

Orientation Guide for Contracted Service Providers

Table of Contents

Who is This Guide Intended for?	3
Long-Term Care and Community-based Services in Ontario	4
Home and Community Care	5
Legislation	5
Seniors Services and Long-Term Care	6
Overview	7
SSLTC Philosophy	9
Our Programs and Services	13
Our Residents and Clients	14
Interprofessional Team	15
Orientation Topics	19
Abuse, Neglect, Mandatory Reporting & Whistle-Blowing	20
Residents' Bill of Rights	24
No Reprisal	27
Dementia, Cognitive Impairment and Responsive Behaviours	28
Infection Prevention & Control (IPAC) and Outbreak Management	29
Emergency Procedures	35
Appendix A – Declaration of Completion and Understanding	38
Appendix B – City of Toronto Seniors Services and Long-Term Care (SSLTC) Declaration and Pledge of Privacy and Confidentiality Contracted Service Providers	40
Appendix C - Infection Prevention and Control for COVID-19	41

Who is This Guide Intended for?

This document serves to provide an orientation and introduction to Seniors Services and Long-Term Care. It is an overview of the services we provide and those we care for. It also contains critical information related to long-term care in Ontario and key areas such as health and safety, infection prevention and control and resident/client considerations.

The guide is meant for contracted service providers that deliver a variety of direct resident care and services in City of Toronto long-term care homes. These contracted services include:

- Spiritual and Religious Care (Coordinators, Spiritual and Religious Care)
- Physiotherapy (Physiotherapists (PT), Physiotherapy Assistants (PTA))
- Occupational Therapy (Occupational Therapists (OT))
- Music Therapy (Music Therapists)
- Art Therapy (Art Therapists)

The guide is also meant for individuals who deliver a variety of building service-related contracted services.

It is expected that organizations providing any of the contracted services above will give a copy of the guide, including the Declaration of Completion and Understanding form (Appendix A) and the Declaration and Pledge of Privacy and Confidentiality (Appendix B), to anyone they employ or contract to provide these services in City of Toronto long-term care homes.

Individual contractors are expected to review the guide as well as print and sign the two declaration forms. Upon the first visit to one of our long-term care homes, the contractor is to give the two signed declaration forms to the Manager, Resident Services or Manager/Supervisor, Building Services who will keep these forms on file at the long-term care home.

Long-Term Care and Community- based Services in Ontario

Home and Community Care

Local Health Integration Networks (LHINs) plan, integrate and fund local health care, improving access and patient experience across Ontario. They are local, provincially-funded agencies that provide healthcare information and coordination to people who need healthcare services within a defined geographic area.

Home and Community Care Support Services is part of the LHINs and coordinates admission to all long-term care homes within the geography served. In addition, they support seniors to live independently at home by coordinating care services, determine eligibility and make arrangements for admission to some adult day programs, supportive housing and assisted living programs, and complex continuing care and rehabilitation facilities.

People apply to their local Home and Community Care Support Services when they need long-term care supports. A Home and Community Care caseworker visits them at home or in hospital, assesses their needs, and determines eligibility for services. They inform the individual as to the different long-term care homes located in their area, the fee structure and information on application and admission processes. They coordinate the application for admission for up to five long-term care homes of the individual's choice.

Legislation

All long-term care homes are regulated under the *Long-Term Care Homes Act, 2007*, which received Royal Assent in 2007 and was proclaimed into force in 2010 along with *Ontario Regulation 79/10*. Long-term care homes must either be licensed or approved to operate by the provincial government. Under the *Long-Term Care Homes Act, 2007*, each municipality is required to operate at least one long-term care home in order to meet local needs. Community-based programs are regulated under the *Homemakers and Nurses Services Act, 1990*, the *Home Care and Community Services Act, 1994*, and the *Assisted Living Services for High Risk Seniors Policy, 2011*.

Funding for long-term care homes and community-based programs is provided to organizations through service accountability agreements.

The Ministry of Long-Term Care has established standards that must be implemented by all long term-care homes in Ontario. They are designed to ensure that all long-term care home residents receive a minimum level of care.

Compliance Inspectors can visit a long-term care home at any time. They perform:

- Annual reviews
- Complaint investigations
- Special reviews

Compliance Inspectors determine whether the long-term care home is meeting standards under *Long-Term Care Homes Act, 2007* and *Ontario Regulation 79/10*.

Seniors Services and Long-Term Care

Overview

Seniors Services and Long-Term Care (SSLTC) is responsible for service planning and strategic integration of City services for seniors.

The scope of services provided includes:

- Community support programs such as adult day programs, supportive housing services, tenancy supports and homemakers and nurses services for vulnerable individuals who reside in the community.
- Directly operating 10 long-term care homes that provide 24-hour resident-focused care for permanent, convalescent, and short-stay admissions; care, services and programs enhance quality of life by responding to individual resident needs.
- Coordinating and improving access to the City's 40+ health, recreation, employment, housing and transportation services for seniors.

SSLTC is one of 43 City of Toronto divisions providing a variety of services to approximately 2.9 million people. City divisions are organized into three main service areas which group together similar-type services; SSLTC is part of Community and Social Services, a grouping of City divisions that provide citizen-centered services.

There are approximately 36,000 employees within the Toronto Public Service; SSLTC has approximately 3,500 employees.

As the fourth largest city in North America, Toronto is a global leader in technology, finance, film, music, culture, and innovation, and consistently places at the top of international rankings due to investments championed by its government, residents and businesses.

Mission

We provide a continuum of high quality long-term care services to eligible adults in both long-term care homes and the community.

Vision

To be recognized leaders in excellence and ground breaking services for healthy aging. Our positive environment, partnerships in education and research integrate knowledge and innovation. Our contributions shape and influence public policy. Our services improve resident and client outcomes; enhance quality of life throughout the continuum of care and for the people of Toronto.

Values

SSLTC believes in the core values of Compassion, Accountability, Respect and Excellence. These **CARE** values are shared by all stakeholders; drive culture, priorities, and provide a framework in which all decisions are based.

Compassion	Accountability	Respect	Excellence
We are committed to providing compassionate care and comforting support that values the strengths, needs and desires of those we serve.	We are committed to acting with integrity and to using City property, services and resources in a responsible, accountable and transparent manner.	We are committed to upholding resident/client rights and respecting diversity; by embracing our differences and supporting others we demonstrate fairness, inclusion and equity.	We are committed to providing the highest quality of care and service; through innovation, teamwork, customer satisfaction, best practices and working co-operatively.

Compassion

We are committed to providing compassionate care and comforting support that values strengths, needs and desires of those we serve.

We live this value every day by:

- providing holistic care and restorative therapies
- delivering interesting and meaningful programs
- assisting in the activities of daily living and promoting wellness

Accountability

We are committed to acting with integrity and to using City property, services and resources in a responsible, accountable and transparent manner.

We live this value every day by:

- following good governance and using resources wisely
- ensuring dealings are conducted fairly, honestly and equitably
- engaging and listening to others
- maintaining safe and secure environments

Respect

We are committed to upholding resident/client rights and respecting diversity. We demonstrate fairness, inclusion and equity, by embracing our differences and supporting others.

We live this value every day by;

- embracing the diversity of all peoples
- ensuring decisions are sensitive to religious, moral and cultural issues;
- providing individualized care that enables people to be as independent as possible
- responding to emerging local community needs.

Excellence

We are committed to providing the highest quality care and service through innovation, teamwork, customer satisfaction, best practices and working co-operatively.

We live this value every day by:

- achieving success through quality improvements and partnerships
- building capacity by investing in a committed and skilled workforce
- embracing innovation and encouraging continuous learning
- striving to be the best by providing exemplary care and service

SSLTC Philosophy

We believe it is the obligation of SSLTC to have a philosophy that is based on the comprehensive needs of our residents, clients, and the community we serve. By fully adopting this philosophy, we can best support Toronto's most vulnerable individuals for healthy aging whether they still live in their own home or reside in a City of Toronto long-term care home.

- We believe SSLTC must provide the highest quality care and services possible and to be inclusive when planning and delivering our programs and services regardless of race, colour, creed, age or financial status.
- We believe that to be considered as leaders in excellence in the development of ground-breaking services in healthy aging and wellness, we require skilled and engaged staff, volunteers and partners sharing a commitment to delivering exemplary care and services to all those we serve. By maintaining a continual program of training, education and evaluation, our staff members actively contribute towards positive resident and client outcomes.
- We believe positive resident and client outcomes are best achieved through teamwork, partnerships, evidence-based practice, research, integrating knowledge and innovation, evaluation of care and services and a quality improvement approach where we continuously improve our services, operations and systems, as well as measure and benchmark our success.
- We believe our approaches in care and service delivery, advocacy, programs and environment need to be designed in a manner that supports residents' and clients' rights to dignity, honesty, safety, quality of life, wellness and well-being.
- We believe each resident's and client's culture, ethno-racial background, family tradition, community, language, sexual orientation, gender identity, gender

expression, life history, socio-economic status, and spiritual belief must be respected when planning and delivering care and services.

- We believe in the importance of establishing a just culture, positive workplaces, engaging staff and working together in inter-professional teams.
- We believe the best way to build an effective continuum of care is through strong, collaborative partnerships with all stakeholders including other healthcare organizations, our partners within the City of Toronto, the wider community, families, staff, volunteers, residents and clients.

Seniors Services and Long-Term Care



All homes provide 24-hour resident-focused care in a welcoming environment, offering special services and programs designed to enhance the quality of life and respond to the needs of each individual resident including:

- nursing and personal care
- behavioural support programs
- medical services
- dietetics and food services
- recreational programming
- spiritual and religious care
- volunteer programs
- diverse and inclusive care and services

HOMES	BEDS	LANGUAGE/CULTURAL PARTNERSHIPS	SHORT-STAY RESPITE BEDS	ON-SITE ADULT DAY PROGRAM	CONVALESCENT CARE PROGRAM
Bendale Acres 2920 Lawrence Ave. E. (Scarborough Centre)	302	<ul style="list-style-type: none"> • French (Pavillon Omer Deslauriers) • Ismaili 	●	●	
Carefree Lodge 306 Finch Ave. E. (Willowdale)	127	<ul style="list-style-type: none"> • Jewish • Korean 			
Castleview Wychwood Towers 351 Christie St. (Toronto - St. Paul's)	456	<ul style="list-style-type: none"> • Hispanic • Jewish • Portuguese • Japanese • Korean 	●		●
Cummer Lodge 205 Cummer Ave. (Willowdale)	391	<ul style="list-style-type: none"> • Cantonese • Italian • Korean • Russian • Farsi • Jewish • Mandarin 	●	●	
Fudger House 439 Sherbourne St. (Toronto Centre)	250	<ul style="list-style-type: none"> • Cantonese • Mandarin 	●		●
Kipling Acres 2233 Kipling Ave. (Etobicoke North)	337		●	●	●
Lakeshore Lodge 3197 Lake Shore Blvd. W. (Etobicoke-Lakeshore)	150				
Seven Oaks 9 Neilson Rd. (Scarborough Guildwood)	249		●		●
True Davidson Acres 200 Dawes Rd. (Beaches-East York)	187	<ul style="list-style-type: none"> • Ismaili 	●		●
Wesburn Manor 400 The West Mall (Etobicoke Centre)	192	<ul style="list-style-type: none"> • Italian • Polish • Spanish • Macedonian • Portuguese 	●	●	



Homemakers and Nurses Services



Offering light housekeeping, laundry, incidental grocery shopping and light meal preparation to help 3,000+ individuals to remain in their own homes and community.



Supportive Housing Services



Providing 500+ clients 24-hour assistance with personal care, light housekeeping, medication reminders, and security checks.

Seniors Housing Services

Integrated Service Model in 83 seniors-designated Toronto Community Housing buildings supporting 14,000 senior tenants.



Long-Term Care Homes

Directly-operating 2,600+ beds in 10 long-term care homes across Toronto, each connected to its local community and responsive to local needs.

In addition to permanent LTC beds, some homes offer short-stay respite beds, convalescent care beds, behavioural supports and specialized care.



Adult Day Programs

Four locations offering a variety of quality activities and services in a safe and supportive environment for individuals who have cognitive impairment or are socially isolated, or whose caregivers require respite support.

Meals on Wheels

Preparing approximately 1,000 meals per week for delivery to vulnerable individuals in the community.



Volunteer Services

2,000+ volunteers provide over 130,000 hours per year which is more than 50 hours of volunteer time per resident.

Our Programs and Services

For those who are no longer able to live on their own and require 24-hour nursing and personal care, high-quality care and accommodation is available in a long-term care home for an extended period of time. Permanent placement in long-term care is for those with the heaviest care needs and increasingly complex needs that cannot be met in the community.

Long-Term Care Homes

In addition to permanent beds, some of our long-term care homes offer short stay respite and convalescent care.

The short-stay program supports families seeking respite from the caregiver role for a period up to 60 continuous days to a maximum of 90 days per year.

The convalescent care program provides 24-hour care to seniors who require specific medical and therapeutic services in a supportive environment for a period of up to 90 continuous days. The program helps the individual recover their strength, endurance and functioning before returning to their home. It supports a transitional care function, enabling seniors to remain at home in the community longer.

Community-Based Programs

SSLTC also operates community-based programs that provide quality care and services to improve and/or maintain functional independence and quality of life to clients that may be isolated, vulnerable, or would otherwise not be able to live independently in their homes. Services include:

- Homemakers and Nurses Services offers light housekeeping and meal preparation, laundry, incidental grocery shopping, to approximately 3,200 individuals living in the city. Applicants are assessed for functional and financial eligibility.
- Supportive Housing Services offer homemaking, light meal preparation, personal care, medication reminders, and security checks to 510 seniors who live in their own apartments, in nine designated buildings across the city. Staff are available onsite 24/7.
- Adult Day Programs offer a variety of quality activities and services in a safe, supportive environment for people who are physically frail, have a cognitive impairment or who are socially isolated.
- Meals on Wheels is supported by preparing meals distributed from two sites.

Seniors Services

- Provides navigation and integration of municipal housing, social and health services for seniors including 27,000 tenants in 83 Toronto Community Housing seniors' buildings.
- Leads the Toronto Seniors Strategy, the City's age-friendly community plan.

Our Residents and Clients

Long-Term Care Resident Profile

The average length of stay in the City's long-term care homes is 1.2 years. Residents entering long-term care homes have more complex care needs, an average of six co-morbidities, are frailer and medically complex requiring specialized and a higher level of medical and health care including end of life and palliative care.

- Average age of 85 years, for those residents over 64 years of age
- 7% of long-stay residents are under 65 years of age
- 69% have moderate to very severe cognitive impairment
- 63% have dementia and 54% exhibit aggressive behaviour symptoms
- 91% are dependent or require extensive assistance with the activities of daily living
- 82% use mobility devices
- 44% receive mechanically altered diets to address chewing/swallowing difficulties
- 42% are dependent or require extensive assistance with meals
- 31 residents are over 100 years of age
- 56% are over 85 years of age
- 70 countries of origin, 56 languages/dialects and 34 faiths
- 42% are subsidized and require financial assistance or rate reductions
- Almost 10% are administered by the Office of Public Guardian and Trustee (OPGT).

Homemakers and Nurses Services Clients

- 53 different languages spoken
- 45% are 75 years of age and older
- 23% are 65-74 years of age
- 32% are under 65 years of age
- 38% are physically disabled with a musculoskeletal disorder
- 13% have cardiovascular disease
- 11% have a mental health diagnosis.

Supportive Housing Program Clients

- 39 different languages spoken
- 74% are 75 years of age and older
- 23% are 65-74 years of age
- 4% are under 65 years of age
- 26% are physically disabled with a musculoskeletal disorder
- 25% are chronically ill with cardiovascular disease
- 13% are chronically ill with an endocrine/metabolic disease (diabetes).

Adult Day Program Clients

- 44% are between 80-89 years of age
- 23% are over 90 years of age
- 87% live with family or others
- 51% have a primary diagnosis of dementia
- 24% have a primary diagnosis of cardiovascular disease
- 79% attend the program 2-3 days a week
- 26% receive a subsidized rate for services.

**As of January 2020*

Interprofessional Team

In each of our ten long-term care homes, there is an interprofessional team that provides resident-focused care and services.

The team's role is to assess, plan, implement and evaluate care and services in order to develop and maintain the resident plan of care and to integrate care and services to achieve resident quality of life expectations and family satisfaction.

Individual team members bring unique knowledge, skills and experiences within which discipline-specific and integrated team interventions strive to meet resident goals and expectations. These team members are employees, contracted service providers, volunteers and family members.

Each long-term care home has an Administrator who is responsible for the overall function of the home. The Administrator works with the management team to ensure safe and high quality resident care and services are delivered.

Administrative Services

Responsible for providing resident access to trust, banking services and providing clerical and information technology support and customer service.

Building Services

Responsible for all environmental services related to building maintenance, housekeeping, laundry and fire/safety programs.

Food & Nutrition Services

Responsible for preparing and serving food in the resident dining rooms, assessments, menu planning and special diets.

Medical Services

Responsible for ensuring resident access to medical and consultative services.

Nursing

Responsible for organizing and providing the home's nursing services, including personal care and the infection prevention and control program.

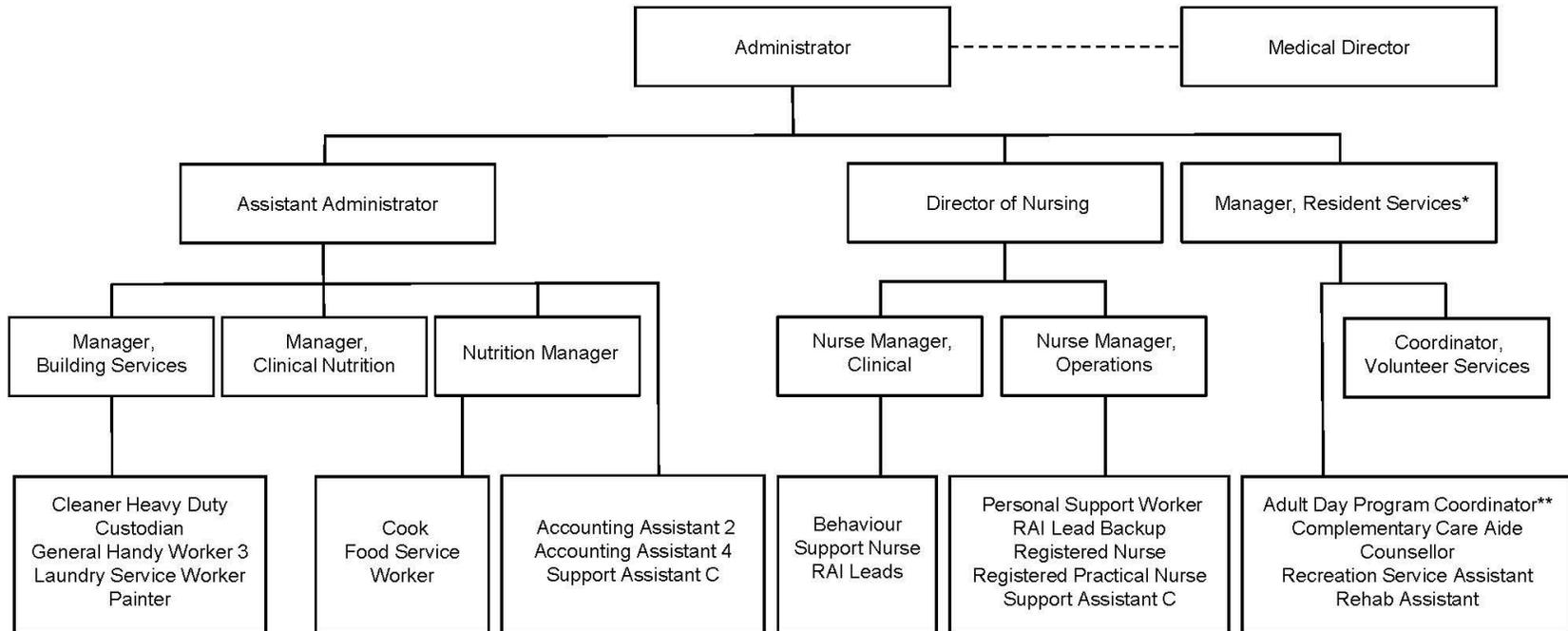
Resident Services

Responsible for programs and services that contribute to the residents' quality of life, such as social work, recreation, rehabilitation, complementary care, music therapy, physiotherapy, occupational therapy, art therapy, spiritual and religious care and volunteer services.

Volunteer Services

Assist residents/clients to maintain an active and independent lifestyle and a high quality of life.

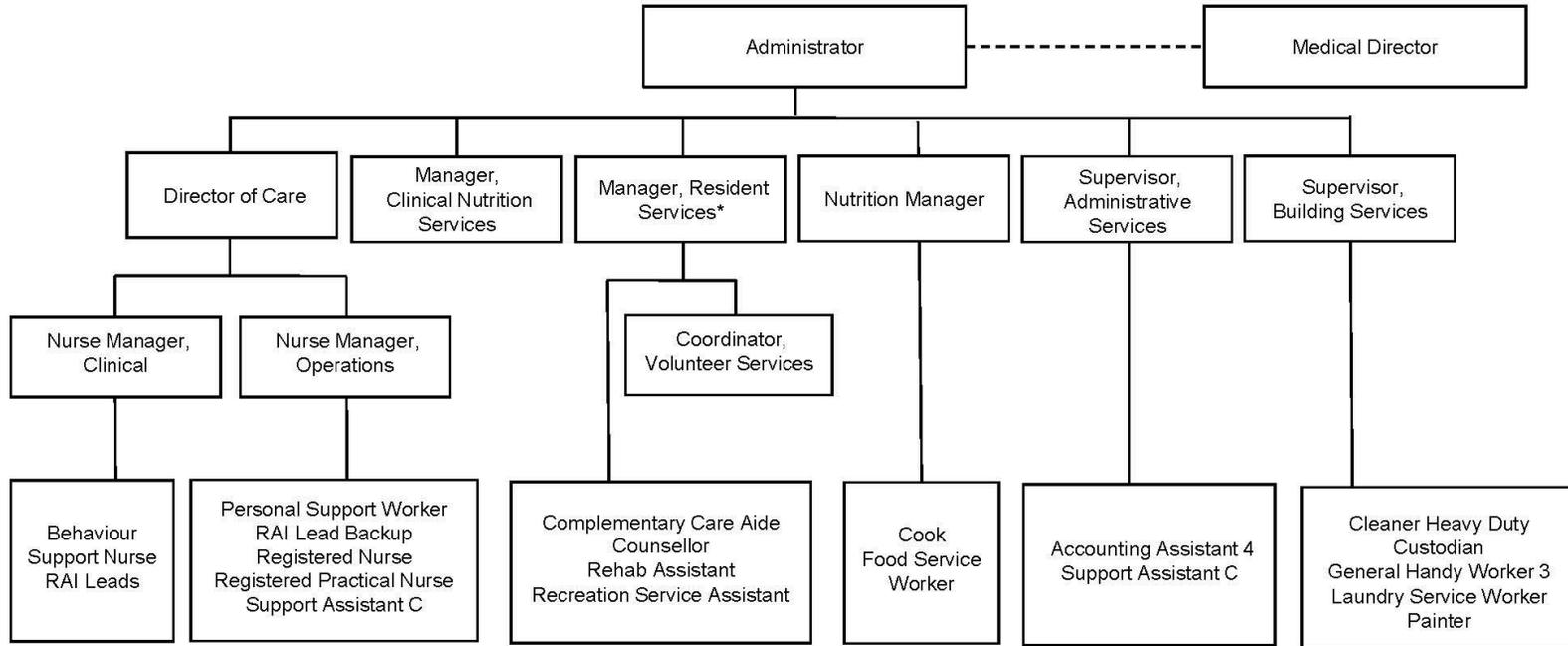
Sample Large/Mid-Size Home



*Additional contracted services within Resident Services include Spiritual & Religious Care and Allied Health Services (e.g. physiotherapy)
 **For Bendale Acres, Cumber Lodge and Kipling Acres only

Organizational Chart 7
 February 2020

Sample Small Home



*Additional contracted services within Resident Services include Spiritual & Religious Care and Allied Health Services (e.g. physiotherapy)

Organizational Chart 8
February 2020

Orientation Topics

Abuse, Neglect, Mandatory Reporting & Whistle-Blowing

SSLTC will not tolerate any form of abuse either by a staff person, volunteer, contracted service provider, resident/client or family member. We have a responsibility to provide care that is respectful and helpful while providing safe working environments.

Abuse

Resident/client abuse includes any action or inaction that puts the health, safety or well-being of a person at risk. Abuse includes but is not limited to:

- Physical
- Sexual
- Emotional
- Neglect
- Verbal
- Financial

Physical Abuse

The definition of physical abuse is:

- The use of physical force by anyone other than a resident that causes physical injury or pain,
- Administering or withholding a drug for an inappropriate purpose, or
- The use of physical force by a resident that causes physical injury to another resident.

Sexual Abuse

Sexual abuse definitions include:

- Any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
- Any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Emotional Abuse

Definitions of emotional abuse include:

- Any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
- Any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Verbal Abuse

Definitions of verbal abuse include:

- Any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or
- Any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Financial Abuse

The definition of financial abuse is:

- Any misappropriation or misuse of a resident's money or property

Neglect

Neglect is the failure to provide the care and assistance required for the health, safety or well-being of residents/clients. Neglect is an inaction that jeopardizes the health or safety of one or more residents/clients. It includes, but is not limited to the failure to: provide care as described in the resident's/client's plan of care, summon or provide assistance when required or respond to a resident's/client's request for assistance.

Prevention of Abuse and Neglect: Duty to Protect

Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the license or staff.

Procedure for Reporting Abuse

- Inform Registered Nurse (RN)/Registered Practical Nurse (RPN), manager/supervisor immediately on becoming aware of any and every alleged, suspected or witnessed incidents
- RN/RPN will notify the family or Substitute Decision Maker (SDM) of the resident(s) involved immediately about the alleged, suspected or witnessed incident of abuse
- The Nurse Manager notifies the MOLTC immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect and completes and saves an on-line Critical Incident System (CIS) report
- Administrator and Director of Nursing (DON)/Director of Care (DOC) review and submit on-line CIS report immediately and notify police of any alleged, suspected or witnessed incidents of abuse or neglect that could constitute a criminal offence.

Mandatory Reporting

As outlined in the *Long-Term Care Homes Act, 2007* a long-term care home must have written procedures for initiating complaints and how the home will deal with those complaints.

There is also mandatory reporting to the Ministry of Long-Term Care (MOLTC) by any person (except a resident) where the following resulted in either harm or a risk of harm to a resident:

- improper or incompetent treatment or care
- abuse of a resident by anyone or neglect of a resident by a staff or the home
- unlawful conduct that resulted in harm or a risk of harm to a resident
- misuse or misappropriation of a resident's money
- misuse or misappropriation of funding

The results of investigations must be reported to the MOLTC within 10 days of the awareness of the incident.

There are requirements related to the immediate reporting of critical incidents. Incidents requiring immediate reporting to the MOLTC include:

- emergencies – loss of essential services, fire, unplanned evacuation, intake of refugees or flooding
- unexpected or sudden death
- missing resident for 3 hours or more
- missing resident returning with an injury or adverse change in condition
- outbreak of a reportable or communicable disease

Other reportable incidents include those which must be reported within one business day after the occurrence. These include:

- a missing or unaccounted controlled substance
- injury requiring hospitalization
- medication incident or drug reaction and resident is hospitalized

Critical incidents that require reporting to the MOLTC within one business day include:

- A resident who is missing for less than 3 hours and who returns to the home with no injury or adverse change in condition
- An environmental hazard (security system, breakdown of equipment affecting care, safety, well-being of residents for more than 6 hours)
- A missing or unaccounted controlled substance
- Injury requiring hospitalization
- When a resident is hospitalized as a result of a medication incident or drug reaction

Whistle-blowing Protection

An increasing number of jurisdictions, including Ontario, support whistle-blowing protection legislation. The *Long-Term Care Homes Act, 2007* and *Regulation 79/10* include the concept of whistle-blowing. The Toronto Public Service By-Law also includes whistle-blowing under the Disclosure of Wrongdoing and Reprisal Protection. The By-Law provides protection against demotion, any punitive measure that adversely affects the employment or working conditions of the employee and directing or counselling someone to commit a reprisal.

Whistle-blowing protection provides an opportunity to address public interest concerns before harm is done.

Who is a Whistle Blower?

A “whistle-blower” is a person who raises a concern about a wrongdoing or serious action that is contrary to the public interest occurring in an organization and reports it to the proper authorities, within the organization or to another party.

Section 26 of the *Long-Term Care Homes Act, 2007* provides whistle-blowing protection and prohibits retaliation and threats of retaliation against a person for:

- Disclosing anything to an inspector
- Disclosing to the Director any matter concerning the care of a resident or the operation of the home.

Section 26 of the *Long-Term Care Homes Act, 2007* provides whistle-blowing protection and prohibits retaliation and threats of retaliation such as:

- Dismissing a staff member
- Disciplining or suspending a staff member
- Imposing a penalty upon a person and,
- Intimidating, coercing or harassing any person.

Residents' Bill of Rights

The Residents' Bill of Rights is mandated by provincial legislation. For residents living in long term care homes in Ontario, there are 27 Residents' Rights.

SSLTC incorporates the Residents' Bill of Rights into all resident care and services. A resident's right to dignity, privacy, respect and individuality are protected during all interactions with staff, contracted service providers and volunteers.

Copies of the Bill of Rights are posted in French and English in the main lobby of the long-term care home and at the elevators.

Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,

- ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
 - iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
- i. the Residents' Council,
 - ii. the Family Council,
 - iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
 - iv. staff members,
 - v. government officials,
 - vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Source: *Long-Term Care Homes Act, 2007*

No Reprisal

The Residents' Bill of Rights refers to reprisal. Reprisal is an act of retaliation against another person.

We are committed to ensuring that no resident of a City of Toronto long-term care home will ever experience any adverse consequence because they – or someone acting on their behalf – raised a question, concern or complaint.

We cannot react negatively or unfavourably if a resident, family member or substitute decision maker may have raised a question, concern or complaint about your work, your abilities or the home's policies and procedures.

Complaints and concerns are part of our business, they will come up and we will deal with them fairly and equitably and ensure we adhere to policies and procedures and applicable legislation.

We know that sometimes this can be difficult, but we must always maintain professionalism and courtesy. Remember the division's CARE values – compassion, accountability, respect and excellence.

Click on the link below to view "No Reprisal" video:

<https://www.youtube.com/watch?v=JjeDFqmt1K0>

Dementia, Cognitive Impairment and Responsive Behaviours

Dementia

Definition - the death of brain cells resulting in loss of thinking and memory.

If the cells are damaged or die, then the brain is not able to do its work; from the blink of an eye to the most complex acts, such as playing a violin.

We tend to associate the word dementia with the elderly, and may think it is just a part of growing old. This is incorrect. Dementia is not a normal part of aging.

Many diseases can cause dementia. The most common in our long-term care homes are Alzheimer's disease, Lewy Body disease and multi-infarct brain attack (such as transient ischemic attacks (TIAs) or strokes).

Cognitive Impairment

Definition - an individual's inability to think clearly and to understand and respond to the world.

Cognitive impairment may occur as a result of trauma, infections, metabolic disturbances, neurologic disturbances, drug interaction, cardiac and respiratory disturbances, drug and alcohol interaction, constipation and dehydration, etc.

Responsive Behaviours

Definition - an action directed towards other people or objects when an individual feels threatened or unsafe or highly anxious. This behaviour may be verbal, physical, sexual or emotional.

Behaviours common in residents with cognitive impairment can be described as non-conforming responses to the environment. Behaviours such as verbal/physical aggression, sexual aggressiveness are often associated with cognitive impairment. Such behaviours may be demonstrated as a result of:

- fearfulness
- high social isolation
- panic/catastrophic reactions
- changes in eating habits
- sleep disturbances

Individualized plans of care are developed by the interprofessional team on admission, quarterly, annually and when there is a significant change in health status. The plans contain strategies to prevent responsive behaviours and assist and support each resident responding to stimuli they find upsetting. "All behaviours have meaning" and we are challenged to develop creative strategies that minimize disruption and maximize resident quality of life.

Infection Prevention & Control (IPAC) and Outbreak Management

Residents/clients are vulnerable and at risk for infections.

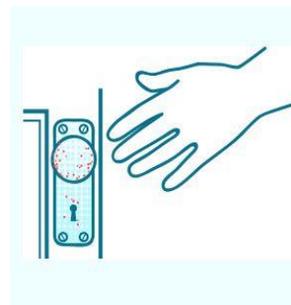
Modes of Transmission

Infections are spread from person to person by contact, droplet or airborne routes.

Contact

Germs can be transferred directly by physical contact between the infected person and the susceptible person, such as a handshake.

Direct contact requires close contact with the infected individual such as contact with oral secretions, or body lesions.



Indirect contact. Germs can be transferred indirectly when a susceptible person touches a contaminated surface such as: handles, tables, chairs, medical instruments, computer keyboards.

Droplet

Droplets containing germs are generated when a person talks, coughs or sneezes. If the infected droplets come in contact with surfaces of the eye, nose or mouth of another person, this may cause infection. The droplets are too large to remain in the air so they settle quickly.

Airborne

Droplet nuclei which are residue from evaporated droplets or dust particles containing germs can remain suspended in the air for a long time and then enter the body through the respiratory tract. Only a limited number of diseases spread this way such as tuberculosis (TB), chickenpox and measles.

Chain of Transmission

The transmission of microorganisms and subsequent infection may be represented by a "chain" with each link representing a factor related to the spread of microorganisms. Transmission occurs when the agent, in the reservoir, exits the reservoir through a portal of exit, travels via a mode of transmission and gains entry through a portal of entry to a susceptible host. By eliminating any of the 6 links through effective infection prevention and control measures, or "breaking the chain", transmission doesn't occur.

The first link in the chain is the **Infectious Agent**. It includes infectious agents such as Bacteria, Fungi, Viruses, Parasites, and Prions. The agent can be eliminated or inactivated by Antimicrobial therapy, Disinfection and Sterilization.

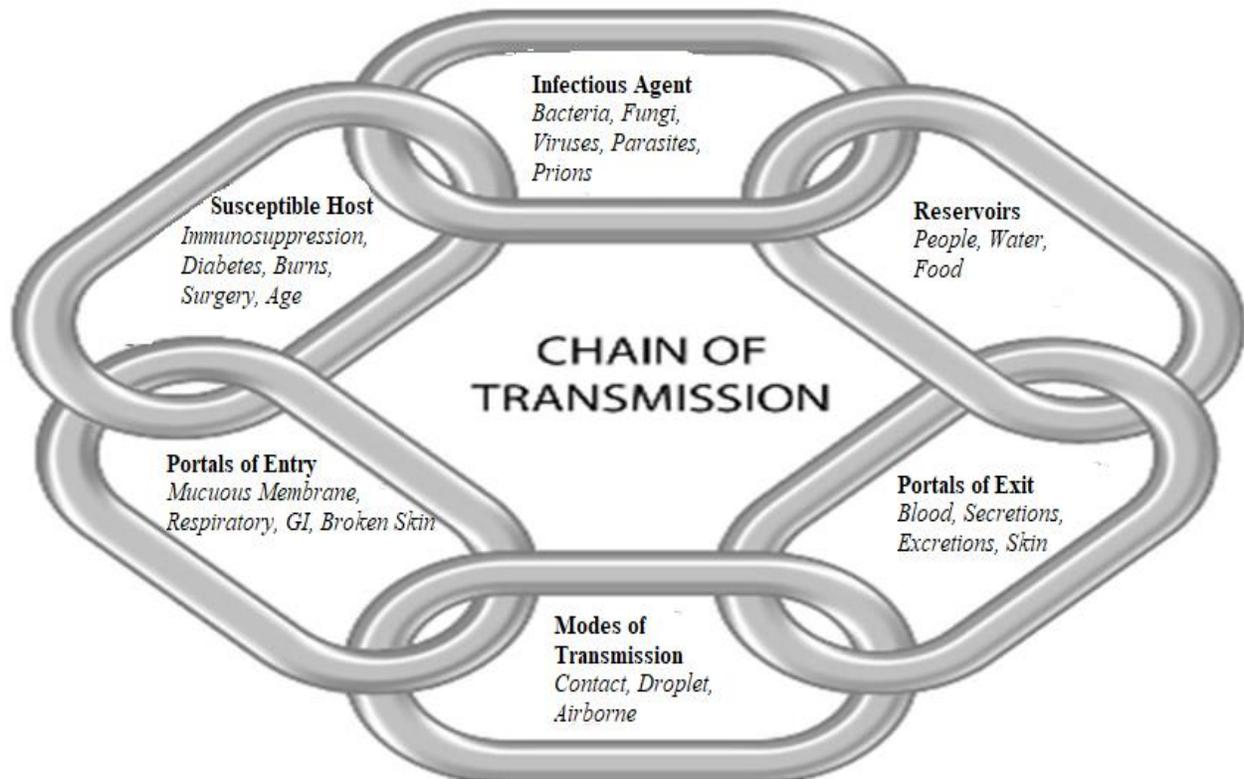
The second link is **Reservoirs**. Reservoirs can be People, Water, or Food. Engineering Controls such as plexiglass barriers protect staff admitting new patients in emergency department. Other strategies include environmental cleaning and disinfection, proper food storage and water treatment.

The third link is **Portals of Exit**. Germs exit the body via blood and body fluids and skin. Good hand hygiene, proper disposal of waste and contaminated linen and control of body fluids can break the chain at this point.

The 4th link is **Modes of Transmission**. Infections are spread from person to person by Contact, Droplet or Airborne Routes. Spatial separation such as providing residents meals in their room is one way to break the chain at this point. Good hand hygiene, environmental and equipment cleaning and disinfection and personal protective equipment (PPE) are other practices.

The 5th link is **Portals of Entry**. Germs gain access to our body via the eyes, nose and mouth, by broken skin, by breathing and/or through the gastrointestinal route by eating contaminated food. Transmission can be interrupted by hand hygiene, aseptic technique, good wound and catheter care and wearing PPE.

The 6th link is **Susceptible Host**. The following factors put a person at increased risk of acquiring infections: age, immunosuppression, diabetes, burns and surgery. Strategies to break the chain at the 6th link include: good nutrition, immunization, treatment, recognition of high-risk residents.



Hand Hygiene

Soap and water should be used when the hands are visibly soiled. Jewellery harbours bacteria and interferes with good hand hygiene. Remove them before hand washing, or better still leave them at home. Wet hands before applying the soap as it is easier on your skin then pat dry. Apply hand lotion frequently and liberally. Don't use hand sanitizer after hand washing as this will cause skin breakdown.

Hand sanitizer is the preferred method of hand hygiene in healthcare settings. Like hand washing, remove jewellery first. Use a palm full of product and rub all surfaces until dry. Do not rinse with water nor wash hands afterwards.

The 4 moments of hand hygiene are:

Moment 1 BEFORE initial resident / resident environment contact

Clean your hands before touching resident and/or any object or furniture in their environment (i.e. their room, their wheelchair).

Moment 2 BEFORE aseptic procedures

Clean your hands immediately before any aseptic procedure (e.g., oral dental care, eye drops, catheter insertion and changing a dressing).

Moment 3 AFTER body fluid exposure risk

Clean your hands immediately after an exposure risk to body fluids (and after glove removal).

Moment 4 AFTER resident / resident environment contact

Clean your hands after touching resident and/or any object or furniture in their environment (i.e. their room, their wheelchair).

Your 4 Moments for Hand Hygiene



1 BEFORE initial patient/patient environment contact	<p>WHEN? Clean your hands when entering the patient's environment:</p> <ul style="list-style-type: none"> • before touching patient or • before touching any object or furniture <p>WHY? To protect the patient/patient environment from harmful germs carried on your hands</p>
2 BEFORE aseptic procedure	<p>WHEN? Clean your hands immediately before any aseptic procedure; for instance: changing a dressing, oral care, drawing blood, administering IV medication</p> <p>WHY? To protect the patient against harmful germs, including the patient's own germs, entering his or her body</p>
3 AFTER body fluid exposure risk	<p>WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal)</p> <p>WHY? To protect yourself and the health care environment from harmful patient germs</p>
4 AFTER patient / patient environment contact	<p>WHEN? Clean your hands when leaving the patient's environment:</p> <ul style="list-style-type: none"> • after touching patient or • after touching any object or furniture <p>WHY? To protect yourself and the next patient from harmful patient germs</p>

Adapted from WHO poster "My 5 Moments for Hand Hygiene," 2008.

publichealthontario.ca/JCYH



Outbreaks

A home may experience an outbreak where several residents and sometimes staff are ill. To minimize further spread of illness, the affected units/areas are closed and communal activities are reduced.

Each home has a Nurse Manager with responsibility for IPAC along with an IPAC Practitioner and several IPAC Champions. These positions provide leadership at the home level.

Cleaning and Disinfection

Cleaning of equipment must always be carried out prior to disinfection. If an item is not cleaned of soil (i.e. blood, body fluids, dirt), the disinfection process cannot take place. This is because soil can protect the organism by inactivating the disinfectant.

Disinfection of equipment must be carried out after thorough cleaning. Failure to use disinfection products appropriately has been associated with transmission of healthcare-associated infections.

All equipment, instruments and supplies intended for single service use and items that cannot be disinfected adequately shall be disposed of after point of use.

Emergency Procedures

Resident safety is a priority. Each long-term care home has a specific fire and disaster plan. The following is provided in the event that you are at one of our long-term care homes and there is an emergency code.

Code Red

Code Red - Within SSLTC, every home has a written fire plan and procedures with specific directions on fire emergency procedures and evacuation sequence.

Fire is always a concern in a long-term care home. Fire drills are practiced regularly in the homes. Here are some simple steps to follow should you smell smoke or discover a fire.

Remove all residents from immediate danger.

Enclose the fire. Close doors and windows.

Activate closest fire alarm.

Call Communication Centre (specific location and phone extension in each home) and 9-911

Try to extinguish the fire if safe to do so.

The order in which you do these steps will depend on the individual situation.

With the Code Red announcement over the P.A. system:

- Listen for the location of the fire
- Visitors should remain where they are at the time of the alarm until the "ALL CLEAR" has been announced.
- Do not use the elevators
- Do not use the telephones

The Unit Captain may be the Registered staff person on the unit or the RN-in-Charge. They:

- are responsible for evacuating residents on unit
- wears an orange vest
- are assigned at shift change and may be responsible for re-setting the pull station

Other codes that may occur are:

Code Green: Evacuation

Code Yellow: Missing resident

Code Black: Bomb threat

Code Orange: External disaster

Code Blue: Medical emergencies

Code White: Violent behaviour

Follow any announcements and instructions from staff should one of these other codes be announced while you are in the long-term care home.

Smoking

In accordance with the *Smoke-Free Ontario Act*, there shall be no smoking throughout the home. The purpose of the Act is:

- to provide a healthy, comfortable and safe environment for residents, staff, visitors, volunteers and students;
- to comply with the Ontario Regulation 48/06 of the *Smoke-Free Ontario Act*; and
- to reduce the risk of fire within the home

Smoking is permitted outside, nine metres from the entrance/exit.

Contractor Sign in/Log Book

- Contractors are required to sign in daily
- Contractors are required to wear identification (name tag that will be provided by the home)

Eye Wash Station/Bottles

The home provides and maintains eye wash station/bottles(s) in areas where individuals face a high risk of splash exposure to biological and chemical substances which have the potential to result in eye injury. Eyes are to be flushed for a minimum of 15 minutes. Medical attention should be sought immediately. Ideally another person should dial 911. The sooner medical attention can be given, the chances of not sustaining permanent damage or blindness are greatly improved.

Lock Out/Tag Out

Each worksite shall ensure that effective lockout/tagout programs are developed and implemented to protect all who perform maintenance or repairs on equipment where an energy source can pose safety risk to a worker.

Workplace Hazardous Materials Information System (WHMIS)

Use WHMIS products and the required personal protective equipment as per safety data sheets (SDS) sheets.

Appendix A – Declaration of Completion and Understanding Seniors Services and Long-Term Care (SSLTC) Contracted Service Providers

Orientation Guide Sections	Contractor Initials
Long-Term Care and Community-based Services in Ontario	
Seniors Services and Long-Term Care	
Orientation Topics	
Abuse, Neglect, Mandatory Reporting & Whistle-Blowing	
Residents' Bill of Rights	
Dementia, Cognitive Impairment and Responsive Behaviours	
Infection Prevention & Control and Outbreak Management	
Emergency Procedures	
Infection Prevention & Control for Novel Coronavirus (COVID-19)	

I declare that I have reviewed the above orientation material contained within this document (*City of Toronto Seniors Services and Long-Term Care Orientation Guide for Contract Service Providers*), fully understand the information presented and will comply with the practices and procedures required to ensure the safety of all residents, staff and visitors.

Long-Term Care Home(s) Contracted to Work in: _____

Your Name (First, Last): _____

Your Position: _____

Your Organization: _____

Signature: _____ Date (yyyy-mm-dd): _____

SSLTC Manager Name (First, Last): _____

SSLTC Manager Signature: _____

*Give original signed document to SSLTC Manager you report to
To be filed in contractor file*

Appendix B – City of Toronto Seniors Services and Long-Term Care (SSLTC) Declaration and Pledge of Privacy and Confidentiality Contracted Service Providers

I pledge to maintain the privacy and confidentiality of all personal information and personal health information regarding any person who is a resident, client or applicant of Seniors Services and Long-Term Care (SSLTC), in accordance with the requirements of the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA) and the *Personal Health Information Protection Act, 2004* (PHIPA).

I understand that I have an obligation to conduct myself with personal integrity, ethics, honesty, and diligence in performing my duties. I understand that I have an obligation to avoid putting myself in a situation where my personal interests conflict with the interests of the City or my obligations as a contracted service provider. As an example, I understand that I may not accept gifts or money from residents/clients or their families, and that I may not work privately for any resident or client, or refer my family members or friends to do so.

I understand that audits are performed on an ongoing basis to ensure resident and client information is protected and that SSLTC is in full compliance with its legislated duties. Any unauthorized access, collection, use or disclosure of confidential information and/or personal health information will be fully investigated, and, based on the outcome of the investigation, may result in disciplinary action, up to and including termination of contract, removal from SSLTC workplaces, reporting to your regulatory college (if applicable) and legal action, as appropriate.

Long-Term Care Home(s) Contracted to Work in: _____

Your Name (First, Last): _____

Your Position: _____

Professional Designation (if applicable): _____

Your Organization: _____

Signature: _____ Date (yyyy-mm-dd): _____

Give original signed document to SSLTC Manager you report to

To be filed in contractor file

Appendix C - Infection Prevention and Control for COVID-19

Infection Prevention and Control (IPAC) for Novel Coronavirus (COVID-19) for Contracted Service Providers and Physicians

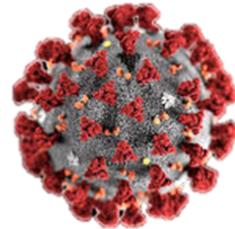
Updated March 2021

Objectives

- To understand standard infection prevention and control precautions that will apply to all residents.
 - To understand how COVID-19 is spread by learning about the '*Chain of Transmission*.'
 - To understand how to prevent COVID-19 by using routine practices.
 - To understand and apply the Point-of-Care Risk Assessment (PCRA).
 - To understand the principles of environmental cleaning and disinfection.
-

What is COVID-19?

Coronaviruses are a large family of viruses that originate in animals but are known to cause respiratory illness in humans.



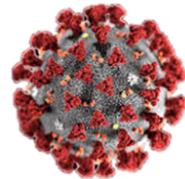
COVID-19 is a new disease that has not been previously identified in humans. The situation is rapidly evolving

(Public Health Ontario, 2020)

How COVID-19 Spreads

The COVID-19 virus can spread from an infected person's mouth or nose when they cough, sneeze, speak, sing or breathe heavily.

The virus can also spread after infected people sneeze, cough on, or touch surfaces, or objects, such as tables, doorknobs and handrails. Other people may become infected by touching these contaminated surfaces, then touching their eyes, noses or mouths without having cleaned their hands first.



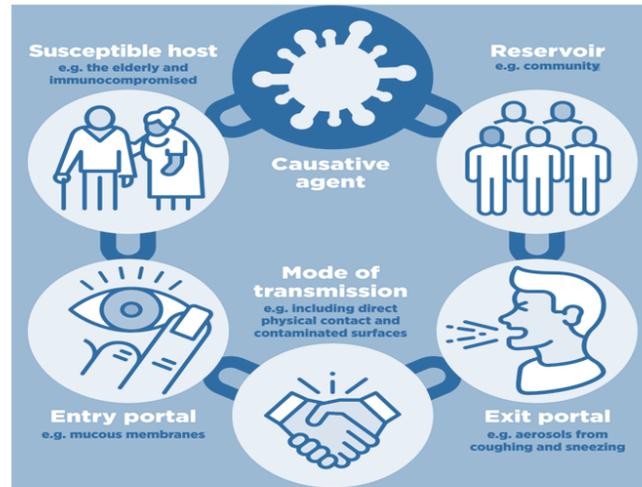
Other people can catch COVID-19 when the virus gets into their mouth, nose or eyes, especially when people are in direct or close contact (less than 2 meter apart) with an infected person.

(World Health Organization, 2020)

Break the Chain of Transmission of COVID-19

STOP THE SPREAD BY:

- WASHING** your hands
- WEARING** a mask
- DISPOSING** of used tissue in bin
- PRACTICING** physical distancing
- USING** personal protective equipment
- CLEANING** high touch surfaces

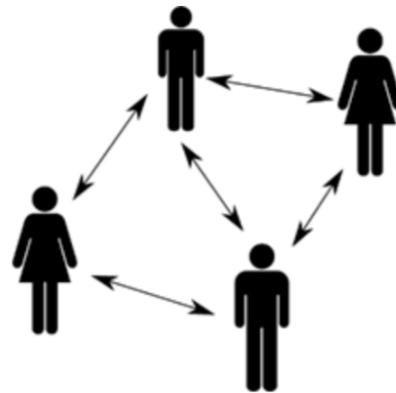


(Australian Commission, 2020)

Physical Distancing

Physical distancing means staying at least 2 metres (or 6 feet) away from other people whenever possible.

The purpose of physical distancing is to prevent droplets from an infected person from being dispersed into the environment and onto people within 2 metres (or 6 feet) distance.



(Public Health Ontario, 2020)

Physical Distancing (continued)



There are posters and other visual reminders in the home to reinforce the need to physically distance. You may find these in common areas, such as break rooms, screening stations. Please follow visual reminders in the home and practice physical distancing.

(Public Health Ontario, 2020)

Workplace Clothing Precautions



Studies have shown that germs can live on healthcare uniforms (e.g. scrubs) and fabrics when providing direct care.

If you provide direct care, it is **strongly recommended** that you bring a set of clothes/uniform to change into before your shift and to change out of after your shift and before leaving the long-term care home.

Respiratory Hygiene/Etiquette



Cough/sneeze into
your sleeve if no
tissue is available.



Cover your nose and
mouth with a tissue.



Immediately dispose
the tissue in a waste
bin after each use.



Wash your hands
with soap and water
or alcohol-based
hand rub.

Active Screening Part 1: Symptoms

Long-term care homes
must actively screen
all staff, essential
visitors and anyone
else entering the home
for COVID-19.

Active screening is
identifying if anyone has a
fever, cough or symptoms
of COVID-19, including
temperature checking

Please complete the **electronic** screening tool prior to entering/exiting home and be prepared to have your temperature taken **when entering and exiting the home.**

Active Screening Part 2: Rapid Test

Long-term care homes must implement mandatory rapid antigen testing by March 15th 2021

Rapid antigen testing will be completed immediately after initial symptoms screening on the day of entry.

Once the test is complete, do not have any resident contact for 15 minutes.



Rapid test can be done in 3 ways:

- 1) NP Swab
- 2) Deep Nasal (2.5cm swab into both nares) *Self-swabbing available
- 3) Throat and Nostril

Note: Only one rapid antigen test to be completed per day.
Documentation can be given if individuals are going to multiple homes.

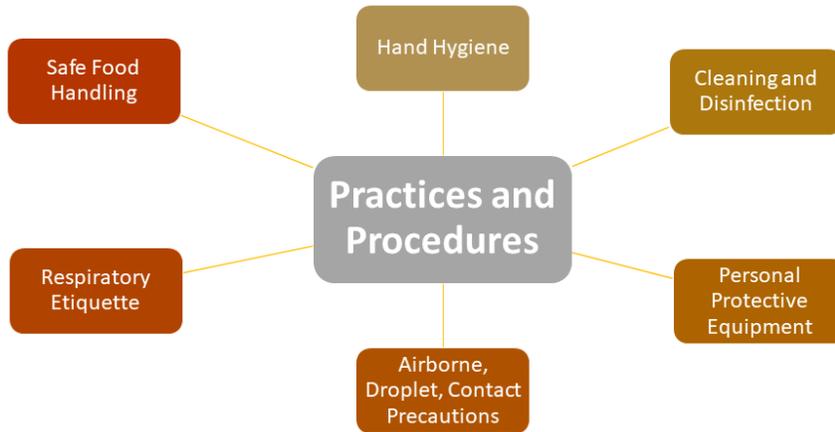
* Self-swabbing conducted with **supervision**

What is Infection Prevention and Control (IPAC)?

Infection Prevention and Control (also known as IPAC) are practices and procedures that can prevent or reduce the spread of germs.



Infection Prevention and Control



Why Hand Hygiene?

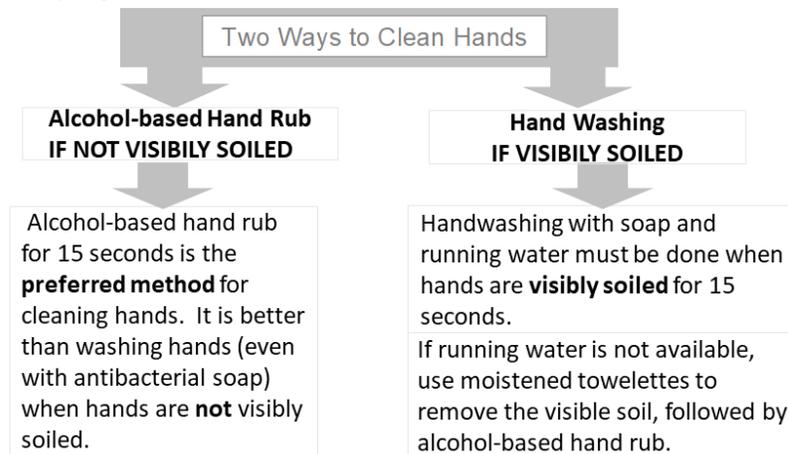


- Breaks transmission of organisms between residents
- Kills and removes organisms in 15 seconds
- Resident/client safety (health care associated infections is the 4th leading cause of death for Canadians)

4 Moments for Hand Hygiene

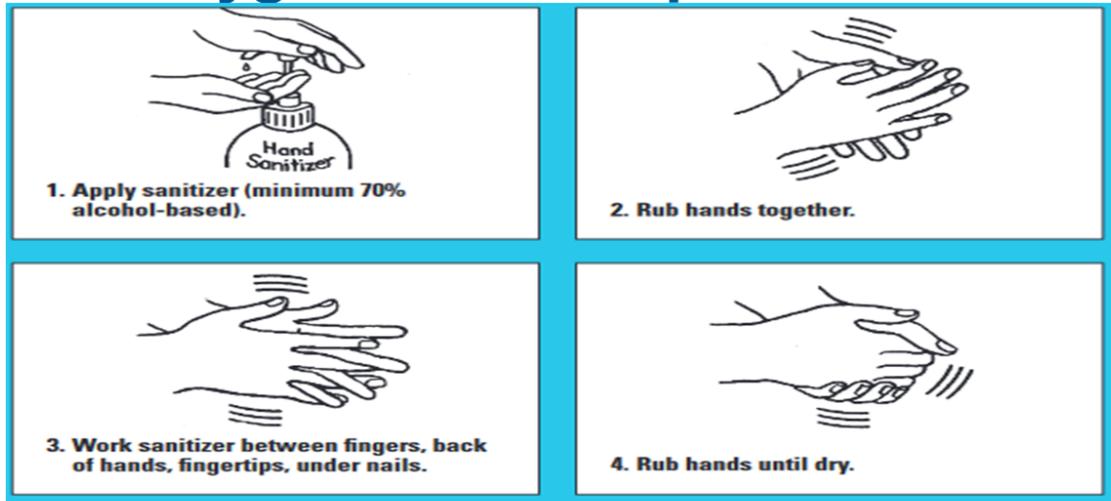


Hand Hygiene Techniques

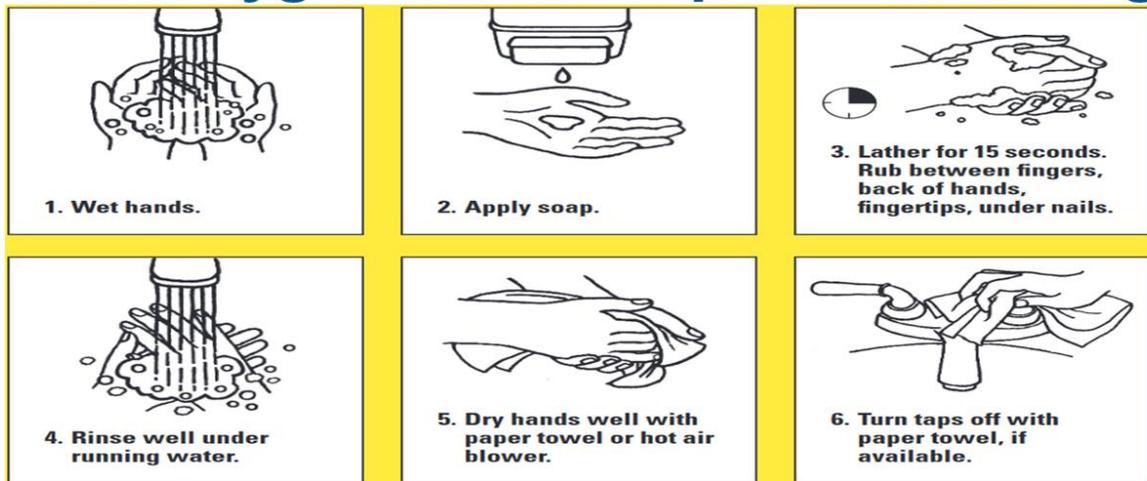


Adapted from Just Clean Your Hands Program Version 1.1, Public Health Ontario

Hand Hygiene Techniques - Sanitizer



Hand Hygiene Techniques – Washing



Hand Hygiene: When



- Before and after each resident contact.
- Before performing invasive procedures.
- Before preparing, handling, service or eating food.
- Before putting on and after taking off gloves and other PPE.
- After personal body functions (e.g. blowing one's nose).
- After touching items in the resident's room.
- After touching high-touch surfaces.
- After care involving body fluids and before moving to another activity.
- Whenever hands come into contact with secretions, excretions, blood and body fluids.

Factors that affect Hand Hygiene



Chipped nail polish or nail polish worn for more than four days has been shown to foster the presence of microorganisms which resist removal by hand washing.

When performing hand hygiene, nails should be free of nail polish.



It has been found that skin under jewelry may be more heavily colonized with microorganisms. Rings have been associated with tearing gloves.

Jewelry (e.g. watches, rings, bracelets) are to be removed by those having direct contact with a resident during hand hygiene.



Artificial nails can harbour microorganisms and have been associated with tearing gloves.

Artificial nails are not to be worn by those having direct contact with a resident.

COVID Suspected/ Confirmed Residents: Droplet and Contact Precaution



For affected COVID-19 floors, all residents will be under droplet contact precautions



GOWNS ARE REQUIRED



SURGICAL MASKS ARE REQUIRED



EYE PROTECTION (GOGGLES) ARE REQUIRED



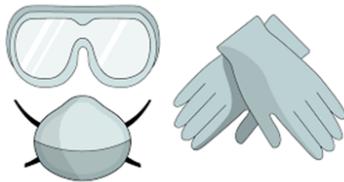
FACE SHIELDS ARE ALTERNATIVE TO GOGGLES



GLOVES ARE REQUIRED



Personal Protective Equipment (PPE)



Equipment worn to protect against germs that your body could be exposed to.

PPE includes gloves, gowns, masks, respirators, eye protection, and face shields.

Should be worn right before the activity that needs it and thrown out right after the activity.

Wearing PPE when it is not needed might accidentally spread germs in the environment.

Personal Protective Equipment (PPE)

Safe Handling Reminders



Gloves

- Do **not** clean or reuse gloves
- Do **not** put hand sanitizer on your gloves
- Always clean hands before putting on gloves and after taking them off



Gowns

- When removing a gown, unfasten the ties, peel the gown away from the neck and shoulders (turning it inside out), fold or roll into a bundle, and discard if disposable or place into identified hamper if reusable.



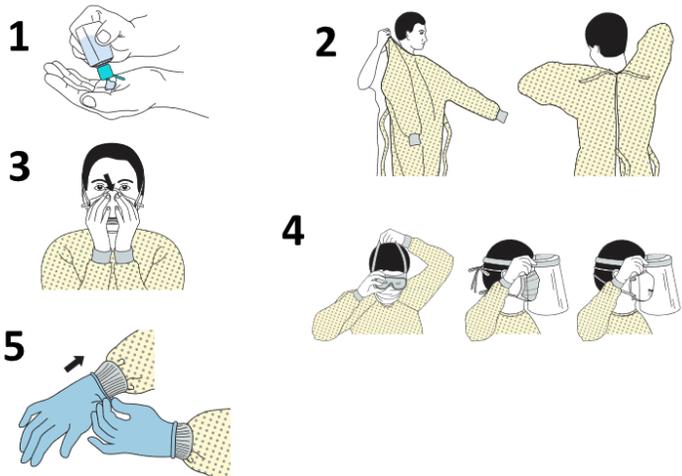
Masks

- Change your mask if it becomes wet.
- Do **not** hang masks around your neck or on the top of your head.
- Never touch your face without sanitizing first while wearing mask or any PPE.

Putting On Full PPE (Donning)

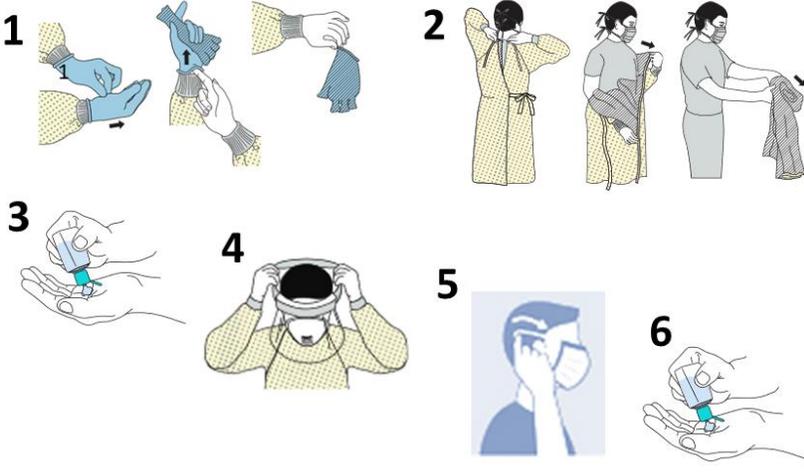
PUTTING ON PERSONAL PROTECTIVE EQUIPMENT

- | | | |
|----------|-------------------------------|---|
| 1 | PERFORM HAND HYGIENE |  |
| 2 | PUT ON GOWN |  |
| 3 | PUT ON MASK OR N95 RESPIRATOR |  |
| 4 | PUT ON EYE PROTECTION |  |
| 5 | PUT ON GLOVES |  |

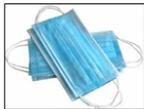


Taking Off Full PPE (Doffing)

REMOVING PERSONAL PROTECTIVE EQUIPMENT		
1	REMOVE GLOVES	
2	REMOVE GOWN	
3	PERFORM HAND HYGIENE	
4	REMOVE EYE PROTECTION	
5	REMOVE MASK OR N95 RESPIRATOR	
6	PERFORM HAND HYGIENE	



Mask Guidelines



Ear Loop Surgical Masks



Discontinued N95 Pleats Plus

- All staff working in our long-term care homes will receive two surgical masks depending on work location and nature of work.
- The screener at the front door will dispense the mask(s) to staff accordingly. All staff must remove their personal mask upon entry to home and wear a medical-grade surgical mask provided by the screener.
- The surgical mask should not be removed unless:
 - it becomes visibly soiled, damaged,;
 - it becomes very moist, hard to breathe through;
 - it makes contact with a resident or their bodily fluids; or
 - on break consuming food or beverages in a designated break area
- All staff must wear a new surgical mask after their breaks and lunch
- **Always perform hand hygiene if you accidentally touch the front of your mask**

Safe Masking Reminders

DO'S	 <p>Clean your hands for 15 seconds before removing your mask</p>	 <p>Remove the mask using the ear loops</p>	 <p>Ensure that the inside (white side) of the mask is facing up and place on clean towel</p>	 <p>Clean your hands for 15 seconds after removing your mask</p>
	 <p>Do not hang the mask from one ear</p>	 <p>Do not leave your nose exposed</p>	 <p>Do not hang the mask around your neck</p>	 <p>Do not pull mask under your chin</p>

Safe Gown and Gloves Reminders

Gown and gloves should not be worn in hallways, common areas or at the nursing station.

Gowns and gloves are considered contaminated and must be removed before leaving resident room



Safe Eye Protection Reminders



Take care not to touch the outside of your goggle/face shield. If you do, perform hand hygiene immediately.

Goggle/face shield is not required in common areas (e.g. break rooms where physical distancing is maintained)

If the exterior of the reusable goggle/face shield is contaminated, remove it, perform hand hygiene and clean with low level disinfectant wipes.

How to Disinfect Eye Protection

- 1 • Perform hand hygiene
- 2 • Don new pair of medical gloves
- 3 • Remove face shield/goggle by only touching the back strap
- 4 • Using one disinfectant wipe at a time, thoroughly wipe/disinfect in the following order:
 - ⑩ *The interior; and*
 - ⑩ *The exterior of the visor/goggle*
- 5 • Ensure all surfaces of the eye protection remain wet as per disinfectant contact time

Aerosol-Generating Medical Procedures (AGMPs)

Wear N95 mask under the following conditions:



CPAP



Open Airway Suctioning



CPR during Airway Management



Nebulized Medication Administration

This is an excerpt from Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007

Airborne Precaution – AGMP only



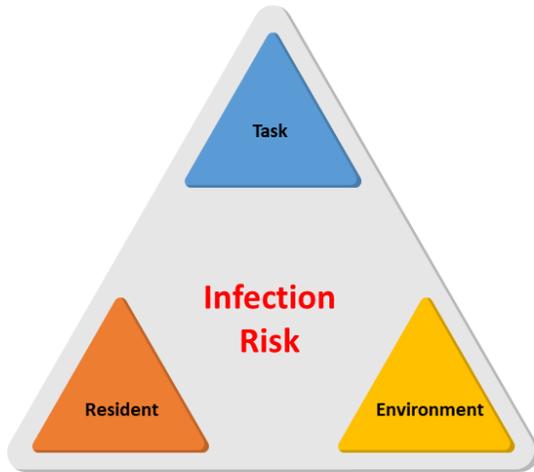
Airborne spread has not been a common mode of transmission for COVID-19. However, aerosols can happen with aerosol generating medical procedures (AGMPs). Therefore, one shall take airborne precautions if you are working with AGMPs for a suspected/confirmed COVID-19 case

For Airborne Precautions:

- Wear N95 Mask and Eye Protection during AGMPs in addition with droplet and contact precaution.
- Keep door closed at all times.

This is an excerpt from Routine Practices and Additional Precautions In All Health Care Settings (Appendix L)

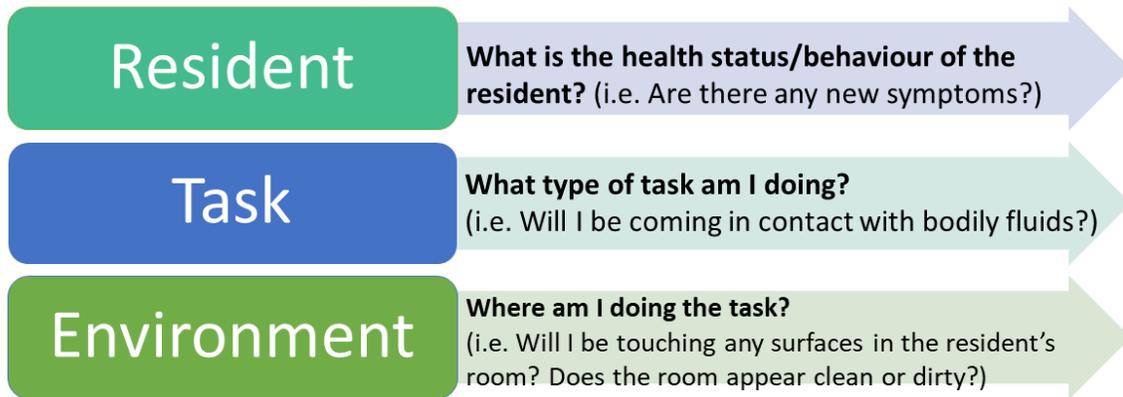
Point-of-Care Risk Assessment (PCRA)



- A point-of-care risk assessment (PCRA) is to determine what IPAC precautions you need to take **before** every resident interaction.
- The PCRA involves an assessment of the **resident, environment, and task** to determine whether you are at risk of being exposed to an infection.
- **All** staff who interact with residents or the resident environment should perform a PCRA.

How to Perform PCRA

To determine the appropriate actions, **ask yourself** these questions before every resident interaction.



Ask Yourself: Interaction

Will I have contact with the resident or their environment?



Perform hand hygiene before contact

Ask Yourself: Hand Exposure

Will my hands be exposed to blood, excretions, secretions, tissues, rashes, non-intact skin or contaminated items in the environment?



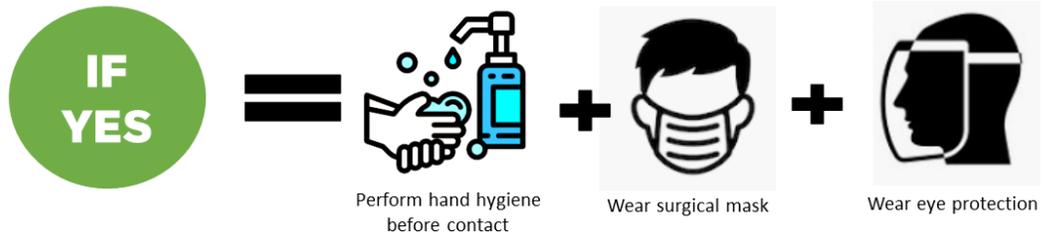
Perform hand hygiene before contact



Put on gloves

Ask Yourself: Face Exposure

Will my face be exposed to a splash, spray, uncontained cough or sneeze? Will I be within 2 metres of a coughing resident?



Ask Yourself: Bodily Fluids

Will my skin or clothing be exposed to splashes or items contaminated with blood, body fluids excretions, secretions or non-intact skin?



Ask Yourself: Aerosol/Airborne

Am I performing an aerosol-generating medical procedure (AGMP) on a resident with suspected or confirmed novel or emerging respiratory pathogen?



Cleaning and Disinfection

Keeping a clean and safe environment, such as cleaning and disinfecting high-touch surfaces, which is a key component of infection prevention and control.



High Touch Surfaces

High-touch surfaces are surfaces that are frequently touched throughout the day by multiple people. High-touch surfaces require cleaning and disinfection at least twice daily, and more frequently where the risk of contamination with germs is higher than usual.

Example: *doorknobs, light switches, elevator buttons, computer keyboard, handrails, overbed tables*



Cleaning and Disinfection

Cleaning

The physical removal of germs, dirt, body fluids, and dust of a surface.



Disinfection

The process of using chemicals to kill most germs on a surface.



Disinfecting Best Practices

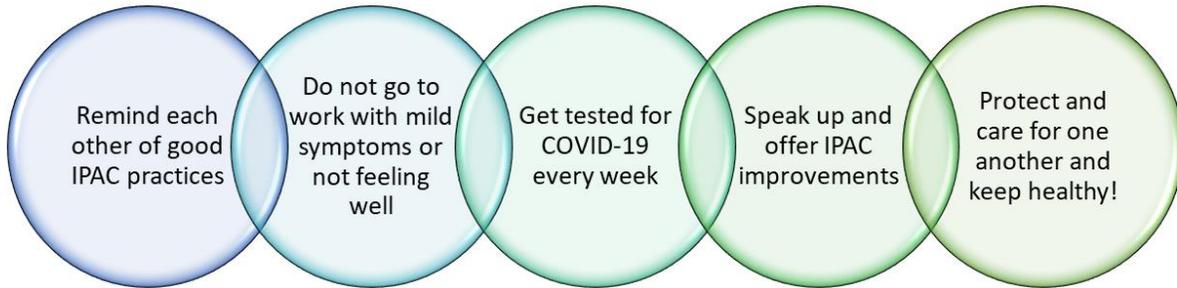
- Use Health Canada-approved disinfectants.
- Use disinfecting wipes to clean high touch surfaces
- If using disinfecting solutions, soak disinfectant into the paper towel or cloth.
- Wipe all areas accessible to touch, including handrails, chair handles, seats and dining table.
- A new area of the cloth should be used for each surface (*fold your cloth in half, and then in half again*)
- If a disinfectant bucket is used, never double-dip.
- Dispose of paper towel or cloth.

IPAC Practitioner



Reach out to your IPAC Practitioner and IPAC Champions if you have any questions, concerns, or recommendations for continuous improvement on IPAC and COVID-19

IPAC: Everyone's Responsibility



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