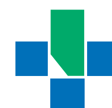
April 2024

Continuing Care Communicable Disease Emergency Response Guide 2024



Seniors Health & Continuing Care

Policy, Practice, Access & Case Management

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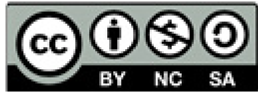

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Contact Info

For more information please contact continuingcare@ahs.ca

CHAPTER ONE – COMMUNICABLE DISEASE MANAGEMENT OVERVIEW

Applicability

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

The 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.

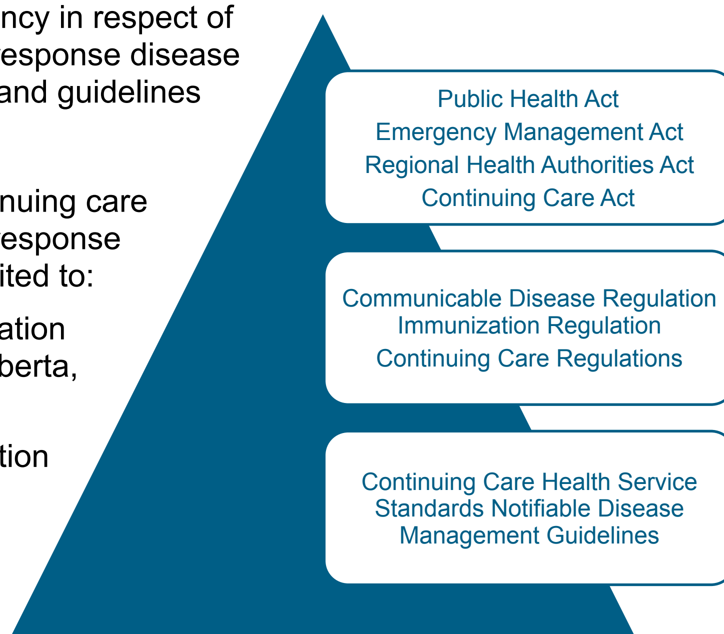
All AHS resources are available on the Continuing Care Connection (CCC) (https://connection.albertahealthservices.ca/web/default.aspx) and/or the AHS website (www.ahs.ca).

Legislative Structure

The Alberta Public Health Act, 2023, sets out requirements for communicable disease notification and reporting as well as powers during an emergency in respect of communicable disease emergency response disease 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:

- Supportive Living Accommodation Standards (Government of Alberta, 2010)
- Long Term Care Accommodation Standards (Government of Alberta, 2010)
- 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, 2023)
- 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., 2018) which should be inclusive of all information set out in legislation.

Guiding Resources

Operators (including clinical and non-clinical staff) must be knowledgeable about the following guiding resources in accordance with their respective care stream and specific job, position, authority or designation.

- Continuing Care Home (CCH) - The Guide for Outbreak Prevention and Control in Long Term Care, Designated Supportive Living & Hospice Sites 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-ltc-dsl-hospice.pdf.
- Home and Community Care (HCC) - HCC staff attending to supportive living facilities shall refer to the Guide for Outbreak Prevention & Control in Non-Designated Supportive Living Sites located at https://www.albertahealthservices.ca/assets/info/hp/cdc/if-hp-cdc-ob-guide-for-outbreak-prevention-and-control-in-non-ndsl-sites.pdf.
- All HCC and CCH - When outbreak response extends beyond the site level, the Continuing Care Communicable Disease Emergency Response Plan (CC-CDERP) will also be in effect.

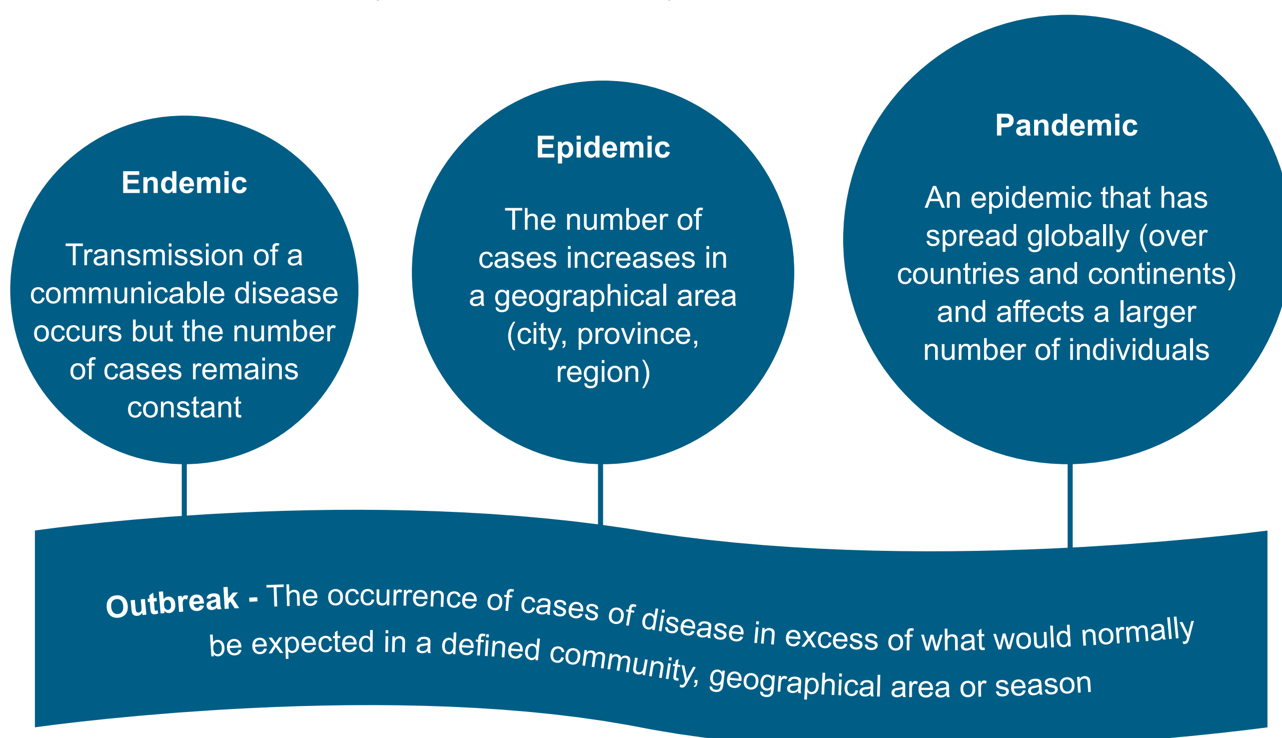
Additional guiding resources include, but are not limited to:

- 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, required equipment, and supply processes).

- Processes for:
    - Admission, discharge, and transfers (e.g., information transfer and risk assessment);
    - Safety and security;
    - Supplies and equipment;
    - Surveillance and reporting;
    - Designated family, support person(s), and visitation;
    - 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 public health professionals (including environmental public health and communicable disease control), infection control professionals, health care providers, impacted Albertans (e.g., residents, designated family/support persons), the RHA, Alberta Health (AH) and AHS leadership to facilitate a prompt response to help minimize the impact of a communicable disease emergency.

The **Regional Health Authority** (RHA) 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
  - 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 appropriate exceptions 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 most responsible health care provider (e.g., community Physician, Nurse Practitioner) accessibility 24/7 (inclusive of telephone consultation) for all CCH residents.
  - Physician/NP coverage in CCH Type A is coordinated through the site Medical Director. The Zone Seniors Health Medical Director will disseminate information to all site Medical Directors.
  - 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, access to required/essential medications, ward stock, schedule 2 drugs, schedule 3 drugs, and medication for end-of-life care.
- 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.
  - 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:

- Processes to access respiratory assessment and supplies: oxygen canisters, oxygen concentrators, and oxygen masks, and tubing.
- Processes to provide infusion therapy: access to supplies, equipment, staff training, and referral process.

  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.
- Process to provide aerosol generating medical procedures including access to supplies and equipment (e.g., PPE) and staff training.

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

- When managing residents requiring oxygenation, hydration, antipyretics, and analgesics, refer to organizational governance and Lippincott Procedures (via Continuing Care Connection).
- 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 (2018).
- Processes to ensure resident's Daily Care Plan or Bedside Care Instructions (AHS form 07933), or equivalent, are kept up to date for each resident, aligns with the comprehensive care plan, and are available for staff at the point of care.

- Processes to review and update goals of care designations and advanced care planning.
- Processes for implementing symptom screening (e.g., Resident Daily Screening Questionnaire form 21703 and/or Continuing Care Residents Communicable Disease Screening Tool form 21625) 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 the RHA in consultation with AH and communicated to residents and stakeholders.
- Note: Resident 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 meet record management requirements as set out in the operator policy.
- Process to access external providers or services to maintain service provision (e.g., meals, security, facility maintenance, etc.).

Consideration for care and treat 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 treat in place. 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 space or facility, 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:
  - Minimum of two (2) metres between residents.
  - Availability of hand hygiene in accordance with all IPC requirements located at https://www.albertahealthservices.ca/ipc/page6426.aspx.
  - Space available for soiled and clean equipment, supplies and linens.
  - Garbage containment and collection.
  - Availability of toilet and shower/bathing facilities near proximity (or a space for commodes).
  - Carpeted areas are discouraged.
  - 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 (e.g., CCH Access and Waitlist Management Procedure, AHS Appropirate Prioritization of Access to Health Services Policy) 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:

- AHS 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 (include reference to 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 the RHA 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 RHA 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.
- During recovery and resumption, AHS Coordinated Access services will work with operators to review and prioritize waitlists.

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, physicians, consultants, residents, family members, alternate decision makers, volunteers, relevant AHS 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 AHS 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:
  - AHS
    - Website: www.albertahealthservices.ca
    - Insite: http://insite.albertahealthservices.ca
  - Continuing Care Connection: http://connection.albertahealthservices.ca
  - Alberta Health:
    - 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.
- AHS Provincial Seniors Health and Continuing Care (PSHCC) 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@ahs.ca email.

Human Resources Planning

All HCC and CCH 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.
  - Process for provision of required education for physicians and staff (regulated and unregulated), volunteers and students (Education material is available at http://connection.albertahealthservices.ca), including documentation of education.
  - Streamlined education for staff may be required (e.g., virtual education for comfort care aides, HCA Skills sessions, basic care training).
- 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 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:

    - An increase in staffing needed to manage the increased resident acuity and isolation.
    - Increased staffing to support Care and Treat in Place.
    - 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 (e.g., AHS *Attending Work with COVID-19 Symptoms or a Positive COVID-19 Test Directive*, Alberta Health *Guidance for Management of Symptomatic Healthcare Workers*).

  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.
- Process to ensure 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 assess, track and make available immunizations and antiviral prophylaxis.

  Note: Refer to the AH immunization and routine immunization schedule, the 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 availabile when face-to-face meetings and education as well as unneessary 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/Public Health strategies, 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 resources and Notifiable Disease & Outbreak Management resources for infection prevention, identification, response, management, and control measures located at:

  - Infection Prevention & Control
  - Notifiable Disease & Outbreak Management
- Process to evaluate adherence to IPC practices including appropriate use of PPE (e.g., PPE Safety Coach, site based risk assessment).
- Process to procure (e,.g., through the RHA and/or other provincial sources), store, and access personal protective equipment (PPE), alcohol based hand rub (ABHR), 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 receptables in resident care areas, coordinating large dumpsters for waste collection outdoors, increased frequency of waste pick-up, and clear processes for removing 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 removing 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 to implement immunization programs and tracking for CCH & HCC staff, students, residents and volunteers.

- Process to implement site-based immunization for residents and staff 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 and Public Health.
- Process to support and oversee diligent attention to the IPC risk assessment (IPCRA), routine practices and additional precautions, health care workers exposure prevention and management, and cleaning standards inclusive of enhanced cleaning measures given increased resident volumes/care needs, staff vacancy and prevalence of symptoms.
- 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 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 AH and the CMOH in consultation with your area MOH/designate in administering immunizations in your facility.
- 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:

- Process to complete a communicable disease assessment on admission.
- Process to complete a symptom assessment at point of care.
- Process to review the communicable disease assessment and update any changes prior to discharge or transfer.

Considerations for communicable disease emergency response plans related to admission, discharge and transfer include, but is 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 and Temporary Relocation

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

- Process to assess 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.).
- Process to assess for appropriateness of the temporary relocation of a resident to community or alternate location during service disruptions.
- Process to communicate 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 during a leave of absence (e.g., financial, communication, etc.).
- Information for the interdisciplinary team to consider when planning for a leave of absence with a resident and family (e.g., equipment, alternate care services, etc.).

Safety & Security

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

- Processes to designate single entry and exit points to aide in reporting, point of entry assessment, and contract tracing.
- Processes to obtain on-site security staff.

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.

Supplies & Equipment

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

- A list of required supplies and equipment needed (see below table; also see IPC section for specific PPE supply requirements) in addition to usual/basic daily supplies and equipment (e.g., beds, commodes, linens, etc.).
- Processes to procure and obtain required supplies and equipment.

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

- Agreements with local service providers may need to be established and maintained by operator (e.g., oxygen providers, pharmacies, etc.).
- Agreements with alternate service providers may be essential to maintain the flow of critical supplies and equipment.

Supplies and Equipment		
Infusion therapy supplies (hypodermoclysis)	Portable / disposable thermometer	Human remains pouch / body bag
Biohazard bins	Call bell system / monitoring system	Oxygen supplies including pulse oximeters
Isolation room carts	Stock of single resident use or disposable items	Large, soiled holding receptacles and bags

Surveillance and Reporting

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

- Processes to support and communicate all required reporting.
- Processes to conduct ongoing surveillance, monitoring and reporting during a communicable disease emergency response, looking for unusual clusters of illness in residents / staff, and identifying possible outbreaks.

  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.

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.

  Note: CDC reporting occurs according to Public Health Surveillance processes under the Alberta Public Health Act and may be updated based on the pathogen, mode of transmission, etc.

- Additional direction regarding reporting may be provided from the Government or CMOH.

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 designated family, support person(s), visitor practices, and guides operator decisions related to identification of essential care partners.
- Processes to manage or establish limits on designated family, support person(s), 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 continuing care facilities 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).
- Designated family, support person(s) 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.
- Process to access the attending physician/nurse practitioner 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 the RHA and will be dependent on the death rate.
- Most continuing care sites 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 nurse practitioners may change due to altered coverage models and call schedules. The resident's most responsible practitioner may not be immediately available at the time of death or may rotate off a clinical service before a Medical Certificate of Death can be completed. 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 HCC and CCH based on the level of activation.
- Operator requirements to document a comprehensive communicable disease emergency response plan.

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 three tables provide the basics for a comprehensive communicable disease emergency response plan. As part of their communicable disease emergency response plan review process, operators should complete the checklist and update all operator process documents (resources, policies, memos, etc.) that provide additional information for their staff.

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 volume; 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 / zone 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" plan / alternative plan for care in place. Identify which individuals need essential visits for interventions such as specific medications (insulin, infusion therapy) that may put them at risk of hospitalization if not received.	Maintain services on site. Maintain social activities. Ensure residents have a "back-up" plan / alternative plan for care provision. Identify which residents need essential visits for interventions such as specific medications (insulin, infusion therapy) that may put them at risk of hospitalization if not received.	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 visits, 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.	Instead of home visits, maximize utilization of existing clinics. Provide necessary and essential visits only. May need to prioritize essential/required visits. Implement telephone 'visits' where able. Cancel Adult Day Support Programs.	Maintain services on site. May need to prioritize essential/required care (e.g., medication, medical interventions). Modify social / leisure programming. Reschedule non-urgent medical appointments. Cancel facility respite. Mobilize volunteer / family assistance for care provision. Evaluate residents for feasibility of being discharged temporarily to home with family or home with Home Care (if Home Care capacity allows).	Deploy staff to other teams within the same service area. Utilize HCC surge capacity for early discharges from acute care or temporary transfers home from CCH or Supportive Living facilities. Utilize CCH surge capacity to care for admissions from acute care or home-living residents not able to be managed in the home. Consider utilizing spaces freed up by residents able to be cared for in alternate setting (Family or Home Care).
System Wide Prioritization	Services when decrease of 30%+ in staffing levels.	Essential visits only. Telephone screening prior to visit to assess for symptoms. Maximize telephone visits.	Temporarily discharge residents' home with family, home with Home Care (if Home Care capacity allows) or consolidate at other CCH. For remaining on-site residents, provide medically necessary care and treatments with specific attention to essential care, hygiene, nutrition and hydration.	Deploy staff throughout all continuing care services. Request individuals receiving services activate back-up plan for care provision where possible.

Continuing Care Service		HCC Recommended Services	CCH Recommended Services	Additional Considerations
Level of Activation	**Staffing Level**			
Recovery	Services when less than 20% decrease in staffing levels and returning to normal.	Provide necessary and essential visits and resume routine home visits. Resume usual clinic schedule. Initiate resumption of Adult Day Support Programs.	Implement phased approach to resume services on site. Resume services for residents that were relocated. Resume usual vacancy management processes.	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.
Resumption	Services when returned to usual seasonal staffing levels.	Resume home visits. Resume clinics. Resume all Adult Day Support Programs.	Resume services on site. Resume social activities.	Return deployed staff to prior work location and schedule.

Communicable Disease Emergency Response Plan Checklist

Preparation		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Roles and Responsibilities	Develop and update (annually) an operator/facility specific communicable disease emergency response plan inclusive of all requirements and considerations in the Communicable Disease Management Guide.	
	Responsibility:	
	Location:	
	Promote, facilitate and track education for staff including operator communicable disease emergency response plan, safe care practices and outbreak management.	
	Responsibility:	
	Location:	
	Identify capacity statistics (e.g., spaces in Supportive Living, spaces in CCH and total number of HCC clients) as requested.	
	Responsibility:	
	Location:	
	Track expenses related to communicable disease emergency response (e.g., staffing, overtime, equipment and supplies, pharmacy costs) as requested by finance/designate.	
	Responsibility:	
	Location:	
	Notify ZSHCC of triggers that would change the level of activation (e.g., increased staff vacancy).	
	Responsibility:	
	Location:	
	Attend and participate in any communicable disease emergency response plan information sessions.	
	Responsibility:	
	Location:	
	Participate in a tabletop simulation exercise, as appropriate.	
	Responsibility:	
	Location:	
	Review and update service level recommendations.	
	Responsibility:	
	Location:	

Preparation			
Topic		**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Care Provision	Care and Treat in Place	Develop appropriate exceptions to care and treat in place (e.g., when acute episodic illness requires surgical intervention and/or other urgent acute care services).	
		Responsibility:	
		Location:	
		Processes to continue to provide services to current residents.	
		Responsibility:	
		Location:	
		Processes to maintain appropriate level of care for all residents.	
		Responsibility:	
		Location:	
	Professional Health Services	Plans for most responsible health care provider (e.g., community Physician, Nurse Practitioner) accessibility 24/7 (inclusive of telephone consultation) for all CCH residents.	
		Responsibility:	
		Location:	
		A process for assessment to occur virtually or on-site depending on clinical need.	
		Responsibility:	
		Location:	
		A plan for all staff 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.	
		Responsibility:	
		Location:	
	Clinical Support Services	Process to refer to external healthcare providers or services (e.g., Alberta Referral Directory).	
		Responsibility:	
		Location:	
		Documented identification of pharmacy service requirements including after-hours service, access to required/essential medications, ward stock, schedule 2 drugs, schedule 3 drugs, and medication for end-of-life care.	
		Responsibility:	
		Location:	
		Providing options for virtual health and other technology assisted appointments.	
		Responsibility:	
		Location:	

Preparation			
Topic		**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Care Provision	Clinical Support Services	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 resident's assessed needs.	
		Responsibility:	
		Location:	
	Management of Illness	Process to access respiratory assessment and supplies: oxygen canisters, oxygen concentrators, oxygen masks, and tubing.	
		Responsibility:	
		Location:	
		Processes to provide infusion therapy: access to supplies, equipment, staff training, and referral process.	
		Responsibility:	
		Location:	
		Process to provide aerosol generating medical procedures including access to supplies and equipment (e.g., PPE) and staff training.	
		Responsibility:	
		Location:	
	Care Planning	Process to ensure the appropriate comprehensive assessment (e.g., interRAI instrument) is completed.	
		Responsibility:	
		Location:	
		Process to ensure comprehensive care plans are up to date and inform service provision for all HCC and CCH residents in accordance with the requirements in the CCHSS (2018).	
		Responsibility:	
		Location:	
		Processes to ensure Resident's Daily Care Plan or Bedside Care Instructions (AHS form 07933), or equivalent, are kept up to date for each resident, aligns with the comprehensive care plan and are available for staff at the point of care.	
		Responsibility:	
		Location:	
		Process to review and update goals of care designations and advanced care planning.	
		Responsibility:	
		Location:	

Preparation			
Topic		Task	Action Complete (Yes/No/Partially/ Not Applicable)
Care Provision	Care Planning	Processes for implementing symptom screening (e.g., Resident Daily Screening Questionnaire form 21703 and/or Continuing Care Residents Communicable Disease Screening Tool form 21625) and other assessment and treatments when required (e.g., as per CMOH Orders, additional outbreak measures, etc.).	
		Responsibility:	
		Location:	
	Accommodation & Non-Clinical Support Services	Process to meet record management requirements as set out in the operator policy.	
		Responsibility:	
		Location:	
		Process to access external providers or services to maintain service provision (e.g., meals, security, facility maintenance, etc.).	
		Responsibility:	
		Location:	
Surge Capacity	Surge Capacity	Plan to designate all available beds to be used as surge capacity.	
		Responsibility:	
		Location:	
		Identification of surge capacity of 1-2 beds for every CCH facility, as appropriate.	
		Responsibility:	
		Location:	
		Processes to manage bed capacity and surge capacity expectations (additional bed capacity, additional staffing, additional equipment, etc.) if additional spaces are required.	
		Responsibility:	
		Location:	
		The addition of beds/spaces for surge capacity must comply with all usual IPC requirements (including those listed on page 14 of this guide).	
		Responsibility:	
		Location:	
	Capacity Prioritization	Implementation of applicable governance that informs capacity prioritization.	
		Responsibility:	
		Location:	
		Prioritization of service provision is completed according to the Service Level Recommendations.	
		Responsibility:	
		Location:	

Preparation			
Topic		**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Surge Capacity	Waitlist Management	Operator processes include reference to the AHS CCH Access and Waitlist Management Procedure for direction on changes to normal operating procedures during an emergency response.	
		Responsibility:	
		Location:	
		Process to communicate changes to normal operating procedures (when activated) to staff, volunteers, students and residents.	
		Responsibility:	
		Location:	
		Process for CCH operator to provide timely notification of vacancy to the RHA to facilitate activation of the changes to normal operating procedure.	
		Responsibility:	
		Location:	
Communication and Contacts		Maintain up to date contact lists (phone numbers, addresses, and email addresses) for organizational leaders, staff, physicians, consultants, residents, family members, alternate decision makers, volunteers, relevant AHS stakeholders (e.g., Communicable Disease, Infection Prevention and Control, etc.) and other key contacts relevant to communicable disease emergency response planning and activation.	
		Responsibility:	
		Location:	
		Establish multiple mechanisms (e.g., email, phone message blasts, virtual or in person meetings, letters) for communicating with these stakeholder groups.	
		Responsibility:	
		Location:	
		Ensure mechanisms are in place 24/7 for providing urgent communication to these stakeholder groups.	
		Responsibility:	
		Location:	
		Ensure AHS has current contact information for site and organizational leadership, including after-hours contact information.	
		Responsibility:	
		Location:	
		Process to follow the incident command system (ICS) and report back through identified channels.	
		Responsibility:	
		Location:	

Preparation		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Human Resources	Documentation of necessary minimum staffing levels, including volunteers and other service providers to maintain minimum care and treat in place requirements.	
	Responsibility:	
	Location:	
	Process to consider alternate work arrangements for individuals that can continue their job duties via the internet and phone.	
	Responsibility:	
	Location:	
	Process for provision of required education for staff (regulated and unregulated), volunteers and students.	
	Responsibility:	
	Location:	
	Process to sequester or mandate certain or essential staff.	
	Responsibility:	
	Location:	
	Process to quickly obtain additional staff to replace and/or augment staff through strategies such as agency contracts.	
	Responsibility:	
	Location:	
	Processes to rapidly and safely orientate new staff (e.g., agency staff).	
	Responsibility:	
	Location:	
	Process to communicate staffing levels (e.g., vacancies, augmented staffing).	
	Responsibility:	
	Location:	
	Process to request additional funding for care related needs.	
	Responsibility:	
	Location:	
	Process to mobilize the workforce across multiple facilities in the organization.	
	Responsibility:	
	Location:	

Preparation		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Human Resources	Process to address staff, volunteers, and students attending work with symptoms or when recovering from a communicable disease (e.g., AHS *Attending Work with COVID-19 Symptoms or a Positive COVID-19 Test* Directive, Alberta Health Guidance for Management of Symptomatic Healthcare Workers).	
	Responsibility:	
	Location:	
	Process to ensure 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.	
	Responsibility:	
	Location:	
	Process to assess, assess, track, and give access to immunizations/antiviral prophylaxis, as applicable.	
	Responsibility:	
	Location:	
Infection Prevention and Control	Implementation of comprehensive IPC and CDC/Public Health strategies, resources and guidance that prevent the transmission of communicable diseases with or without the availability of vaccines and treatments.	
	Responsibility:	
	Location:	
	Process to evaluate/audit adherence to IPC practices including appropriate use of PPE (e.g., PPE Safety Coach, site based risk assessment).	
	Responsibility:	
	Location:	
	Process to procure (e.g., through the RHA and/or other provincial sources), store, access personal protective equipment (PPE), alcohol based hand rub (ABHR), PPE carts and disinfectant/ cleaning products to meet the needs of all staff, volunteers, students, residents, and visitors.	
	Responsibility:	
	Location:	

Preparation		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Infection Prevention and Control	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 receptables in resident care areas, coordinating large dumpsters for waste collection outdoors, increased frequency of waste pick-up, and clear processes for removing waste from the building to minimize risk of contamination and further transmission.	
	Responsibility:	
	Location:	
	Process for handling clean and soiled linens/laundry including laundry separation, additional receptacles, processes for removing 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.	
	Responsibility:	
	Location:	
	Process to implement immunization programs and tracking for CCH & HCC staff, students, residents and volunteers.	
	Responsibility:	
	Location:	
	Process to implement site-based immunization for residents and staff during a communicable disease emergency response.	
	Responsibility:	
	Location:	
	Process to implement communicable disease surveillance and reporting practices beyond regular surveillance and reporting at the discretion of ECC and Public Health.	
	Responsibility:	
	Location:	
	Process to support and oversee diligent attention to the IPC risk assessment (IPCRA), routine practices and additional precautions, health care workers exposure prevention and management, and cleaning standards inclusive of enhanced cleaning measures given increased resident volumes/care needs, staff vacancy and prevalence of symptoms.	
	Responsibility:	
	Location:	
	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).	
	Responsibility:	
	Location:	

Preparation			
Topic		**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Admission, Discharge and Transfer	Admission	Process to complete a communicable disease assessment on admission.	
		Responsibility:	
		Location:	
		Process to complete a symptom assessment at point of care.	
		Responsibility:	
		Location:	
		Process to review the communicable disease assessment and update any changes prior to discharge or transfer.	
		Responsibility:	
		Location:	
	Resident Outings, Leaves of Absence and Temporary Relocation	Process to assess 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.).	
		Responsibility:	
		Location:	
		Process to assess for appropriateness of the temporary relocation of a resident to community or alternate location during service disruptions.	
		Responsibility:	
		Location:	
		Process to communicate 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.).	
		Responsibility:	
		Location:	
Safety and Security		Process to designate single entry and exit points to aide in reporting, point of entry assessment, and contract tracing.	
		Responsibility:	
		Location:	
		Process to obtain on-site security staff.	
		Responsibility:	
		Location:	

Preparation		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Supplies and Equipment	A list of required supplies and equipment needed in addition to usual/basic daily supplies and equipment (e.g., bed, commode, linens, etc.).	
	Responsibility:	
	Location:	
	Process to procure and obtain supplies and equipment detailed in the list.	
	Responsibility:	
	Location:	
Surveillance and Reporting	Process to support and communicate all required reporting.	
	Responsibility:	
	Location:	
	Process to conduct ongoing surveillance, monitoring and reporting during a communicable disease emergency response, looking for unusual clusters of illness in residents and staff, and identifying possible outbreaks.	
	Responsibility:	
	Location:	
Designated Family, Support Person(s) and Visitation	Policy that sets the expectations for safe designated family, support person(s) and visitor practices and guides operator decisions related to identification of essential care partners.	
	Responsibility:	
	Location:	
	Process to manage or establish limits on designated family, support person(s) and visitor attendance at a CCH or HCC site.	
	Responsibility:	
	Location:	
Care of the Deceased	Process for supplies (e.g., body bags), storage and transfer of the deceased.	
	Responsibility:	
	Location:	
	Process to access the attending physician/nurse practitioner for completion of the Medical Certificate of Death.	
	Responsibility:	
	Location:	
	Process to support cultural and spiritual/religious ceremony when handling deceased bodies.	
	Responsibility:	
	Location:	

Initiation / Surge			
Topic		**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Roles and Responsibilities	Communication & Contacts	Communicate change in Level of Activation (INITIATION) to HCC and CCH staff.	
		Responsibility:	
		Location:	
		Provide regular reports of unusual clusters of illness to MOH.	
		Responsibility:	
		Location:	
		Activate and communicate cost centers, eligible costs and billing processes (if applicable).	
		Responsibility:	
		Location:	
		Communicate with and alert personnel of additional surveillance and reporting requirements.	
		Responsibility:	
		Location:	
	Human Resources	Orientate personnel on workplace health and safety procedures (e.g., fit for work, immunization, attending work)	
		Responsibility:	
		Location:	
		Increase frequency of scheduled education on emergency preparedness.	
		Responsibility:	
		Location:	
	Admission, Discharge & Transfer	Assess and identify residents likely to be discharged and identify needs for community services or alternate care facilities.	
		Responsibility:	
		Location:	
	Safety & Security	Ethics consultation and Critical Incident Stress Management (CISM) plans prepared.	
		Responsibility:	
		Location:	

Selective Prioritization		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Roles and Responsibilities	Communication to staff regarding change in Level of Activation to SELECTIVE PRIORITIZATION.	
	Responsibility:	
	Location:	
	Initiate incident command centre.	
	Responsibility:	
	Location:	
	Promote, facilitate and track education for staff including operator communicable disease emergency response plan, safe care practices and outbreak management.	
	Responsibility:	
	Location:	
Surveillance	Activate enhanced surveillance tracking program.	
	Responsibility:	
	Location:	
Communication & Contacts	Communicate with and alert personnel of communicable disease assessment processes.	
	Responsibility:	
	Location:	
IPC	Prepare for activation of assessment centres, where applicable.	
	Responsibility:	
	Location:	
	Schedule and implement infection prevention and control skills lab, coaching (e.g., PPE Safety Coach).	
	Responsibility:	
	Location:	
	Prepare for staff and resident cohorting.	
	Responsibility:	
	Location:	
	Stock surge capacity bed spaces.	
	Responsibility:	
	Location:	

Selective Prioritization		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Admission, Discharge & Transfer	Resident admission screening, discharge planning, decision support prepared.	
	Responsibility:	
	Location:	
Human Resources	Activate human resources recruitment / deployment plan.	
	Responsibility:	
	Location:	
	Identify and notify personnel of potential redeployment to assigned areas.	
	Responsibility:	
	Location:	
Designated family, Support person(s) and Visitors	Implement changes to visitor policy, if applicable.	
	Responsibility:	
	Location:	
Safety & Security	Ethics consultation and Critical Incident Stress Management (CISM) plans implemented.	
	Responsibility:	
	Location:	
	Activate single entry and exit points to aide in reporting, point of entry assessment, and contract tracing.	
	Responsibility:	
	Location:	
	Obtain on-site security staff, if necessary.	
	Responsibility:	
	Location:	

System Wide Prioritization		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Roles and Responsibilities	Notify ZSHCC of triggers that would change the level of activation (e.g., increased staff vacancy).	
	Responsibility:	
	Location:	
	Attend and participate in any communicable disease emergency response plan information sessions.	
	Responsibility:	
	Location:	
Communication & Contacts	Communicate Level of Activation to SYSTEM WIDE PRIORTIZATION to employees, public, and partners.	
	Responsibility:	
	Location:	
	Daily status update reports to staff and public.	
	Responsibility:	
	Location:	
	Communicate assessment centre(s) location, principles guidelines to all personnel.	
	Responsibility:	
	Location:	
Human Resources	Applicable staffing model implemented.	
	Responsibility:	
	Location:	
	Personnel deployment plan activated.	
	Responsibility:	
	Location:	
	Physician / NP accessibility activated.	
	Responsibility:	
	Location:	
IPC	Establish assessment centre(s) where applicable.	
	Responsibility:	
	Location:	
	Prepare for Mass Vaccination Program.	
	Responsibility:	
	Location:	

System Wide Prioritization		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Care Provision	Prepare for potential establishment of alternate care sites.	
	Responsibility:	
	Location:	
	Assessment centers, alternate care sites, and essential service delivery reviewed and revised as necessary.	
	Responsibility:	
	Location:	

Recovery		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Roles and Responsibilities	Review and update service level recommendations.	
	Responsibility:	
	Location:	
	Closure of incident command centre.	
	Responsibility:	
	Location:	
Communication & Contacts	Communicate Level of Activation to RECOVERY to employees, public, and partners.	
	Responsibility:	
	Location:	
Care Provision	Implement phased approach to resumption of pre-system wide prioritization service delivery based on assessment of current scenario.	
	Responsibility:	
	Location:	
Human Resources	Implement formal staff recognition program to recognize contributions during emergency response.	
	Responsibility:	
	Location:	
	Participate in provincial, zone and/or operator debriefings.	
	Responsibility:	
	Location:	
	Initiate business recovery and resumptions plan.	
	Responsibility:	
	Location:	

Resumption		
Topic	**Task**	**Action Complete** (Yes/No/Partially/ Not Applicable)
Roles and Responsibilities	Process/plan to resume normal service levels.	
	Responsibility:	
	Location:	
	Participate in provincial, zone and/or operator post-incident analysis of all components of the communicable disease emergency response.	
	Responsibility:	
	Location:	
Communication & Contacts	Communication to staff about change in Level of Activation to RESUMPTION.	
	Responsibility:	
	Location:	
Human Resources	Implement phased approach to resumption of pre-pandemic service delivery based on assessment of current scenario.	
	Responsibility:	
	Location:	
	Review/evaluate and revise Human Resources communicable disease response plans, as necessary.	
	Responsibility:	
	Location:	
	Completion of evaluation.	
	Responsibility:	
	Location:	
	Complete business recovery and resumptions plan.	
	Responsibility:	
	Location:	
	Develop plan for implementation of recommendations from evaluation.	
	Responsibility:	
	Location:	

Additional Roles and Responsibilities

The Continuing Care Communicable Disease Emergency Response Guide – Roles and Responsibilities Table has been separated from the Guide to support just in time updates to roles and responsibilities for continuing care communicable disease emergency response during the Alberta Health System Refocusing. Once the health system refocusing is complete or stabilized the contents will be found in the Guide.

COMING SOON - Roles and Responsibilities Table link will be added once document finalized.

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 below table) 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.

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	• Similar numbers as in moderate or severe seasonal influenza outbreaks • Mild to moderate clinical features (in most cases)	• Higher number of cases than large seasonal outbreak, but similar clinical severity • Overall increased numbers needing medical care and with severe disease	• Similar number of cases as with large seasonal outbreak, but illness is more severe • Overall increased numbers needing medical care and with severe disease	• 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	• Ambulatory and acute care services stressed but able to cope • Intensive Care Units (ICUs) at capacity • Public health and laboratory services stressed • Continuing care may or may not be affected (depending on pre-existing immunity)	• Ambulatory and acute care services very stressed • Influenza Assessment • Centres (IACs) implemented • Health care 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	• 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	• 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	• Limited workplace disruption • Some school disruption • Elevated public concern	• High absenteeism • Some services experience pressures • Schools likely disrupted • Some supply chain problems • Elevated public concern	• Potential absenteeism and school disruption from fear of exposure • Considerable public concern over occurrence of very severe disease	• High absenteeism • Services and businesses under extreme pressure • Potentially severe supply chain problems • Could disrupt provision of basic services • Extreme public concern
Economic impact	• Minimal if any	• Productivity may be affected	• Productivity may be affected	• Very high

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 drill is to test setup requirements for vaccination deployment at your continuing care facility. At the end of the drill, 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. 2. such as health care workers, support and logistics staff, administration personnel and cleaners. 3. Participants successfully completed the required vaccination training for health workers. 4. Include all vaccination stages/stations for the actual set-up, including screening stations, waiting areas, registration, vaccination area, documentation area, etc. 5. 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 and that is available, 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.** 6. Include IPC measures and other useful items (e.g., signage, physical distancing, floor marking, one-way flow, screens and other IPC measures as required). 7. DO NOT compromise sterile components at this stage (don't open sterile packaging but place sealed objects where they would be used). 8. 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). 9. Required paperwork, including forms, tally sheets, and other reporting forms including tracking for additional dose/booster as needed. 10. Develop list with contact phone numbers (e.g. supervisor, focal person for adverse events following immunization, ambulance). 11. One exercise facilitator managing the drill, from beginning to end. 12. 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 are recipients 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 public health 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 drill.
   - 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	Appropriate location for the session (1-2 meters of space in all directions, space for documentation and supplies, space for vaccine storage and preparation). All required equipment and supplies collected and prepared. Sufficient post administration observation area (e.g., chairs, assigning staff to observe/monitor).	
Vaccine Calculations	Staff references and follows immunization guidance. Calculations for required doses and wastage completed correctly. Vaccine wastage minimized as much as possible. Calculation for vaccine consumables are made adequately.	

Evaluation Criteria	Observations	Status (Yes/No/Partially) and Comments
Infection Prevention and Control Measures	Proper signage in place Proper PPE available and used correctly • Routine and additional precautions are described to reduce the risk of transmission • Donning and doffing process is followed • PPE discarded after single use Participants describe the standard IPC precautions needed, including: • 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 Waste bags/containers are available Hand hygiene product is available Workspace is clean and clutter free	
Recipient Entry & Registration	Recipient is screened for symptoms before entering the vaccine administration area or prior to the staff entering the resident care area. Recipient eligibility information verified (e.g., consent).	
Waiting area	Limited number of individuals in the waiting area or any common area used for pre and post administration.	

Evaluation Criteria	Observations	Status (Yes/No/Partially) and Comments
Communication & Reporting	Adequate information is provided to recipients about the vaccination process steps. Vaccination register, tally sheets or other record/reporting. forms are correctly used (i.e. electronic immunization registry. medical record system, monthly/periodic reports). Sufficient information is provided to the recipient before leaving the vaccination area (e.g.,. 2nd injection if applicable, common side effects). Recipient receives instructions on how to access their vaccine information.	
Vaccination Administration	Medication order is verified, if applicable. Dose is prepared according to instructions. Medication rights and safety checks are completed according to operator policy. Injection is completed in accordance with proper procedure (e.g., intramuscular injection procedure). Recipient is observed for minimum 15 minutes in a designated area or their room.	

*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 public health 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 used to ensure a safe and efficient vaccination session.
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	Participants identify the need for cohorting. Participants bring all supplies including staff schedules, assignments, communicable disease assessment records and tracking and alternate/ additional work locations (if known). Participants planning takes into account the resident population, facility size, facility layout and staff complement.	
IPC Measures	Assignment, relocation and movement of staff occurs in a way that reduces the risk of cross-contamination/transmission to both staff and residents. Appropriate and adequate barriers, signage and supplies are identified including PPE. Staff are assigned to residents or groups of residents based on resident exposure to, or infection with, the same laboratory-confirmed pathogen or symptomology. • 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	Staff who are considered close contacts of the symptomatic residents are assigned according to operator policy for fitness for work. Participants ensured assignment of staff appropriate to who is familiar with residents and their care needs.	

Evaluation Criteria	Observations	Status (Yes/No/Partially) and Comments
Communication and Reporting	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. Additional emotional and social needs of residents and how these will be met with the existing staff model is considered and included in communications.	
Staff entry and exit	Staff symptom screening is established at points of entry and exit to the facility and or cohorted unit/area. 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.	

Additional Simulation Exercises

1. SafeCare BC, COVID-19 Scenario Exercises, located at https://www.safecarebc.ca/covid-19-scenario-exercises/.
   a. Scenario 1 – Resident presenting with COVID-19 symptoms
   b. Scenario 2 – Resident tests positive for COVID-19
   c. Scenario 3 - Resident with COVID-19 will not self-isolate
   d. Scenario 4 – Staff member tests positive for COVID-19
2. World Health Organization, COVID-19 Simulation Exercises Packages, located at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/simulation-exercise.
   a. Drill – COVID-19 Vaccine Drill
   b. Tabletop Exercises – Supply chain and communication strategies
   c. Tabletop Exercises – Regulatory and safety issues
   d. Tabletop Exercises – Public health and social measures
   e. Tabletop Exercises – Urban
   f. Tabletop Exercises – Point of entry
   g. Tabletop Exercises – Health facility and Infection Prevention and Control
   h. Tabletop Exercises – Generic COVID-19 exercise

CHAPTER SIX – RESOURCES

Forms

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

Alberta Health Services. Risk Assessment Worksheet. Located at https://www.albertahealthservices.ca/frm-19669.pdf.

Alberta Health Services. Surveillance Case Tracking Sheet. 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. Aerosol Generating Medical Procedures. COVID-19. Located at https://www.albertahealthservices.ca/topics/Page17091.aspx.

Alberta Health Services. Infection Prevention and Control. Infection Prevention and Control Risk Assessment for Personal Protective Equipment Selection. Located at https://www.albertahealthservices.ca/assets/healthinfo/ipc/hi-ipc-routine-practices-algorithim-cc.pdf.

Alberta Health Services. Infection Prevention and Control. Personal Items and Laundry Tip Sheet for Continuing Care Residents Families and Visitors. Located at https://www.albertahealthservices.ca/assets/healthinfo/ipc/hi-ipc-covid-cont-care-tips-pers-clean-laund-z0-info-sht.pdf.

Alberta Health Services. Provincial Seniors Health and Continuing Care. CPAP/BPAP in Continuing Care During Communicable Disease Response. Located at https://www.albertahealthservices.ca/assets/info/seniors/if-sen-cdem-cpap-bpap-cc-during-communicable-disease.pdf.

Alberta Health Services. Provincial Seniors Health and Continuing Care. Outings and Relocation from a Continuing Care Home During an Outbreak or Emergency Response. https://www.albertahealthservices.ca/assets/info/seniors/if-sen-cdem-outings-relocation-during-outbreak-emergency-response.pdf.

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

Training and Education

Provincial Health Services Authority. BC Centre for Disease Control. Education and Development. Located at http://www.bccdc.ca/health-professionals/education-development.

Government of Alberta. Alberta's Pandemic Influenza Plan. 2014. Located at https://open.alberta.ca/publications/alberta-s-pandemic-influenza-plan.

World Health Organization. OpenWHO Training. Coronavirus disease (COVID-19) training: Online Training. Located at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/online-training.

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.

World Health Organization. COVID-19 Simulation Exercises Packages. Drills. Located at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/simulation-exercise.

CHAPTER SEVEN: 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.

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

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) five Zone Emergency Operations Centre's (ZEOC), 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.

- **ZEOC:** the physical location where zone representatives come together during an emergency to coordinate response and recovery actions and resources of the Sites and Services within the zone. The ZEOC 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 HCC and CCH operator/ site 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 Regional Health Authority 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.