



Assisted Living
Alberta

Continuing Care Communicable Disease Emergency Response Guide 2025/2026

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Project team

Prepared by

Provincial Seniors Health & Continuing Care

Assisted Living Alberta

continuingcare@assistedlivingalberta.ca



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This document has been prepared by Provincial Seniors Health & Continuing Care, Assisted Living Alberta (ALA) in partnership with the Continuing Care Communicable Disease Emergency Management Working Group, Infection Prevention & Control, Environmental Public Health, Primary Care Alberta, Assisted Living and Social Services (ALSS), Alberta Health Services Emergency / Disaster Management and Alberta Health Emergency / Disaster Management.



Chapter One – Communicable Disease Management Overview

Applicability

The information in this resource is applicable to all Home and Community Care (HCC) providers and Continuing Care Home (CCH) operators in Alberta.

This guide aligns with the Alberta Emergency Plan and Alberta Health Services (AHS) Communicable Disease Emergency Response Plan (CDERP). It will be regularly updated as provincial and organization wide plans are revised. This guide is part of a suite of resources that inform outbreak and emergency response.

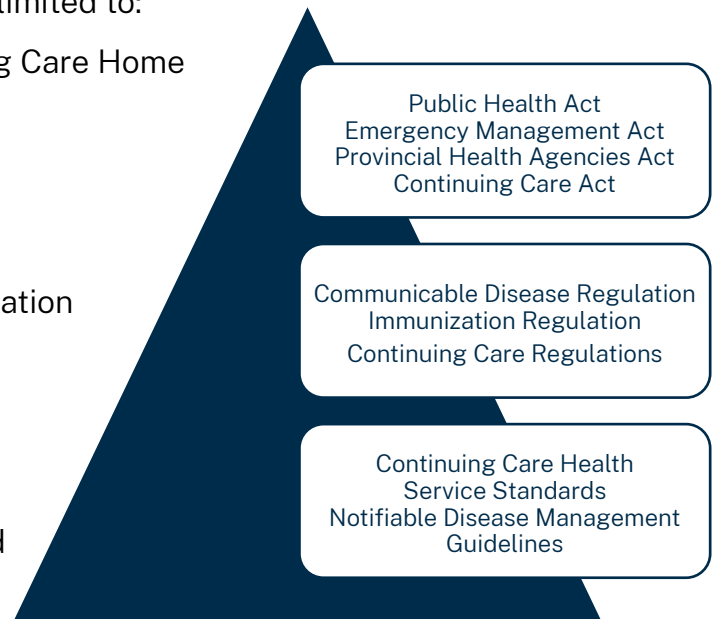
All resources are available on the Continuing Care Connection (CCC) (<https://connection.albertahealthservices.ca/web/default.aspx>) and/or the external AHS website (www.ahs.ca) or Assisted Living Alberta website (<https://www.assistedlivingalberta.ca/>).

Legislative Structure

The Alberta Public Health Act, 2024, sets out requirements for communicable disease notification and reporting as well as powers during an emergency in respect of communicable disease emergency response whereas the regulations, standards and guidelines support administration of the Act.

Additional legislation related to continuing care communicable disease emergency response requirements includes, but is not limited to:

- Accommodation Standards, Continuing Care Home (Government of Alberta, 2024)
- Occupational Health and Safety Act (Government of Alberta, 2021)
- Occupational Health and Safety Regulation (Government of Alberta, 2021)
- Occupational Health and Safety Code (Government of Alberta, 2024)
- Standards for Infection Prevention and Control - Accountability and Reporting (Alberta Health and Wellness, 2011)



Continuing Care operators in Alberta are responsible for providing training to their leaders and staff regarding emergency preparedness, communicable disease emergency response preparedness and service continuity (CCHSS, S.9.2.iv., 2024) which should be inclusive of all information set out in legislation.

Guiding Resources

Operators and staff (clinical and non-clinical) must understand and follow all guiding resources relevant to their care stream and specific role, authority or designation.

- Continuing Care Home (CCH) -The Guide for Outbreak Prevention & Control in Continuing Care Homes shall act as the foundational guiding resource for communicable disease outbreak. Preparation, prevention, management, and response for all CCHs is located at <https://www.albertahealthservices.ca/assets/info/hp/cdc/if-hp-cdc-ob-guide-for-outbreak-prevention-and-control-in-continuing-care-homes.pdf>.
- Home and Community Care (HCC) -HCC providers attending Supportive Living Accommodations shall refer to the Guide for Outbreak Prevention & Control in Supportive Living Accommodations located at <https://www.albertahealthservices.ca/assets/info/hp/cdc/if-hp-cdc-ob-guide-for-outbreak-prevention-and-control-in-supportive-living-accommodations.pdf>.
- All Continuing Care operators -When outbreak response extends beyond the site level, the Continuing Care Communicable Disease Emergency Response Plan (CC-CDERP) will also be in effect.

Additional guiding resources include, but are not limited to:

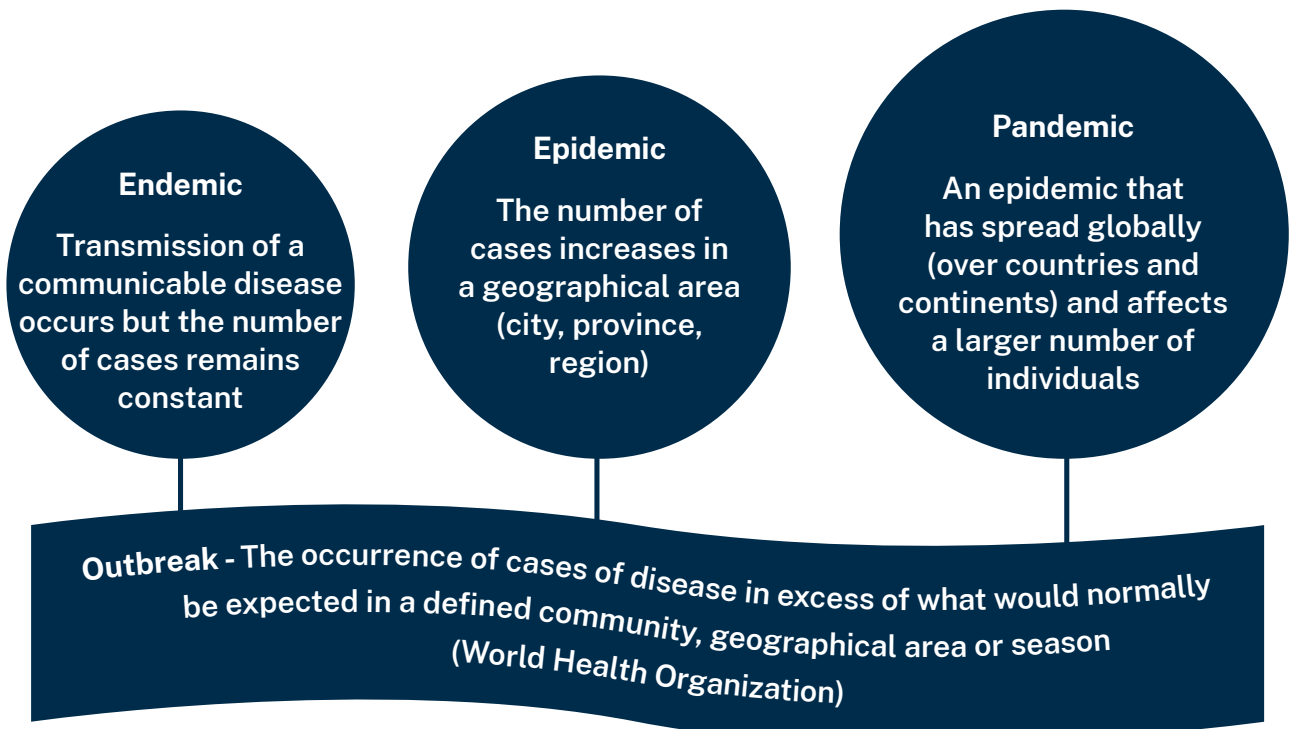
- [Alberta Notifiable Disease Guidelines](#)
- [Infection Prevention and Control Strategy](#) (Alberta Health, 2015).
- AHS IPC Required Organizational Learnings located at <https://www.albertahealthservices.ca/ipc/ipc.aspx>.



Chapter Two – Communicable Disease Emergency Response

Introduction

Communicable disease emergency response includes preparedness, planning, management, response, and recovery activities that need to occur to respond to an outbreak, epidemic, pandemic and endemic through varied, and sometimes unpredictable situations **(levels of activation)**.



Purpose and Objectives

The purpose of communicable disease emergency response planning is to:

- Ensure an appropriate level of care is being provided to all clients during a(n) outbreak, epidemic, and pandemic.
- Ensure a balanced and safe approach to manage service levels when bed capacity, staff vacancy, and service capacity is challenged.

Communicable disease emergency response objectives are to:

- Provide a safe environment for building occupants, staff, students, volunteers, and visitors.
- Minimize the risk of spreading communicable diseases while maintaining operations and services.
- Apply communicable disease control, infection prevention, and control practices consistently in all HCC and CCH environments.
- Provide clear roles for all stakeholders to understand their responsibilities in preventing and controlling the spread of communicable diseases.
- Provide key consistent resources and practice guidance to help staff understand their responsibilities for mentorship, education, and training.
- Provide communication pathways to improve sharing of information.
- Comply with orders from the Chief Medical Officer of Health (CMOH) and Alberta Occupational Health and Safety requirements.



Chapter Three – Information & Procedures

Purpose

- Outline requirements and additional considerations of a comprehensive communicable disease emergency response plan.
- Incorporate communicable disease emergency response plan requirements and considerations informed by the learnings from the COVID-19 Global Pandemic of 2020-23.
- Support communicable disease emergency response preparedness and planning processes that reflect best practice for continuing care while supporting consistency across the health system.

Minimum Requirements of a Comprehensive Communicable Disease Emergency Response Plan

A comprehensive communicable disease emergency response plan must include the following information:

- Roles and responsibilities (e.g., roles and designations of staff -responsibilities assigned to each role or designation).
- Direction on care provision (e.g., strategies to implement care and treat in place, end of life care, surge capacity identification, capacity prioritization, identification of essential services, and response needs for increasing levels of activation).
- Communication planning (e.g., activation of an incident command centre (ICS), maintenance of contact lists, location of contact lists staff fan-outs, non-contract/contracted partners, agencies, and suppliers).
- Human resource planning (e.g., strategies for staff recruitment and deployment; volunteer recruitment and roles, student recruitment and roles, competencies/skills inventory, training / orientation plans, tools for care delivery, alternate staffing models, and minimum staffing requirements).
- Infection prevention and control guidance (e.g., enhanced cleaning, additional precautions, cohorting, PPE, and hand hygiene).

- Processes for:
 - o Admission, discharge, and transfers (e.g., information transfer and risk assessment);
 - o Supplies and equipment;
 - o Surveillance and reporting;
 - o Designated family / support person(s) (DFSP), and visitation;
 - o Safety and security;
 - o Care of the deceased (including mass casualty).
- Reference to applicable organizational governance (e.g., policy, procedure, etc.).
- Reference to applicable Legislation / Acts (e.g., CCHSS, Accommodation Standards, etc.).
- Planning documents such as checklists, forms, procedures, processes, guidelines, protocols, algorithms, flowcharts, and lists that need to be completed or updated in the event of a communicable disease emergency response (e.g., Surge Capacity guidelines, Care and Treat in Place, Capacity Management, etc.).

NOTE: Changes may be made to the minimum requirements and considerations dependent upon the type of communicable disease requiring a communicable disease emergency response and the level of activation required.



Roles and Responsibilities

Continuing Care operators work collaboratively with environmental public health (EPH), communicable disease control (CDC), infection control professionals, healthcare providers, impacted Albertans (e.g., residents, DFSP), Assisted Living Alberta, Assisted Living and Social Services, Health Shared Services, and other Provincial Health Agencies and Provincial Health Corporations to facilitate a prompt response to help minimize the impact of a communicable disease emergency.

As the **Provincial Health Agency for Continuing Care, Assisted Living Alberta** is responsible to ensure that requirements for communicable disease emergency responses are clearly identified. Operators are responsible for ensuring that each requirement has individuals assigned to carry out the tasks; essentially, the individuals require the appropriate skills and competency.

Additional details regarding roles and requirements are located in [Chapter 4](#).

Care Provision

Care provision in a communicable disease emergency response is based on three primary principles:

- Care and treat in place
- Surge capacity
- Capacity prioritization

Care and Treat in Place

Minimum requirements for communicable disease emergency response plans related to care and treat in place plans include:

- Processes to continue to provide services to current residents.
 - If a resident is admitted to acute care, CCH operators must facilitate the resident to return to their prior living environment as soon as the acute episode has been stabilized.
- Processes to maintain appropriate level of care for all residents including
 - Testing for and managing (including tools: e.g., clinical pathway) the care of residents who develop symptoms of a communicable disease in their current living environment (e.g., develop Influenza-Like Illness (ILI) or Severe Acute Respiratory Illness (SARI)).
 - Managing the care of residents who develop additional or more severe medical conditions.
- Process to develop limitations to care and treat in place (e.g., when acute episodic illness requires surgical intervention and/or other urgent acute care services).

Considerations for communicable disease emergency response plans related to care and treat in place include:

- Clinical judgement must always inform service provision.
- Service provision will be dependent on the level of activation in a communicable disease emergency response.
- Any decisions to discontinue admissions to acute care will be determined by the Level of Activation, as directed by the Emergency Command Center (ECC).

I. Professional Health Services

Minimum requirements for care and treat in place related to physician and clinical support include:

- Plans for 24/7 accessibility to a Physician or Nurse Practitioner (NP), inclusive of telephone consultation, for all CCH residents.

- o Physician/NP coverage in CCH Type A is coordinated through the site Medical Director. The Zone /corridor Chief Medical Officer, or designate will disseminate information to all site Medical Directors.
- o Assessment may occur virtually or on-site depending on clinical need.
- All staff are required to work to their full role and scope of practice to support continuing care residents which may require additional skills assessment, skills inventory, and additional training.

II. Clinical Support Services

Minimum requirements for care and treat in place related to clinical support services include:

- Processes to refer to external healthcare providers or services (e.g., Alberta Referral Directory).
- Documented identification of pharmacy service requirements including after-hours service, and access to required/essential medications.
- Documented referral processes to ensure access to required clinical support services such as physiotherapy, occupational therapy, registered dietitian, social work, etc. in accordance with the residents' assessed needs.
- Options for virtual health and other technology assisted appointments.
- Options for psychosocial supports and recreation therapy to meet the needs of residents in accordance with their plan of care.

Considerations for care and treat in place related to clinical support services include:

- Appointments may need to be limited to those with acute illness or to prevent acute care admission. Alternative options to provide services that benefit the overall health and wellbeing of residents should be considered.
 - o There may be limited ability to provide scheduled/routine diagnostic procedures (e.g. lab and X-ray). Routine diagnostic procedures may need to be delayed ensuring capacity for those with urgent and emergent needs.
- Medication management activities may need to be limited to those that are medically necessary. Activities may include review and streamlining of medication assistance and administration times and completion of a medication review to hold medications that are not essential/needed for an immediate health concern (e.g., atorvastatin, vitamin D, etc.).

III. Management of Acute Infections/Illness

Minimum requirements for care and treat in place related to management of acute infections/illness include:

- Plans to provide oxygen support, infusion therapies, aerosol generating procedures and other interventions that may be required.

Note: Vascular access device initiation is dependent on resources, maintenance, and can vary depending on location. This includes but is not limited to home parenteral therapy programs, virtual home hospital services, mobile community paramedic program, assess treat refer emergency medical services, etc. Continuing Care operators are to use existing referral processes, as appropriate, to access these services.

- Identifying what training/education staff may require (refer to Human Resources).
- Processes for accessing supplies and equipment to provide care and treat in place (refer to Supplies and Equipment).

Consideration for care and treat in place related to management of acute infection/illness include:

- Refer to organizational governance and Lippincott Procedures (accessible on Continuing Care Connection) when treating residents requiring oxygenation, hydration, antipyretics, analgesics, etc.
- Treatment of symptomatic residents and transfers to acute care are based on the Level of Activation and the resident's Goals of Care Designation.
- Treatment options to reduce the severity and improve recovery from the communicable disease are to be provided in accordance with the resident's Goals of Care Designation and operational policies for informed consent.
- Access to community service providers (e.g., respiratory services, foot care, hair care) may be reduced or limited and agreements with alternate providers may be necessary to ensure availability.

IV. Comprehensive Assessments and Care Planning

Minimum requirements for care and treat in place related to comprehensive assessments and care planning include:

- Processes to ensure the appropriate comprehensive assessment (e.g., interRAI instrument) is completed.

- Processes to ensure comprehensive care plans are up to date and inform service provision for all residents in accordance with the requirements in the CCHSS (2024).
- Processes to ensure resident care needs are communicated at the point of care, and maintained in alignment with the comprehensive care plan (e.g., Daily Living Support Plan, Bedside Care Plan, or equivalent).
- Processes to review and update goals of care designations and advanced care planning.
- Processes for implementing symptom screening and other assessment and treatments when required (e.g., as per CMOH Orders, additional outbreak measures, etc.).

Consideration for care and treat in place related to comprehensive assessments and care planning include:

- Comprehensive assessments provide valuable information for prioritizing resident care during periods of outbreak or communicable disease emergency response.
- Completion of comprehensive assessments at the required intervals keep care plans up-to-date and reflective of resident needs.
- Any change to the frequency of comprehensive assessments shall be approved by Assisted Living Alberta in consultation with Assisted Living and Social Services and communicated to residents and stakeholders.
- Note: Patient Care Based Funding (PCBF) outbreak business rules will be implemented where applicable.
- Once the communicable disease emergency response is ended, the service provider shall determine whether a routine or significant change assessment is required for each resident.

V. Accommodation and Non-Clinical Support Services

Minimum requirements for care and treat in place related to management of accommodation and non-clinical support services include:

- Process to continue to meet record management requirements as set out in the operator policy.
- Verify existing contingency processes remain in place to access external providers or services to maintain service provision (e.g., meals, security, facility maintenance, etc.).

Consideration for care and treatment in place related to accommodation and non-clinical support services include:

- Staff positions that include both clinical and non-clinical duties (i.e. “multi-skilled workers”) may need to be reassigned to focus on clinical responsibilities to support care and treatment in place. For example, security staff could be assigned to clean and disinfect surfaces touched by residents wandering out of their rooms, or restocking isolation/PPE carts and other non-clinical duties.
- Operators should consider the need to hire additional staff or have arrangements in place with service providers to ensure accommodation and non-clinical services are maintained.

Surge Capacity

Minimum requirements for communicable disease emergency response plans related to identification of surge capacity include:

- During a communicable disease emergency response, all available additional beds/spaces should be used as surge capacity.
- Identification of surge capacity of at least 1-2 beds/spaces for every CCH, as appropriate.
- Processes to manage bed capacity and surge capacity expectations (additional bed capacity, additional staffing, additional equipment, etc.) in the event that additional spaces are required.
- The addition of beds/spaces for surge capacity must comply with all usual IPC requirements including:
 - o Minimum of two (2) metres between residents.
 - o Availability of hand hygiene in accordance with all IPC requirements located at <https://www.albertahealthservices.ca/ipc/page6426.aspx>.
 - o Space available for soiled and clean equipment, supplies and linens.
 - o Garbage containment and collection.
 - o Availability of toilet and shower/bathing facilities near proximity (or a space for commodes).
 - o Carpeted areas are discouraged.
 - o Space for staff and visitors.

Considerations for communicable disease emergency response planning related to surge capacity include:

- Levels of activation and staff availability will impact the ability of operators to fill surge capacity spaces.



Capacity Prioritization

Minimum requirements for communicable disease emergency response plans related to capacity prioritization include:

- Relevant AHS policies and procedures are to be followed to ensure that available capacity is prioritized appropriately during a communicable disease emergency response.
- Prioritization of service provision is completed according to the [Service Level Recommendations](#).

Considerations for communicable disease emergency response planning related to capacity prioritization include:

- Assisted Living Alberta will facilitate transfers/moves from acute care to community.
- Waitlisting and transition activities should not stop if transition/admission can occur safely to sites considering outbreak status, staffing shortages, etc.
- All health, community, and social service providers will be called upon to cooperate with the provincial and local communicable disease emergency response response.
- Additional capacity may be requested through an Expression of Interest process. See the [Alberta Purchasing Connection](#).
- Alternate care options should be considered to avoid emergency department utilization and acute care admission among individuals living in the community (e.g., informal caregivers, temporary community options, added and extraordinary care funding, etc.)

Note: See Admissions, Transfers, and Discharges to CCH section for additional information.

Waitlist Management

Minimum requirements for communicable disease emergency response plans related to waitlist management include:

- Processes that align with relevant AHS policies and procedures for direction on changes to normal operating procedures during an emergency response.
- Processes to communicate changes to normal operating procedures (when activated) to staff, volunteers, students, residents and families

Note: Notification must be provided to all impacted residents and caregivers.

- Process to coordinate with ALA to allocate CCH spaces based on the clinical health needs of the resident.
- Process for CCH operators to provide timely notification of vacancy to the ALA to facilitate activation of the changes to normal operating procedure.

Considerations for communicable disease emergency response planning related to waitlist management include:

- There will be increased demands on **coordinated access** processes throughout the communicable disease response including in the recovery and resumption phases (see [Levels of Activation](#)).
- During recovery and resumption, usual operating waitlist management procedures will resume.

Communication and Contacts

Minimum requirements for communicable disease emergency response plans related to communication and contacts include:

- Maintaining up to date contact lists (e.g., phone numbers, addresses, and email) for organizational leaders, staff, physician/NP, consultants, residents and their designated family/support person(s), alternate decision makers, volunteers, relevant stakeholders, (e.g., Communicable Disease, Infection Prevention and Control, etc.) and other key contacts relevant to communicable disease emergency response planning and activation.
- Establishing multiple mechanisms (e.g., email, phone message blasts, virtual or in person meetings, letters) for communicating with these stakeholder groups.
- Ensuring mechanisms are in place 24/7 for providing urgent communication to these stakeholder groups.
- Ensuring Assisted Living Alberta and Zone/Corridor Seniors Health & Continuing Care has current contact information for site and organizational leadership, including after-hours contact information.
- Processes to follow an **incident command system** (ICS), including the establishment of site command posts, and reporting through identified channels.

Note: Existing communication pathways and contact lists for outbreak management and response can be referenced. Additional communication structures may be required depending on the level of activation (see [Levels of Activation](#) and [Service Level Recommendations](#)).

Considerations for communicable disease emergency response planning related to communication and contacts include:

- Communication during a communicable disease emergency response may be available through a number of sources. Additional communication may be available at:
 - o AHS
 - Website: www.albertahealthservices.ca
 - Insite: <http://insite.albertahealthservices.ca>
 - o Continuing Care Connection: <http://connection.albertahealthservices.ca>
 - o Alberta Government:
 - <https://www.alberta.ca>
 - <https://www.alberta.ca/coronavirus-info-for-albertans>.
- Each service provider is encouraged to have a communicable disease emergency response communication designate to ensure information is effectively communicated with staff, residents, and the public.
- Assisted Living Alberta (ALA) shall appoint an individual to act in the role of Operator Liaison to organize, track, and respond to all requests for information.
- Access to the **Operator Liaison** shall be obtained through the continuingcare@assistedlivingalberta.ca email.

Human Resources Planning

All Continuing Care operators will be required to support the provincial and local communicable disease emergency response. Staffing levels in HCC and CCH vary according to service provision, funding, staffing models, type of program or facility, size of the program or facility, shift, and the location of the facility (urban or rural).

Minimum requirements for communicable disease emergency response plans related to human resources planning includes:

- Documentation of necessary minimum staffing levels, including volunteers and other service providers, to maintain minimum care and treat in place requirements.

- Process to consider alternate work arrangements for individuals that can continue their job duties remotely.
- Identification of required education.
 - o Process for provision of required education for physicians/NPs and staff (regulated and unregulated), volunteers and students (Education material is available at <http://connection.albertahealthservices.ca>), including documentation of education.
 - o Streamlined education delivered in a variety of modalities may be required (e.g., virtual, onsite skills sessions, self-learning modules, etc.).
- Process to sequester or mandate certain or essential staff.
- Process to quickly obtain additional staff to replace and/or augment staff through strategies such as agency contracts.
- Processes to rapidly and safely orientate new staff (e.g., agency staff).
- Process to communicate staffing levels (e.g., vacancies, augmented staffing).
- Process to request additional funding for care related needs.

Note: Refer to the AHS Added and *Extraordinary Care Funding* Policy <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-prov-continuing-care-added-care-policy.pdf> and related processes. Funding for additional staffing costs incurred will be considered in accordance with the *AHS Added and Extraordinary Care Funding* Policy for, but not limited to:

 - o An increase in staffing needed to manage the increased resident acuity and isolation.
 - o Increased staffing to support Care and Treat in Place.
 - o Increased staffing to support surge capacity.
- Process to mobilize the workforce across multiple facilities in the organization.
- Process to address staff, volunteers, and students attending work with symptoms or when recovering from a communicable disease which align with relevant policies, procedures and communicable disease management guidelines.

Note: Processes to support online self-assessment for healthcare workers, home test kits, as well as Fit for Work screening (prior to attending work) were implemented during the 2020-23 COVID-19 Global Pandemic and may be beneficial in future communicable disease emergency response events.

- Adherence to Occupational Health and Safety legislation and requirements including tracking of staff/volunteer/student communicable disease assessment, organizational policies for the management of staff reassignment as deemed appropriate based on their communicable disease assessment, and antiviral prophylaxis for staff.
- Process to track and make available immunizations and antiviral prophylaxis for staff, including students and volunteers.

Note: Refer to the Government of Alberta Immunization and Routine Immunization Schedule, (<https://www.alberta.ca/immunization-routine-schedule>) related AHS policies regarding immunization, and applicable Occupational Health and Safety legislation.

Considerations for communicable disease emergency response plans related to human resources include:

- Account for reduced staffing for long periods of time and across multiple sectors that may impact staffing availability (e.g, school closures, day care closures, travel advisories, etc.).
- Address the need for individual/teams/groups of staff to be able to work across locations, operators and organizations (e.g., redeployment, sharing across buildings or unit, assigning on-call duties) when allowed.
- Make arrangements with other organizations/staffing agencies to have cooperative agreements for staffing in the event of a public health emergency.
- Plan for expedited orientation and training for new and agency staff through strategies such as comprehensive orientation binders, site and unit orientation, buddy shifts, ensuring new staff are aware of designated unit leader, orientation to documentation systems including electronic health records and end of shift follow up.
- Obtain union, labour relations, human resources and legal consultation (when/as applicable) to ensure that any impacts for employee contracts or union agreements are accounted for.
- Have virtual options available when face-to-face meetings and education as well as unnecessary travel may be postponed.
- Make arrangements for psychosocial and mental health resources and/or supports for staff, volunteers and students.

Infection Prevention & Control (IPC)

Minimum requirements for communicable disease emergency response plans related to IPC planning includes:

- Processes to ensure continuous implementation of comprehensive IPC and CDC/EPH strategies, training/education, resources and guidance that prevent the transmission of communicable diseases with or without the availability of vaccines and treatments.

Note: Refer to all applicable AHS IPC, notifiable disease, and outbreak management resources for infection prevention, identification, response, management, and control measures located at:

- o [Infection Prevention & Control](#)
- o [Notifiable Disease & Outbreak Management](#)
- Process to evaluate adherence to IPC practices through site based risk assessment or equivalent, including, but not limited to:
 - o IPC Risk assessment (IPCRA)
 - o routine practice and additional precautions
 - o hand hygiene
 - o appropriate use of PPE
 - o cleaning and disinfection practices
 - o waste handling and management
- Process to procure (e.g., through ALA and/or other provincial sources), store, and access PPE, alcohol based hand rub (ABHR), dedicated isolation/PPE carts and disinfectant/cleaning products to meet the needs of all staff, volunteers, students, residents, and visitors.
- Process for waste management that accounts for the increased volumes of waste that may be produced during significant outbreaks. The plans should include, but are not limited to: procuring adequate waste receptacles in resident care areas, coordinating large dumpsters for waste collection outdoors, increased frequency of waste pick-up, and clear processes for transporting waste from the building to minimize risk of contamination and further transmission.
- Process for handling clean and soiled linens/laundry including laundry separation, additional receptacles, processes for transporting contaminated laundry from outbreak areas to minimize risk of transmission, and additional precautions for handling laundry on the unit/site and in the laundry facilities.

- Process for specimen collection for communicable diseases, including identifying how to obtain orders for testing, determining who collects specimens, as well as procuring the required testing supplies.
- Process for a resident immunization program, including tracking and site-based immunization during a communicable disease emergency response.
- Process to implement communicable disease surveillance and reporting practices beyond regular surveillance and reporting at the discretion of ECC, IPC and CDC/EPH.
- Process to implement revised IPC guidance based on the pathogen, mode of transmission, etc. that may change based on learnings through the communicable disease emergency response (e.g., cohorting staff and residents based on the pathogen).

Considerations for communicable disease emergency response plans related to IPC include:

- Operators must follow most recent guidance from Assisted Living and Social Services and the CMOH in consultation with zone/corridor MOH/designate for administering immunizations.
- Arrangements with operators nearby for provision of PPE and other supplies may be helpful in a short notice or urgent situation.

Admission, Discharge and Transfer

Minimum requirements for communicable disease emergency response plans related to admission, discharge and transfer include having processes for:

- Completion of a communicable disease assessment on admission and review/update prior to transfer or discharge.
- Completion of a symptom assessment at point of care.

Considerations for communicable disease emergency response plans related to admission, discharge and transfer include, but are not limited to:

- Implementation of revised guidance based on the pathogen, mode of transmission, etc. that may change based on learnings through the communicable disease emergency response (e.g., daily symptom assessment, symptom assessment on admission and immediately preceding discharge or transfer).

Resident Outings, Leaves of Absence (LOA) and Temporary Relocation

Minimum requirements for communicable disease emergency response plans related to resident outings, leaves of absence and temporary relocation include processes for:

- Assessment for appropriateness of the resident outing and leave of absence in consideration of disease specific guidance (e.g., CMOH Orders, federal or provincial government requirements for travel, etc.).
- Assessment for appropriateness of the temporary relocation of a resident to community or alternate location during service disruptions.
- Communicating the requirements of a resident outing, leave of absence or temporary relocation to the resident, DFSP(s), and interdisciplinary team (e.g., care needs, financial accountabilities, reassessment requirements, etc.).

Considerations for communicable disease emergency response plans related to resident outings, leaves of absence and temporary relocation include:

- Information for residents and families regarding their responsibilities while away or off-site (e.g., financial, communication, etc.).
- Information for the interdisciplinary team to consider when planning for a leave of absence or temporary relocation with a resident and family (e.g., equipment, alternate care services, etc.).

Surveillance and Reporting

Minimum requirements for communicable disease emergency response plans related to surveillance and reporting include processes to:

- Processes to implement communicable disease surveillance, symptom monitoring based on IPC and CDC/EPH guidance (e.g., daily, at admission, transition, discharge, return from outings).
- Review surveillance and symptom monitoring to identify clusters of illness in residents and staff.
Note: This surveillance data may drive the communicable disease emergency response and be used to determine the level(s) of activation as well as progression through the level(s) of activation.
- Processes to support and communicate all required reporting.

Considerations for communicable disease emergency response plans related to surveillance and reporting include:

- Continuing care operators may be required to implement revised surveillance and reporting requirements as per the direction from the Government or CMOH.
- Note:** Public Health Reporting reporting by CDC and EPH, is completed under the Alberta Public Health Act and may be updated based on the pathogen, mode of transmission, etc.

Supplies & Equipment

Minimum requirements for communicable disease emergency response plans related to supplies and equipment include reviewing existing:

- A list of required supplies and equipment needed to meet anticipated needs of the population (see below table and IPC section for specific PPE supply requirements).
 - o Supplies and equipment will be needed to provide care and treat in place (e.g., oxygen tubing and concentrators, infusion pumps, PPE for aerosol generating procedures, etc.).
 - o Additional supplies and equipment beyond daily operational needs will be required to support care and surge capacity (e.g., beds, commodes, linens, single-use items, etc.).
- Processes to procure and obtain required supplies and equipment. Verify provider has contingency plan to ensure availability of supplies and equipment.

Considerations for communicable disease emergency response plans related to supplies and equipment include reviewing existing:

- Agreements with local service providers (e.g., oxygen providers, pharmacies, etc.).
- Agreements with alternate service providers to maintain the flow of critical supplies and equipment.

Examples of Supplies and Equipment		
Infusion therapy supplies (hypodermoclysis)	Portable / disposable thermometer	Human remains pouch / body bag
Biomedical waste containers	Communication device for virtual consultations	Oxygen supplies including pulse oximeters
Dedicated isolation /PPE carts	Stock of single resident use or disposable items	Large, soiled holding receptacles and bags

Safety & Security

Minimum requirements for communicable disease emergency response plans related to safety and security include processes for:

- Designating single entry and exit points to aide in reporting, point of entry assessment, and contact tracing.
- Providing on-site security staff, as required.

Considerations for communicable disease emergency response plans related to safety and security include:

- Protection from theft and vandalism may be a high priority due to the potential of limited supplies and equipment and potential supply chain interruption.
- Protection from harassment and abuse may be a high priority due to the potential of restricted access and potential value conflicts.

Designated Family/Support person(s) and Visitors

Minimum requirements for communicable disease emergency response plans related to visitation include:

- Policies that set the expectations for safe DFSP, visitor practices, and guides operator decisions related to identification of essential care partners.
- Processes to manage or establish limits on DFSP and visitor attendance at a CCH or HCC site when required.

Considerations for communicable disease emergency response plans related to visitation include:

- General visiting may need to be limited and managed in accordance with restrictions such as CMOH Orders.
- Visitors attending facility-based continuing care to assist in providing care will require additional education and support with Infection Prevention and Control measures.
- Limits to visitation should be considered in the context of quality of life, personal choice of the resident, and special circumstances (e.g., end-of-life).
- DFSP and visitors may benefit from resources and/or supports for psychosocial and mental health.

Care of the Deceased

Minimum requirements for communicable disease emergency response plans related to care of the deceased include:

- Process for supplies (e.g., body bags), storage, and transfer of the deceased that align with [Alberta Government Bodies of Deceased Persons Regulation \(2021\)](#)
- Process to access the attending physician or NP for completion of the Medical Certificate of Death.
- Process to support cultural and spiritual/religious ceremony when handling deceased bodies.

Considerations for communicable disease emergency response plans related to care of the deceased include:

- The storage and transfer of the deceased will be determined in collaboration with ALA and will be dependent on the death rate.
- Most CCHs do not have deceased body holding areas. CCH operators need to consider locations for body holding areas, establish relationships with local funeral homes, develop a contingency plan for alternative holding space (e.g. ice rink, refrigerated truck, etc.), and potential mass casualty events.
- Usual patterns of attendance to residents by physicians and NPs may change due to altered coverage models and call schedules. The resident's physician or NP may not be immediately available at the time of death, or may rotate off a clinical service before a Medical Certificate of Death (MCOB) can be completed. In Alberta, NPs are permitted to complete a MCOB in specific circumstances. At the same time, maintaining resident flow, bed efficiency, and morgue capacity requires timely completion of required documentation after death.



Chapter Four – Documenting the Plan and Levels of Activation

Purpose

The purpose of this chapter is to provide an outline of:

- The triggers that change the level of activation.
- The recommended service levels for Continuing Care operator based on the level of activation.

A comprehensive communicable disease emergency response plan will need to account for a variety of factors including the level of activation as well as the type and nature of the communicable disease (transmissibility and virulence).

The following two tables, combined with the minimum requirements and additional considerations in Chapter 3, provide the basics for a comprehensive communicable disease emergency response plan. As part of the annual review of the communicable disease emergency response plan, operators have been provided optional checklists (see Appendices 1 to 6). Following the annual review, operators should update all process documents that provide additional information for their staff (e.g., resources, policies, etc.).

Frequency of Review/Completion

As per contractual and regulatory requirements, Continuing Care operators are to review their communicable disease emergency response plan at minimum annually and following the conclusion of any communicable disease emergency response.

Levels of Activation

Level of Activation	Triggers	Overarching Goal
Preparation	Current resident volumes; Current to less than 10% decrease in staffing levels; Current functional capacity	Increase readiness of organization, staff and public.
Initiation/Surge	Increase of 10-20% in resident volumes; Decrease of 10-20% in staffing levels; Decrease of 10-20% in functional capacity (* depends on type of area affected and number of areas affected)	Activation of contingency planning arrangements. Prevent nosocomial transmission and maintain biosafety.
Selective Prioritization	Increase of 20-40%* in resident volumes; Decrease of 20-30% in staffing levels; Decrease of 20-30% in functional capacity (*depends on type of area affected and number of areas affected.)	Ensure organization or zone/ corridor is ready to scale up response and implement changes in triage and treatment priorities and actions can occur as soon as area(s) are affected.
System Wide Prioritization	Increase of 40%+ in resident volumes; Decrease of 30%+ in staffing levels; Decrease 30%+ in functional capacity	Minimize the impact of the pandemic; sustain critical health service delivery.
Recovery	Within 20%: of surge level resident volumes; of surge level staffing levels; of surge level functional capacity	Phased recovery and evaluation.
Resumption	Usual seasonal resident volume; usual seasonal staffing levels; usual seasonal functional capacity	Complete recovery and evaluation.

Service Level Recommendations based on Level of Activation

Continuing Care Service		HCC Recommended Services	CCH Recommended Services	Additional Considerations
Level of Activation	Staffing Level			
Preparation	Services when normal to less than 10% decrease in staffing levels.	Maintain home visits. Maintain clinics. Maintain Adult Day Support Programs. Ensure individuals receiving services have a “back-up” / alternative plan for care in place. Identify which individuals need essential visits for interventions such as specific medication or treatment that may put them at risk of hospitalization if not received (e.g., insulin, infusion therapy).	Maintain services on site. Maintain social activities. Ensure residents have a “back-up” plan / alternative plan for care provision. Identify which residents need essential care for interventions such as specific medication or treatment that may put them at risk of hospitalization if not received (e.g., insulin, infusion therapy).	Consider risk to individuals that live alone, are immobile without assistance and who are unable to mobilize outside of their home (home bound).
Initiation/ Surge	Services when decrease of 10-20% in staffing levels.	Maintain home visits. Maintain clinics. Maintain Adult Day Support Programs. Non-time sensitive essential visits, such as catheter care, wound care, personal care may need to be spread throughout the day.	Maintain services on site. Focus on ‘care as usual’ including health and accommodation services. Non-time sensitive essential care, such as catheter care, wound care, personal care may need to be spread throughout the day.	Deploy staff to other teams if necessary to assist with preparation and prevention activities (e.g., vaccination) and/ or providing care.

Continuing Care Service		HCC Recommended Services	CCH Recommended Services	Additional Considerations
Level of Activation	Staffing Level			
Selective Prioritization	Services when decrease of 20-30% in staffing levels.	<p>Instead of home visits, maximize utilization of existing clinics.</p> <p>Provide necessary and essential visits only.</p> <p>May need to prioritize essential/required visits.</p> <p>Implement telephone 'visits' where able.</p> <p>Cancel Adult Day Support Programs.</p>	<p>Maintain services on site.</p> <p>May need to prioritize essential/required care (e.g., medication, medical interventions).</p> <p>Modify social/leisure programming.</p> <p>Reschedule non-urgent medical appointments.</p> <p>Cancel facility respite.</p> <p>Mobilize volunteer and/or designated family/support person(s) for care provision.</p> <p>Evaluate residents for feasibility of temporary relocation home with family or home with HCC services (if capacity allows).</p>	<p>Deploy staff to other teams within the same service area.</p> <p>Utilize HCC surge capacity for early discharges from acute care or temporary transfers home from CCH.</p> <p>Utilize CCH surge capacity to care for admissions from acute care or residents not able to be cared for in the home with HCC.</p> <p>Consider utilizing spaces freed up by residents able to be cared for in alternate setting (e.g., temporary discharge to family care or home with HCC services).</p>

<p>System Wide Prioritization</p>	<p>Services when decrease of 30%+ in staffing levels.</p>	<p>Essential visits only. Telephone screening prior to visit to assess for symptoms. Maximize telephone visits.</p>	<p>Temporarily relocate residents home with family, home with HCC services (if capacity allows) or other CCH. For remaining on-site residents, provide medically necessary care and treatments with specific attention to essential care, hygiene, nutrition and hydration.</p>	<p>Deploy staff throughout all continuing care services. Request individuals receiving HCC services activate back-up plan for care provision where possible.</p>
<p>Recovery</p>	<p>Services when less than 20% decrease in staffing levels and returning to normal.</p>	<p>Provide necessary and essential visits and resume routine home visits. Resume usual clinic schedule. Initiate resumption of Adult Day Support Programs.</p>	<p>Implement phased approach to resume services on site. Return residents that were relocated and resume services. Resume usual vacancy management processes.</p>	<p>For information about the emergency management cycle and recovery planning, the most up to date current information will be found at https://www.alberta.ca/provincial-recovery-framework.</p>
<p>Resumption</p>	<p>Services when returned to usual seasonal staffing levels.</p>	<p>Resume home visits. Resume clinics. Resume all Adult Day Support Programs.</p>	<p>Resume services on site. Resume social activities.</p>	<p>Return deployed staff to prior work location and schedule.</p>

Additional Roles and Responsibilities

Continuing Care Communicable Disease Emergency Response Guide Roles & Responsibilities

Role	Responsibility
Assisted Living and Social Services	<ul style="list-style-type: none"> • See the Alberta Emergency Plan and the Alberta Pandemic Influenza Plan. • Collaborate and communicate with Assisted Living Alberta and all continuing care operators on the planning, preparedness, monitoring, and response for all communicable disease emergencies. • Provide monitoring and oversight of all legislated standards related to Continuing Care operator communicable disease emergency response plans. • Collaborate with Assisted Living Alberta to establish monitoring and oversight for comprehensive completion of Continuing Care operator communicable disease emergency response plans. • Collaborate and communicate with the Ministries of Primary and Preventative Health Services and Hospital and Surgical Services, and others as required, on communicable disease emergency response.
AHS Emergency Command Centre (ECC)	<ul style="list-style-type: none"> • Collaborate with Assisted Living Alberta and Assisted Living and Social Services to share information on the planning, preparedness, monitoring, and response for all communicable disease emergencies. • Collaborate with the MOH(s) and CMOH to coordinate a communicable disease emergency response for Continuing Care operators. • Contact the Emergency Operation Centres to initiate a communicable disease emergency response. • Provide direction to Emergency Operation Centres on the impacts for HCC and CCH given the Level of Activation. • In consultation with the Provincial Health Agency for Continuing Care, Assisted Living Alberta, develop a communication strategy to inform staff, residents, family, and public.

Continuing Care Communicable Disease Emergency Response Guide Roles & Responsibilities

Role	Responsibility
Health Shared Services (HSS) Contract Procurement and Supply Management (CPSM) Sourcing and Supply Management	<ul style="list-style-type: none"> • Ensures an adequate stockpile of personal protective equipment (PPE), supplies, and equipment is established in alignment with provincial emergency disaster management stockpile. • Coordinate with ECC, Assisted Living Alberta and Emergency Operations Centres to establish distribution, billing and supply pathways for PPE, supplies and equipment for Continuing Care operators.
AHS Emergency/Disaster Management	<ul style="list-style-type: none"> • Coordinate with HSS CPSM -Sourcing and Supply Management to ensure an adequate stockpile of personal protective equipment (PPE), supplies, and equipment is established. • Coordinate with HSS CPSM -Sourcing and Supply Management and Assisted Living Alberta for the distribution of PPE, supplies and equipment from the stockpile.
Provincial Health Agency for Continuing Care: Assisted Living Alberta (ALA)	<ul style="list-style-type: none"> • Collaborate with the Chief Medical Officer of Health (CMOH), Assisted Living and Social Services, Medical Officer(s) of Health (MOH), and the AHS Emergency Command Centre to ensure timely response specific to the needs of HCC and CCH. • Facilitate annual stakeholder review and revision of the Continuing Care Communicable Disease Emergency Response Guide with consideration of current directing documents including legislation and resources. • Approve updates to the Continuing Care Communicable Disease Emergency Response Guide. • Facilitate development and maintenance of the Continuing Care operator communicable disease emergency response plans. • Collaborate with Assisted Living and Social Services to establish monitoring and oversight for comprehensive completion of HCC provider and CCH operator communicable disease emergency response plans. • Promote a collaborative and integrated communicable disease emergency response in consideration of available resources within HCC and CCH. • Develop communication pathways to improve and sustain fluid and timely communication channels as needed, including engagement with other Provincial Health Agencies , Provincial Health Corporations and Health Shared Services.

Continuing Care Communicable Disease Emergency Response Guide Roles & Responsibilities

Role	Responsibility
Provincial Health Agency for Continuing Care: Assisted Living Alberta (ALA) <i>(continued)</i>	<ul style="list-style-type: none"> • Coordinate communicable disease emergency response between the ECC and Emergency Operation Centres. • Chief Medical Officer will disseminate information to site Medical Directors. • Appoint an individual to the role of Operator Liaison.
ALA: Continuing Care Contracts	<ul style="list-style-type: none"> • Maintain a contact list for all HCC and CCH contract holders. • Facilitate communication to all HCC and CCH contract holders as indicated and directed.
ALA: Coordinated Access/ Transition Services	<ul style="list-style-type: none"> • Facilitate transition/discharge of residents to HCC or CCH. • Identify residents who need to be assessed, waitlisted, and/or transferred to a CCH from acute care
ALA: Communications	<ul style="list-style-type: none"> • Work with Primary Care Alberta Communications, Assisted Living and Social Services, and other identified stakeholders to develop a communication strategy in relation to a communicable disease emergency response to inform staff, residents, designated family/ support person(s), and public.
ALA: Operator Liaison	<ul style="list-style-type: none"> • Respond to inquiries into the centralized email: continuingcare@assistedlivingalberta.ca. • Organize, track, and respond to all requests for information. • Seek out and provide clarification to operators to support implementation of communicable disease emergency response measures. • Ensure surge capacity beds are evenly spread across geographical areas. • Direct the development and revision of additional resources to support clinical practice and education related to communicable disease emergency response measures. • Report identified trends or identified risks to Assisted Living Alberta and Assisted Living and Social Services.

Continuing Care Communicable Disease Emergency Response Guide Roles & Responsibilities

Role	Responsibility
Emergency Operations Centre	<ul style="list-style-type: none"> • Coordinate the response of Continuing Care operators. • Maintain a contact list (email, phone, and manager/delegate) of all Continuing Care operators within their zone/area. • Develop an implementation and communication strategy reflective of resources inclusive of Assisted Living and Social Services, Assisted Living Alberta, other Provincial Health Agencies, Infection Prevention Control (IPC), Communicable Disease Control (CDC), Environmental Public Health (EPH), and all individuals with surveillance and reporting accountabilities. • Monitor risks associated with communicable disease emergency response planning within operators, programs, and sites. • Identify a contact for ECC and Assisted Living Alberta to liaise with in the event of a communicable disease emergency response. • Assign responsibilities in the event of a communicable disease emergency response
ALA: Seniors Health & Continuing Care	<ul style="list-style-type: none"> • Support Emergency Operations Centres in implementation of a communicable disease emergency response. • Facilitate provision of clinical expertise and support to the communicable disease emergency response. • Provide representation of the senior’s health and continuing care program on provincial and national taskforce(s) and committees. • Identify a contact for surge capacity planning and disseminate that contact information to Continuing Care operators. • Coordinate identification of surge capacity of 1-2 beds for every CCH. • Plan surge capacity spaces across the geographical area and report to Operator Liaison. • Coordinate identification of all additional spaces that could be utilized for surge planning (e.g., respite, restorative care). • Coordinate availability of non-contracted spaces from operators.

Continuing Care Communicable Disease Emergency Response Guide Roles & Responsibilities

Role	Responsibility
Medical Directors	<ul style="list-style-type: none"> Establish plans for physician coverage in continuing care homes.
Continuing Care Operators	<ul style="list-style-type: none"> Responsibilities as detailed in the Continuing Care Communicable Disease Emergency Response Guide and in the Communicable Disease Emergency Response Plan Checklists (Appendices 1 to 6)
Operator: Human Resources (HR)/ designate	<ul style="list-style-type: none"> Support the Continuing Care operator to deploy, redeploy and/or recruit as per the applicable operator Human Resources communicable disease emergency response plan, policy or established processes.
Operator: Workplace Health & Safety (WHS)/ designate	<ul style="list-style-type: none"> Provide confirmation of staff immunization (or exemption). Support Continuing Care operator through preparation and communicable disease emergency response. Establish processes to ensure the provision of fit-testing and fit-tester designate training. Track workplace acquired cases and report cases as required.



Chapter Five – Simulation and Evaluation

Communicable Disease Emergency Response Activation - Simulation Exercises

Utilize the information provided in combination with your operator communicable disease emergency response plan to practice the following simulation exercises at your site. Consider the level of activation and the nature and level of impact (see Appendix 7) in your decisions and actions. At the end of the simulation, review the evaluation criteria and feedback from the facilitator, participants and any observers to make any identified changes to your communicable disease emergency response plan and/or supporting resources.

Simulation Exercise A

Scenario: Vaccine Deployment

Level of Activation: Initiation/Surge

Level of Impact: Mild (low transmissibility / low virulence)

Objective and Expected Outcome: The following simulation tests setup requirements for vaccination deployment at a continuing care home. At the end of the simulation, participants are expected to:

1. Setup the site with all equipment needed to successfully operate a vaccination session from start to end.
2. Undertake basic vaccine consumable calculations based on the number of vials of vaccine available and staff and residents requiring vaccination.
3. Identify required learning and documentation to participate in vaccination deployment.
4. Identify organizational requirements to track and report resident and staff immunizations.

Requirements for the exercise: The facilitator can advise the participants to assemble equipment beforehand that they would normally use for a vaccination session.

1. Participants for the drill will be the actual staff involved in the vaccination, including health care workers, support and logistics staff, administration personnel and cleaners.
2. Participants simulating vaccine administration must have successfully completed the required training for health workers.
3. Include all vaccination stages/stations for the actual set-up, including screening stations, waiting areas, registration, vaccination area, documentation area, etc.
4. All equipment required to operate the vaccination session, such as tables, chairs, PPE (masks), vaccine & injection equipment, cold chain equipment, hand hygiene stations, safety boxes, communication & reporting tools etc. It is expected that the drill participants will bring the required equipment themselves, so that gaps in equipment availability will be identified.

NOTE: It is not recommended to have a third party providing equipment just for the drill, as this brings in an artificiality that could mean that equipment deficits are overlooked.

5. Include IPC measures and other useful items (e.g., signage, physical distancing, floor marking, one-way flow, screens and other IPC measures as required).
6. DO NOT compromise sterile components at this stage (don't open sterile packaging but place sealed objects where they would be used).
7. 10-30 volunteers to act as vaccine recipients. The actor recipients just play themselves as they would in real life when they get vaccinated. They are welcome to ask questions to the vaccinators and engage in conversation (see actor instructions).
8. Required paperwork, including forms, tally sheets, and other reporting forms including tracking for additional dose/booster as needed.
9. Develop list with contact phone numbers (e.g. supervisor, focal person for adverse events following immunization, ambulance).
10. One exercise facilitator managing the drill, from beginning to end.
11. One or more evaluators/immunization experts, observing the vaccination sites especially if there are multiple rooms.

Scenario: Vaccine Deployment

Level of Activation: Initiation/Surge

Level of Impact: Mild (low transmissibility / low virulence)

Instructions to participants from facilitators:

1. Using the equipment on hand, setup the entire vaccination session as you would for a COVID-19/influenza/RSV vaccination session (from beginning to end).
2. Organize and set-up the vaccination station(s) and equipment as you would need it for the vaccination sessions.
3. To avoid wastage for the sole purpose of exercising, DO NOT open any sterile packaging at this time.
4. Use and install appropriate IPC measures in place, including use of PPE (at minimum a medical mask).
5. Explain to the exercise evaluators how vaccine calculations are made.
6. When you are ready and organized, you should lead the facilitator and evaluators through the setup as though you were a prospective recipient. You should be able to show and explain the following:
 - Presence of clear signage for directions and other education materials on vaccination process to inform recipients.
 - Where and how recipients are managed and show how the different waiting area(s) or delivery areas are organized (e.g., spatial separation for privacy concerns, storage of equipment and vaccine between recipients).
 - What precautions are undertaken, including what PPE equipment is available and what IPC measures in place (i.e. mask use, hand hygiene stations, cleaning and disinfection, etc.).
 - Other material and equipment that is used to ensure a safe and efficient vaccination session.
 - How and where are the sharps disposed of and other waste managed.
7. When you are finished set up, you should be able to:
 - Manage recipient entry and screening.
 - Show and explain how and where the vaccination is documented including any registration, as required.
 - Invite the recipient for vaccination and explain what will happen.
 - Describe the correct and safe administration including route.
 - *DO NOT use any real injections, and do not administer/inject any vaccine or other substances during this simulation.
 - Demonstrate proper IPC measures and describe injection safety and sharps disposal.
 - Explain to the vaccine recipient what comes next (e.g., waiting and observation period).
 - Explain how and where the vaccination is tracked.
 - Prepare the workspace for the next recipient.

Scenario: Vaccine Deployment

Level of Activation: Initiation/Surge

Level of Impact: Mild (low transmissibility / low virulence)

Instructions to Actors: You are a resident coming for their {COVID-19/influenza/RSV} immunization. You will:

1. Assign roles to the actors to represent varied perspectives on vaccination (supportive, not supportive, fearful, happy, disgruntled, etc.).
2. Ask questions about what is happening.
 - Will it hurt?
 - Why do I need to give my personal information / don't you already know my name?
 - Do I need another vaccine and if so, how long do I need to wait?
 - Can I take the syringe back to my room with me?
 - Can you take a picture of me getting my vaccine?
 - I need to get to recreation. Why do I have to wait 15 minutes?
 - What do I do if the vaccine makes me sick / what do I do if I feel unwell / should I expect to feel unwell?
 - What if I have a reaction, what will happen?

Evaluation Criteria	Observations	Status (Yes/No/Partially) and Comments
Vaccination Session Set-up	<p>Appropriate location for the session (1-2 meters of space in all directions, space for documentation and supplies, space for vaccine storage and preparation).</p> <p>All required equipment and supplies collected and prepared.</p> <p>Sufficient post administration observation area (e.g., chairs, assigning staff to observe/monitor).</p>	
Vaccine Calculations	<p>Staff references and follows immunization guidance.</p> <p>Calculations for required doses and wastage completed correctly.</p> <p>Vaccine wastage minimized as much as possible.</p> <p>Calculation for vaccine consumables are made adequately.</p>	

Evaluation Criteria	Observations	Status (Yes/No/Partially) and Comments
Infection Prevention and Control Measures	<p>Proper signage in place</p> <p>Proper PPE available and used correctly</p> <ul style="list-style-type: none"> • Routine and additional precautions are described to reduce the risk of transmission • Donning and doffing process is followed • PPE discarded after single use <p>Participants describe the standard IPC precautions needed, including:</p> <ul style="list-style-type: none"> • Hand hygiene: use alcohol-based hand rub or clean running water and soap. • Apply safe injection practices. • Safe disposal of waste and sharps. • Environmental cleaning between recipients and after session <p>Waste bags/containers are available</p> <p>Hand hygiene product is available</p> <p>Workspace is clean and clutter free</p>	
Recipient Entry & Registration	<p>Recipient is screened for symptoms before entering the vaccine administration area or prior to the staff entering the resident care area.</p> <p>Recipient eligibility information verified (e.g., consent).</p>	
Waiting area	<p>Limited number of individuals in the waiting area or any common area used for pre and post administration.</p>	

Evaluation Criteria	Observations	Status (Yes/No/Partially) and Comments
Communication & Reporting	<p>Adequate information is provided to recipients about the vaccination process steps.</p> <p>Vaccination register, tally sheets or other record/reporting:</p> <ul style="list-style-type: none"> • forms are correctly used (i.e. electronic immunization registry). • medical record system, monthly/ periodic reports). <p>Sufficient information is provided to the recipient before leaving the vaccination area (e.g., 2nd injection if applicable, common side effects).</p> <p>Recipient receives instructions on how to access their vaccine information.</p>	
Vaccination Administration	<p>Medication order is verified, if applicable.</p> <p>Dose is prepared according to instructions.</p> <p>Medication rights and safety checks are completed according to operator policy.</p> <p>Injection is completed in accordance with proper procedure (e.g., intramuscular injection procedure).</p> <p>Recipient is observed for minimum 15 minutes in a designated area or their room.</p>	

*Adapted from the World Health Organization, COVID-19 Exercise Program, retrieved from <https://www.who.int/publications/m/item/covid-19-exercise-programme---drills-for-vaccine-deployment>.

Simulation Exercise B

Scenario: Staff Cohorting

Level of Activation: System Wide Prioritization

Level of Impact: Severe (high transmissibility / high virulence)

Objective and Expected Outcome: The following drill is to test human resources and infection prevention and control requirements for staff cohorting at your continuing care facility. At the end of the drill, participants are expected to:

1. Setup the staff schedule and assignments with all cohorting requirements addressed.
2. Undertake basic staff cohorting (one unit or area of the building) including changing the staff schedule, resident assignments and identifying opportunities to reduce the risk of transmission to other areas and residents in the building.
3. Identify required learning and documentation to participate in staff cohorting.
4. Identify organizational requirements to track and monitor staff cohorting.

Requirements for the exercise: The facilitator can advise the participants to assemble information beforehand that they would normally use to direct staff cohorting.

1. Participants for the drill will be the actual staff involved in care provision, human resources and cohorting management such as health care workers, non-clinical support staff, administration personnel and management.
2. Participants have reviewed the IPC guidance for staff cohorting in continuing care.
3. All equipment and technology required to cohort staff, such as signage, PPE (masks), work schedules, resident assignments, communication & reporting tools etc. It is expected that the drill participants will bring the required equipment and technology themselves and that is available, so that gaps will be identified.

NOTE: It is not recommended to have a third party providing staffing/scheduling direction just for the drill unless this is the typical process for your operator.

4. Include IPC measures and other useful items (e.g., signage, physical distancing, floor marking, one-way flow, screens and other IPC measures as required).
5. Required paperwork, including forms, tally sheets, and other reporting forms including tracking for additional staff and assignments as needed.
6. Develop list with contact phone numbers (e.g. supervisor, human resources, union, etc.).
7. One exercise facilitator managing the drill, from beginning to end.
8. One or more evaluators/cohorting experts, observing the drill.

Scenario: Staff Cohorting

Level of Activation: System Wide Prioritization

Level of Impact: Severe (high transmissibility / high virulence)

Instructions to participants from facilitators:

1. Using the existing operator resources that inform staff scheduling and assignments, develop a staff schedule that effectively reduces the risk of transmission to other residents in other areas of the building (from beginning to end) when one unit is in a confirmed outbreak with a high transmissibility / high virulent communicable disease.
2. Organize and set-up the staff schedule and assignments as you would need it for cohorting staff on one unit/area of the facility.
3. Use and install appropriate IPC measures in place, including use of PPE (at minimum a medical mask).
4. Explain to the exercise evaluators how decisions for staff cohorting are made.
5. When you are ready and organized, you should lead the facilitator and evaluators through the setup as though you are the staff coming in for the next shift. You should be able to show and explain the following:
 - a. Presence of clear signage to alert staff of the cohorting requirement and any processes.
 - b. Where and how staff are managed as they arrive for work and shown the schedule and assignment.
 - c. What precautions are undertaken, including what PPE equipment is available and what IPC measures in place (i.e. mask use, hand hygiene stations, symptom screening, etc.).
6. Other material and equipment that is needed to coordinate staff cohorting.
7. When you are finished set up of the schedule and assignment, you should be able to:
 - a. Manage staff entry and screening.
 - b. Show and explain how and where the staff schedule and assignment is documented including any sign in, as required.
 - c. Describe the correct cohorting practices.
 - d. Demonstrate proper IPC measures and describe cohorting principles.
 - e. Explain how communication to all staff is disseminated.
 - f. Explain how and where staff assignments are tracked.
 - g. Prepare the resident assignment for the next shift/rotation.

Evaluation Criteria	Observations	Status (Yes/No/Partially) and Comments
Cohorting Set-up	<p>Participants identify the need for cohorting.</p> <p>Participants bring all supplies including staff schedules, assignments, communicable disease assessment records and tracking and alternate/additional work locations (if known).</p> <p>Participants planning takes into account the resident population, facility size, facility layout and staff complement.</p>	
IPC Measures	<p>Assignment, relocation and movement of staff occurs in a way that reduces the risk of cross-contamination/transmission to both staff and residents.</p> <p>Appropriate and adequate barriers, signage and supplies are identified including PPE.</p> <p>Staff are assigned to residents or groups of residents based on resident exposure to, or infection with, the same laboratory-confirmed pathogen or symptomology.</p> <ul style="list-style-type: none"> • Exclusively provide care/service for residents that are asymptomatic (no illness or symptoms of illness), or • Exclusively provide care/service for residents who are symptomatic (have suspected, probable or confirmed illness). 	
Human Resources Measures	<p>Staff who are considered close contacts of the symptomatic residents are assigned according to operator policy for fitness for work.</p> <p>Participants ensured assignment of staff appropriate to who is familiar with residents and their care needs.</p>	

Evaluation Criteria	Observations	Status (Yes/No/Partially) and Comments
Communication and Reporting	<p>Families and residents as part of the planning process to create awareness and understanding of the need to reduce the risk of transmission while supporting resident care needs.</p> <p>Additional emotional and social needs of residents and how these will be met with the existing staff model is considered and included in communications.</p>	
Staff entry and exit	<p>Staff symptom screening is established at points of entry and exit to the facility and or cohorted unit/area.</p> <p>Staff are aware upon reporting for their shift where they are working and have clear instructions on how to avoid cross contamination with other staff.</p>	

Additional Simulation Exercises

1. SafeCare BC. COVID-19 Scenario Exercises. Located at <https://safecarebc.ca/resources/assorted/covid-19-scenario-exercises/>.
2. World Health Organization. COVID-19 Simulation Exercises Packages. Located at <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/simulation-exercise>.
3. Kingston Health Sciences Centre. IPAC Hub Presentations-Hub and Spoke. Located at <https://kingstonhsc.ca/healthcare-providers/se-ipac-hub-and-spoke/ipac-hub-presentations-hub-and-spoke>.



Chapter Six – Resources

Forms and Resources

Alberta Health Services. Resident Bedside Care Instructions (form). Located at <https://www.albertahealthservices.ca/frm-07933.pdf>.

Alberta Health Services. Risk Assessment Matrix to Determine MOH Pre-Approval (resource). Located at <https://www.albertahealthservices.ca/assets/info/hp/cdc/if-hp-cdc-risk-assessment-matrix-moh-pre-approval.pdf>.

Alberta Health Services. Risk Assessment Worksheet (form). Located at <https://www.albertahealthservices.ca/frm-19669.pdf>.

Alberta Health Services. Surveillance Case Tracking Sheet (form). Located at <https://www.albertahealthservices.ca/frm-22017.pdf>.

Surveillance and Reporting

Government of Alberta. Alberta Health. Respiratory virus dashboard located at <https://www.alberta.ca/stats/dashboard/respiratory-virus-dashboard.htm?data=outbreaks>

Clinical Practice Resources

Alberta Health Services. Communicable Disease Control. Outbreak Management. Located at <https://www.albertahealthservices.ca/cdc/Page18153.aspx>.

Alberta Health Services. Infection Prevention and Control. Located at <https://www.albertahealthservices.ca/ipc/ipc.aspx>.

Alberta Health Services. Provincial Seniors Health and Continuing Care. Communicable Disease. Located at <https://www.albertahealthservices.ca/info/Page10914.aspx#communicable>.

Training and Education

World Health Organization. OpenWHO Training. Online Training. Located at <https://openwho.org/channels>.

European Centre for Disease Prevention and Control (ECDC). Infectious Disease Emergency Preparedness and Response Training Portfolio. Located at <https://learning.ecdc.europa.eu/course/view.php?id=649>.

Business Resources

Government of Canada. Canadian Centre for Occupational Health and Safety. Business Continuity Plan – Pandemic. Located at https://www.ccohs.ca/oshanswers/hsprograms/planning_pandemic.html.

Government of Canada. Canadian Centre for Occupational Health and Safety. Emergency Planning. Located at <https://www.ccohs.ca/oshanswers/hsprograms/planning.html>.

World Health Organization. A practical Guide for developing and conduction simulation exercises. 2018. Located at <https://www.who.int/publications/i/item/9789241514507>.

Glossary

Coordinated Access: means a foundation for the individual journey through the continuing care system that guides continuity of care, improves access to information, supports system navigation and ensures all individuals have access to case management services.

Continuing Care Home (CCH): means a facility or part of a facility where facility-based care is provided to residents, some of whom must be eligible residents.

Home and Community Care (HCC): means the prescribed health goods and services and prescribed other goods and services that are provided by a home and community care provider to an eligible individual in the individual's home or community but does not include facility-based care or supportive living services.

Incident Command System (ICS): is a widely used emergency response structure that utilizes a series of common management practices, is flexible and scalable, and utilizes common terminology. The Alberta Emergency Management Agency recommends the use of ICS in all sectors for emergency planning and response activities. The characteristics of ICS support a consistent approach across geographical boundaries and disciplines, no matter the size of the incident.

Incident Management System (IMS): is a governance structure designed to allow for flexibility and scalability relative to the nature and scope of the event. The overall objective of the IMS governance structure is to ensure the effective management of efforts involved in responding to, and recovering from, major stressing events.

In AHS the IMS is a strategic command network, incorporating an AHS Emergency Coordination Centre (AHS ECC), Emergency Operations Centre's (EOC), and several Site/Service and Corporate Command Posts (CP) who support coordination of efforts. These centers can be activated independently to deal with local/zone issues or as part of a strategic command network to support provincial AHS response activities and AHS/Multi-agency Coordination.

For AHS these are further defined as follows:

AHS ECC: a pre-designated location for coordination of Provincial AHS efforts aimed at managing large scale emergencies and disasters. Its primary role is to expedite decision making, reduce duplication and redundancies, define/clarify AHS objectives, manage data and communications, and establish standards/direction relative to a response.

EOC: the physical location where local representatives come together during an emergency to coordinate response and recovery actions and resources of the Sites and Services. The EOC liaises with the Site/Service CP and with local partners and stakeholders.

Site/Service/Corporate CP: provides overall management and coordination of emergency operations at individual urban acute care sites, rural acute care sites and/or community and corporate service areas. Each Continuing Care Operator is encouraged to have an emergency response governance structure that supports an overall ICS approach to ensure information is effectively communicated.

Levels of Activation: is the matrix of escalation for an emergency response that is common amongst a set, or type, of healthcare operators or agencies.

Operator: means a person or organization that operates a continuing care home and provides facility-based care in that continuing care home or, a home and community care provider that provides home and community care in accordance with the Continuing Care Act.

Operator Liaison: means a person, or team of people, employed by the Provincial Health Agency (Assisted Living Alberta) that is assigned to support operators with questions and/or concerns related to communicable disease emergency response. The Operator Liaison will seek out additional expertise as needed to respond to operators. Communication is tracked and themed to inform quality improvement activities related to communicable disease emergency response.

Appendix 1

Communicable Disease Emergency Response Plan Checklist Preparation

Continuing Care Operator Roles and Responsibilities

Responsibilities build upon existing outbreak management guides and legislated requirements, including the *Continuing Care Health Service Standards*, *Accommodation Standards* and the *Occupational Health & Safety Act*.

- Develop and annually update a communicable disease emergency response plan that includes the minimum requirements listed in the Continuing Care Communicable Disease Emergency Response Guide. Plans should identify responsibilities for tasks and location of all information.
- Review and address additional considerations in Chapter 3 of the Continuing Care Communicable Disease Emergency Response Guide.
- Review and update Service Level Recommendations.
- Consider the need to track expenses related to communicable disease emergency response (e.g., staffing, overtime, equipment and supplies, pharmacy costs) for reporting/evaluation.
- Identify triggers that would change the level of activation (e.g., increased staff vacancy).
- Attend and participate in communicable disease emergency response plan sessions.
- Participate in a tabletop simulation exercise, as appropriate

Topic	Task	Status
Care Provision	Plan for Care and Treat in Place that include processes to:	
	<ul style="list-style-type: none"> • continue to provide services for current residents, including those returning from acute care. 	
	<ul style="list-style-type: none"> • test for and maintain appropriate level of care for all residents including those who develop symptoms of a communicable disease and/or additional or more severe medical conditions. 	
	<ul style="list-style-type: none"> • identify limitations to providing care and treat in place (e.g., resident requires surgical intervention or other urgent acute care service). 	
	Plan for Professional Health Services that include:	
	<ul style="list-style-type: none"> • 24/7 access to physician or Nurse Practitioner (NP) for all CCH residents. 	
	<ul style="list-style-type: none"> • process for assessment to occur virtually or on-site depending on clinical need. 	
	<ul style="list-style-type: none"> • a plan for all staff to work to full role and scope of practice when providing care and treat in place (e.g., skills assessment, skills inventory, training). 	

Communicable Disease Emergency Response Plan Checklist

Preparation

Topic	Task	Status
Care Provision	Plan for Clinical Support Services that include:	
	<ul style="list-style-type: none"> • process to refer to external healthcare providers/services (e.g., Alberta Referral Directory). 	
	<ul style="list-style-type: none"> • documented identification of pharmacy service requirements that may be needed (e.g., after-hours services, access to required/essential medication). 	
	<ul style="list-style-type: none"> • documented referral processes for resident access to necessary clinical services (e.g., respiratory services, mental health, dietary, physiotherapy, etc.). 	
	<ul style="list-style-type: none"> • options for virtual health and other technological assisted appointments. 	
	<ul style="list-style-type: none"> • options for psychosocial supports and recreation therapy to meet the needs of residents in accordance with their plan of care. 	
	Plan for Management of Acute Infections/Illness that includes:	
	<ul style="list-style-type: none"> • plans to provide infusion therapies, oxygen support, aerosol generating medical procedures and other interventions as required. See Supplies & Equipment for required items and Human Resources for training. 	
	Plan for Comprehensive Assessment and Care Planning processes to:	
	<ul style="list-style-type: none"> • ensure the appropriate comprehensive assessment (e.g., interRAI) is completed. 	
	<ul style="list-style-type: none"> • ensure comprehensive care plans are updated and inform service provision, as per the CCHSS. 	
	<ul style="list-style-type: none"> • identify what will be used to communicate resident care needs at point of care (e.g., bedside care plan). 	
	<ul style="list-style-type: none"> • review and update goals of care designation and advanced care planning. 	
	<ul style="list-style-type: none"> • implement symptom screening, other assessments and treatments, when required (e.g., CMOH orders, disease management guidelines). 	
	Plan for Accommodation and Non-Clinical Support Services with processes that:	
	<ul style="list-style-type: none"> • continue to meet record management requirements (as per policy) 	
	<ul style="list-style-type: none"> • access external providers or services to maintain service provision (e.g., meals, security, facility maintenance, environmental services/housekeeping, etc.). Verify provider has contingency plan to ensure availability of services. 	

Communicable Disease Emergency Response Plan Checklist

Preparation

Topic	Task	Status
Surge Capacity	Determine surge capacity, prioritization and waitlist management that includes:	
	<ul style="list-style-type: none"> determining if all available beds could be used to meet surge capacity needs 	
	<ul style="list-style-type: none"> identifying if 1-2 additional spaces could be created, that comply with IPC requirements (see page 17 of the Continuing Care Communicable Disease Emergency Response Guide). 	
	<ul style="list-style-type: none"> determining resources needed to manage surge capacity expectations (e.g., additional beds, staffing, equipment) if additional spaces are required. 	
	<ul style="list-style-type: none"> identifying governance (policy) that that directs capacity prioritization. 	
	<ul style="list-style-type: none"> prioritization of service provision according to the Service Level Recommendations (page 31 of the Continuing Care Communicable Disease Emergency Response Guide). 	
	<ul style="list-style-type: none"> prioritization of service provision according to the Service Level Recommendations (page 31 of the Continuing Care Communicable Disease Emergency Response Guide). 	
	<ul style="list-style-type: none"> how to align with and implement any changes to normal operating procedures for waitlist management, as directed by Assisted Living Alberta during a communicable disease emergency response (e.g., what procedure to follow, admission process, vacancy notification timelines, etc.). 	
Communication and Contacts	<ul style="list-style-type: none"> how changes to normal operating procedure will be communicated to staff, residents and designated family/support person(s). 	
	Identify communication processes that include:	
	<ul style="list-style-type: none"> maintaining essential contact lists (phone, address, email) including organizational leaders, Assisted Living Alberta, staff, volunteers, physician(s) and/or NPs, residents and their designated family/support person(s), CDC/EPH, IPC and other key contacts for emergency response planning and activation. 	
	<ul style="list-style-type: none"> multiple mechanisms for communicating with contacts (e.g., automated phone messages, email, virtual or in-person meetings, letters, etc.) 	
	<ul style="list-style-type: none"> mechanisms for providing urgent communication to contacts 24/7. 	
	<ul style="list-style-type: none"> ensuring Assisted Living Alberta and zone/corridor Seniors Health & Continuing Care has current contact information for site and organizational leadership, including after-hours contact information. 	
<ul style="list-style-type: none"> incident command system (ICS) site command posts and reporting. 		

Communicable Disease Emergency Response Plan Checklist Preparation

Topic	Task	Status
Human Resources	Establish Human Resources processes that include:	
	<ul style="list-style-type: none"> identifying minimum staffing levels including volunteers and other service providers to maintain care and treat in place requirements. 	
	<ul style="list-style-type: none"> considerations for alternate work arrangements for staff that may work remotely. 	
	<ul style="list-style-type: none"> identification of required staff education (regulated and unregulated health care providers), students and volunteers. 	
	<ul style="list-style-type: none"> the provision of required education for all staff, streamlined as necessary. 	
	<ul style="list-style-type: none"> how to sequester or mandate certain or essential staff. 	
	<ul style="list-style-type: none"> how to quickly replace/augment workforce with additional staff (e.g., agency staffing, mobilizing across multiple facilities/units in the organization). 	
	<ul style="list-style-type: none"> expedited orientation of new staff (e.g., agency or seconded staff). 	
	<ul style="list-style-type: none"> process to communicate staffing levels (e.g., daily to leadership) 	
	<ul style="list-style-type: none"> how to request additional funding for care related needs (e.g., increased staffing for resident acuity, care and treat in place, surge capacity) 	
	<ul style="list-style-type: none"> processes to mobilize the workforce across multiple facilities in the organization. 	
	<ul style="list-style-type: none"> guidance for staff, students and volunteers symptomatic or recovering from a communicable disease while at work, that aligns with relevant policies, procedures and communicable disease management guidelines. 	
	<ul style="list-style-type: none"> the management of staff based on their communicable disease assessment, immunization and/or antiviral prophylaxis status (e.g., reassignment). 	
<ul style="list-style-type: none"> a tracking process for communicable disease assessment, immunization and antiviral prophylaxis status of staff, students and volunteers. 		

Communicable Disease Emergency Response Plan Checklist Preparation

Topic	Task	Status
Infection Prevention and Control	Identify processes for Infection Prevention and Control that include:	
	<ul style="list-style-type: none"> • how to continuously implement IPC and CDC/EPH guidance based on pathogen, mode of transmission, etc. 	
	<ul style="list-style-type: none"> • evaluation of adherence to IPC practices such as PPE use, hand hygiene, additional precautions, etc. via PPE Safety Coach and/or IPC site consult. 	
	<ul style="list-style-type: none"> • procurement, storage and access to additional required PPE, alcohol based hand rub (ABHR), dedicated isolation/PPE carts, disinfectant, etc. for staff, students, volunteers, residents and visitors, through PHA and/or other provincial sources. 	
	<ul style="list-style-type: none"> • waste management (e.g., additional waste receptacles, dumpsters, pick-up frequency, process for handling waste to minimize transmission). 	
	<ul style="list-style-type: none"> • linen management (e.g., segregating clean and soiled, additional laundry receptacles, handling contaminated linen to minimize transmission). 	
	<ul style="list-style-type: none"> • processes for specimen collection, including orders for testing, identifying who collects specimens, and procurement of testing supplies. 	
	<ul style="list-style-type: none"> • processes for a resident immunization program, including tracking and site-based immunization during a communicable disease emergency response. 	
	<ul style="list-style-type: none"> • communicable disease surveillance and reporting, beyond regular surveillance and reporting. See Surveillance and Reporting. 	
	<ul style="list-style-type: none"> • process to implement revisions to IPC guidance based on pathogen, mode of transmission, etc., which may change during the emergency response (e.g., cohorting of staff and residents). 	
Admission, Discharge, Transfer (ADT), LOA & Outings	Establish processes for ADT, Outings, LOA or Temporary Relocation that include:	
	<ul style="list-style-type: none"> • completion of a communicable disease assessment at admission and review/update prior to transfer or discharge. 	
	<ul style="list-style-type: none"> • symptom assessment at point of care. 	
	<ul style="list-style-type: none"> • assessment of appropriateness for resident outings or LOA in consideration of disease specific guidance (e.g., CMOH orders, federal requirements). 	
	<ul style="list-style-type: none"> • assessment for appropriateness of the temporary relocation of a resident to community or alternate location during service disruptions. 	
	<ul style="list-style-type: none"> • communicating requirements for a resident outing, LOA or temporary relocation to all members of the healthcare team (e.g., health care needs, financial accountabilities, reassessment/monitoring requirements) 	

Communicable Disease Emergency Response Plan Checklist Preparation

Topic	Task	Status
Surveillance and Reporting	Establish processes for surveillance and reporting that includes processes to:	
	<ul style="list-style-type: none"> implement communicable disease surveillance and symptom monitoring based on IPC and CDC/EPH guidance (e.g., daily, at admission, transition, discharge, return from outings). 	
	<ul style="list-style-type: none"> review surveillance and symptom monitoring to identify clusters of illness in residents and staff. 	
	<ul style="list-style-type: none"> report communicable disease surveillance (e.g., resident and staff illness) and any additional reporting required. 	
Supplies & Equipment	Identify supplies and equipment (including IPC supplies) needed to:	
	<ul style="list-style-type: none"> provide care and treat in place (e.g., oxygen tubing and concentrators, infusion pumps, PPE for aerosol generating procedures, etc.). 	
	<ul style="list-style-type: none"> meet care needs and surge capacity beyond daily operational needs (e.g., beds, commodes, linens, single-use items, etc.). 	
	<ul style="list-style-type: none"> procure and obtain supplies and equipment on the lists (e.g., rental agreement from vendors, direct purchase, etc.). Verify provider has contingency plan to ensure availability of supplies and equipment. 	
Safety & Security	Establish processes for safety and security to:	
	<ul style="list-style-type: none"> to designate single entry and exit points to aide in reporting, point of entry screening and contract tracing. 	
	<ul style="list-style-type: none"> provide on-site security, as required. 	
DFSP and Visitors	Establish a policy or process for DFSP and visitors that:	
	<ul style="list-style-type: none"> sets expectations for safe DFSP and visitor practices and guides operator decisions related to identification of essential care partners. 	
	<ul style="list-style-type: none"> manages or establishes limits on DFSP and visitor attendance on-site, when required. 	
Care of the Deceased	Establish processes for care of the deceased including:	
	<ul style="list-style-type: none"> accessing necessary supplies (e.g., body bags), providing storage and/or transfer of the deceased. 	
	<ul style="list-style-type: none"> accessing the attending physician or NP for completion of the Medical Certificate of Death. 	
	<ul style="list-style-type: none"> support for cultural and spiritual/religious ceremony when handling deceased bodies. 	

Appendix 2

Communicable Disease Emergency Response Plan Checklist Initiation/Surge

Continuing Care Operator Roles and Responsibilities

Responsibilities build upon existing outbreak management guides and legislated requirements, including the *Continuing Care Health Service Standards, Accommodation Standards* and the *Occupational Health & Safety Act*.

- Activate plans and processes.
- Communicate change in Level of Activation to INITIATION/SURGE to staff, organizational leaders, partners, DFSPs.
- Review and address additional considerations in Chapter 3 of the Continuing Care Communicable Disease Emergency Response Guide.
- Ensure that the location of information and the responsibility for each task is clearly assigned.**

Topic	Task	Status
Communication and Contacts	Initiate communications, including:	
	• ensuring staff are aware of specimen collection processes and additional surveillance and reporting requirements.	
	• providing regular reports of unusual clusters of illness to the MOH.	
	• activating cost centres, eligible costs and billing processes, as applicable. Communicate cost centres as required.	
Human Resources	Implement human resources processes, including:	
	• orienting staff on workplace health and safety procedures (e.g., fit for work assessments, immunization, work attendance, etc.).	
	• increase frequency of scheduled emergency preparedness education.	
Admission, Discharge, Transfer	Activate Admission, Discharge & Transfer processes to:	
	• prepare for/respond to changes in normal operating procedures for vacancy management.	
	• assess and identify residents who may be appropriate for discharge or temporary relocation.	
	• identify where those resident's needs are best met (e.g., HCC with supports or alternate care facilities).	
Safety & Security	Prepare for Safety & Security needs including:	
	• plans for ethics consultation(s)	
	• planning for Critical Incident Stress Management.	

Appendix 3

Communicable Disease Emergency Response Plan Checklist Selective Prioritization

Continuing Care Operator Roles and Responsibilities

Responsibilities build upon existing outbreak management guides and legislated requirements, including the *Continuing Care Health Service Standards, Accommodation Standards* and the *Occupational Health & Safety Act*.

- Communicate change in Level of Activation to SELECTIVE PRIORITIZATION to staff, organizational leaders, partners, DFSPs.
- Initiate incident command centre (ICS).
- Notify Assisted Living Alberta of risks/indicators that would change the level of activation (e.g., increased staff vacancy)
- Promote, facilitate and track education for staff including:
 - Communicable Disease Emergency Response Plan
 - Safe Care Practices
 - Outbreak Management
- Review and address additional considerations in Chapter 3 of the Continuing Care Communicable Disease Emergency Response Guide.
- Ensure that the location of information and the responsibility for each task is clearly assigned.**

Topic	Task	Status
Communications and Contacts	Communicate changes to service levels and care, including:	
	• process for communicable disease assessment, including specimen collection as directed by IPC, CDC/EPH.	
	• prioritization of essential/required care and changes to services.	
	• modified programming and/or cancelled programming.	
Human Resources	Activate human resources planning including:	
	• recruitment and/or deployment plans.	
	• identify and notify staff of potential redeployment to assigned areas.	
	• coordinate orientation and training for new and agency staff as required.	
	• processes to communicate staffing levels and staffing needs.	

Communicable Disease Emergency Response Plan Checklist

Selective Prioritization

Topic	Task	Status
Infection Prevention & Control (IPC)	Initiate IPC and CDC/EPH strategies including:	
	<ul style="list-style-type: none"> • changes in IPC practices based on recommendations from AHS IPC, CMOH and/or area MOH/designate. 	
	<ul style="list-style-type: none"> • preparations for activation of assessment centres, where applicable. 	
	<ul style="list-style-type: none"> • infection prevention and control skills labs and/or coaching (e.g., PPE Safety Coach). 	
	<ul style="list-style-type: none"> • staff and resident cohorting. 	
	<ul style="list-style-type: none"> • obtaining supplies and equipment to provide care & treat in place. 	
	<ul style="list-style-type: none"> • stocking surge capacity bed spaces, where applicable. 	
Admission, Discharge and Transfer	Initiate changes to Admission, Discharge and Transfer processes, including:	
	<ul style="list-style-type: none"> • resident screening at admission, discharge, transfer and outings or leave of absence, as directed by CMOH and/or area MOH/designate. 	
	<ul style="list-style-type: none"> • admission, discharge and transfer processes. • applying established decision supports to evaluate residents for feasibility of temporary relocation home with family, or home with Home and Community Care (if capacity allows). 	
Surveillance and Reporting	Implement enhanced surveillance and reporting including:	
	<ul style="list-style-type: none"> • changes to communicable disease surveillance based on IPC and CDC/EPH guidance. 	
	<ul style="list-style-type: none"> • reviewing surveillance and symptom monitoring to identify clusters of illness in residents and staff. • reporting communicable disease surveillance (e.g., resident and staff illness) and any additional reporting required as directed by Government or CMOH. 	
Safety & Security	Implement plans for Safety & Security processes, including:	
	<ul style="list-style-type: none"> • establishing single entry and exit points to aide in reporting, entry assessment and contact tracing. 	
	<ul style="list-style-type: none"> • Critical Incident Stress Management for staff health and safety. • Consultation with Ethics for any changes to policies or processes (e.g., visitor policy) 	
	<ul style="list-style-type: none"> • obtaining on-site security staff, if necessary. 	

Topic	Task	Status
Designated Family/ Support Person(s) and Visitors	Address Designated Family/Support Person(s) (DFSP) and Visitor practices including:	
	<ul style="list-style-type: none"> • implementing and communicating changes to visiting policy, if applicable 	
	<ul style="list-style-type: none"> • identifying resident’s DFSP that wish to assist in providing care on-site 	
	<ul style="list-style-type: none"> • providing education and training for DFSP that will be assisting in providing on-site care. 	

Appendix 4

Communicable Disease Emergency Response Plan Checklist System Wide Prioritization

Continuing Care Operator Roles and Responsibilities

Responsibilities build upon existing outbreak management guides and legislated requirements, including the *Continuing Care Health Service Standards*, *Accommodation Standards* and the *Occupational Health & Safety Act*.

- Communicate change in Level of Activation to SYSTEM WIDE PRIORITIZATION to staff, organizational leaders, partners, DFSPs.
- Attend and participate in any communicable disease emergency information sessions.
- Review and address additional considerations in Chapter 3 of the Continuing Care Communicable Disease Emergency Response Guide.
- Ensure that the location of information and the responsibility for each task is clearly assigned.**

Topic	Task	Status
Care Provision	Prioritize care provision:	
	• assessment centres, as applicable.	
	• identify alternate care sites.	
	• review and revise essential services as necessary.	
Communications and Contacts	Communication to contacts including:	
	• informing staff, public and partners of SYSTEM WIDE PRIORITIZATION and changes in levels of service (e.g., service level, temporary relocation).	
	• providing daily status update reports to staff and public.	
	• location, principles and guidelines for assessment centres.	
Human Resources	Activate human resources planning including:	
	• implementation of staffing model required to meet resident care needs.	
	• staff deployment plan.	
	• Activate 24/7 Physician or NP access in CCHs.	

Topic	Task	Status
Infection Prevention & Control (IPC)	Implement IPC and CDC/EPH strategies including:	
	<ul style="list-style-type: none"> • establish assessment centres, where applicable. 	
	<ul style="list-style-type: none"> • prepare for mass vaccinations (e.g., resident, staff, volunteer immunizations with tracking and reporting). 	
	<ul style="list-style-type: none"> • staff and resident cohorting, as required. 	
Admission, Discharge and Transfer	Activate admission, discharge and transfer plans, including:	
	<ul style="list-style-type: none"> • preparing for potential establishment of alternate care sites. 	
	<ul style="list-style-type: none"> • temporarily relocate residents home with family. 	
	<ul style="list-style-type: none"> • applying established decision supports to evaluate residents for feasibility of temporary relocation home with family, or home with Home and Community Care (if capacity allows). 	

Appendix 5

Communicable Disease Emergency Response Plan Checklist Recovery

Continuing Care Operator Roles and Responsibilities

Responsibilities build upon existing outbreak management guides and legislated requirements, including the *Continuing Care Health Service Standards, Accommodation Standards* and the *Occupational Health & Safety Act*.

- Communicate change in Level of Activation to RECOVERY to staff, organizational leaders, partners, DFSPs.
- Review and update service level recommendations.
- Closure of incident command centre (ICS).
- Ensure that the location of information and the responsibility for each task is clearly assigned.**

Topic	Task	Status
Care Provision	Implement approach to pre-system wide prioritization service delivery:	
	• in phases.	
	• based on assessment of current scenario (e.g., staffing, resident illness) to determine phases.	
Communications and Contacts	Communications to contacts including:	
	• resumption of services, programming and vacancy management processes (e.g., resume HCC visits, clinics, Adult Day Programs, residents that were temporarily relocated return to CCH).	
Human Resources	Human resources activities including:	
	• initiation of business recovery and resumption plan (e.g., transitioning staff back from deployment).	
	• participating in provincial, zone/corridor and /or provider/operator debriefings.	
	• implement staff recognition program for contributions during emergency response.	

Appendix 6

Communicable Disease Emergency Response Plan Checklist Resumption

Continuing Care Operator Roles and Responsibilities

Responsibilities build upon existing outbreak management guides and legislated requirements, including the *Continuing Care Health Service Standards, Accommodation Standards* and the *Occupational Health & Safety Act*.

- Plan to resume normal service levels (based on assessment of current scenario).
- Communicate change in Level of Activation to RESUMPTION to staff, organizational leaders, partners, DFSPs.
- Participate in provincial, zone/corridor and/or HCC Provider/CCH Operator post-incident analysis of all components of the communicable disease emergency response.
- Review and address additional considerations in Chapter 3 of the Continuing Care Communicable Disease Emergency Response Guide.
- Ensure that the location of information and the responsibility for each task is clearly assigned.**

Topic	Task	Status
Communications and Contacts	Communications to contacts including:	
	<ul style="list-style-type: none"> • plans to resume pre-pandemic level service delivery based on assessment of current scenario (e.g., resume HCC visits, clinics, Adult Day Programs, social activities, etc.). 	
Human Resources	Human resources activities to resume pre-pandemic services including:	
	<ul style="list-style-type: none"> • return deployed staff to prior work location and resume work schedules. 	
	<ul style="list-style-type: none"> • review/evaluate and revise Human Resources communicable disease emergency response plans, as necessary. 	
	<ul style="list-style-type: none"> • completing the evaluation. 	
	<ul style="list-style-type: none"> • completion of business recovery and resumption plan. 	
	<ul style="list-style-type: none"> • develop plan for implementation of recommendations from evaluation. 	

Appendix 7

Nature and Level of Impact

Nature of Impact	Pandemic Scenario			
	Mild Impact	Moderate Impact	Moderate Impact	Severe Impact
Comparable historical pandemic	pH1N1 (2009)	Asian Flu (1957)	Hong Kong Flu (1968)	Spanish Flu (1918) COVID-19 (2020)
Basic virus characteristics	Low transmissibility / low virulence	High transmissibility/ low virulence	High virulence/ low transmissibility	High transmissibility/ high virulence
Nature and scale of illness	<ul style="list-style-type: none"> • Similar numbers as in moderate or severe seasonal influenza outbreaks • Mild to moderate clinical features (in most cases) 	<ul style="list-style-type: none"> • Higher number of cases than large seasonal outbreak, but similar clinical severity • Overall increased numbers needing medical care and with severe disease 	<ul style="list-style-type: none"> • Similar number of cases as with large seasonal outbreak, but illness is more severe • Overall increased numbers needing medical care and with severe disease 	<ul style="list-style-type: none"> • Large numbers of people ill • High proportion with severe disease

Nature of Impact	Pandemic Scenario			
	Mild Impact	Moderate Impact	Moderate Impact	Severe Impact
Impact on health care services	<ul style="list-style-type: none"> Ambulatory and acute care services stressed but able to cope Intensive Care Units (ICUs) at capacity IPC, CDC, EPH and laboratory services stressed Continuing care may or may not be affected (depending on pre-existing immunity) 	<ul style="list-style-type: none"> Ambulatory and acute care services very stressed Influenza Assessment Centres (IACs) implemented Healthcare services no longer able to continue all activities ICUs under severe pressure Continuing care may or may not be affected Settings with limited surge capacity, such as remote nursing stations, maybe even more stressed 	<ul style="list-style-type: none"> Ambulatory and acute care services very stressed Health care services no longer able to continue all activities ICUs under severe pressure Surge plans for continuing care implemented Settings with limited surge capacity, such as remote nursing stations, may be even more stressed Selective prioritization of health care services initiated 	<ul style="list-style-type: none"> Ambulatory and acute care services very stressed Health care services no longer able to continue all activities ICUs under severe pressure Surge plans for continuing care at capacity. Alternate care centres implemented Settings with limited surge capacity, such as remote nursing stations, may be even more stressed System wide prioritization of health care services initiated.

Nature of Impact	Pandemic Scenario			
	Mild Impact	Moderate Impact	Moderate Impact	Severe Impact
Broader societal impact	<ul style="list-style-type: none"> Limited workplace disruption Some school disruption Elevated public concern 	<ul style="list-style-type: none"> High absenteeism Some services experience pressures Schools likely disrupted Some supply chain problems Elevated public concern 	<ul style="list-style-type: none"> Potential absenteeism and school disruption from fear of exposure Considerable public concern over occurrence of very severe disease 	<ul style="list-style-type: none"> High absenteeism Services and businesses under extreme pressure Potentially severe supply chain problems Could disrupt provision of basic services Extreme public concern
Economic impact	<ul style="list-style-type: none"> Minimal if any 	<ul style="list-style-type: none"> Productivity may be affected 	<ul style="list-style-type: none"> Productivity may be affected 	<ul style="list-style-type: none"> Very high