reviews daily surveillance and liaise with TPH if an outbreak is identified or suspected. The home successfully managed 2 COVID 19 outbreaks in which individual staff tested positive but there was no spread among residents or other staff. There is an outbreak management team in place and meetings are held daily during outbreaks. The home is affiliated with Scarborough Long Term Care IMS - LTC Partners SHN, PH, OH, MLTC and participates in weekly teleconferences held to prepare LTCHs in responding to the current pandemic.

3. Partnerships and Sustained Operations

Key Factor: Partnerships and Sustained Operations	Level 1	Level 2	Level 3	Level 4	Level 5
3A. COMMUNICATIONS **Communication and engagement processes and protocols in place for effective and timely communication with residents, staff, partners and families.** **Questions to think about:** 1. What is the culture of leadership in this home? What is the relationship between front line staff, residents and leadership? Between staff and families/residents? 2. Is a robust strategy in place to support a variety of communication mechanisms that are available to all staff, residents and families?	• No demonstrated strategy in place • No demonstrated capacity to support communication strategy • Disengaged staff, residents and/or partners		• Plans, activities, and communications have been developed in collaboration with residents and families • Established communication strategy that demonstrates success in communicating with staff		• Strong connection to Community of Practice • Strong connection to Resident and Family Councils • Strong connection to staff • Strong connection to local/community response tables
Choose Your Preparedness Level:	☐	☐	☐	☐	☒

Comments: (Please describe why you chose the level above.)

We have been actively communicating with our Residents, Staff, Families, Family Council and Residents Council during the Pandemic. We have communicated with our community partners and send in reports to SHN when required.

We liaise with Toronto Public Health and our Infection Control Consultants at Extendicare.

The Leadership Team has maintained links with staff and residents by doing daily rounds, unit meetings, general staff meetings. DOC, ADOCs' are on the units mentoring staff and assisting with care issues.

Our BSO lead has participated in Community of Practice meetings relating to our BSO Programs.

Key Factor: Partnerships and Sustained Operations	Level 1	Level 2	Level 3	Level 4	Level 5
3B. PARTNERSHIP / MENTORSHIP SUPPORT **Partnership and/or mentorship support relationships established with local community partners (e.g., Ontario Health, local Public Health Unit/s, hospital/s, primary care, other).** **Questions to think about:** 1. How is this home connected to their sector partners (i.e., other LTC homes) and their other health system partners?	• Leadership disconnected from external partners and local tables		• Relationship to local response / partnership table in place and leveraged for ongoing support and action planning • Attendance at Community of Practice meetings (if available)		• Dedicated engagement in a Community of Practice for LTC • Strong connections to local/community response table • Mentorship in place for leadership team including medical/clinical staff
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

We work closely with Toronto Public Health, , Extendicare IPAC consultants.
Extendicare provides support in Leadership training and development.
We work closely with our Medical Director and Attending Physicians.
We have a Services Agreement with Scarborough Health Network (SHN). SHN has done an initial testing of all staff and residents for Covid-19, Education on PPE, Environmental review and review of our Infection Control Practices
Our BSO Lead participates in Community of Practice meetings.

Key Factor: Partnerships and Sustained Operations	Level 1	Level 2	Level 3	Level 4	Level 5
3C. SUSTAINABILITY **Plan for sustainable operations.** **Questions to think about:** 1. How strong is the sustainability plan and what has been the historical capacity to action this plan? 2. How strongly connected is the home and leadership team to external supports and resources?	• No existing business continuity or operational plans • No capacity to action existing plans		• Documented plans in place for key factors described above for staffing and IPAC • Documented business continuity plan • Established IMS structure • Engaged/Active board and/or Corporation • Strong community linkages		• Demonstrated ability to embed and sustain best practices across the organization • Demonstrated organizational commitment to excellence, including strategic plan and learning culture • Dedicated Quality Improvement resources within the home
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

We have a strong infection control team at Tendercare. We receive strong support from Extendicare and SHN. Our staffing resources are augmented with agreements with 2 staffing agencies and with Scarborough Health Network. We are presently interviewing applicants for a new FT infection control nurse to sustain our operations going forward. We have an IMS team in place. Our Board and Extendicare is engaged and supportive in our operations.

We have an active Family Council and Residents Council. We have a quality improvement Team and conduct Quality Protocols and evaluations through the year.

Key Factor: Partnerships and Sustained Operations	Level 1	Level 2	Level 3	Level 4	Level 5
3D. GOVERNANCE AND DECISION-MAKING **Clear, reliable and accessible governance and decision-making structures.** **Questions to think about:** 1. Existing leadership team competencies and capacity to work collectively with responsibility and accountability? 2. How strongly connected is the leadership team to their corporation and their board- what are those practices like and what is available? 3. How does the leadership team make decisions? How strong is this process? Could it be strengthened?	• Lack of authority and/or accountability demonstrated within the home by the leadership team • Lack of leadership structures in place to support decision making		• Emergency Incident Management System structure in place • Leadership and team structures, roles and responsibilities are clear, transparent, and well-documented • Demonstrated capacity for data analytics to support decision making		• Distributed leadership culture fostered • Investment in decision support infrastructure, including data analysts and IT data collection tools • Investment in an evidence-based culture that uses data for decision-making • Data used for ongoing quality improvement and partnership programs
Choose Your Preparedness Level:	☐	☐	☐	☒	☐

Comments: (Please describe why you chose the level above.)

We have a strong leadership team supported by the Board and Extendicare. Our Leadership Team demonstrated their skills and experience in managing our first outbreak when a staff tested positive for Covid- 19. We successfully managed the ourbreak with support from Toronto Public Health and our IPAC consultants from Extendicare.

We have had no residents who have tested positive for Covid-19.

We analyze our quality Indicators quarterly and follow up with action plans for improvement