Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-05	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	BOIL WATER ADVISORY		July 2022

SUMMARY

Loss of Water Supply may result in failure of facility systems such as loss of:

- Safe drinking water supply.
- Domestic water supply for toilets, bathing, etc.
- Use of equipment requiring water supply, e.g., steam cooker, coffee urns, washers.

ALTERNATE WATER SUPPLY

In the event of a water main break or other disaster resulting in the interruption of normal water supply, arrangements should be made to access water from nearby fire hydrant. Facility water system can be set up with a "T" in line and special hose connectors to accept a 2-inch fire hose.

Note: Fire hydrant water may be treated or untreated water and may not be suitable for consumption, therefore, alternate potable sources of water will be needed.

The temporary water supply should be protected from freezing in cold climatic conditions. This can be achieved by wrapping the hose with batts of fiberglass insulation and keeping a substantial flow of water flowing, preferably through 3/4-inch pipe or by covering with electrical heating blankets.

Note: Public Health may issue a boil water advisory should the municipal water become contaminated. Should this occur, please follow the procedure as outlined below:

PROCEDURE

1. The kitchen will need to ensure that all water used in cooking, drinking and in beverages be brought to a rolling boil for a minimum of 1 minute before cooling.
   - Storing in clean sanitized containers with tight covers.
2. Notices not to drink the tap water will be posted at all water fountains and sinks.
3. The Charge Nurse/Incident Manager/Designate will contact Public Health to confirm that the water is safe for bathing and other direct uses on the skin.
4. Laundry can continue during a boil water advisory.

RELATED CHECKLISTS

- **"Boiled Water Advisory- Training Record of Attendance Checklist (05-01-03)"**

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-05	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	BOIL WATER ADVISORY		July 2022

IMPACT OF LOSS/CONTINGENCY PLANS

Facility specific impact of a boiled water advisory:

Bottled water would be brought in and move to disposable dining wear as dishwasher would also be effected.

If needed pre-made meals would be sources from local restaurants and Sysco.

Add telephone numbers of any specific agency(s) required to the Emergency Telephone Lists: **2-01-015 "Departmental Emergency Telephone List"** and **01-03-07 "Emergency Telephone List"**

- **APPENDIX W: List of Bottled Water, Portable Toilet & Water Tank Suppliers Rep Contact Information**

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-06	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	NATURAL GAS LEAK		July 2022

PURPOSE

To provide clear direction on the process that must be followed to protect residents, staff, volunteers and property from potential emergencies related to natural gas.

DEFINITIONS

NATURAL GAS

Natural Gas is a hydrocarbon gas used as a fuel for appliances such as stoves, ovens, laundry driers, hot water heaters, centralized heating systems and backup generators. Natural gas can be explosive in the proper concentrations.

REGISTERED STAFF

Refers to Registered Nurses, Registered Practical Nurses, and Licensed Practical Nurses;

CARE STAFF

Refers to Healthcare Aides, Nursing Assistants, and Personal Support Workers

BACKGROUND

For safety purposes a Natural Gas Alarm has been installed in the kitchen and near gas fired appliances.

The Natural Gas Alarm is specifically designed to detect natural gas and other combustible gasses.

Sulfur based compounds are added to domestic natural gas services to aid in the detection in the event of a leak. At times this odour may be smelt in low concentrations without there being a leak.

SCOPE

This policy applies to all UniversalCare homes.

POLICY

In the event of a natural gas alarm is activated, a strong odor of natural gas is detected, or a visible leak has occurred the fire alarm will be activated and a Code Green (evacuation) will be activated.

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-06	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	NATURAL GAS LEAK		July 2022

PROCEDURES

NATURAL GAS ODOUR

ALL STAFF

1. From time to time, the gas stoves will emit a slight natural gas odour. This, however, does not mean there is a natural gas leak or build up in the area and does not pose a hazard. Turning on the exhaust fans over the stoves for a short period of time can dissipate the odour
2. If the light odour persists ventilate the area and notify the Maintenance Supervisor. If they are unavailable notify the Charge Nurse
3. If the odour is strong or a visible leak is detected, natural gas should be shut off (if shut off available), clear the area and notify the charge nurse or closest supervisor
4. Call the Fire Department 9-1-1

NATURAL GAS ALARM (If available in your facility)

ALL STAFF

1. If the natural gas alarm sounds, there is the potential that natural gas or other combustible gasses are present. The alarm will sound well before the levels reach a dangerous level.
2. Turn off all equipment in the area
3. Remove residents / staff from the area of the alarm
4. Notify the Charge Nurse or closest Supervisor
5. Call the Fire Department 9-1-1

INCIDENT MANAGER

1. Upon notification of a Natural gas Alarm or strong odour of natural gas, ensure all staff and residents are removed from the area beyond fire doors.
2. Determine the need for Code Green – evacuation. If it is determined that a partial or full evacuation is required, active the fire alarm and initiate an evacuation
3. Note: if there is a rupture to a natural gas line within the building a total emergency evacuation (“Code Green”) must be initiated immediately. Refer to **03-03-01 "Code Green Procedure"**
4. Call the Fire Department 9-1-1
5. Notify the Administrator/Designate and Supervisor of Building Operations

ACCOUNTABILITIES FOR COMPLIANCE

VP OF OPERATIONS/DESIGNATE

- Accountable for removing and reporting of barriers to compliance
- Responsible for supporting, advising and directing the home’s management team

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-06	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	NATURAL GAS LEAK		July 2022

- Accountable for promoting and confirming implementation and application of the policy within their region

ADMINISTRATOR

- Accountable for ensuring the home's operations align with corporate objectives and priorities and jurisdictional requirements

DIRECTOR OF CARE

- Accountable to oversee the implementation of the policy and procedures in the home
- Responsible for ensuring the policy and procedure is communicated to all persons having any type of working relationship with the home
- Accountable for ensuring each employee and volunteer is made aware of the contents of the policy through orientation and implementation of staff /volunteer training
- Responsible for ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the Natural Gas Leak policy and procedures

ALL STAFF

- Responsible to ensure that they understand and comply fully with the Natural Gas Leak policy

TRAINING AND EDUCATION

Kitchen and laundry staff will be fully trained on the proper use of the stoves and dryers as per the manufacturer's specifications

RELATED CHECKLISTS

- **"Code Green Checklist (03-03-01)"**
- **"Natural Gas Leak- Training Record of Attendance Checklist (05-01-03"**

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-07	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	UTILITIES DISRUPTION- HVAC		July 2022

STATEMENT OF INTENT

To ensure adequate heating, cooling and ventilation is maintained throughout Villa Marconi LTC Home.

HVAC equipment and hot water distribution system are located in Basement

- **APPENDIX X: Floor Plan Outlining Location of HVAC Systems**

Definition

HVAC – Heating, ventilation, air conditioning.

PROCEDURE

Registered Nurse

1. In the event of a HVAC system malfunction or breakdown, contact the Administrator.
2. Were the systems inspected and reset (if applicable)?
3. Investigate the cause of the malfunction/breakdown and contact the mechanical services company or utility as required.
4. Where the malfunction /breakdown is anticipated to be extended and temperatures are such that it will create an uncomfortable situation for residents (i.e. less than 18C or higher than 26C), notify the Administrator

Administrator

1. Upon notification of an HVAC system failure that is anticipated to be extended, assume the role of Incident Manager and assess the situation.
2. In consultation with the Director, Property and Environmental Services, service contractor, and / or utility, assess the potential restoration time and impact of the outage.
3. Keep staff informed of the actions being taken to resolve the outage.
4. In the event that a heating failure will be extended alternative plans shall include:
   - Providing extra blankets
   - Ensuring all curtains and blinds are closed
   - Limiting exterior door use
   - Moving residents into a lounge or other room where multiple people will provide warmth
   - Using supplemental heating units (e.g. electric heaters) in closely supervised situations
   - Discharging appropriate residents to family until the heat is restored
   - Non-emergency evacuation in situations where the temperature becomes a health or safety risk
5. In the event that a cooling failure will be extended alternative plans shall include:

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-07	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	UTILITIES DISRUPTION- HVAC		July 2022

- Implement NP 05-04-08: Hot Weather Prevention and Illness Management plan
- Providing cold beverages and snacks (popsicles, ice cream, etc.) to residents and staff
- Ensuring all curtains and blinds are closed to areas exposed to the sun
- Moving residents out of rooms where the exterior walls are being exposed to the sun
- Limiting exterior door use if the outdoor temperature is higher than the indoor temperature
- Opening windows and exterior doors, with proper supervision, during cooler night time hours
- Discharging appropriate residents to family until the cooling is restored
- Non-emergency evacuation in situations where the temperature becomes a health or safety risk

6. The Incident Manager shall complete an critical incident report outlining the cause and length of the outage and the solutions implemented to restore the HVAC for all HVAC failures that last more than 2 hours where the temperature drops below 22C or exceeds 26C.

IMPACT OF LOSS/CONTINGENCY PLANS

Facility specific impact of an HVAC Utilities Disruption, listing equipment or systems that will not operate without HVAC systems and identify cooperative arrangements.

IMPACTED EQUIPMENT
-Heating
-A/C to Specialty Unit

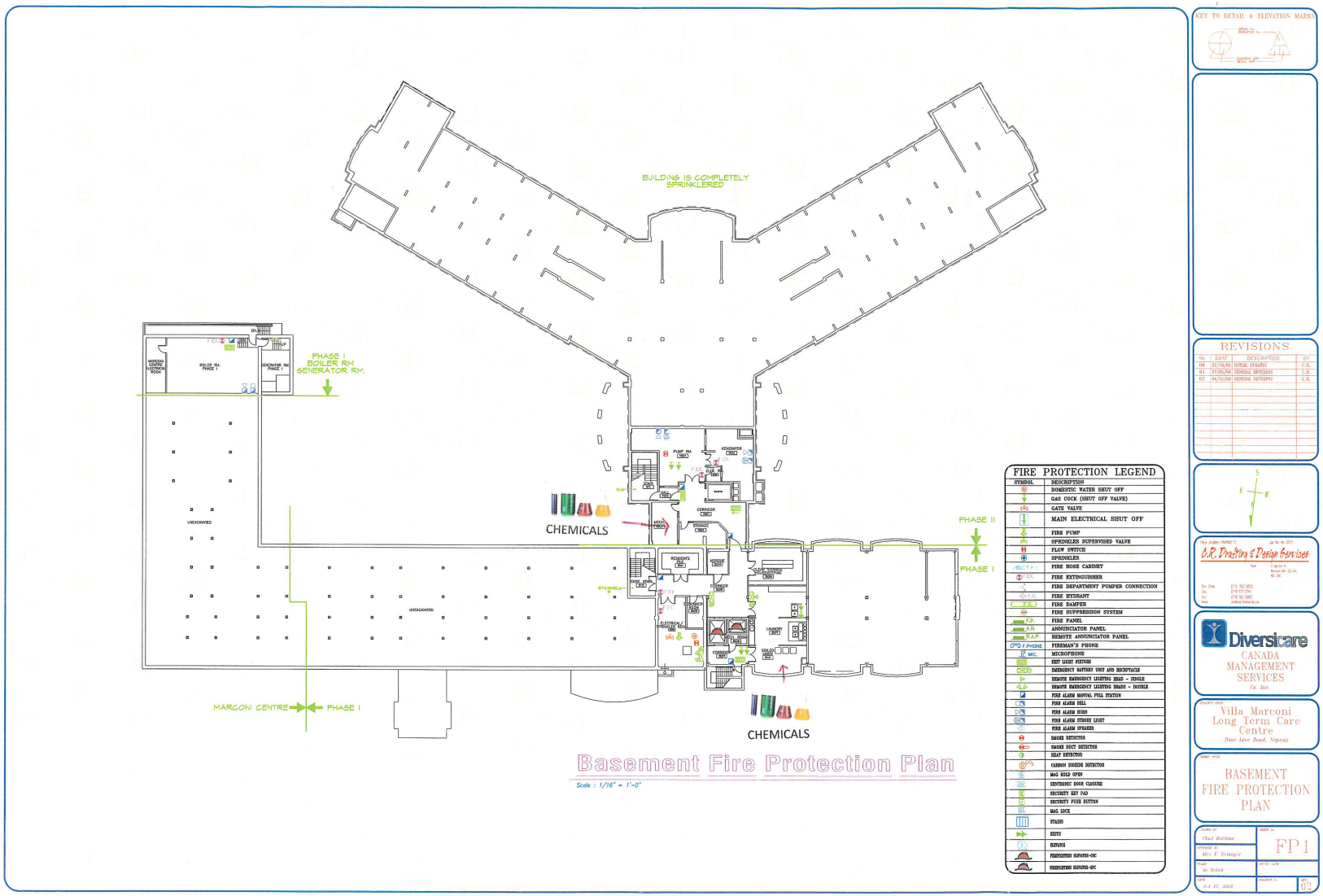
Alternatives
-portable heating units are available
-portable a/c units are available

Add telephone numbers of any specific agency(s) required to the Emergency Telephone Lists: (**02-01-015 "Departmental Emergency Telephone List"**) and **01-03-07 "Emergency Telephone List"**

APPENDIX K: Copies of Cooperative Arrangements

UNIVERSALcare

Floor Plan Outlining Location of HVAC Systems



Section: CORPORATE AND ADMINISTRATIVE ORGANIZATION	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-08	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	UTILITIES DISRUPTION- CARBON MONOXIDE ALARMS		July 2022

PURPOSE

To provide clear direction on the process that must be followed to protect residents, staff, and volunteers from potential emergencies related to carbon monoxide.

BACKGROUND

For safety purposes Carbon Monoxide alarms have been installed in the strategic positions in the home.

Carbon Monoxide is not combustible in atmospheric levels and does not pose a fire / explosion hazard.

Carbon Monoxide alarms alert to the possible presence of a higher concentration of carbon monoxide.

The most common symptoms of carbon monoxide poisoning may resemble other types of poisonings and infections, including symptoms such as headache, nausea, vomiting, dizziness, fatigue, and a feeling of weakness. In higher or prolonged concentrations, it can lead to confusion, disorientation, visual disturbance, syncope, seizures, and death.

The most common source for carbon monoxide in buildings are fuel burning appliances such as gas stoves, water heaters, furnaces, gas dryers, and generators.

SCOPE

This policy applies to all UniversalCare homes.

POLICY STATEMENT

All gas fired appliances will be properly inspected and maintained as per the manufacturer's recommendations.

Carbon Monoxide detectors will be installed in any room with a fuel burning appliance such as the kitchen, laundry, HVAC equipment rooms etc. In addition, a Carbon Monoxide alarm will be installed at each nursing station.

DEFINITIONS

Carbon Monoxide (CO)

A colorless, odorless, and tasteless gas that is slightly lighter than air. Carbon Monoxide is naturally occurring in the atmosphere; however, it can be toxic to humans when encountered in higher concentrations

Nurse(s):

Refers to Registered Nurses, Registered Practical Nurses, and Licensed Practical Nurses

Section: CORPORATE AND ADMINISTRATIVE ORGANIZATION	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-08	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	UTILITIES DISRUPTION- CARBON MONOXIDE ALARMS		July 2022

Care Staff:

Refers to Healthcare Aides, Nursing Assistants, and Personal Support Workers

PROCEDURES

CARBON MONOXIDE ALARM

INCIDENT MANAGER

If a carbon monoxide alarm sounds, there is the potential that higher than normal levels of carbon monoxide are present. The alarm will sound well before the levels reach a dangerous level.

When you hear the alarm:

1. Remove residents and staff from the area or home area affected
2. Open the windows and outside doors leading to that area
3. Turn off all fuel burning appliances in the area (e.g., stove, dryer)
4. Call for a service technician to attend
5. Notify the Maintenance Manager/Designate and Administrator
6. In the event of residents / staff feeling ill call 9-1-1 and commence a Code Green (Evacuation) for the area where the alarm has been activated

- **APPENDIX Y: Floor Plan Outlining Location of Carbon Monoxide Alarms**

ACCOUNTABILITIES FOR COMPLIANCE

STAFF

- Responsible to ensure that they understand and comply fully with the policy and procedures

VP OF OPERATIONS/DESIGNATE

- Accountable for removing and reporting of barriers to compliance
- Responsible for supporting, advising, and directing the home's management team
- Accountable for promoting and confirming implementation and application of the policy within their region

ADMINISTRATOR

- Accountable for ensuring the home's operations align with corporate objectives and priorities and jurisdictional requirements

DIRECTOR OF CARE

- Accountable to oversee the implementation of the policy and procedures in the home

Section: CORPORATE AND ADMINISTRATIVE ORGANIZATION	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-08	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	UTILITIES DISRUPTION- CARBON MONOXIDE ALARMS		July 2022

- Responsible for ensuring the policy and procedure is communicated to all persons having any type of working or non-working relationship with the home
- Accountable for ensuring each employee and volunteer is made aware of the contents of the policy through orientation and implementation of staff / volunteer training
- Responsible for ensuring that at least once in every calendar year, an evaluation is made to determine the effectiveness of the policy and procedures

Facility specific impact of a Carbon Monoxide Alarm, listing equipment or systems that will not operate during this time and identify cooperative arrangements.

HVAC
Stoves
Boiler
Gas Dryers

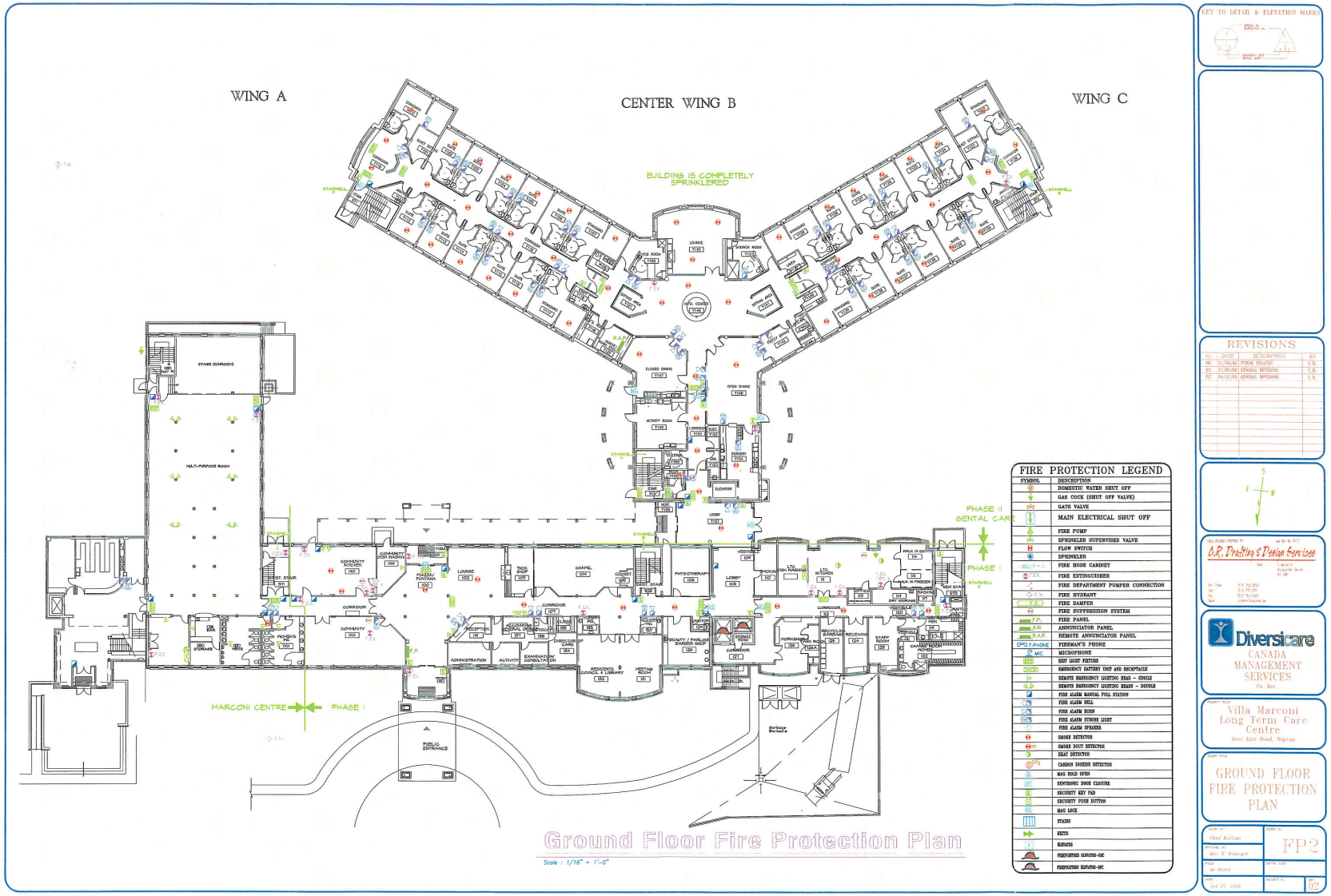
If carbon monoxide alarms did not operate additional alarms would be purchased. In the meantime, gas equipment will be turned off.

Add telephone numbers of any specific agency(s) required to the Emergency Telephone Lists: (**02-01-015 "Departmental Emergency Telephone List"**) and **01-03-07 "Emergency Telephone List"**

- **APPENDIX K: Copies of Cooperative Arrangements**

UNIVERSALcare

Floor Plan Outlining Location of Carbon Monoxide Alarms



Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-09	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	FLOODING		July 2022

PURPOSE

Each Administrator/Designate will determine, by contacting the local CEMC (Community Emergency Management Coordinator) whether or not the facility is located on a flood plain.

POLICY- Facility is <u>not located</u> on a flood plain

If the Long-Term Care facility is <u>not located</u> on a flood plain a major flood requiring the evacuation of the facility or having a long-term impact is an extremely low risk. The types of flooding that may impact the facility include:

- Sudden surface water entering the building due to torrential rain or sudden snow melt
- Back up of sewage lines
- Broken water main or other water line

PREVENTION

The Administrator/Designate shall ensure the following:

1. Snow will not be piled or allowed to accumulate immediately next to the building in large volumes.
2. Ditches, creeks, drainage piles will be maintained and kept clear of debris.
3. Sump pumps will be maintained and checked weekly by the maintenance department.
4. Staff noticing a back up of water or sewage anywhere in the building will immediately contact the maintenance department.
5. Backflow preventors will be installed on all outgoing sewage and drainage lines that have the potential to back up into the building.

RESPONSE

1. With the prevention strategies noted, any flooding that could occur will be minor and localized to nonresident areas such as the basement.
2. Maintenance should be immediately notified and provide a report to the Administrator within 30 minutes, if a resident area is impacted.
3. If a resident area is impacted the resident(s) will be moved to a non-impacted area until the situation can be resolved.
4. The area will be assessed for secondary risks (e.g., electrical wires impacted) and appropriate action taken.
5. Attempt to conceal the flood (where applicable).
6. Emergency numbers (available 24 hours a day) for building restoration companies that provide pumps, wet vacuums, fans, and other equipment and/or staffing will be maintained at each site.
   - **APPENDIX A- Master Emergency Telephone List.**

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-09	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	FLOODING		July 2022

POLICY- Facility is located on a flood plain

If the Long-Term Care home is located on a flood plain a major flood requiring the evacuation of the facility or having a long-term impact is an extremely high risk. The types of flooding that may impact the facility include:

- Sudden water entering the building due to torrential rain or extreme weather, high sea levels etc.
- Back up of sewage lines
- Broken water main or other water line

PREVENTION

The Administrator/Designate shall do the following:

- Through the CEMC determine the high-water risks.
- Take the high-water risk level and multiply it by 1.5 to identify potential worst-case scenario.
- Once the worst-case scenario has been identified or has been calculated, identify the impact points on the property and buildings. Including basements and underground infrastructure such as elevator pumps. Elevator shafts and hydraulic equipment may be located up to 5m below the lowest floor the elevator travels to.
- In a worst-case scenario anticipate the failure of sump pumps and drainage lines.
- With the high-level water identified at the property of the building the Administrator/ Designate will make a list of the potential impacts of flooding. Including but not limited to:
  - Flooding Elevator hydraulics
  - Electrical wiring and outlets
  - Fuse panels
  - Computer equipment and servers
  - Laundry
  - Kitchen
  - Offices
  - Document storage
  - Resident rooms
  - Generators
  - HVAC equipment
  - Access to parking
  - Fire escapes
- Once the points of failure have been identified, an assessment of the risks and vulnerabilities based on each point of failure must be measured.

FLOOD PLAN

- The impacts of these points of failure on residents, staff and visitors must be taken into consideration with a flood plan created.

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-09	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	FLOODING		July 2022

- Depending on the severity of the flood the plan may include the evacuation of some or all residents.
  - **Code Green: 03-03-01 "Procedure"**
- With the anticipation of a possible flooding incident be sure to consult with you local CEMC during plan development.
- The Administrator or Designate is always responsible for monitoring the potential risks and taking action to prevent or mitigate those risks.
- The flood plan when developed by the Administrator will be sent to the Vice President of Operations/Designate for approval.

Other potential prevention and mitigation steps:

- Assess the current sump pumps for load capacity
- Monitor drainage and runoff infrastructure
- Assess whether sand bagging or flood barriers would be useful
- Assess the roadways and access to the home to ensure entry via local roads
- If the home is in a flood-prone area, consider engineered options such as berms

Response

1. Even with the prevention strategies noted, due to the facilities flood plain location any flooding that occurs can be major and located in all areas of the home.
2. Maintenance should be immediately notified and provide a report to the Administrator within 30 minutes, if a resident area is impacted.
3. If a resident area is impacted the resident(s) will be moved to a non-impacted area until the situation can be resolved.
4. Some flood may require a total evacuation or residents
   - **Code Green: 03-03-01 "Procedure"**
5. Notify the CEMC of any potential flooding incident.
6. The area will be assessed for secondary risks (e.g., electrical wires impacted) and appropriate action taken.
7. Emergency numbers (available 24 hours a day) for building restoration companies that provide pumps, wet vacuums, fans, and other equipment and/or staffing will be maintained at each site.
   - **APPENDIX A- Master Emergency Telephone List.**

RELATED CHECKLISTS

- **"Flooding- Training Record of Attendance Checklist (05-01-03)"**

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: PLANNING FOR LOSS OF SERVICES	Policy #: 02-03-09	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	FLOODING		July 2022

Flood Plan Summary: List Facility specific details i.e whether or not the facility is located on a Flood Plain and the potential risks:

Villa Marconi is not located on a Flood Plain.

- **APPENDIX Z: Facility Flood Plan, Photo of Flood Plain Location and Surrounding Area**

Section:	Subject:	Policy #: 02-04-01	
EMERGENCY PREPAREDNESS: PRE-PLANNING	PLANNING FOR CHEMICAL SPILL	Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	CHEMICAL SPILL/HAZARDOUS MATERIAL		July 2022

SUMMARY

Chemical spill and disposal are often categorized by type, volume and location. Preparedness and handling procedures will involve the expertise of government personnel from the Ministry of Labour, Occupational Health and Safety and Hazardous Materials Department.

The facility should determine criteria for “major” and “minor” spills and assess provincial and city resources for the handling of these chemical spills, as well as disposal of hazardous material procedures.

In that specific actions will be dependent on the type of chemical volume and location, it is important that agencies that have responsibility and authority in these circumstances be identified for the facility.

Add telephone numbers to the Emergency Telephone Lists (**02-01-015 "Departmental Emergency Telephone List"**)

List Chemical Spill Agency and Government Department Contact Information

Provincial Environmental Agency-Ministry of Environment 416-325-4000 or 1-800-564-4923

Provincial Spills Action Centre-416-325-3000 or 1-800-268-6060

Refer to: **03-07-01 "Code Brown- Procedure"**

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	DISASTER BOXES		July 2022

SUMMARY

\Disaster Box(es) shall be prepared by the home and will contain articles needed in the event of an emergency response requiring evacuation. The Disaster Box(es) will be boldly labeled, easily transportable, and stored at 2 separate locations - one at a nursing station and one in the designated Emergency Operations Centre

GUIDELINES

CONTENTS OF THE DISASTER BOX(ES)

- Recommended contents for the Disaster Box at the nursing station:
- Foil blankets – 1 per resident
- Emergency Response Binder including:
- Staff Call Back List
- Telephone list of government agencies and emergency services
- Floor Plans
- Emergency Response Logs – (25)
- White tags or adhesive labels for name tags for employees, residents, volunteers, and other agencies, along with markers
- Pens, felt markers, and grease pencils
- Flashlight(s)/separate batteries or wind-up flashlights (minimum of 2)
- Glow sticks (A minimum of 4 each: green, yellow, red, blue)
- Adhesive backed directional arrows
- Clipboards (minimum of 2)
- Notepads
- 2 orange/neon safety vests
- Roll of “Caution tape” to block off access (e.g. triage area, etc.)
- 2 pairs – paramedic shears/scissors
- 2 pair- work gloves
- 2 bottles – hand sanitizer
- Small first aid kit with pressure dressings
- 1 box surgical masks
- 1 box disposable medical gloves - large
- Recommended contents for the Disaster Box in the Emergency Operations Centre:
- Portable radio (wind up)
- Analogue telephone
- Emergency Response Binder including:
- Staff Call Back List
- Telephone list of government agencies and emergency services
- Floor Plans
- Emergency Response Logs – (25)
- White tags or adhesive labels for name tags for employees, residents, volunteers, and other agencies, along with markers

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	DISASTER BOXES		July 2022

- Pens, felt markers, and grease pencils
- Flashlight(s)/separate batteries or wind-up flashlights (minimum of 2)
- Glow sticks (A minimum of 4 each: green, yellow, red, blue)
- Adhesive backed directional arrows
- Clipboards (minimum of 2)
- Notepads
- 2 orange/neon safety vests
- Roll of “Caution tape” to block off access (e.g., triage area, etc.)
- 2 pairs – paramedic shears/scissors
- 2 pair- work gloves
- 2 bottles – hand sanitizer
- Small first aid kit with pressure dressings
- 1 box surgical masks
- 1 box disposable medical gloves - large

ACCOUNTABILITIES FOR COMPLIANCE

ADMINISTRATOR

Responsible for ensuring that the two disaster boxes are fully stocked, and information contained (staff lists, telephone numbers etc.) are updated monthly

Administrator will ensure the packages are **checked regularly** and **monitored for expiry dates**

DIRECTOR OF CARE

Responsible for ensuring that all the staff are aware of the location of the disaster boxes and know to remove them during an evacuation

INCIDENT MANAGER

Responsible for ensuring that the disaster kits are removed from the building to the evacuation meeting area in the event of an evacuation (where safe to do so)

Outline the locations of your Disaster Box Below:

At the 3 Nursing Stations and Primary Command Centre.

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-02	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	FOOD AND FLUID PROVISIONS		July 2022

PURPOSE

The importance of home-level planning in the event of an emergency/disaster regarding food and fluid provisions.

POLICY

All homes must ensure they have a signed Memo of Understanding with their Food/Fluid Vendors.This agreement must outline pre-arranged support or alternate source for emergency resources including food, disposables and bottle water available as needed during a disaster situation.

PROCEUDRE

The home's Administrator along with the Food Service Manager must develop a home specific Food and Fluid Provisions Plan.

1. Review your Vendors Disaster Contingency Plan
   - **APPENDIX AA: Food/Fluid Vendor Disaster Contingency Plan**
2. Assess your Dietary Inventory Stockpile to ensure there are at least 72 hours of Food/ Fluids available on-site in the event of an Emergency. Refer to: **02-05-03 "Dietary Inventory"**
3. Plan your Food and Fluid inventory based on the example Emergency Menus provided by your Food and Fluid Vendor.
   - **APPENDIX AB: Emergency Menus Day 1-3, No Power**
   - **APPENDIX AC: Emergency Menus Day 1-3, No Water**
4. Develop a Dietary Staffing Contingency Plan
   - **APPENDIX AD: Dietary- Staffing Contingency Plan**
5. Coordinate with Volunteer Services and/or an Ontario Health Team (where applicable) to consider what roles can be outsourced i.e bringing in pre-prepared meal services and dietary aides to support residents with eating etc.

List Alternative Food/Fluid Vendors/Partners:

-Sysco: 1-855-222-0617
-Cardinal Health (for nutrition for protein drinks) 1-877-778-7778
-Local grocery stores: Ayra Food Market 613-594-3636
Loblaws 613-232-4128

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-02	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	FOOD AND FLUID PROVISIONS		July 2022

Food/Fluid Rep General Contact Information:

Sysco: 1-855-450-3069

FOOD AND FLUID PROVISIONS PLAN: CONTENT OVERVIEW

- **APPENDIX AA: Food/Fluid Vendor Disaster Contingency Plan**
- **APPENDIX AB: Emergency Menus Day 1-3 No Power**
- **APPENDIX AC: Emergency Menus Day 1-3 No Water**
- **APPENDIX AD: Dietary- Staffing Contingency Plan**
- **APPENDIX AE: Food/Fluid Vendor Memo of Understanding**
- **APPENDIX AF: Dietary Inventory Form**
- **APPENDIX AG: Food/Fluid Vendor Rep Contact Information**

References

- LTC Emergency Preparedness Manual P.15

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: DIETARY REQUIREMENTS	Policy #: 02-05-03	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	DIETARY INVENTORY		July 2022

POLICY

It will be important that the Food Services Manager to be able to approximately project the number of days the usual inventory of key food and supply products would last in the event the facility was unable to access additional supplies for a period of 72 hours.

Note: The Nursing Home Act 2007, Regulation 79/10, S72(2)b states that the food production system must, at a minimum, provide for; (a) 24 hour supply of perishable and a three day supply of non-perishable foods; (b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable

Sample Form - Dietary Inventory

FOOD ITEMS	# OF DAYS IN INVENTORY	COMMENTS
Milk	5-7	
Bread	4-5	
Juice	5	
Eggs	3	
Water.	240 bottles + 8 2L Jugs	
SUPPLY ITEM	**# OF DAYS IN INVENTORY**	**COMMENTS**
Paper Plates	6	
Paper Cups	3	
Knives	14	
Forks	14	
Spoons	10	
Etc.		

- **APPENDIX AF: Dietary Inventory Form**

To print above form refer to **"Dietary Inventory Form (02-04-01)"**

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-04	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	DRUG PROVISIONS		July 2022

PURPOSE

To ensure that each Home has a Drug Provisions Plan agreement with their pharmacy.

PROCEDURE

Administrator

The Administrator of each Home will ensure their pharmacy has a Emergency and Evacuation Contingency Plan for the provision of medication to the Long-Term Care facility. A copy of this plan will be provided to the Administrator along with 24/7 contacts in the event of an emergency.

The Emergency and Evacuation Contingency Plan must include storage and back up of prescriptions and medication records, ensuring adequate supply of medication along with a backup plan if supplies run short, and a delivery plan with back up delivery methods identified. The plan must clearly demonstrate the steps the pharmacy will take to ensure the consistent reliability of medication, even in an emergency or disaster situation.

Registered Staff

1. Notify the Administrator immediately of any drug provision challenges.
2. Work with the physician and pharmacist to identify options should a specific medication not be immediately available.

Pharmacy General Contact Information:

Care Rx Pharmacy
Phone #: 1-866.970-1950
Rep: Dan

DRUG PROVISIONS PLAN: CONTENT OVERVIEW

- **APPENDIX AH: Pharmacy Emergency Service Memo of Understanding**
- **APPENDIX AI: Pharmacy Emergency and Evacuation Contingency Plan**
- **APPENDIX AJ: Pharmacy Rep Contact Information**

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-05	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	HAND HYGIENE PRODUCTS		July 2022

PURPOSE

Resource Stockpiling is a tool used in the event of an Emergency/Disaster to ensure the homes have the necessary tools to support residents and maintain operations.

When developing a resource list and planning for its use, homes may consider:

- Completing assessments of each resident's resource needs,
- Estimating short-term resources that must be available immediately, and whether longer-term resource requirements may become necessary,
- Consulting different departments within the home,
- How resource stockpiles may differ based on if and where residents will need to be evacuated,
- Where stockpiles can be stored and how they can be monitored and managed to avoid expiry,
- Determining how many weeks of supplies might be required

Note: Resource Stockpiling is not limited to Hand Hygiene and Cleaning Supplies. Other Resources/Equipment required in an emergency can be added to your inventory lists, utilizing the same rationale and inventory management practices.

DEFINITION

Hand Hygiene

A general term referring to any action of hand cleansing. Hand hygiene includes the following products:

- Alcohol Based Hand Run
- Antimicrobian Medicated Soap
- Antiseptic Agent
- Antiseptic Hand Wipe
- Detergent
- Plain Soap
- Waterless Antiseptic Agents

POLICY

Homes must ensure that they have **at least 2- weeks** of stock for all Hand Hygiene Products on hand in the event of a Emergency/Disaster.

This includes, but is not limited to the following:

- Alcohol Based Hand Rub: Individual and Wall Pumps
- Resident Shampoo/Body Wash
- Detergent

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-05	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	HAND HYGIENE PRODUCTS		July 2022

- Hand Soap

For your Alcoholic Hand Rubs (individual pumps) account for the following:

- The total number (#) of resident beds
- Daily burn rates.

For your Alcoholic Hand Rubs (Wall pumps) account for the following:

- The total number (#) of wall pumps in the facility
- Daily burn rates

For all other Hand hygiene Products:

- Monitor your Daily Burn Rates to determine what would be required to have on hand for 2-weeks based on the size of your home.

- **APPENDIX AK: Resource Stockpiling: List of Vendors and Rep Contact Information**
- **APPENDIX AL: Resource Stockpiling: Inventory Lists**

INVENTORY MANAGEMET

1. Create an itemized list outlining your current inventory i.e item name, lot #, quantity and expiry date.
   - **APPENDIX AL: Resource Stockpiling: Inventory Lists**
2. Monitor Daily Burn Rates to ensure stockpile quantities are maintained in accordance to these rates. If changes need to be made, update/replenish stockpile quantities as required.
3. Monitor expiration dates weekly and rotate stockpile based on these dates.

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-05	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	HAND HYGIENE PRODUCTS		July 2022

Vendor Names and General Contact Information:

Cardinal Health - 1-877-878-7778
Sales Rep: Melanie

Natura Lifestyle:
Sales Rep: Ralph
Phone: 905-264-5274

Ecolab
1-800-352-5326

References

- LTC Emergency Preparedness Manual, Pg: 16
- WHO Guidelines: Hand Hygiene in Healthcare

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-06	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	CLEANING SUPPLIES		July 2022

PURPOSE

Resource Stockpiling is a tool used in the event of an Emergency/Disaster to ensure the homes have the necessary tools to support residents and maintain operations.

When developing a resource list and planning for its use, homes may consider:

- Completing assessments of each resident's resource needs,
- Estimating short-term resources that must be available immediately, and whether longer-term resource requirements may become necessary,
- Consulting different departments within the home,
- How resource stockpiles may differ based on if and where residents will need to be evacuated,
- Where stockpiles can be stored and how they can be monitored and managed to avoid expiry,
- Determining how many weeks of supplies might be required

<u>Note:</u> Resource Stockpiling is not limited to Hand Hygiene and Cleaning Supplies. Other Resources/Equipment required in an emergency can be added to your inventory lists, utilizing the same rationale and inventory management practices.

DEFINITION

Cleaning Supplies

Cleaning material means a solvent used to remove contaminants and other materials such as dirt, grease, oil, and dried (e.g., depainting) or wet coating from a substrate before or after coating application; or from equipment associated with a coating operation, such as spray booths, spray guns, tanks, and hangers.

This may include, but is not limited to the following:

- Hydrogen Peroxide Disinfectants
- Multipurpose Cleaner
- Floor Cleaner
- Garbage Bags
- Alcohol
- Chlorine and chlorine compounds
- Formaldehyde
- Glutaraldehyde
- Iodophors
- Ortho-phthalaldehyde (OPA)
- Peracetic acid
- Peracetic acid and hydrogen peroxide
- Phenolics
- Quaternary ammonium compounds

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-06	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	CLEANING SUPPLIES		July 2022

POLICY

Homes must ensure that they have **at least 2- weeks** of stock for all Cleaning Supplies on hand in the event of a Emergency/Disaster.

Cleaning Supplies:

- Monitor your Daily Burn Rates to determine what would be required to have on hand for 2-weeks based on the size of your home.

- **APPENDIX AK: Resource Stockpiling: List of Vendors and Rep Contact Information**
- **APPENDIX AL: Resource Stockpiling: Inventory Lists**

INVENTORY MANAGEMET

1. Create an itemized list outlining your current inventory i.e item name, lot #, quantity and expiry date.
   - **APPENDIX AL: Resource Stockpiling: Inventory Lists**
2. Monitor Daily Burn Rates to ensure stockpile quantities are maintained in accordance to these rates. If changes need to be made, update/replenish stockpile quantities as required.
3. Monitor expiration dates weekly and rotate stockpile based on these dates.

Vendor Names and General Contact Information:

EcoLab
Customer Service Number 1-800-352-5326

Rep. Rod

Section:	Subject:	Policy #: 02-05-07	
EMERGENCY PREPAREDNESS: PRE-PLANNING	RESOURCE STOCKPILING		
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	COMMUNICATIONS EQUIPMENT		July 2022

POLICY

External Communication System

The Administrator of each UniversalCare facility will ensure that the facility has a primary telephone system along with a secondary (back up telephone system) that is available in the event the primary system fails.

As most telephone systems are digital hardline or IP based systems, an acceptable secondary system would be an analogue telephone line or a cell phone.

- **APPENDIX AM: Telephone System Vendor Rep Contact Information**

Vendor Names and General Contact Information:

MDL Telecom

Phone #: 819-246-0203

Internal Communication System

As most facilities use wireless phones for internal communications each facility will have a back up to these phones should the primary system fail.

The backup could be the use of walkie talkies or assigning a staff member or volunteer as a runner. If a runner is used, this person should be dedicated to this task and not expected to carry out other duties in addition during the communications outage.

The Administrator will document the backup / secondary system to be used for both the external and internal communications system.

Section:	Subject:	Policy #: 02-05-07	
EMERGENCY PREPAREDNESS: PRE-PLANNING	RESOURCE STOCKPILING	Implemented	Revised
Approved by Senior Director of Corporate and Building Services	COMMUNICATIONS EQUIPMENT		July 2022

List back up Internal/external Communication System Alternatives:

Internal Communication System Alternatives:

Walkie Talkies

External Communication System Alternatives:

Cell Phone Duty Manager

Section: EMERGENCY PREPARDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-08	
		Implemented	Revised
Approved by Senior Director of Corporate & Building Services	PPE		July 2022

POLICY

Personal Protective Equipment (PPE) stock in the home must be monitored on a daily basis to ensure there is at least 14 days of stock on hand in the event of an Outbreak.

PPE stock data must be managed by calculating Daily Burn Rates using an Average Daily Burn Rate Calculator Spreadsheet, that outlines the total number of days left of stock per PPE Category.

Expiration dates must be monitored and PPE stock should be rotated monthly in accordance to these dates.

PPE stock totals must be submitted to the Ministry on a weekly basis.

PPE Items include:

- Gloves
- Isolation Gowns
- Surgical Masks
- Respirators
- Eye protection i.e face shields and eye goggles
- Disinfectant Wipes
- Hand Sanitizer

PROCEDURE

1. Monitor the current PPE stock totals by calculating Daily Burn Rates i.e what is removed from your current Stockpile.
   - Be sure to organize your Stockpile and Burn Rates by PPE Category, Brand, Level/Certification etc.
   - Order your PPE stock in accordance to the **PPE Order Guide**
2. Monitor Expiration dates and rotate your PPE Stock Monthly
3. Ensure PPE stock is readily available and replenished on the Units and throughout the home as needed.
   - Monitor the PPE stock found units for expiry dates.
   - All expired stock must be discarded.
4. If an Outbreak is declared, ensure your Daily Burn Rates are updated accordingly
   - **How to determine Outbreak Burn Rates:**
   - Multiply the total number (#) of resident beds by a minimum average of 21 care points per day per PPE item:
   - This formula will be used for all disposable PPE items that cannot be preserved like Eye Protection i.e Shield and Goggles.

RELATED FORMS

- **PPE Burn rate Calculator Spreadsheet**
- **PPE Order Guide**

Section: EMERGENCY PREPARDNESS: PRE-PLANNING	Subject: RESOURCE STOCKPILING	Policy #: 02-05-08	
		Implemented	Revised
Approved by Senior Director of Corporate & Building Services	PPE		July 2022

- Ministry Portal to submit PPE Stock https://ontario-ppecse-survey.mgcs.gov.on.ca/Login

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: CRISIS COMMUNICATIONS PLAN	Policy #: 02-06-01	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	REQUIREMENTS		July 2022

INTRODUCTION

Communications during an emergency is critical to provide reassurance to residents, their families, staff, volunteers, and the public.

All communications to residents, sdm's, families, staff, volunteers, students, and the residents council and family council, external partners, stakeholders, the public and the media will be accurate, concise, coordinated and respect the privacy of staff/residents and their families.

POLICY

Each message must include the beginning of the emergency, when there is a significant status change, and when the emergency is over.

In order to maintain a consistent and clear message, all communications with the public and media will be approved by the Administrator or the Incident Manager during a major event.

Ensure that the individual responsible for day-to-day operational communications is aware of scheduled services, such as deliveries, agency staff supporting the home, and others may be helpful when developing communications

PROCEDURES

All Staff, Students and Volunteers

All staff, students and volunteers must understand that it is critical to the reputation of the organization that opinions and inaccurate information do not taint the reality of the situation. Therefore, all staff, students and volunteers are asked not to comment to the media, post information/comments to social media, or send/transmit information, photos, video or other recordings to any person during an emergency unless authorized by the Incident Manager.

If a staff member is approached by the media or someone suspected of being the media, their comments should be restricted to a calm and professional statement such as:

"At this time, our staff and emergency services are actively responding to the situation and our residents are our first priority. The Administrator or a representative will have the opportunity to speak to you shortly."

The staff member should immediately notify the designated Public Information Officer or the Administrator if they have been approached by a media person or suspected media person.

Note: that the person may or may not have typical media equipment (e.g. camera, recorder, note pad).

Some media personnel may not present themselves as being part of the media, but as other interested parties including claiming to be family members, residents, etc. in order to engage a conversation. Therefore, staff should always be conscious of their comments to any person around them. Further, there is no such thing as "off the record".

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: CRISIS COMMUNICATIONS PLAN	Policy #: 02-06-01	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	REQUIREMENTS		July 2022

Administrator/Corporate Directors

In an emergency event, the Administrator will consult with their corporate directors to determine if there is a need to designate a Public Information Officer and who will fill that role.

The first priority will be to provide communications to the residents, families, staff and volunteers to reassure them that all appropriate actions are being taken to ensure the health, safety and well being of the residents, staff, visitors and volunteers on site.

Understanding that the media will create a story with or without input from the organization, it is important to work with the media. An organization that appears to be hiding sends a message through the media. Even if it is bad news, it is better that you communicate that with your side of the story, than to have the media create their own version.

The media should never be asked not to print or broadcast a story as this may be interpreted as an attempt to hide an issue or manipulate the press.

If a statement is made to the media by someone other than the Public Information Officer, the Public Information Officer should be notified as soon as possible so that the information can be confirmed and the Public Information Officer can prepare for follow up questions from the media.

Notify the Administrator/Corporate Directors of any contentious issues that may be in the media.

The Administrator/Corporate Directors may consider contacting a professional firm to fill the role of the Public Information Officer for major or contentious issues. This firm would not be the public spokesperson, which should be a representative of the Home, but would provide crisis communications support and guidance.

Public Information Officer (PIO)

The Public Information Officer(s) must work closely with the organization to ensure that a single consistent message is communicated.

Understanding that the media will create a story with or without input from the organization, it is important to work with the media. An organization that appears to be hiding sends a message through the media. Even if it is bad news, it is better that you communicate that with your side of the story, than to have the media create their own version.

The media should never be asked not to print or broadcast a story as this may be interpreted as an attempt to hide an issue or manipulate the press.

The PIO will inform the Incident Manager and Administrator of any contentious issues that may be in the media.

News Briefings: Press Release, E-mail/Newsletter Communications

When a press release, e-mail/newsletter is made, copies should be made available either in hard copy or electronically to all Home personnel. This ensures that everyone is aware of the same information that is being released to the media in the event that the media follows up with someone else within the organization.

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: CRISIS COMMUNICATIONS PLAN	Policy #: 02-06-01	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	REQUIREMENTS		July 2022

Prior to releasing information, it is critical to ensure that the facts have been confirmed rather than making a premature statement and having to retract or correct it later. Only confirmed facts should be presented. At no time should personal opinions, speculations, feelings or comments regarding the incident or the response be made in public or to the media. Statements should never be made that you would not want quoted in the media.

All media releases must conform to confidentiality policies and legislation.

All media statements should be made using plain English, not using media or medical terminology either written or verbally.

If a statement is made to the media by someone other than the Public Information Officer, the Public Information Officer will be notified as soon as possible so that the information can be confirmed and the Public Information Officer can prepare for follow up questions from the media.

The spokesperson for news briefings may be someone other than the Public Information Officer, such as the Administrator, the Director of Care etc. In these situations, the role of the Public Information Officer is to assist this person with their statements, anticipate potential questions, and draft answers in advance. During the news briefing, the Public Information Officer acts as the mediator and ends the briefing as soon as the allotted time is done.

If multiple agencies are involved in the incident, the Public Information Officer should work closely with those filling the Public Information Officer role for the other agencies. Working together with other agencies and staff within your facility will ensure that information released is coordinated, sending a single message.

News media staff should be asked for their credentials (e.g. I.D. Cards) before they are included in a media briefing or tour.

Where possible, record all interviews, briefings or other discussions with the media to create a “record” of the interaction for both quality assurance and training purposes.

Keep media outside of the emergency area or zone, or from areas where their presence may cause clients, families and volunteers to feel uncomfortable.

When setting up a media area, it should have easy access without traveling through the facility or area where emergency operations are occurring. Media personnel may want to take pictures (either video or still photos) of the “action”, and therefore a guided tour to an area where they can take photos may be appropriate if deemed appropriate by the Administrator, and as long as it is not detrimental to the incident response or facility operations. By offering a media tour in a coordinated manner, it should reduce the media’s drive to get into areas that may disrupt operations.

A white board/bulletin board should be set up to display information such as the next briefing time and approved information.

Additional staff should always be present in the media room while any news conference is in session to provide security and ensure the safety of all visitors. Uniformed security staff should be avoided so as to not provide the impression of “controlling” the media.

Section: EMERGENCY PREPAREDNESS: PRE-PLANNING	Subject: CRISIS COMMUNICATIONS PLAN	Policy #: 02-06-01	
		Implemented	Revised
Approved by Senior Director of Corporate and Building Services	REQUIREMENTS		July 2022

PROCEDURE

The Public Information Officer and any assigned speaker to the media will:

1. Be knowledgeable and provide the basic facts of the incident being covered.
2. Briefly respond to questions by providing essential information only.
3. State only the facts and avoid speculation about causes and long-term effects of the incident.
4. Avoid comment on areas that are not within their field of expertise or responsibility by advising that you do not know, but will follow up and obtain further information. Do not use “no comment” or “we cannot comment”, but use words such as, “that is out of my personal knowledge and we will get back to you with more information” or “we will provide information as soon as it is available”, or “as you understand, personal client information cannot be released”.
5. Provide reassurance that appropriate resources are being used to resolve the incident and provide the best possible safety and security to residents, family members, volunteers, staff and others involved in the incident.
6. Do not speak for or comment regarding other organizations unless previously agreed to.

On-camera Interviews

If a staff member is asked to participate in an interview, they will:

1. Obtain authorization from the Administrator.
2. Ask the reporter to provide the questions beforehand and plan a properly phrased response. Be prepared however, to be asked questions that are not provided.
3. Listen to each question carefully and take a moment to compose an answer that is factual, concise and grammatically correct.
4. Understand there is no obligation to answer every question.
5. Be conscious of appearance and body language.
6. Avoid humour as it is incompatible with the seriousness of the situation.

References

- LTC Emergency Preparedness Manual Pg: 19

CHECKLISTS

- **"Public Information Officer Check Sheet (02-06-01)"**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	SECTION INTRODUCTION		July 2022

SUMMARY

The responsibilities of each employee, visitor, volunteer and service personnel to prevent and/or respond to a fire, are contained in this Section.

The response and subsequent responsibilities for an emergency other than fire are similar.

This Section has been prepared as a strawman to reflect what would be the more frequent assignment of authority and responsibility. Each position will need to be developed specific to the needs of the facility based on staff classifications. This section does not negate the responsibilities or response as outlined in the approved Fire Safety Program.

Refer to Code Red: 03-010-01 "Code Red- Procedure"

The Administrator will approve of all “Hot Work” occurring in or on the building including applying tar to the roof, welding, grinding, or other types of maintenance work using torches, welding equipment, grinders, or using heating devices. This approval will only occur after a plan has been developed to have the work area monitored for at least 60 minutes following such work to ensure that there is no risk of fire, smoldering, re-ignition, etc. This monitoring may be done by the contractor or a competent person from the facility. The person doing the monitoring must have a communication device or be in close proximity to a fire pull station, have a fire extinguisher, and a log to record observations every 15 minutes following the conclusion of the hot work.

The contents of this section are used by the Administrator/Designate to develop specific Departmental Plans that are to be reviewed annually by all employees.

The response of the facility to an acute emergency will generally include the steps listed below. (The steps do not have to be followed the order listed).

- Initial Response;
- Rescue of Victims;
- Establishment of an Assessment and Treatment Centre;
- Triage and categorization of injured;
- Establishment of Command Centre;
- Establishment of Transfer and Discharge;
- Establishment of Temporary Morgue;
- Call-in off-duty staff;
- Evacuation;
- Account for all residents and notify authorities of missing person;
- Communication/Notification of Senior Staff/Government;
- Insurance Agency.

Many of the steps may occur simultaneously and may be interchangeable depending on the nature of the emergency situation.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-02	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	INITIAL RESPONSE		July 2022

SUMMARY

In the Initial Response to an acute emergency, it is imperative that all staff know as quickly as possible that an emergency response is required and that concern for the safety of residents and staff exists.

- Initiate R.E.A.C.T.
- Retrieve Disaster Box(es)

In urban centres, pulling the fire alarm and/or calling 911 may bring the following emergency personnel:

- Fire Department
- Police Department
- Ambulance/Rescue Unit

Note: it is important to call 9-1-1 even if the fire alarm has been activated and the alarm company is responsible for notifying the fire department. Speaking directly to the fire department dispatcher provides the fire department with valuable information to assist in their arrival.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-03	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	COMMAND CENTRE		July 2022

SUMMARY

It is the responsibility of the Incident Manager to establish Command Centre.

- Retrieve Disaster Box(es).
- Establish at Reception or the Administrator's office.
- Identify an alternate location if required.
- Designate an individual responsible for the functions of the Command Centre.
- Centralize internal communication.
- Designate a runner.
- Police and ambulance communication systems will be used as support to the facility's systems. Police are equipped with portable, hand-held radios and can serve as a mobile network.
- Establish initial BRIEFING meeting. **"Incident Briefing Report (01-02-05)"**
- Determine the extent of the emergency.
- Set initial priorities.
- Review and confirm emergency response log responsibilities.
- Review and confirm checklist responsibilities in the absence of department head until their arrival.
- Determine the need for a morgue; report need to the Municipal/Regional Emergency Response Team.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-04	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	CONDUCTING A ECG MEETING		July 2022

GUIDELINES

The Incident Manager will chair the Briefing unless relieved by a senior officer from the primary (e.g. fire for fires, police for violence) first response agency. The Incident Manager will delegate a staff member to take meeting minutes.

The Incident Manager will chair and record minutes of the scrum unless relieved by the Community Emergency Response planner.

Representatives should include DOC, Dietary Manager, Office Coordinator, Maintenance Supervisor, Housekeeping rep, Laundry rep and/or Environmental Supervisor, and representation from the Fire Department and Police Department, Transit, Utilities, etc. when possible.

The scrum may need to be conducted at ½ hour intervals initially until the majority of issues have been prioritized and initiated. Intervals may then be reduced to 1 hour or any other appropriate interval.

Each representative will be asked to:

- State current status of his/her area; or assigned responsibility;
- Report concerns/questions arising from his/her area;
- Indicator priorities to be accomplished in his/her area.

Response by each group member is important; all concerns and questions are important. The group will establish priorities and assign departmental responsibilities. Emergency Response Log (see **03-01-06 "Emergency Response Log"**) and Emergency Response Checklists (see **02-01-016 "Administrator Pre-Planning Responsibilities Checklist"**) will be important tools to be used to assist with reporting at scrums and to record, if necessary, the next set of priorities. See **"ECG Checklist For Evacuation (03-01-06)"** to assist in the establishment of a scrum.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-05	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	ECG CHECKLIST FOR EVACUATION		July 2022

Time

1. ____ Ensure that one person has overall charge of the plan (Administrator/Delegate)
2. ____ Designate a central communication area.
3. ____ Arrange where evacuees are to go.
4. ____ Establish liaison with administration of area of refuge and evacuation sites.
5. ____ Decide how individual residents are to be transported.
6. ____ Make a list by departments of the necessary equipment to be evacuated.
7. ____ Notify the Ministry of Health authorities and other government departments as necessary.
8. ____ Call in staff as appropriate for evacuation assistance and as necessary to report to Command Centre.
9. ____ Delegate to one staff member in each area the responsibility of maintaining a resident head count.
10. ____ Ensure those residents requiring special medical attention (or nursing attention) are designated to go to the appropriate facility.
11. ____ Ensure sufficient medical documentation accompanies residents.
12. ____ Keep residents completely informed of the situation.
13. ____ Ensure that all residents are individually identified, including condition and diet; e.g. Tags or Resident identification bands/bracelets.
14. ____ Assign necessary personnel to the appropriate means of transportation.
15. ____ Assign necessary personnel as appropriate to inform families of situation by telephone.
16. ____ Ensure that families who decide to take responsibility for residents are properly informed as to the condition of the resident, receive the necessary medications and equipment, and are requested to leave a forwarding address.
17. ____ Ensure residents being evacuated are properly clothed and covered as appropriate.
18. ____ Double check all evacuated areas to ensure they are cleared.
19. ____ Restrict building to all unauthorized persons.
20. ____ Assign personnel as appropriate to handle telephone inquiries from families.
21. ____ Notify advisory physician and attending physicians of the situation.
22. ____ Ensure parking area is clear to allow sufficient room for evacuating and emergency vehicles.
23. ____ Make final check of empty building to ensure that all appropriate equipment is turned off, heat is lowered, windows and doors closed and locked.
24. ____ Ensure that all evacuated areas are sealed off/taped and appropriately secured. (Do not barricade as this makes it difficult for the fire department to access).
25. ____ Notify police that building is evacuated or with minimal staff on duty.
26. ____ Obtain security guards if appropriate.
27. ____ Post signs on door indicating whereabouts and phone number.

To print above checklist refer to **"ECG Checklist For Evacuation (03-01-06)"**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-06	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	EMERGENCY RESPONSE LOG		July 2022

SUMMARY

An Emergency Response Log will be used as part of the Scrum to retain a chronological account of the activities and decisions made within each department during an emergency response situation. It will include names, contacts, and times. This log will also assist in the preparation of a final report.

PROCEDURE

An Emergency Response Log will be distributed to all department heads/delegates and members of scrum team.

Events will be recorded by time, person, event, and brief notation of activity; i.e., by each department head.

1:05	Joe Black Firm XYZ	Delivered 12 doz. 10 gal purified water bottles to Command Centre front door
1:10	Employee ABC	Reporting to duty for 3p.m. Extra to assist with supper, Command Centre.

It is critical that the log be used to record discussion of situations, the decision(s) made, both individually and a team.

To print view: **"Emergency Response Log Form (03-01-07)"**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-07	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	CALLING IN OF OFF DUTY STAFF		July 2022

SUMMARY

Off duty staff may be required to:

- Assist on location with the care or evacuation of residents;
- Provide supervision or escort to residents in areas of refuge;
- Provide care to residents in evacuation site.

GUIDELINES

The need to bring in extra personnel depends on the nature of the disaster and the needs of the facility. Call in requirements will be decided by the Incident Manager preferably as part of the ECG Meeting.

Call in requirements may be assigned and needs may be:

- Position specific, or
- Full fan out by department
- Full fan out for facility.

Person(s) responsible for call in of staff will be assigned. All staff will report to Command Centre unless otherwise directed. Call back list/Fan out list (staff record by name, proximity, and availability) will be maintained by the facility and a copy placed in the Disaster Box(es) and will be checked monthly. Computer print-outs should be used.

Staff and visitor registry forms are to be completed by having each staff and visitor fill in required information. These registries will be administered at the Command Centre to keep track of all people who have been called in; to assist and their allocated area in which to provide that assistance.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-07	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	CALLING IN OF OFF DUTY STAFF		July 2022

Sample - Visitor Registry

DATE	TIME IN	NAME (ENTRANCE SIGNATURE	RESIDENT CONTACT	TIME OUT	EXIT SIGNATURE

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-07	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	CALLING IN OF OFF DUTY STAFF		July 2022

Sample - Staff Registry

DATE	TIME IN	NAME (ENTRANCE SIGNATURE	RESIDENT CONTACT	TIME OUT	EXIT SIGNATURE

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-08	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	ASSESSMENT & TREATMENT CENTRE		July 2022

ASSESSMENT AND TREATMENT CENTRE

1. Establish an Assessment and Treatment Centre preferably close to an evacuation route and adjacent to Nursing Station.
2. Victims to be taken to the Assessment & Treatment Centre for triage using universal colour coding for first aid or initial treatment.
3. Restrict access to the area to those injured and those required to deliver care.
   - Registered Nurses (reassigned to area)
   - PSW/Aides (as re-assigned)
4. Restrict families access into the Assessment and Treatment Centre only at the discretion of the Assessment and Treatment Centre.
5. Establish a resident information function to provide information as it becomes available, under the direction of the Physician or Nurse in charge of the Assessment and Treatment Centre.
6. Residents who are obviously in no distress may be taken directly to an area of refuge.

- **APPENDIX G: Physicians and Medical Director Name and Contact Information**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-09	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	TRIAGE/CATEGORIZATION		July 2022

CATEGORIZATION OF INJURED

TAG COLOUR	INDICATES
Red	• Serious injuries; immediate medical attention
Yellow	• Moderate injuries, medical attention required after seriously injured have been attended to.
Green	• Slightly injured, no immediate medical attention necessary
Black	• Deceased

SUMMARY

In the event of an emergency/disaster the process of Triage ‘Cateogrization of Injured’ can be invoked when acute care cannot be provided in a disaster due to lack of resources.

In some larger centres, the injured will be reassessed by the paramedical staff or the Community Emergency Response Team prior to treatment or transport.

DEFINITIONS

Triage:

The assignment of degrees of urgency to wounds or illness to decide the order of treatment for a large number of residents or casualties.

Note: Triage Tags are to be kept in the Disaster Box. They are available on the internet through company’s such as:

- www.disasterstuff.com
- www.statband.com
- www.tragetags.com
- www.moremedical.com
- www.grainger.com

CHECKLISTS

- **"Triage Categorization- Training Record of Attendance (05-01-02)"**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-010	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	AREA OF REFUGE		July 2022

SUMMARY

Rescue of victims should occur with the awareness of safety concerns for residents, staff, and visitors.

GUIDELINES

1. The Incident Manager will establish an area of refuge to which all residents in danger can be transferred.
2. The area will permit establishment of Assessment & Treatment Centre.
3. Transport severely injured to hospital.

Resident Information Centre

The Area of Refuge may also be designated as the area to which family and other visitors are assigned to await messages being conveyed from physician(s) and/or facility representatives.

- **APPENDIX Q: Area of Refuge Agreements**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-011	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	ESTABLISHMENT OF TRANSFER & DISCHARGE		July 2022

SUMMARY

Once the decision has been made to transfer residents or other persons to an external area of refuge or evacuation site, discharge resident/injured person to hospital or to home of family member, the Transfer and Discharge procedure will be implemented.

Implement the Transfer and Discharge procedure to expedite the relocation process. The Incident Manager will assign a Registered Nurse, (if possible) as the Transfer and Discharge Supervisor. Authorities such as the Ministry of Health & Long Term Care may be involved in this process in the case of a Long Term Care Home.

PROCEDURE

1. Chronologically numbering the residents who are transferred or discharged is important until such time as the following procedure can be carried out in a safe manner:
2. Implement the Transfer & Discharge Record to document transfer/ discharge.
3. Serially number each resident or injured person being transferred and enter the name opposite the assigned number.
4. Place adhesive tape on the person with name and number as time permits, regardless of whether the person has been assessed and is wearing a triage identification tag.
5. Transfer to a hospital of an injured person shall be determined by the Assessment Treatment Centre and Paramedics.
6. Transfer to home will be determined by a Registered Nurse.
7. The “TD” sheets will be used to later reconcile the location of all residents and others.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-011	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	ESTABLISHMENT OF TRANSFER & DISCHARGE		July 2022

Sample: Transfer and Discharge Record

SHEET #:			**DATE:**		
FACILITY:			**"TD" SUPERVISOR:**		
ASSIGNED #	**NAME (R)/(O)**	**TRANSFERRED TO**	**NOTIFICATION OF KIN**	**EXIT LOCATION**	**TRIAGE TAG #**
01	Jones, Bill (R)	University Hospital		West Wing	736747
02					
03					
04					

- (R) – Resident
- (O) - Other (staff, visitor, volunteer, etc.)

To print: **"Transfer and Discharge Form (03-01-13)"**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-012	
		Implemented	Reviewed
Approved by Senior Director of Corporate & Building Services	ACCOUNT FOR RESIDENTS/STAFF AND SEARCH FOR MISSING PERSONS		July 2022

ACCOUNT FOR RESIDENTS/STAFF AND SEARCH FOR MISSING PERSONS

When the evacuation is complete, the Incident Manager or designate will coordinate an official census process to:

- Account for all residents;
- Account for residents on leave according to resident L.O.A. Book.
- Tally count with the Transfer and Discharge Record refer to **03-01-011 "Establishment of Transfer & Discharge"**.

If count cannot be reconciled, inform the Authorities of the missing person(s). They will re-enter and search the facility.

Fire Department personnel are equipped and trained to search areas that would pose a danger to staff.

Supervisors and Charge Nurses will ensure that their staff is safe and accounted for by verifying staff count with the schedule and sign-in sheet.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-013	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	NOTIFICATION OF SENIOR STAFF		July 2022

NOTIFICATION GUIDELINES

The person in charge of the building will notify:

- Administrator or delegate;
- Maintenance Supervisor;
- Director of Care.

The Administrator or delegate will notify:

- Senior Management;
- Department Heads.

The Director of Care or delegate will notify:

- Medical Advisor;
- Coroner, if necessary.

The Senior Management Stakeholders will notify appropriate parties:

- Corporate Teams;
- Board Members;
- Insurance Company;
- Owners.

Keep up to date a list of names and numbers under these guidelines.

- **APPENDIX AN: Notification: Senior Corporate Staff and Stakeholder Contact Information**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-014	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	NOTIFICATION OF GOVERNMENT AGENCIES		July 2022

SUMMARY

Any internal/external disaster which affects residents, staff, or property of a long term care facility will be reported to appropriate government agencies.

NOTIFICATION GUIDELINES

Insert provincial/region specific requirements for notification to government agencies, contact person and number; e.g.

Coroner/Medical Examiner

The Coroner/Medical Examiner must be notified in the event of a death of a resident or employee and:

- Critical injuries and deaths must be reported IMMEDIATELY;
- Other injuries must be reported within 4 days;
- All notifications are to be followed up by a written report of the circumstances.

Fire Marshall/Chief

As necessary, specific to the circumstances of an internal/external disaster; i.e., fire involving actual flaming combustion in the facility or immediate area, is to be reported to the Fire Commissioner's Branch.

Environmental Spill Report Centre

Chemical or hazardous spills are to be reported immediately to the Environmental Spill Report Centre with a written report to the Department of Environment and Public Safety, within 7 days.

Occupational Health & Safety

As necessary, situations involving potential injury or injury to employees must be reported to the OH&S Branch.

- **APPENDIX AO: Notification: Government Agencies Rep Contact Information**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-014	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	NOTIFICATION OF GOVERNMENT AGENCIES		July 2022

Workers Safety Insurance Board

As necessary, workplace situations of injury for not time or time lost accidents are to be reported to the WSIB.

Relevant Government Agency Phone and Fax #'s:

Ministry of Labour call center - 1-877-202-0008

WSIB form 7 can be found online at https://wsib-form-7.com

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-015	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	NOTIFICATION OF INSURANCE AGENCIES		July 2022

SUMMARY

All incidents resulting in damage to property or persons must be reported to the insurance carrier for the facility as soon as possible. When possible, photographs of damage are desirable to help describe the extent of damage.

GUIDELINES

To report contact:

- Company Name: UniversalCare Canada Inc.
- Fax: 905-558-8001
- Phone: 905-558-800
- E-mail: info@universalcareinc.ca

Alternate:

- Company Name: Same as above
- Fax:
- Phone:
- E-mail:

Copies of all Reports to:

Information required by the insurance carrier includes:

- General extent of damage;
- Cause (if known);
- Potential liability.

The insurance adjuster will visit the facility to assess damage.

A final report will be submitted to the insurance company, detailing the extent of damage, action taken, cause, costs, and any potential liabilities.

- **APPENDIX AP: Notification: Insurance Agencies Rep Contact Information**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: ACUTE EMERGENCY RESPONSE	Policy #: 03-01-016	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	NOTIFICATION OF MEDIA		July 2022

MEDIA GUIDELINES

Incident Manager will instruct all staff to maintain complete confidentiality and refer inquiries to designated spokesperson.

The media WILL NOT be allowed to enter the building.

Senior company personnel authorized to make press releases should do so with 1/2 hour releases faxed to radio, T.V., and newspaper. (This should be done in consultation with the Stakeholders.)

Whenever possible the spokesperson for the Ministry of Health or Emergency Measures Organization should also be utilized to keep the media informed.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: CONTROLLED EMERGENCY RESPONSE	Policy #: 03-02-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	SECTION INTRODUCTION		July 2022

SUMMARY

Emergency responses that arise due to utility loss, for example, generally give facilities an extended decision making and planning period of time.

This type of response can also arise from weather conditions such as a severe snow storm which isolates the facility from the community for an extended period of time.

Emergency Preparedness professionals recommend that planning cover a 72 hour period in which a facility may need to be self-sufficient in terms of having no access to community assistance.

In these circumstances, organizational scrums may be arranged with the Emergency Response Administrator for department heads or delegates, and conducted at intervals of ½ to 1 hour until the emergency is resolved.

Appropriate protocols can be accessed from information contained in Tab 03.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: CONTROLLED EMERGENCY RESPONSE	Policy #: 03-02-02	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	FACILITY ISOLATION		July 2022

SUMMARY

There may be emergencies in which the facility becomes isolated from the community and the community emergency services for a period of 48-72 hours.

Typically, as in severe snow storms, the risks of inaccessibility are often compounded by a loss of power, for example.

GUIDELINES

In the above situation, the emergency response must be such that:

- The facility operate with staff that are on site at the facility
- The facility operate with the supplies/food that are on site
- The facility must respond to the physical environment which may have no heat or no light supply
- The facility must respond to medical emergencies with the resources of the facility and the staff
- The facility must remain cognizant of the pressure of these situations on both residents and staff (particularly the staff)

At some point in these emergencies, there may come a time when the facility moves from supplying care and comfort to one of the providing elements of survival.

In such a situation, details which must be considered include:

- Modification to normally accepted rules and regulations based on an informed decision of value versus risk;
- The absolute necessity to document the extenuating circumstances, discussion and decision(s) made.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: EVACUATION - CODE GREEN	Policy #: 03-03-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	PROCEDURE		July 2022

INTRODUCTION

Code Green is to provide guidelines on a safe and efficient evacuation of an area, wing, floor, building or the entire Villa Marconi LTC Home.

Examples of circumstances necessitating an emergency evacuation include; fire / explosion, bomb threat, community disaster (e.g. toxic spill, tornado), structural failure (e.g. roof collapse), etc.

TYPES OF EVACUATION

Horizontal Evacuation:

Involves moving from one area of the floor to another area, on the same floor, behind fire barrier doors.

Vertical Evacuation:

Involves moving from one floor towards the ground floor.

While the preference in a partial evacuation is a horizontal evacuation, due to the risks of moving residents via stairways, this may not be an option where it is not safe to move towards a fire door (e.g. the incident is between the resident and the closest fire doors making moving towards a stairway the only exit route)

DO NOT use the elevators unless approved by the Fire Department or other authority involved in the evacuation (e.g. police for a bomb threat)

Total Evacuation:

Involves total evacuation of the building to the outside and would be carried out only in an extreme emergency. The emergency services will normally be on location to provide assistance.

PROCEDURE

Decision to Evacuate

Each emergency situation will have an Incident Manager responsible for the safety of all persons in the building, the initiation of the emergency plan, and delegating responsibilities to ensure the emergency plan(s) are properly activated.

Where possible, the decision to evacuate an area is to be made in consultation with the Administrator or the Administrator on call on duty in their absence.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: EVACUATION - CODE GREEN	Policy #: 03-03-01	
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Approved by Senior Director of Corporate and Building Services	PROCEDURE		July 2022

Originating Staff

1. If discovering an emergency that is potentially life threatening, immediately sound the alarm for the type of emergency, and where safe to do so, remove residents and all others from harm's way.
2. If there are no person(s) in immediate danger, notify the Charge Nurse of the emergency. The Charge Nurse will assume the role of Incident Manager and will make the decision to evacuate, if required.
3. Follow the directions of the Incident Manager.

Charge Nurse/Incident Manager

1. Upon notification of an emergency situation, assume the role of Incident Manager until relieved by a more Senior Manager.
2. Determine the need for an emergency evacuation (Code Green).
3. Determine the extent of a Code Green (partial or total evacuation).
4. In fire emergencies a partial evacuation will be initiated evacuating persons from the area of the fire / smoke (refer to Code Red).
5. Where there is not an immediate danger and time to wait for the emergency services to arrive the decision to evacuate and the extent of the evacuation will occur in conjunction with discussion with the emergency services.
6. For a partial evacuation the RHA Leader for the floor will advise all staff and visitors of a "Code Green" for the specific wing / floor.
7. When the decision has been made to initiate an emergency evacuation, activate the fire alarm pull station to set off the alarm bells for a first stage alarm (short beat). The second stage alarm is activated by using an alarm key, located at nursing stations and reception, at any pull station to activate.
8. Announce, or have announced, a Code Green 3 times.

For a **partial evacuation** a "Code Green (location)" will be announced and repeated 3 times. Identify the area and the floor number:

"Code Green (location) (floor number)"

"Code Green (location) (floor number)"

"Code Green (location) (floor number)"

In the event of a **total evacuation** a "Code Green (insert name) Home" will be announced 3 times

"Code Green Villa Marconi LTC Home"

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: EVACUATION - CODE GREEN	Policy #: 03-03-01	
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Approved by Senior Director of Corporate and Building Services	PROCEDURE		July 2022

"Code Green Villa Marconi LTC Home"

"Code Green Villa Marconi LTC Home

9. Send a staff member to the fire control panels to repeat the page over the fire alarm paging system.
10. Call 9-1-1 stating the type and location of the emergency.

All Staff

1. All Fire Alarms will be treated as an emergency and evacuation of the fire area will be commenced immediately.
2. When a decision is made for an emergency evacuation **Evacuate Now!**

Priority of Evacuation

1. Residents in immediate danger will be evacuated first. i.e Room on each side of the emergency site, room of the emergency site and room directly across from the emergency site.
2. All ambulatory residents under supervision. Residents able to walk should be led to another fire barrier area. If a resident is aggressively resistant move on to the next resident so as to not delay the evacuation process. Staff will return to aggressively resistant residents once others at imminent risk are safe.
3. All wheelchair residents should be assisted to safe fire barriers and, if their wheelchairs are required for other residents, are to be removed from their wheelchairs.
4. All non-ambulatory residents. Most residents can be carried or pulled on a blanket to a safe area if necessary. **(Review Safe Lifting and Transferring Policies found in the Resident Care Manual).** Moving beds will cause congestion and should be a last resort.
5. Residents who aggressively resist the evacuation.

Note: Where possible, traffic in the corridors and stairwells will move in one direction for ease of flow. Where two directional traffic flow is necessary, staff will keep to the right to minimize directional conflict.

During a Partial Evacuation

Incident Manager

1. Initiate the staff call back list and activate the Senior IMS team.
2. Set up a command post at reception, if safe to do so, or alternative location announced to staff.
3. Direct the activities of all Villa Marconi LTC Home personnel.
4. Retrieve the "evacuation kit" (kept at reception and all nursing stations) containing "Code Green" staff assignments and policies, procedures, tags, transfer forms, resident information and updated resident photos.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: EVACUATION - CODE GREEN	Policy #: 03-03-01	
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5. Ensure that all residents are identified with wrist bracelets.
6. Transport the Residents' chart to the place where the Residents have been relocated.
7. Remove staff schedules, visitor and volunteer logs to the command post to assist with a safety accountability of all staff.
8. Provide for the continuing care of the residents.
9. Ensure a Liaison Officer is appointed to maintain continuous communications with the Emergency Services.
10. Receive communication from the Emergency Services and participate in assessing the situation with the emergency agencies.
11. Ensure a safety officer is appointed to monitor the safety of all personnel in the building other than emergency service personnel.
12. Ensure a Public Information Officer is appointed to ensure appropriate communications with families, staff, and the media.
13. Notify the MOHLTC.
14. Contact the Vice President of Operations and the Medical Director.

Note: In order for these tasks to be carried out effectively, they must be delegated appropriately as staff resources are available.

Registered Staff/Supervisors

1. Ensure one staff member stays in their assigned area to continue the care of their residents and send all other staff to assist with the Code Green. Additional staff may be required to monitor exits and/or stairways for the safety of wandering residents.
2. Provide direction and guidance to staff participating in the evacuation.
3. Take direction from and report to the Incident Manager or other Incident Management System managers.
4. Ensure that all evacuees are identified with wrist bracelets.
5. Be responsible for maintaining a head count of residents and staff, and keeping the Incident Manager informed.
6. Responsible for the removal of the resident charts and medication carts if time and situation permits.
7. Provide for the continuing care of the residents.

All Staff

1. Upon notification of a Code Green, assist with the evacuation procedure beginning with those closest to the identified area.

Note: One staff member on each floor is to remain on their floor to supervise the residents. All other staff will proceed to the Code Green location. Additional staff may be delegated back to the units to monitor exits and stairways for the safety of wandering residents.

2. If you are responding to the emergency call back, report to the command post for further instruction.

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3. Assure the residents and visitors in your work area are in a safe location. For example, remove any resident that is bathing from the tub/shower.
4. Properly shut down any equipment in the area (e.g. ovens, laundry equipment, etc.) and close all doors.
5. Proceed directly to the area of the Code Green. Use the stairs – DO NOT use the elevators unless approved by the Fire Department or other authority involved in the evacuation (e.g., police for a bomb threat, structural engineer for a roof collapse).
6. If you are not in your work area when the Code Green is activated (e.g. on break), return to your own work area to ensure all equipment is turned off and doors are closed (unlocked). Then proceed to the Code Green location.
7. Report to the Incident Manager or designate.
8. Remove residents and visitors from the Code Green area to an area determined as safe by the Incident Manager or designate. In many cases this will be behind fire doors (horizontal evacuation) where safe to do so. Utilize a vertical evacuation where life safety is at risk and a horizontal evacuation is not possible.
9. Close all unlocked doors to contain the fire and smoke.
10. Ensure each room in the assigned area is properly and thoroughly searched and evacuated indicators used identifying, that the room is vacant. Do not use an evacuated indicator if a person is still in the room

During a Total Evacuation

Incident Manager

1. Initiate the staff call back list and activate the Senior IMS team.
2. Set up a command post at reception, if safe to do so, or alternative location announced to staff.
3. If necessary, designate a staff member to contact the transfer facilities to advise that residents will be coming and confirm that these alternate facilities are prepared to receive residents. Confirmation of facilities to be communicated to the Incident Manager.
4. Direct the activities of all Villa Marconi LTC Home personnel.
5. Retrieve the “evacuation kit” (kept at reception and all nursing stations) containing “Code Green” staff assignments and policies, procedures, tags, transfer forms, resident information and updated resident photos.
6. Designate two outside exit areas as safe resident pickup sites to bring residents from the evacuation prior to being transferred to another facility or with family.
   - Area one – will be for non-injured and stable residents.
   - Area two (triage) – will be for resident(s) requiring emergency care, either as a result of the emergency itself or due to some pre-existing medical condition(s).
7. Designate Registered Staff or a Department Head to supervise the pickup site. Delegate additional staff/volunteers to assist as resources are available.
8. Communicate with the RHA Leaders on the nursing units the list of residents to go to each holding area.

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9. Confirmation of residents at each pickup site will be made with designated staff member supervising the area.
10. Ensure that all residents are identified with wrist bracelets and transfer information tags.
11. Residents will be prioritized for transportation to the hospital or other temporary facilities, with ambulance directed to the most seriously injured, in order of severity.
12. Alternative transportation will be arranged for ambulatory residents and other residents who do not require an ambulance for transport (i.e. relative of residents, staff and volunteers).
13. Log each Resident's destination, who they left with and how they were transported.
14. Transport the Residents' charts to the place where the Residents have been relocated.
15. Remove staff schedules, visitor and volunteer logs to the command post to assist with a safety accountability of all staff.
16. Provide for the continuing care of the residents.
17. Ensure a Liaison Officer is appointed to maintain continuous communications with the Emergency Services.
18. Receive communication from the Emergency Services and participate in assessing the situation with the emergency agencies.
19. Ensure a safety officer is appointed to monitor the safety of all personnel in the building other than emergency service personnel.
20. Ensure a Public Information Officer is appointed to ensure appropriate communications with families, staff, and the media.
21. Notify the MOHLTC.
22. Contact the Vice President of Operations and the Medical Director.

Note: In order for these tasks to be carried out effectively, they must be delegated appropriately as staff resources are available.

Registered Staff/Supervisors

1. Provide direction and guidance to staff participating in the evacuation.
2. Take direction from and report to the Incident Manager or other Incident Management System managers.
3. Ensure the emergency evacuation kits are removed from the building with the first resident.
4. Ensure that all evacuees are identified with wrist bracelets.
5. Prepare relevant transfer information for each resident and fasten these tags to the Residents' right shoulder.
6. Be responsible for maintaining a head count of residents and staff, and keeping the Incident Manager informed.
7. Responsible for the removal of the resident charts and medication carts if time and situation permits.
8. Be responsible for tracking the destinations of the residents.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: EVACUATION - CODE GREEN	Policy #: 03-03-01	
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9. Provide for the continuing care of the residents.
10. If the “Code Green” is isolated to another wing / floor, one staff member will stay in their assigned area to continue the care of their residents and send all other staff to assist with the Code Green. Additional staff may be required to monitor exits and/or stairways for the safety of wandering residents.

All Staff

1. Upon notification of a Code Green, assist with the evacuation procedure beginning with those closest to the identified area.

Note: One staff member on each floor is to remain on their floor to supervise the residents. All other staff will proceed to the Code Green location. Additional staff may be delegated back to the units to monitor exits and stairways for the safety of wandering residents.

2. If you are responding to the emergency call back, report to the command post for further instruction.
3. Assure the residents and visitors in your work area are in a safe location. For example, remove any resident that is bathing from the tub/shower.
4. Properly shut down any equipment in the area (e.g. ovens, laundry equipment, etc.) and close all doors.
5. Proceed directly to the area of the Code Green. Use the stairs – DO NOT use the elevators unless approved by the Fire Department or other authority involved in the evacuation (e.g., police for a bomb threat, structural engineer for a roof collapse).
6. If a staff member is not in their work area when the Code Green is activated (e.g. on break), return to your own work area to ensure all equipment is turned off and doors are closed (unlocked).Then proceed to the Code Green location.
7. Report to the Incident Manager or designate.
8. Remove residents and visitors from the Code Green area to an area determined as safe by the Incident Manager. In many cases this will be behind fire doors (horizontal evacuation) where safe to do so. Utilize a vertical evacuation where life safety is at risk and a horizontal evacuation is not possible.
9. Close all unlocked doors to contain the fire and smoke.
10. Ensure each room in the assigned area is properly and thoroughly searched and evacuated indicators used identifying, that the room is vacant. Do not use an evacuated indicator if a person is still in the room.
11. Staff assigned to the pickup sites will assist in monitoring the residents and preparing the wrist identification bracelets and transfer information tags which will be attached to each Residents right shoulder.

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Debrief

Incident Manager

1. Ensure that all documentation is completed.
2. Chair a Code Green Evacuation Debrief session within 24 hours of the event. Upon completion of this meeting, all Managers will provide a short debrief to their teams at their next staff meeting, identifying what went well and what needs improvement.
3. If the Home is un-operational for a period of time contact staff and inform them of when they will be expected to return.

Director of Care

4. Complete the Critical Incident Form and submit it to the Ministry of Health & Long Term Care when the incident is over.
5. Prepare to present a briefing note at the next Quality and Risk Committee of the Board.

Training Exercises

Training exercises for a “mock” Total Evacuation will take place at least once every three years or more often as determined by the priorities of the home.

Training exercise for a horizontal evacuation will take place annually. To address the provisions of Sentence 2.8.3.2.(6) of Division B of the Fire Code.

The Administrator will keep a detailed log of all Emergency Exercises including which area of the building was evacuated, who initiated the exercise, what time of day the exercise occurred, how many staff were on site, how long the evacuation of the affected area took, debriefing of staff and comments on improvement. A report of all staff in attendance will be forwarded to the Administrator.

Any changes to the evacuation plan will be communicated to staff as soon as possible.

CHECKLISTS

- **"Code Green- Incident Manager Checklist (03-03-01)"**

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INTRODUCTION

Code Black covers the emergency procedure required when the facility is threatened or affected by a bomb or terrorist incident.

PROCEDURE

Threat via Telephone

Person Receiving the Threat

In the event that a bomb threat is received by telephone, the following action will be taken:

1. Remain calm and courteous. **DO NOT HANG UP**
2. use the **"Threatening Call Information Sheet (03-04-01)"** take notes as the caller talks (do not ask him/her to wait while searching for pen/paper or while you write)
3. Attempt to prolong the conversation and extract as much information as possible from the caller.

Ask the following questions:

- When will the bomb explode?
- Where is the bomb? (Specific location)
- What does it look like?
- Why did you place the bomb there?
- What is your name?
- Where are you calling from?

4. Document as much of the conversation and background as possible. Include:

- Date, time and approximate length of the call;
- The exact wording of the threat;
- Any identifying characteristics of the caller:
  - Sex;
  - Estimated age group;
  - Accent;
  - Voice (e.g. loud, soft, effeminate);
  - Speech (fast, slow, nervous);
  - Diction (good, nasal, lisp);
  - Command of the language (articulate, poor, words out of context, mispronunciation);
  - Manner (calm, emotional, vulgar); and
  - Mannerisms (pet phrases, uncommon words)
- Anything familiar about the voice;
- Any background noises;
- Whether the caller seemed to be familiar with the area or building;
- What phone line the call was received on; and
- If there was anything showing on the call display screen

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5. Be alert of subsequent calls of the same nature
6. When the conversation with the caller has terminated, immediately notify the Charge Nurse or your direct supervisor (if immediately available), who will assume the role of Incident Manager
7. Under the direction of the Incident Manager, call the police services 9-1-1 and provide as much detail as possible about the threat received and the caller

Charge Nurse/Incident Manager

1. Upon notification of a telephone threat, assume the role of Incident Manager
2. Announce calmly to all visitors and staff (or have announced) a “Code Black” three times

If the caller identified a specific location the announcement will be:

- “Code Black (location). All visitors and staff, please turn off all cell phones and other wireless devices immediately. Thank You”
- “Code Black (location). All visitors and staff, please turn off all cell phones and other wireless devices immediately. Thank You”
- “Code Black (location). All visitors and staff, please turn off all cell phones and other wireless devices immediately. Thank You”

then initiate an evacuation of the identified floor by announcing

- Code Green (location)"
- "Code Green (location)"
- "Code Green (location)"

Note: as this is not a fire, the elevators may be used for the evacuation (always evacuating to a lower level but not below ground level.)

If the caller was not specific as to the location the announcement will be:

- “Code Black Villa Marconi LTC Home. All visitors and staff, please turn off all cell phones and other wireless devices immediately. All staff commence a search of your work area. Thank You”
- “Code Black Villa Marconi LTC Home. All visitors and staff, please turn off all cell phones and other wireless devices immediately. All staff commence a search of your work area. Thank You”
- “Code Black Villa Marconi LTC Home. All visitors and staff, please turn off all cell phones and other wireless devices immediately. All staff commence a search of your work area. Thank You”

3. Utilize the Incident Manager Checklist - Bomb/Terrorism to track actions and log the times of the response
4. Set up a command post in the Board Room or equivalent
5. Ensure the area used for the command post is searched for a threat before use

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All Staff

1. Immediately turn off cell and wireless phones and two way radios (walkie-talkies) upon the announcement of a Code Black. Use landlines for all communications
2. Use the floor plans located on the clipboards in the emergency pocket on each unit and department to document each area searched
3. Report back to the Incident Manager with your completed audit forms and follow their directions
4. If you are available, respond to the command post in the Board Room/equivalent. At a minimum, one staff member will remain in each Resident Home Area to maintain the safety and security of the other residents

Written or Mailed Threat

These procedures apply to various types of written threats including letters, emails, texts and social media.

Person Receiving the Threat

1. If you open a letter and recognize it as a threat avoid handling the document and envelope so fingerprint / DNA evidence will be preserved
2. If you receive an email, text or social media message that contains a threat, do not delete it
3. Immediately notify the Charge Nurse or your direct Supervisor (if immediately available) who will assume the role of Incident Manager
4. Follow the instructions of the Incident Manager

Charge Nurse/Incident Manager

1. Upon notification of a written or mailed threat, assume the role of Incident Manager
2. Announce calmly to all visitors and staff (or have announced) a “Code Black” three times

If the threat identified a specific location the announcement will be:

- “Code Black (location). All visitors and staff, please turn off all cell phones and other wireless devices immediately. Thank You”
- “Code Black (location). All visitors and staff, please turn off all cell phones and other wireless devices immediately. Thank You”
- “Code Black (location). All visitors and staff, please turn off all cell phones and other wireless devices immediately. Thank You”

then initiate an evacuation of the identified floor by announcing

- "Code Green (location)"
- "Code Green (location)"
- "Code Green (location)"

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Note: as this is not a fire, the elevators may be used for the evacuation (always evacuating to a lower level but not below ground level.

If the threat was not specific as to the location the announcement will be:

- "Code Black Villa Marconi LTC Home. All visitors and staff, please turn off all cell phones and other wireless devices immediately. All staff commence a search of your work area. Thank You"
- "Code Black Villa Marconi LTC Home. All visitors and staff, please turn off all cell phones and other wireless devices immediately. All staff commence a search of your work area. Thank You"
- "Code Black Villa Marconi LTC Home. All visitors and staff, please turn off all cell phones and other wireless devices immediately. All staff commence a search of your work area. Thank You"

3. Utilize the Incident Manager Checklist - Bomb/Terrorism to track actions and log the times of the response
4. Set up a command post in the Board Room
5. Ensure the area used for the command post is searched for a threat before use

All Staff

1. Immediately turn off cell and wireless phones and two way radios (walkie-talkies) upon the announcement of a Code Black. Use landlines for all communications
2. Use the floor plans located on the clipboards in the emergency pocket on each unit and department to document each area searched
3. Report back to the Incident Manager with your completed audit forms and follow their directions
4. If you are available, respond to the command post in the Board Room/equivalent. At a minimum, one staff member will remain in each Resident Home Area to maintain the safety and security of the other residents

A Threat to a Specific Location

Incident Manager

1. If the threat identified a specific bomb location, announce a "Code Green" for the specific floor/area identified
2. Call for additional help, as required, using a landline phone
3. Facilitate evacuation of the identified floor / area according to Code Green procedures
4. Discuss with police if the evacuation should be expanded to include other floors

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All Staff

1. Upon announcement of a Code Green, evacuate all residents from the identified location, following Code Green procedures, and close fire doors
2. Once the area is evacuated stay out of the identified area. The police will initiate the search of that area
3. If you were not involved in the evacuation or have completed the evacuation, conduct a search of your own work area
4. If you discover a threat, notify the Incident Manager or Police

Incident Manager

1. If the threat is non-specific as to location, set up a command post in the Board Room/ equivalent
2. Ensure the area used for the command post is searched for a threat before use
3. Delegate personnel to initiate the staff call-back list
4. Request additional help, as needed, using a landline phone
5. Provide details of the threat and a floor plan of the facility to staff to initiate the search for the bomb in order of the checklist. This will include a search of the grounds. It is recommended that staff be assigned to search the area of the facility they are most familiar with
6. Review the information with the police to determine additional actions to be taken

All Staff

1. If you are responding to the call back, report to the Administration Office by reception or alternate location
2. When reporting in from the staff call back list, you will be assigned to assist in the search
3. Follow search instructions from the Incident Manager
4. Searches will include closets, bathrooms, toilets, garbage cans, laundry carts, medication carts, cabinets, under chairs, tables, and beds. Rooms should be searched in a counter clockwise rotation and from ceiling to floor.
5. As rooms are searched identify them with a “Searched” indicator
6. Each search team will report to the Incident Manager every 10 minutes to provide an update and to be given further instruction. The reporting in will be done by physically reporting in

Suspicious Object/Package Located or Received

Person Discovering the Threat

1. Do not touch, move or open the object
2. Leave the area immediately

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3. Notify the Incident Manager or Police of the location and external appearance of the suspicious object
4. Keep residents and other staff members out of the area where the threat is located
5. Follow the directions of the Incident Manager and Police

Incident Manager

1. Upon notification of the location of a suspicious object, initiate evacuation of the area by announcing, or having announced, “Code Green (location)” (repeat 3 times)
2. Advise the Police of the location and external appearance of the suspicious object
3. Facilitate evacuation of the floor by following the Code Green procedures
4. Provide instructions to staff members involved in the evacuations and ensure the area to which residents are being moved is searched before they are moved into it
5. If the device is confirmed to be an explosive device, initiate a Code Green and coordinate an orderly evacuation of the entire facility, one area at a time, starting with those areas closest to the location of the device
6. Notify the Administrator immediately

All Staff

1. Upon announcement of a Code Green, follow evacuation procedures and remove residents, staff and others from the location identified and secure the area

Note: the area to which the residents are being moved must be searched before the residents are moved into it.

2. In the area near the suspicious object do not activate light switches, slam doors, move nearby objects or use portable radios or wireless phones
3. It must never be assumed that there is only one device. Continue the search in all other areas of the facility until thoroughly complete

Administrator

1. Upon notification of the discovery of a suspicious object, in consultation with the Director of Care, immediately establish the senior IMS Team
2. Notify, or designate a senior staff member to notify, the Ministry of Health and Long Term Care

After the Threat has Concluded

Incident Manager

1. Complete the Ministry of Health Incident Report and forward it to the Administrator or delegate
2. Conduct a short debriefing at the command post to obtain timely feedback from staff on the handling of the event

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3. Ensure the **"Code Black- Incident Manager Checklist (03-04-01)"** is complete
4. Compile a report of all staff in attendance and attach it to the Checklist-Bomb/ Terrorism
5. Prepare briefing notes and present them at the next Quality and Risk Committee of the Board meeting

Managers

1. Provide a short debrief to your team at your next staff meeting, identifying what went well and what needs improvement

All Staff

1. Participate in debriefings
2. Provide feedback to the Incident Manager regarding the response to the threat
3. Direct any media calls or external inquiries to the Administrator

Administrator

1. Review the Incident Report and forward it to the Ministry of Health
2. Receive reports from staff involved in the incident
3. Conduct a debriefing of all the managers involved in the incident

CHECKLIST/FORMS

- **"Code Black- Incident Manager Checklist (03-04-01)"**
- **"Threatening Call Information Sheet (03-04-01)"**
- **"Code Black- Training Record of Attendance Checklist (05-01-02)"**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: TORNADO ALERT PROTOCOL - CODE PINK	Policy #: 03-05-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	SUMMER WEATHER NOTICE		July 2022

SUMMARY

During the summer months, there is an increased risk of severe weather, therefore it is necessary for the home to be prepared in the event of any weather warnings that may be issued during this time.

PROCEDURE:

Charge Nurse/Incident Manager

1. The Incident Manager i.e the Nurse Manager or Designate will announce:
   - a CODE PINK “Summer Weather Notice” insert type of Servere Weather Warning/ watch_____
   - a CODE PINK “Summer Weather Notice” insert type of Servere Weather Warning/ watch_____
   - a CODE PINK “Summer Weather Notice” insert type of Servere Weather Warning/ watch_____
2. The Incident Manager will Announce "ALL CLEAR" when the Severe Weather Warning has ended

All Staff

3. Personnel shall move all residents to corridor and internal central areas, away from windows. Close all drapes to help reduce injury from flying glass.
4. Move beds of residents who are bed ridden into the corridor. Put the brakes on the bed.
5. Leave room doors open.
6. Keep residents as calm as possible and away from windows and doors.
7. Instruct visitors to remain in the corridors with residents.
8. Leave the radio/T.V. on to listen for tornado information.
9. Assign a staff member to monitor the radio and Internet weather stations for updated information.

Assemble the following supplies in a central area: ® Care Plans;

- Chart Rack;
- Dressing tray with supplies;
- Med Cart & all med bins;
- Urinals;
- Bedpans;
- Blankets;
- Flashlights;
- Portable phone;
- Staff phone numbers;
- Battery operated radio; L.O.A. Book.

Section:	Subject:	Policy #: 03-05-01	
EMERGENCY PREPAREDNESS: PROTOCOL	TORNADO ALERT PROTOCOL - CODE PINK	Implemented	Reviewed
Approved by Senior Director of Corporate & Building Services	SUMMER WEATHER NOTICE		July 2022

Severe Thunderstorm Watch

This is the first level of alert of possible thunderstorms. It is often used before clouds have even begun to form, based on the potential for severe storm development. It is valid for large sections of the province. If a watch is in effect for your area stay tuned to local radio, T.V. or weather radio stations for possible warnings. Be on the lookout for thunderstorm clouds.

Severe Thunderstorm Warning

A warning is issued when information is received that the thunderstorms are causing, or are likely to cause damage in your area. It is valid for individual counties, districts and communities. If a warning is issued, pay close attention to announcements. Watch the sky carefully. Be prepared to take safety precautions if necessary.

Tornado Watch

On some occasions, the ingredients necessary for tornado formation are very strong and apparent. When this occurs, a tornado watch may be issued. Be particularly alert for warnings which may be issued.

Tornado Warning

A tornado warning means that a tornado has been sighted or is imminent. Take immediate precautions. [From Atmosphere Environment Service of Environment Canada]

CHECKLIST

- **"Code Pink- Incident Manager Checklist (03-05-01)"**
- **"Code Pink- Training Record of Attendance Checklist (05-01-02)"**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: EXTERNAL AIR EXCLUSION - CODE GREY	Policy #: 03-06-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	CODE GREY- PROCEDURE		July 2022

PURPOSE

To provide an effective and efficient procedure for restricting the entry of outside air into the Villa Marconi LTC Home in the event of hazardous gases/fumes being present in outside air.

External air exclusion is only put into action where evacuation into the open air would be more hazardous to the health and safety of residents and staff (e.g. external chemical cloud, considerable smoke from local fire, abnormally high outside ambient temperatures).

PROCEDURE

Charge Nurse/Incident Manager

1. Upon being notified of an incident or potential incident producing hazardous fumes external to the facility, the Charge Nurse will assume the role of the Incident Manager until relieved by a more senior manager.
2. Advise all staff of the “Code Grey” advising them to “close all open windows and exterior doors.” 3 times.
   - CODE GREY ‘EXTERNAL AIR EXCLUSION’
   - CODE GREY ‘EXTERNAL AIR EXCLUSION’
   - CODE GREY ‘EXTERNAL AIR EXCLUSION’
3. Notify the Director, Property and Environmental Services or designate and the Administrator.
4. Have residents that are outside return inside.
5. Instruct Maintenance to ensure that the external ventilation system is turned off.
6. Ensure residents, staff and visitors are monitored for abnormal breathing difficulties.
7. Establish contact with the local emergency services (Fire / Police), as appropriate, to gather information on the extent of the hazard and provide an update on the status of the facility.

All Staff

1. Upon notification of a Code Grey, close all open windows and exterior doors in your area.
2. If outside, move staff and residents indoors.
3. Follow the instructions of the Incident Manager.
4. Report any abnormal breathing difficulties to the Incident Manager.

CHECKLIST

- **"Code Grey- Incident Manager Checklist (03-07-01)"**
- **"Code Grey- Training Record of Attendance Checklist (05-01-02)"**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: CHEMICAL SPILL PROTOCOL - CODE BROWN	Policy #: 03-07-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	CODE BROWN- PROCEDURE		July 2022

INTRODUCTION

Code Brown covers the emergency response to a situation where hazardous materials may affect the health of the residents or the security of the facility.

Where hazardous materials are spilled and the spill is of the size or potential hazard where unit or maintenance staff is unable to carry out safe clean up, a “Code Brown” will be called.

A spill may include liquids, powders, or even gaseous substances.

PROCEDURE

Originating Staff

1. Upon discovery of a spill of a hazardous or unknown substance, notify the RHA Leader or your Supervisor who will assume the role of Incident Manager.
2. Follow the direction of the Incident Manger.
3. Notify the Incident Manager if you have been contaminated or if you are experiencing any health effects related to contamination.

Incident Manager/Charge Nurse/Designate

1. Upon notification of a spill of a hazardous material assume the role of Incident Manager until relieved of the role by the Director, Property and Environmental Services or delegate.
2. Proceed to the location to assess the situation.
3. Cordon off the area and keep people away from the area until the spill is cleaned up.
4. Notify staff in the area of the spill of the “Code Brown” identifying the location (wing/ area).
   - CODE BROWN “Chemical Spill Protocol’ Location_____
   - CODE BROWN “Chemical Spill Protocol” Location_____
   - CODE BROWN “Chemical Spill Protocol” Location_____
5. **If the spill is of a flammable material or there are any injuries/illness from the spilled material then the spill is <u>deemed unmanageable:</u>**
   - Call 9-1-1.
   - Clear the area of all persons.
   - Ensure there are no sources of ignition; and
   - Ventilate the area by opening windows (if safe to do so).
   - Shut down the air handling system to prevent fumes from traveling through the rest of the building
6. Attend to any people who may be contaminated. Contaminated clothing must be removed immediately, and the skin flushed with water for no less than fifteen minutes. Clothing must be laundered before reuse.
   - Eye wash stations are located in all kitchen areas, housekeeping closets, nursing stations and maintenance shop.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: CHEMICAL SPILL PROTOCOL - CODE BROWN	Policy #: 03-07-01	
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- Showers that can be used for emergency decontamination are located in each tub room on each Resident Home Area and in the staff, locker rooms in the basement.

Note: if the product is flammable or highly toxic, then contaminated clothing should be disposed of properly – not laundered.

7. Where safe to do so, determine the name and quantity of the substance spilled.
8. Obtain the Material Safety Data Sheet.
9. Determine if an evacuation is required. If an emergency evacuation of the spill zone or a greater area is required, activate a Code Green, and notify the Administrator or delegate.
10. After business hours notify the Administrator on call or designate if there are injuries, an evacuation of residents from their home area, or the fire department has been called.
11. Arrange for a commercial spill response team if spill is outside of the capability of the Maintenance staff and initiate the Senior IMS Team.
12. Notify the MOHLTC immediately if any evacuation or displacement of residents occurs or if there is any disruption to the facility operations.
13. If the spill does not create a major difficulty an incident report may be faxed to the MOHLTC.
14. Notify the Ministry of Labour if there are any critical injuries to staff members.

Protocol for Spill Clean-up team:

1. Upon notification of a hazardous material spill report to the Incident Manager.
2. Assess the spill from a safe location to determine if it is within the capability of the team to clean up. The complexity and detail of the cleanup plan will depend upon the physical characteristics and volume of materials being handled, their potential toxicity, and the potential for releases to the environment.
3. Review Material Safety Data Sheets (MSDSs) or other references for recommended spill cleanup methods and materials, and the need for personal protective equipment (e.g. masks, goggles, gloves, protective clothing, etc.).
4. Ensure proper Personal Protective Equipment (PPE) is utilized based on the chemical spilled as per the MSDS sheet.
5. Obtain the Spill Kit stored in the nursing storage room. This kit will include absorbent materials and other equipment to disperse, collect and contain spill control materials (e.g., brushes, scoops, sealable containers).
6. Protect all floor drains or other means of environmental release.
7. Distribute loose spill control materials over the entire spill area working from the outside, circling to the inside. This reduces the chance of splash or spread of the spilled chemical.
8. When spilled materials have been absorbed, use brush and scoop to place materials in an appropriate container. Polyethylene bags may be used for small spills. Five-gallon pails with polyethylene liners may be appropriate for larger quantities.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: CHEMICAL SPILL PROTOCOL - CODE BROWN	Policy #: 03-07-01	
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9. Complete a hazardous waste sticker, identifying the material as Spill Debris involving (identify) chemical, and affix onto the container. Spill control materials may need to be disposed of as hazardous waste – refer to municipal public works for specifics based on the type and quantity of the chemical spilled.
10. Decontaminate the surface where the spill occurred using a mild detergent and water when appropriate.

CHECKLIST

- **"Code Brown- Incident Manager Checklist (03-07-01)"**
- **"Code Brown- Training Record of Attendance Checklist (05-01-02)"**

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: MISSING RESIDENT – CODE YELLOW	Policy #: 03-08-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	CODE YELLOW- PROCEDURE		July 2022

POLICY

A “Code Yellow” procedure will be implemented immediately upon discovering a Resident is missing. A Resident is considered missing when they are not in a location where staff would expect to find them.

Staff members will conduct a short search, as defined in the procedure below, before a Code Yellow is announced.

PROCEDURE

In the event that a Resident is missing, the following action will be taken:

FIRST PHASE 5 MINUTE- time frame

Originating Staff

1. If you realize a resident is unaccounted for inform the RHA Leader.
2. Assist in the search process under the direction of the RHA Leader/Incident Manager.

RHA Leader/Incident Manager/Designate

1. Upon notification that a resident is unaccounted for, assume the role of Incident Manager and direct staff to begin a systematic search of the wing, checking areas the resident may have gone, querying other staff and checking sign in/sign out sheets. Staff will use the Incident Manager Checklist located on the clipboards in the emergency pocket on each unit.
2. Utilize the **Incident Manager Check List – Code Yellow** to track actions and log the times of the response.
3. Document the time the search began
4. If the resident is still unaccounted for after the initial 5 minute search, inform the Charge Nurse who will take over as Incident Manager.
5. Notify the DOC/Designate
6. A nurse from the unit will take the residents chart to the command post (reception desk) with a description of what the resident is wearing. ‘
7. Photocopy the photo found in the resident’s chart for distribution to people searching for the resident

All Staff

1. As directed, search the unit, check areas the resident may have gone, query other staff and check sign in/sign out sheets.
2. Use the floor plans located on the clipboards in the emergency pocket on each unit and department to document each area searched.
3. Report back to the Team Leader with the completed audit forms and follow their directions.

Section: EMERGENCY PREPAREDNESS: PROTOCOL	Subject: MISSING RESIDENT – CODE YELLOW	Policy #: 03-08-01	
		Implemented	Reviewed
Approved by Senior Director of Corporate and Building Services	CODE YELLOW- PROCEDURE		July 2022

Charge Nurse

1. Upon notification from a RHA Leader that a resident has been unaccounted for 5 minutes, assume the role of Incident Manager.
2. Use the **Code Yellow Incident Manager Check List.**

SECOND PHASE-10 MINUTE time frame

Incident Manager

1. Announce Code Yellow calmly to all visitors and staff (or have announced), three times.
   - "Attention please, would (resident/client's name/room#/clothes being worn) please return to (wing/program area) immediately."
   - "Attention please, would (resident/client's name/room#/clothes being worn) please return to (wing/program area) immediately."
   - "Attention please, would (resident/client's name/room#/clothes being worn) please return to (wing/program area) immediately."

Repeat this announcement again after 3 minutes if the resident/client does not return.

2. Organize the unit staff to do a follow up search of the unit and areas of the facility where the resident may routinely visit; recheck the sign in/out sheets; and follow up with visitors that may have visited the resident that day.
3. If it is suspected that the resident has left the building with a family member, delegate a staff member to call the family to confirm.
4. Notify all staff on other units/program areas to determine if the resident is on other floors or areas.
5. Direct staff to check external sitting areas.

If the Resident is not located within 10 minutes, have the RHA Leader complete the Resident Profile and bring it to Reception along with the Resident's chart and picture.

Note: This stage shall last no longer than 10 minutes for a total of 15 minutes after the first indication that resident/client was missing

All Staff

1. Follow the direction of the Incident Manager.
2. Assist with the follow up search and contacting visitors/family members, as requested by the Incident Manager.
3. Be on the lookout for the missing resident. If you do not know what the missing resident looks like, be alert to persons in your area that seem lost or are unknown to you.
4. Report to the Incident Manager any person in your area that you do not know and fits the description of the missing resident or who appears lost.

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THIRD PHASE- initiated 15 MINUTES after the first indication the resident was missing

If the resident has not been located within 10 minutes of the Incident Manager being notified, regardless of the completeness of the current search, the following tasks will be completed:

Incident Manager

1. Commence paging for a “Code Yellow” following the paging procedure posted at the fire panel at reception or nursing station. Announce calmly to all visitors and staff (or have announced) a “Code Yellow” three times:

- “Code Yellow (Resident/Client name/room #/clothing worn) (Resident Home Area).”
- “Code Yellow (Resident/Client name/room #/clothing worn) (Resident Home Area).”
- “Code Yellow (Resident/Client name/room #/clothing worn) (Resident Home Area).”

The announcement will be repeated after 5 minutes

2. Notify the police 9-1-1, providing a description of the resident/client.
3. Complete a Missing Person Report.
4. Retrieve the disaster box from reception in order to access emergency phone numbers and any other equipment required (e.g. flashlights).
5. Move to reception which will become the command post where all responding staff will report for instruction.
6. Give staff a description of the resident (physical description and clothing), including photo and a search floor plan/area map for them to initiate the search of the resident. Where possible, assign staff to search areas that they are most familiar with (e.g. dietary staff to search kitchen and support areas, nursing staff search the unit they are working on) for the initial search.
7. Direct maintenance staff to bring the elevators down to the main floor and put on service with the doors open.
8. When Police arrive, provide them with a photo of the resident/client, a copy of the Missing Person Report and a summary of the actions taken prior to their arrival. The staff search will continue in supplement to the police action.
9. Notify the Administrator or the Administrator on call.
10. Outside of peak staffing hours (11:00 p.m-7:00 p.m) initiate the Emergency Fan Out List
11. The search will include a search of the grounds. Any search external to the building (including on the grounds) will be done in pairs.

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- If it is suspected that the resident may have left the building, you may direct specific staff to start an external facility search at the same time an internal search is being performed.
- Provide maps for all the designated search areas beyond the grounds of the facility.

12. Direct staff to report back to you at a minimum every 10 minutes.
13. After staff have reported back that their assigned search is complete, reassign them to another search area.
14. Assign staff members, who are reporting in from the Emergency Fan Out List, to search in pairs beyond the grounds of the facility and provide them with maps.
15. When sufficient staff is present, commence a second search of the facility and the grounds
    - Determine if the search area should be expanded further.
16. Request maintenance or designate to review video surveillance.
17. Notify the family of the resident.
18. Notify the physician of the resident
19. Ensure all actions prior to the search, during the search and immediately after the search is documented. Can Include:
    - Time resident last seen and by whom
    - Time resident discovered as missing
    - Any unusual behaviour
    - Search procedures and involvement
    - Notification time of pertinent individuals

All Staff

1. Following the announcement of a Code Yellow, if you are available for the search, respond to the command post at reception.

Note: At a minimum, one staff member will remain in each Resident Home Area to maintain the safety and security of the other residents.

2. Conduct a search in an organized fashion, using the floor map by checking:
    - Each room, on/under beds
    - Each bathroom
    - Utility rooms
    - Linen closets
    - Stairwells
    - Elevators
    - All keyed doors
3. When conducting a search of a floor start the search at the Nursing Station and complete the search, ensuring that each room has been searched twice.
4. As rooms are searched, identify them with “Searched” indicators and mark them on the search map. Then search the stairwells.

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5. Report back to the Incident Manager every 10 minutes to provide an update and to be given further instruction. The reporting can be done either by physically reporting in, by cell phone, or by other device.
6. Once your assigned search area is complete, return to the Incident Manager for further assignment.
7. Notify the Incident Manager immediately upon the location of the missing resident.

Administrator

1. Establish the Senior IMS Team in the Meeting Room.
2. Contact the Ministry of Health and Long-Term Care and the Vice President of Operations.

AFTER THE INCIDENT HAS CONCLUDED

Incident Manager

1. Once the Resident has been located notify:
   - The Police Services (9-1-1)
   - Resident POA
   - Administrator
   - Director of Care/Designate
   - Vice President of Operations
   - Medical Director
   - All units and departments by paging an “All Clear” 3 times

- “Code Yellow, (Resident Name), All Clear”
- “Code Yellow, (Resident Name), All Clear”
- “Code Yellow, (Resident Name), All Clear”

2.Advise all searchers and authorities that have been contacted that the resident/client has been located. (i.e. Administrator, Police, Ministry of Health and Long-Term Care, and Vice President of Operations.)
3. Contact the resident’s family to advise them that the resident has been found.
4. Complete the Progress note using the Incident Form.

Charge Nurse

1. Complete an assessment of the Resident’s condition. Document and indicate follow-up. The Physician will see the resident the next day, where appropriate.
2. If required, the resident may need to be sent to ER for assessment (e.g. exposure to cold

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DEBRIEF

Incident Manager

1. Ensure that all documentation is completed.
2. Chair a Code Yellow Debrief session within 24 hours of the event. Upon completion of this meeting, all Managers will provide a short debrief to their teams at their next staff meeting, identifying what went well and what needs improvement. A briefing note will be prepared to present at the next Quality and Risk Committee of the Board.

Administrator/ Director of Care

1. Complete the Critical Incident Form and submit to the Ministry of Health & Long Term Care.
2. Schedule a more detailed review within one week of any incident where police were notified.

CHECKLIST

- **"Code Yellow- Incident Manager Checklist (03-08-01)"**
- **"Missing Resident Search Checklist (03-09-01)"**
- **"Code Yellow- Training Record of Attendance Checklist (05-01-02)"**

RELATED POLICIES/FORMS

Policies/Forms

- Nursing Manual: 05-01-08 “Critical Incidents- CIS Analysis”
- Nursing Manual: 05-01-10 “Missing Residents and Potential Wanderers”

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INTRODUCTION

Code White covers the procedures required during an uncontrolled violent situation that may result in serious injury.

PURPOSE

To ensure Code White is used every time immediate response is needed to manage violent/ aggressive behaviours. A staff member assessing a situation as posing an immediate danger to themselves and/or others can call a “Code White” at any time. In situations where assistance in de-escalation and/or control of the disruption/violence is necessary, responding staff will use non-violent interventions (Gentle Persuasive Approach). The primary aim is to remove all persons from the situation to minimize the risk of injury.

PROCEDURE

This procedure will provide direction in a situation where there is a potential for serious injury or uncontrollable behavior. (For controllable situations, the same procedure will be followed omitting the steps which involve contact with police services.) In the event that a serious violent or potentially uncontrollable situation occurs, the following action will be taken:

Potentially Violent Situation

Originating Staff

1. If you identify a crisis situation remove yourself from the confrontation and immediately notify the police services by calling 9-1-1 and provide as much detail as possible.
2. Announce a Code White (repeat 3 times), identifying the location of the incident:

- “Code White (location)”
- “Code White (location)”
- “Code White (location)”

Note: the announcement will not include if a weapon is involved

3. Notify the Charge Nurse or your direct Supervisor (if immediately available) of the situation, providing as much information as possible.

Charge Nurse/Incident Manager

1. Upon notification of a potentially violent situation take lead as the Incident Manager.
2. Call back the police (9-1-1) with an update of the situation within 5 minutes.

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3. Delegate a staff member to meet the police at the main entrance and provide directions to the scene as well as alternative access to the area (e.g. location of the stairways and the elevator).
4. Delegate a staff member to call the Administrator or designate.

All Staff

1. Upon notification of a Code White, if you are in the area of the emergency or able to respond to the situation, assist by evacuating residents from the area of the threat. The Incident Manager may send you back to your duties if further assistance is not necessary.
2. Reception (or if after hours, a designate chosen by the Incident Manager) will direct visitors/residents entering the Home away from the area until the incident has been confirmed safe by the Incident Manager.
3. Use tactical verbal communication and non-violent interventions to de-escalate the situation if it is safe to do so.
4. If the aggressor has a weapon, do not attempt to remove the weapon or to subdue the person. The only goal will be to remove others from the situation.
5. If any injuries are incurred, provide first aid in a safe location and notify EMS 9-1-1.

Administrator

1. In a serious situation, determine the need to establish the Senior IMS team.

Incident Concluded

Incident Manager

1. Once an incident has been controlled and the concerned area is safe for everyone to enter, announce, or have announced an “All Clear” (repeat 3 times):

- “Code White All Clear”
- “Code White All Clear”
- “Code White All Clear”

2. At the conclusion of the incident complete the Incident Report and forward it to the Administrator or designate.
3. Contact resident POA’s who were involved / affected by the incident.

Administrator

1. Notify the Health & Safety Committee and the Ministry of Labour if any staff suffers a critical injury (as defined by the Occupational Health & Safety Act).
2. Determine if the Ministry of Health should be notified.

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3. Schedule a detailed review within one week of any Code White incident where the police are involved.

All Staff Involved

1. If you were involved in the situation, complete a written report of the details of the incident and submit it to the Administrator within 24 hours of the incident. The report should be completed before leaving the facility.

CHECKLIST

- **"Code White- Incident Manager Checklist (03-09-01)"**
- **"Code White, Non-Resident- Training Record of Attendance Checklist (05-01-02)"**

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PURPOSE

To outline procedural guidelines which:

- Ensure accountable, interdisciplinary resident care that is individual, respectful,
- culturally sensitive, and ethical within a flexible, therapeutic environment
- Meet corporate and professional standards, applicable legislation and evidence
- based best practices
- Promote resident, visitor and staff safety

POLICY

Code White is used to signal a need that assistance is required due to another person behaving in a potentially dangerous manner towards himself or others. There can be a potential that this behaviour may escalate causing further risk and harm to others.

The staff responding to a Code White will do so in a non-violent manner; least restraint approaches will only be implemented after all other options have been tried. Should staff feel that

the situation is beyond their ability to intervene effectively or the behaviour involves a person other than a resident 911 will be called.

Annually, all staff will be trained in responding to a Code White. Training programs that are to be used are either Gentle Persuasion or Non-Violent Crisis Intervention.

CORPORATE PROCEDURES

1. Upon discovery of a situation where a resident is demonstrating responsive behaviour that could potentially harm the resident or others the staff member will GET HELP. IMMEDIATELY by notifying another staff of a “CODE WHITE” situation.
2. The Staff member discovering the situation will remain with the resident; however will remain outside the reach of the resident displaying the responsive behaviour.
3. The staff member receiving the report will immediately notify the Registered Staff on the Home Area or the nearest Registered Staff of the situation.
4. The Registered Staff will immediately alert other staff members of the CODE WHITE situation using the home’s paging or notification system.
5. Once the Code has been activated the Registered Staff will immediately go to the situation to attempt to de-escalate the resident.
6. The first Registered Nurse in charge of the home will assign tasks to staff who responds. Tasks include (if safe to do so):
   - Removing other residents from the area;
   - Removing objects that could be used as weapons from the area;
   - Removing visitors from the area;
   - Establishing a safe perimeter
   - Reviewing the resident chart for orders or family to contact
   - Contacting the physician, and/or contacting the family.

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7. Registered Staff can use the following to de-escalate the situation:
   - Establish and maintain eye contact
   - Talk in a slow gently reassuring voice; try to keep the resident talking
   - Offer the resident tea or coffee or offer a snack
   - Do not patronize the resident or talk in a degrading manner
   - Ask simple questions of the resident
   - Offer them a seat or the option of going back to bed
   - Offer to call a relative and let them talk with the Other Registered Staff responding to the situation should review physician order's for physical or chemical restraint orders. If orders are present prepare the appropriate restraint
8. If no orders, attempt to contact the physician for orders
9. If the resident does not settle and continues to pose a risk contact the physician regarding a Form 1 under the Mental Health Act. If the resident is Formed call 911 for transport to the hospital for assessment.

Note: The original of the Form 1 form must accompany the resident to the hospital; a copy is kept for the resident chart.

10. Once the situation is de-escalated consider assigning one-on-one staffing to the resident for the remainder of the shift or the next shift. (Contact the DOC or designate for approval).
11. Following the conclusion of the situation all staff should meet to debrief on how to situation was handled, what worked well, what didn't work, how staff felt in the situation, what care changes will be made, what about use of medications, and what would be done differently in the future. This debriefing session should be documented, attached to the Incident Report form, and forwarded to the Joint Occupational Health and Safety Committee for review.
12. Documentation to include:
    - Progress Notes – should clearly document the occurrence from the beginning to the end. Clearly identify the trigger if known; state what worked and what didn't work; what made the situation better, what made it worse; what actions did staff take; who was called and when; were restraints used or not; if used what was response, etc.
    - Care Plan – should clearly identify risk for behavioural outbursts. Include what triggers the behaviour, time of day risk is highest, what are the effective interventions, etc.
    - Critical Incident Report– if 911 was called or if there were any injuries a Ministry of Health Critical Incident Report Form is to be completed.
    - Resident Incident Report – Complete and forward to the Director of Care
    - Employee Incident Report – Complete if there were any negative effects on the staff.
13. The Administrator will notify the Universal Care Regional Director of all instances of Code White that result in injury of anyone or in the transfer of a resident to hospital under a Form 1

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CHECKLIST

- **"Code White, Residents- Training Record of Attendance Checklist (05-01-02)"**
- **"Code White-Resident-Incident Manager Checklist (03-09-02)**