Valley Manor
LONG TERM CARE

EMERGENCY PLAN

Emergency Contact Information

See Appendix "C" – Communication Plan for the following contact information and phone numbers

- **Urgent Services Contractors Suppliers Call List**
- **MediSystem Disaster Plan**
- **Call Back List**
- **Fan Out List**

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SUBJECT:	Disclaimers	POLICY #:	EMP00-002
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Disclaimers

Appendices

Please note that Appendices referenced throughout the document are not included online as they contain confidential and sensitive security information. The full Emergency Management Plan including the appendices are available for review by the Ministry of Long-Term Care and the Fire Department at the long-term care home.

In the event of any "real" Emergency Event (not a drill):

On day shift, if you cannot find, or get to, the Charge Nurse in a timely manner (1-2 mins) please go to the closest Manager with a phone and have them make the appropriate CODE announcement; then call 911 if required. If you cannot find a manager, proceed with the Code announcement yourself, then find the Charge Nurse or a Manager. For example, codes for a fire (Red) or Active Shooter/Armed Intrusion (Silver). Then continue to find the Charge Nurse so they can activate the remainder of the appropriate emergency plan procedures.

OR

If it is night shift, follow the previous protocol of a timely code announcement, but also call 911 right away for most any emergency event. Then implement the Fan-Out List call in list right away for any code/emergency event. Night shift has considerably less staff, and extra help will be required for any emergency. For example, Code Yellow the OPP can start searching straight away along their way to the home, and local nearby staff can help start the search as quickly as possible. Night shift staff cannot be spared to start an immediate search outside. The staff called in can start as soon as a couple arrive at the home.

SUBJECT:	**Overall Duties of Staff Involved in Emergency Management Plan**	**POLICY #:**	**EMP00-003**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 4**
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Overall Duties of Staff Involved in Emergency Management Plan

Charge Nurse will be responsible for:

- The safety and security of residents.
- Supervising and directing other staff and for identification wears an orange safety vest.
- Assigns Staff Leads and gives them vests to wear.
- Assign a scribe at code events drills.
- He/she will oversee and take charge of staff, the evacuation and make decisions to support resident safety until such time as another member of the Disaster Control Committee arrives to provide assistance and support.
- Deciding if extra staff are required and initiates Staff call-back system and assigns this duty to another person.
- Must be familiar with Fire Safety Equipment, Procedures and Systems as outlined in this manual.

Assigned Staff Leads will be responsible for:

- The residents' kardexes.
- Calling in staff to assist.
- Provision of resident medications. If during evacuation, the med rooms remain accessible, meds will be labelled and transported to the location where residents have been relocated. If med rooms are not accessible refer to Resource List for other Pharmacy arrangements.
- Resident care including first aid, calls for ambulance and physician services.
- Must be familiar with Fire Safety Equipment, Procedures and Systems as outlined in this manual.

Director of Care will be responsible for:

- Assumes the responsibilities of the Administrator in their absence and provide assistance when required.
- Ensure staff have access to a copy of the Fire and Disaster Plan.

- Must be familiar with Fire Safety Equipment, Procedures and systems as outlined in this manual.
- Ensuring the continuation of Nursing Services.
- Assisting in the evacuation of residents and supporting their safety and care.
- Establishing and maintaining contact with residents' families/next-of-kin and Administrator at Disaster Headquarters.
- Providing/procuring adequate nursing supplies in support of nursing services.
- Scheduling staff according to needs, contacting outside sources for nursing services if required.

Nursing Staff are responsible for:

- All nursing staff go to the fire area prepared to assist with the exception of those who have assigned duties.
- Staff must know how to shut off propane gas (at both locations) if required.
- Be prepared to assist where required.
- Must be familiar with Fire Safety Equipment, Procedures and systems as outlined in this manual.
- The care of the residents and attending to their needs.
- Preparing for transfer to another location.
- Assisting in the relocation.

CEO (also may be referred to herein after as Administrator) is responsible for:

- Oversees all operations.
- Contacts Board of Directors and keeps them informed of situation.
- Contacts Authorities such as Ministry of Health, Long Term Care Office, and Insurance agency, etc.
- Reviews/revises manual as required.
- Must be familiar with Fire Safety Equipment, Procedures and systems as outlined in this manual.
- Overseeing and assisting in the safe evacuation of all residents to other locations.
- Cooperation with civil authorities (Fire, OPP, etc.).
- Ensure sufficient supply of resources (food, supplies, beds, human resources etc.).
- Maintaining contact and coordinating actions with other committee members.
- Information and press releases.
- Transportation and messengers.
- Records keeping.
- Contact evacuation centers and make arrangements for resident’s transportation to those locations.

Medical Staff/Physicians are responsible for:

- The provision of medical care as required.
- Transfer of residents who are in need of more complex care to other institutions.

Maintenance Manager is responsible for:

- In the event of a fire/Drill, will go immediately to area and provide assistance.
- Responsible for orientation of all staff to Fire Safety and to conduct Fire Tours.

- Responsible for conducting 3 fire drills per month, one on each shift.
- Responsible for maintenance of fire safety equipment and systems.
- Works on and reviews/revises this manual in cooperation with Disaster Control Committee.
- Responsible for maintaining liaison with Madawaska Valley Township Fire Department and advising on changes to our facility and fire safety systems.
- Assists in arranging for in service education sessions pertaining to Fire Safety and Emergency procedures.
- Assisting with the disaster plan and evacuation.
- Keeping the building safe and secure.
- Working in cooperation with civil authorities.
- Making a final check of the building to ensure that all appropriate equipment is turned off, windows and doors are closed and locked and a security system is established.

Management Staff are responsible for:

- Provide assistance as required.
- Ensure staff have access to a copy of the Fire and Disaster Plan.
- Must be familiar with Fire Safety Equipment, Procedures and systems as outlined in this manual.

Dietary Staff are responsible for:

- At the sound of the alarm, the supervisor/designate assigns one member of the dietary staff to stay in the kitchen and one member to remain in the dining room, while all other staff proceed to the zone where the drill/fire is located
- Staff must know how to shut off propane gas (at both locations) if required.
- Staff should shut off all electrical equipment, cooking equipment, coffee pots, etc. in a safe manner.
- Close all windows/doors in kitchen.
- Assist in moving residents from dining room area to a safe zone if required.
- Assisting where required.
- Ongoing provision of meals for residents according to residents' needs, at alternate locations.
- Providing refreshments to workers/volunteers.
- Must be familiar with Fire Safety Equipment, Procedures and Systems as outlined in this manual.

Activities Staff are responsible for:

- At the sound of the alarm, staff proceed to zone where drill/fire is located, if program in progress, one staff member is assigned to stay and monitor those residents.
- Other staff report to zone where fire/drill is located.
- Close doors, windows in area.
- Assisting where required.
- Offering suitable activities for residents at alternate locations if not evacuating.
- Must be familiar with Fire Safety Equipment, Procedures and Systems as outlined in this manual.

Main Office Staff are responsible for:

- If alarm sounds--check the annunciator panel and announce over the PA system: "Code Red Zone__", "Code Red Zone __."
- Place a call to 9-1-1 as requested by charge person.
- Be prepared to plug in the emergency phone system in case of power failure.
- Place valuables in the safe and lock it.
- Turn off office equipment, and close door to inner office area.
- Direct the Fire Dept. or other authorities to the fire area.
- Keep a written record including proper sequence and time of events and phone calls.
- Answer incoming calls--keeping lines free for emergency calls--tell the caller--"sorry, your call cannot be answered at this time" and hang up
- May be called upon to redirect visitors.
- Staff must know how to shut off propane gas (at both locations) if required.
- Must be familiar with Fire Safety Equipment, Procedures and Systems as outlined in this manual.
- Assisting with evacuation as required.
- Communication and secretarial duties required.
- Keeping a list of staff by name and telephone numbers.
- Keeping track of resident relocation.
- Keeping a list of family, next-of-kin, P.O.A. for all residents.

Housekeeping Staff are responsible for:

- Assisting where required.
- Keeping building clean, safe and free of debris.
- Must be familiar with Fire Safety Equipment, Procedures and Systems as outlined in this manual.

Laundry Staff are responsible for:

- Assisting where required.
- Providing adequate linens to alternate locations.
- Keeping a tally of linens used.
- Must be familiar with Fire Safety Equipment, Procedures and Systems as outlined in this manual.

All management is responsible for keeping records of supplies used.

Information and Press

The **Administrator/CEO** will be responsible for preparing press releases and contacting the newspaper, radio and tv. It is important to keep the public informed as to what has occurred, the type of disaster plan in effect, suspension of visiting arrangements, the location of evacuated residents and who to contact for further info concerning residents' condition. At the time of the disaster and evacuation, it may be necessary for the Charge Nurse/designate to call upon OPP to control the press.

SUBJECT:	**Urgent Maintenance Services, Fan-Out List and Valley Manor Contact Information**	**POLICY #:**	**EMP01-001**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 2**
SECTION:	**Introduction**	**REFERENCES:**	
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Urgent Maintenance Services Policy

In the event that a home is experiencing an emergency and is in need of urgent maintenance service, e.g. utility failure, building emergency, or any environmental condition immediately affecting resident or staff well-being and safety, the person in charge of the home will ensure the following procedure is followed.

Urgent Maintenance Services Procedure

1. Consult the Call Back List in Appendix 'C' - Communication Plan, for emergency contact information.
2. If the emergency is weather related such as snowy or icy conditions contact the snow removal contractor listed for the home in the Call Back List.
3. If the emergency requires maintenance personnel to be contacted, call the home's Maintenance Manager.
4. If the home's Maintenance Manager is unavailable, do not leave a message and proceed to contact the home's additional maintenance personnel.
5. If the home's maintenance personnel are unavailable, do not leave a message and proceed to call the Administrator, located in Appendix 'C' - Communication Plan.

Upon receiving the call, the person will immediately:

a. Call the home.
b. After assessing the problem, he/she will either:
   - Respond to the home;
   - Contact a service company to correct the problem.

To ensure twenty-four-hour emergency protection, the Maintenance Manager or designate shall have available to him/her:

1. A list of resources, including Emergency Contact Information as listed in Appendix 'C' of the Emergency Management Plan,
   a. Emergency Fan Out System;

b. Valley Manor Contact Information;
c. Call Back List; and
d. Emergency keys for the home.

Fan-Out List Location

1. The fan-out list shall be placed in the front of Appendix 'C' - Communication Plan located in the Emergency Management Plan;
2. The fan-out list shall also be posted in the Nurses Station for easy access; and
3. The fan-out list shall be available to all managers at their individual homes.

Fan-Out List Procedure

1. First call is made and the flow continues based on the following diagram;
2. Individuals being called are to notify the staff in their column if they have one on the list;
3. If a person cannot be reached, the individual next in line will be called;
4. Be certain to indicate the location and type of emergency; and
5. Upon arrival to the home, Managers are to report to emergency crews/Charge Nurse.

See Appendix 'C' – Communication Plan

SUBJECT:	**Purpose and Locations of Emergency Management and Fire Safety Plans**	**POLICY #:**	**EMP01-002**
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Emergency Management Plan

The Emergency Management Plan replaces the Disaster Code Manual.

Purpose of an Emergency Management Plan

Emergency situations require an appropriate, well-coordinated response by many people, including staff, residents, visitors and community partners.

The purpose of an emergency plan is to provide an effective, coordinated and appropriate plan of action to respond to and recover from an emergency event.

Effective emergency plans:

1. Identify the lines of authority;
2. Identify the assignment of staff;
3. Describe the actions occupants should take during the emergency;
4. Identify the building safety features and systems that pertain to the emergency;
5. Identify community partners and resources needed to assist with the emergency;
6. Describe the actions needed to recover from the emergency at its conclusion.

No amendments to these plans are permissible unless approved by the CEO.

These plans have been developed in accordance with the *Fixing Long Term Care Act, 2021* (FLTCA) and Ontario Regulation (Ont. Reg.) 246/22 made under the FLTCA.

Purpose of a Fire Safety Plan

The Ontario Fire Code, Section 2.8 requires the establishment and implementation of a Fire Safety Plan for buildings containing assembly occupancy or care or detention occupancy.

The implementation of a Fire Safety Plan helps to assure effective utilization of life safety features in the building and to protect people from fire.

Ont. Reg. 246/22

s. 268(11): If there is a conflict or an inconsistency between a provision of the fire code under the *Fire Protection and Prevention Act, 1997* and a provision of an emergency plan, the fire code prevails to the extent of the conflict or inconsistency.

Locations – Emergency Management and Fire Safety Plans

See Appendix 'I' – Fire Zones, Floor Plans (Home Specific), Location of Emergency Plans, Location of First Aid Kits by Department, Fire System Check

SUBJECT:	**Appendices – Supporting Materials**	**POLICY #:**	**EMP01-003**
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Purpose

Appendices are supporting materials and information that shall be used and consulted according to the Emergency Management Plan. A summary of the supporting materials in these sections is as follows:

Appendix 'A': Emergency Reports, Required Actions Checklists & Signage

a) Emergency Drill Report (all codes) (complete immediately after incident/drill);
b) Required Actions Checklists (applicable codes).
c) Signage

Appendix 'B': Emergency Response Plan Summary Sheets and Testing of Emergency Plans Schedule

a) Testing of Emergency Plans schedule;
b) Emergency Response Plan "Debrief & Action Plan" sheets (complete within 30 days of incident/drill).

Appendix 'C': Communication Plan

a) Urgent Services Contractors Suppliers Call List;
b) Care Home Disaster Plan;
c) Call Back List;
d) Emergency Fan-Out System List for emergencies, after-hours calls; and
e) Emergency Management Plan Communication Requirements Log.

Appendix 'D': Reciprocal Relocation Agreements

a) Alternate shelter arrangements and contact information for an activation of the **Code Green** Emergency Response Plan.

Appendix 'E': Transportation Plan

a) Resident transportation arrangements and contact information for activation of the **Code Green** Emergency Response Plan;

b) Transportation arrangements and processes for the movement of medical supplies, PPE and other emergency equipment for residents and staff during a relocation or evacuation.

Appendix 'F': Extreme Weather Plan

a) Extreme Weather Plan Checklist in support of EMP01-013.

Appendix 'G': Emergency Resource Stockpiles

a) Emergency Resource Audit Forms in support of EMP01-016.

Appendix 'H': Hazard Identification Risk Assessments (HIRA)

a) HIRA template in support of EMP01-017.

Appendix 'I': Location of Emergency Plans, Fire Zones and Floor Plans

a) Home specific Emergency Management Plan locations,
b) Home specific Fire Safety Plan locations,
c) Home specific fire zones and floor plans,
d) Home specific First Aid Kit locations.

Appendix 'J': Resetting Main Fire Alarm Control and Annunciator Panels Instructions

a) Home specific information on the resetting of fire alarm control systems.

Appendix 'K': Media Relations Policy and Protocol

SUBJECT:	**Definitions**	**POLICY #:**	**EMP01-004**
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For the purpose of this manual the following words, abbreviations and phrases have the following meaning:

Adverse effect means one or more of:

a) impairment of the quality of the natural environment for any use that can be made of it;
b) injury or damage to property or to plant or animal life;
c) harm or material discomfort to any person;
d) an adverse effect on the health of any person;
e) impairment of the safety of any person;
f) rendering any property or plant or animal life unfit for use by man;
g) loss of enjoyment of normal use of property; and
h) interference with the normal conduct of business.

All Other Staff: Any staff member not specifically identified in the emergency plans including but not limited to:

1. Registered Nurse (not designated as “Charge Nurse”);
2. Registered Practical Nurse;
3. Personal Support Worker (not designated as “Charge Nurse”);
4. Dietary staff;
5. Housekeeping staff;
6. Laundry staff;
7. Administration staff; and
8. Activities staff.

Charge Nurse: A staff member responsible for coordinating the efforts of staff assigned to an area of the home, for the purpose of carrying out duties under an emergency plan.

Comprehensive Drill: A simulated emergency whereby emergency systems are activated and staff with responsibilities in the emergency plan will carry out these responsibilities including, in the event of a fire drill, physically evacuating the affected area. Note: staff will not evacuate residents when the health or safety of the resident may be compromised, volunteers may be used as an alternate.

EMP: Emergency Management Plan

Emergency: means an urgent or pressing situation or condition presenting an imminent threat to the health or well-being of residents and others attending the home that requires immediate action to ensure the safety of persons in the home. Including, but not limited to:

1. Fire or smoke;
2. Evacuation;
3. Search for missing resident;
4. Loss of essential services e.g. water, heat, electricity, cooling;
5. Natural Disaster – flood, tornado;
6. Extreme Weather – wind, winter storm;
7. Bomb threat;
8. Relocation of residents, internally or externally;
9. Acceptance of additional residents and/or other persons into the home, or expansion of services relating to a situation outside the home;
10. Violence;
11. Medical emergency; and
12. Lockdown.

Fire Safety Coordinator: Maintenance Manager or designate.

Joint Health and Safety Committee (JHSC): The LTCH's certified labour and management representatives.

LTCH: Long Term Care Home.

Major Chemical Spill: Any spill of a pollutant that creates a hazard to the health of a person (i.e.: a chemical that generates hazardous or toxic vapors, corrosive etc.) that occurs in a quantity that requires the response from an emergency service.

Medical Emergency: A serious situation that arises suddenly and threatens the life or welfare of a resident, staff member or visitor.

Minor Chemical Spill: Any spill of a pollutant in a quantity that does not create a hazard to the health of a person other than the hazards associated with the safe handling of the product.

MLTC: Ministry Long Term Care.

Occupants: All persons within a building including but not limited to residents, family members, visitors, volunteers, or other staff members.

Owner: Any person, firm or corporation having control over any portion of the building or property under consideration and includes the persons in the building or property (FC ON Reg 213/07). The home's Administrator is considered the owner.

PSW: Personal Support Worker.
RHA: Resident Home Area.
RPN: Registered Practical Nurse.
RN: Registered Nurse.
Silent Drills: Simulated emergencies whereby emergency systems (i.e. fire alarm

system) are not activated but staff will respond to the emergency and demonstrate/simulate their emergency response activities.

Supervisory Staff: Any staff member who has some delegated responsibility for the safety of other occupants under the emergency plan.

Table Talk Exercise: Similar to a silent drill but does not involve a physical demonstration/simulation of the emergency response activities. Table talk exercises involve facilitated discussions surrounding example emergency scenarios.

Violent Outburst: When an individual displays a substantial loss of control and aggressive/responsive behaviour is imminent or has erupted and available resources are not sufficient to safely manage the situation.

Outbreak: An outbreak is a sudden rise in the number of cases of a disease and it carries the same definition of epidemic, but is often used for a more limited geographic area.

Endemic: the usual incidence of a given disease within a geographical area during a specified time period.

Epidemic: an excess over the expected incidence of disease within a given geographical area during a specified time period. If the expected number of cases of a disease in a province is 8 per year, and 16 occur in 1 year, this indicates an epidemic. It should be noted that an epidemic is not defined on the absolute number of cases but on the number of cases in comparison to what is expected.

Pandemic: an epidemic spread over a wide geographical area, across countries or continents, usually affecting a large number of people. It differs from an outbreak or epidemic because it:

- affects a wider geographical area, often worldwide;
- is often caused by a new virus or a strain of virus that has not circulated;
- among people for a long time. Humans usually have little to no immunity against it. The virus spreads quickly from person-to-person worldwide;
- causes much higher numbers of deaths than epidemics; and
- often creates social disruption, economic loss, and general hardship.

EMP01-004 Definitions

LIST OF ABBREVIATIONS

Acronym	Description
ADS	Adult Day Service
AHU	Air Handling Unit
AQI	Air Quality Index
BAS	Building Automation System
BCP	Business Continuity Plan
BLR	Boiler
BSO	Behavioural Support Ontario
CAO	Chief Administrative Office
CEO	Chief Executive Officer
CEMC	Community Emergency Management Coordinator
CIS	Critical Incident System
CLT	Centre Leadership Team
CN	Charge Nurse
CO	Carbon Monoxide
CQI	Continuous Quality Improvement
CSS	Community Support Services (ADS)
DOC	Director of Care
EFAP	Employee and Family Assistance Program
eMAR	Electronic Medication Administration Record
EMP	Emergency Management Plan
EMS	Emergency Medical Services
EOC	Emergency Operations Centre
FACT	Filter and Coating Technology Inc.
FLTCA	Fixing Long Term Care Act, 2021
FMC	Fire Monitoring of Canada
HIRA	Hazard Identification and Risk Assessment
HEM	Health Emergency Management
HVAC	Heating, Ventilation, Air Conditioning
IC	Incident Commander
IMS	Incident Management System
LHIN	Local Health Integration Network
LTC	Long Term Care
LTC CG	Long Term Care Control Group
MAR	Medication Administration Record
MLTC	Ministry of Long Term Care
MOE	Ministry of Environment
MSDS	Material Safety Data Sheets
NF	Nursing Forms
NOK	Next of Kin
OHS	Occupational Health and Safety
Ont. Reg. 246/22	Ontario Regulation 246/22 made under the Fixing Long Term Care Home Act, 2021
PA	Public Address
PCC	Point Click Care
POC	Point of Care
PSN	Program Support Nurse
PSW	Personal Support Worker
RAI	Resident Assessment Instrument
REM	Regional Emergency Management
RHA	Resident Home Area
RN	Registered Nurse
RPN	Registered Practical Nurse
RTU	Roof Top Units
SARS	Severe Acute Respiratory Syndrome
SAO	Service Area Office of MOHLTC
SDM	Substitute Decision Maker
SOC	Supervisor of Care

SUBJECT:	**Authority – Declaration and Chain of Command**	**POLICY #:**	**EMP01-005**
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External Emergency (Disaster)

An external emergency will be declared by the mayor of the local municipality Committee, who will declare a "Disaster Alert" and designate a "Disaster Area". In this situation, the Commissioner of Community Services, or his/her alternate, will consult with and receive appropriate direction from the Disaster Co-ordinating Committee and/or related community protection services.

Long-Term Care Home Emergency

An internal emergency can be declared by the Charge Nurse, CEO or in his/her absence, designated personnel, as authorized by the Administrator in succession as follows:

1. Director of Care;
2. Infection Prevention and Control (IPAC) Lead; and
3. Maintenance Manager

Administrator/CEO

In the event that the home's Charge Nurse is not fulfilling the duties of the role; the Administrator or in his/her absence, designated personnel, as authorized above will assume the role of the Charge Nurse.

Charge Nurse

The In-Charge Registered Nurse (Charge Nurse) for the home will be responsible for carrying out the duties of the "Charge Nurse" as detailed in the emergency plans here in.

Assigned Staff Lead - Resident Home Areas

The home will delegate the duties of the "Assigned Staff Lead" to nursing staff members which may include the Registered Nurse (RN) (other than the Charge Nurse), Registered Practical Nurse (RPN), or Personal Support Worker (PSW).

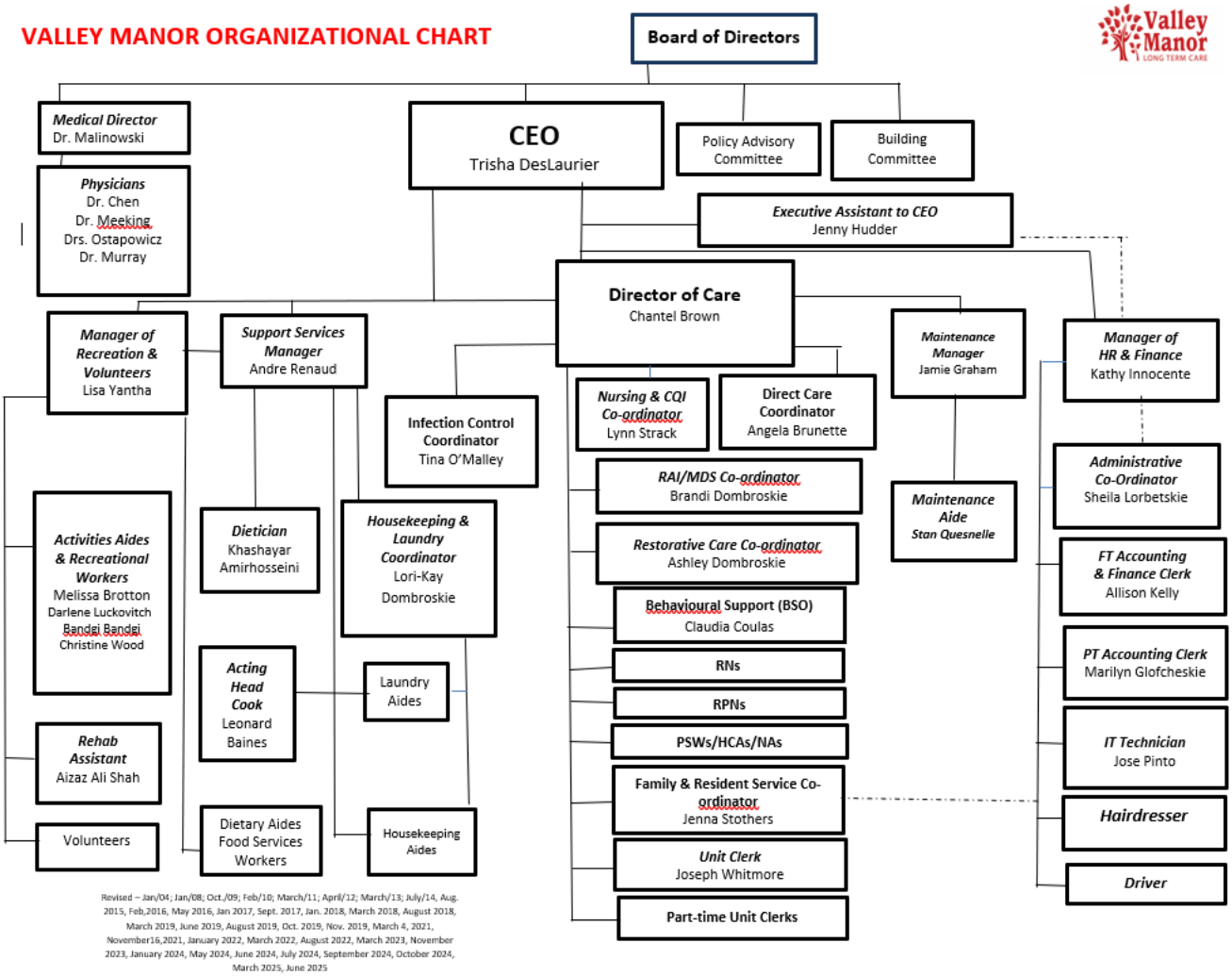
Staff designated “Assigned Staff Leads” for a Resident Home Zones will carry out the duties of the “Assigned Staff Leads” as detailed in the emergency plans here in.

Assigned Staff Lead - Central Areas/Administration Areas

The home will delegate the duties of the Assigned Staff Lead for central areas/administration areas to:

1. An RN, RPN, or PSW staff member or;
2. A member of the home’s management team or; and
3. The Administrative Coordinator or Administrative Assistant to CEO.

Figure 1.1 Management Structure:



SUBJECT:	**Attestation**	**POLICY #:**	**EMP01-006**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 1**
SECTION:	**Introduction**	**REFERENCES:**	
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Purpose

Every licensee is required under the *Fixing Long Term Care Act*, *2021* (FLTCA) s. 90(3) to attest to their compliance with FLTCA s. 90 – Emergency plans.

Requirements

According to ss. 270(1) of Ont. Reg. 246/22, this attestation must include:

1. The licensee's legal name;
2. The name of the home;
3. The date of the attestation;
4. The full name and title of the person attesting;
5. A statement attesting that the requirements under s. 90 of the Act, and s. 268 and 269 under this regulation are complied with;
6. A statement attesting that all the information and answers provided in the attestation are complete, true, and correct; and
7. A statement attesting that the licensee understands that any misrepresentation, falsification, or omission of any material facts may render the attestation void.

Documentation

The attestation will be completed by the long-term care home Administrator and will be submitted annually to the Director named in the regulation.

A record of every attestation shall be maintained on site in the Administrator's Testing of Emergency Plans binder.

PRE-INCIDENT PLANNING AND TRAINING

Pre-planning activities such as the development of the Emergency Plan, education and training of staff and volunteers, establishing emergency supplies, and maintenance of the Plan are activities designed to ensure staff know the approved emergency protocols.

The Director of Care and Home Administrators will work to maintain partnerships with the Ministry of Long-Term Care, the Home and Community Care Support Agencies, other Long Term Care homes, and other agencies that may support incidents.

Orientation and Education Sessions

The Valley Manor's LTC Centres engage in a variety of activities designed to teach, test and exercise the Emergency Plan knowledge of the staff and volunteers.

Emergency Plan orientation (including threats and hazards) and basic fire safety instruction is provided as follows:

- Before commencement of duties for all staff and reviewed again annually or more often as needed. In the case of emergencies or exceptional and unforeseen circumstances only, it is acceptable for staff to receive the training within one week of the date the staff member begins performing their job;
- All volunteers receive an orientation booklet that provides information on the centre's Emergency procedures;
- All employees are expected to be aware of the Plan, identify where it can be found, and understand their individual and collective roles and responsibilities during an emergency situation;
- All staff participate in training modules on emergency codes and a mandatory education session regarding fire and emergency response on an annual basis;
- Fire drills are conducted once per month (on each of 3 shifts) and require staff participation;
- Significant changes to the Plan are shared with staff at annual mandatory In-Service or Team Meetings and reinforced in subsequent training;
- Service providers are informed in writing of their expectations in emergency response;
- The Resident Admission Package provided to residents and their families upon admission outlines the safety and security expectations and considerations required of residents and their families during a real or mock emergency event.

SUBJECT:	**Training**	**POLICY #:**	**EMP01-007**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 2**
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Training

As per Ont. Reg. 213/07, s 2.8.2.1(7), any training of supervisory staff in a care and treatment occupancy carried out under a fire safety plan shall be recorded.

As per Ont. Reg. 246/22, s. 268(14) homes must train staff, volunteers, and students on emergency and evacuation procedures before they perform their work duties. In the event of an emergency or exceptional and unforeseen circumstances, the training set out above must be provided within one week of when the person begins performing their responsibilities. Retraining is to occur annually thereafter.

Training will be conducted in all emergency response plans as per the applicable legislation and each long-term care home's Hazard Identification and Risk Assessment (HIRA).

Department Managers will be responsible for ensuring the staff within their department have been trained with respect to their roles and responsibilities as detailed in the approved Fire Safety Plan and Emergency Management Plan.

Mandatory Information for Training:

1. Location of emergency plans (Emergency Management Plans).
2. Content and lay-out of the Emergency Management Plans:
    a. Emergency contact information;
    b. Emergency Drill Reports and Required Actions Checklists;
    c. Floor plans; and
    d. System Reset Information.
3. **Code Red** -Fire Procedures:
    a. Roles and responsibilities;
    b. Location of annunciator panels;
    c. Location of fire alarm pull stations;

d. Location of posted fire exits;
e. Location and use of fire extinguishers and blankets;
f. Location and use of telephones, communication systems; and
g. Location of fire doors and identification of the fire zones.

4. **Code Green** – Evacuation Procedures.
5. **Code Yellow** - Missing Resident Procedures.
6. **Code Grey** - Building Emergency, Natural Disaster and Extreme Weather Procedures.
7. **Code Black** - Bomb Threat Procedures.
8. Code Brown - Chemical Spill Procedures.
9. Code Orange - Community Disaster Procedures.
10. **Code White** - Violent Outburst Procedures.
11. **Code Blue** - Medical Emergency Procedures.
12. **Silver** - Active Shooter/Armed Intrusion Situation Procedures.
13. **Code Purple** - Lockdown/Threatening Visitor/Hostage Situation Procedures.

Records of Training

All staff training will be documented and recorded; records will be maintained for a minimum of two years. All **Code Red** Fire Procedure and **Code Green** Evacuation training records will be maintained by the Maintenance Manager in their Testing of Emergency Plans binder for review by the Chief Fire Official at his/her request.

EMP01-008 Communication Plan

COMMUNICATIONS DURING AN EMERGENCY

Immediate and direct communications to those involved in an emergency are essential. Refer to the Communication Plan and Media Relations Policy and Protocol. Copies found in Appendix “K”.

During an emergency, you will receive communication from one or more of the following:

- Emergency Personnel;
- Management Leadership Team;
- Your Supervisor or other Supervisors in your area; and
- Long-Term Care Emergency Operations Centre (LEOC).

Follow the direction of Emergency Personnel (Police, Fire, Paramedics) during an event.

Communication may be any combination of the following:

- Alarm system if you have to prepare to evacuate or begin to evacuate;
- By voice command, including Public Address (PA) system, megaphone or simple verbal directions;
- Broad communication via email approved by the Management Team;
- Other methods such as email or alerts on digital platforms approved by the Management Team;
- Walkie Talkies (Channel 20) or Cell phones; and
- Runner/courier.

Social Media

- Your safety is the highest priority;
- **Do NOT take photos and/or post to social media during an emergency;**
- Follow the directions provided by Emergency Personnel, or instructions through the communications methods listed above;
- Do not use social media as a guide unless from official sources.

SUBJECT:	**Communication Plan**	**POLICY #:**	**EMP01-008**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 3**
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Description

Communication strategies and requirements are imbedded within the emergency response plans. Additional communication strategies and requirements are as follows:

Ont. Reg. 246/22 s. 268

(2) Every licensee of a long-term care home (LTCH) shall ensure that the emergency plans for the home are recorded in writing.

(3) In developing and updating the plans, the licensee shall,

a) Consult with entities that may be involved in or provide emergency services in the area where the home is located including, without being limited to, community agencies, health service providers partner facilities and resources that will be involved in responding to the emergency, and keep a record of the consultation; (see Communication Log - located in Testing of Emergency Plans binder)

b) Ensure that hazards and risks that may give rise to an emergency impacting the home are identified and assessed, whether the hazards and risks arise within the home or in the surrounding vicinity or community; (see Appendix 'H'), and

c) Consult with the Residents' Council and Family Council, if any (see Testing of Emergency Plans binder).
Identification of entities that may be involved in or that may provide emergency services in the area where the home is located including, without being limited to, community agencies, health service providers as defined in the *Connecting Care Act, 2019*, partner facilities and resources that will be involved in responding to the emergency and the current contact information for each entity. (See Call Back List –Appendix 'C')

(4) The licensee shall ensure that the emergency plans for the home are evaluated and updated,

(a) At least annually, including the updating of all emergency contact information of the entities referred to in paragraph four of subsection 268 (4); (see EMP

review/revision dates) and;

(b) Within 30 days of the emergency being declared over, after each instance that an emergency plan is activated. (see Testing of Emergency Plans binder)

(5) The licensee shall keep current all arrangements with entities that may be involved in or provide emergency services in the area where the home is located including, without being limited to, community agencies, health service provider's partner facilities and resources that will be involved in responding to the emergency. (See Appendix 'C' – Call Back List)

Communication before an Emergency

Advance communication to building occupants and applicable stakeholders will occur where such notice is given, including but not limited to:

a) Extreme weather warnings;
b) Planned utility outages;
c) Planned water shut-offs; and
d) Any other applicable planned shutdowns or interruptions of service.

All staff will follow their roles, responsibilities and associated communication requirements as noted by the applicable emergency response plan that has been activated in a case where advance notice is provided.

Communication during an Emergency

The Charge Nurse will communicate the beginning and end of emergency situations to building occupants and fill out the Emergency Drill Report (Appendix 'A') as per emergency response plan requirements.

All departmental staff, including the Charge Nurse, Assigned Staff Leads, and Managers will follow their roles, responsibilities and associated communication requirements as noted by the applicable emergency response plan that has been activated.

The Administrator (or designate) shall ensure frequent and ongoing communication to residents, substitute decision-makers, if any, staff, volunteers, students, caregivers, the Residents' Council and the Family Council, if any, on the emergency in the home including at the beginning of the emergency, when there is a significant status change throughout the course of the emergency, and when the emergency is over.

Communication after an Emergency

The Charge Nurse will fill out the Emergency Drill Report (Appendix 'A') and Debrief Checklist & Action Plan with home staff and occupants in the area(s) impacted by the emergency as per response plan requirements. Completed Emergency Drill Reports and Debrief Checklist & Action Plans are stored in the Testing of Emergency Plans binder:

- Emergency Drill Report – to be completed immediately following incident/drill; and
- Debrief Checklist & Action Plan – to be completed within 30 days following the incident/drill.

Communication will also be issued to other stakeholders from the Administrator or Managers

as required based on the impact and duration of the emergency situation. This communication will be noted on the Communication Log.

Communication Log

Any communication as noted above will be documented on the Communication Log. The sender, receiver, message and format delivered will all be logged on the Communication Log template located in Appendix 'C'. Completed Communication Logs will be stored in the Administrator's Testing of Emergency Plans binder.

Communication Equipment and Methods

Each LTCH has multiple forms of communication equipment that staff shall be made aware of in training:

a) Landlines;
b) Computers;
c) Radios;
d) Cell phones; and
e) Runners (if the need to transfer the message physically arises).

Emergency Contact Information can be found at the Nurses Station in the Emergency Management Plan, Appendix 'C'.

SUBJECT:	**Building Access**	**POLICY #:**	**EMP01-009**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 1**
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Building Access during an Active Emergency

Access by friends, relatives and the public shall be prohibited during any emergency unless authorized by emergency crews or the Charge Nurse in consultation with emergency crews (as applicable).

Long-term care homes under activated emergency situations will maintain the safety of staff and residents and be aware of all building occupants to provide the most effective response. Building access is limited during these situations.

SUBJECT:	**Staff Reporting**	**POLICY #:**	**EMP01-010**
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Policy

To ensure the safety of residents and continued provision of services staff are expected to report as per their scheduled shifts and/or as per the call back list if a home is in an emergency situation.

Description

Staff may be asked to alter shift start times if an emergency situation is forecast with advance notice (i.e. Special Weather Statements).

Staff may be asked to work at relocation facilities in the provision of resident care if a LTCH is forced to evacuate (**Code Green**).

Staff are encouraged to make the necessary preparations to report as scheduled in extreme weather, i.e. winter storm warnings, wind warnings, tornado warnings, and flood warnings.

When a LTCH is short staffed during an emergency situation the adverse effect it has on all building occupants is amplified.

Food and Fluid During an Emergency

During an emergency the Valley Manor has developed plans with partners to ensure a regular and healthy diet is always provided to our residents and clients.

Our LTC Homes will maintain at a minimum a 24-hour supply of perishable and three-day supply of non-perishable foods. An emergency 3-day menu guideline that includes regular, therapeutic and texture modified diets is available at each Long-Term Care home.

Plans are in place to ensure food and fluid provision during an emergency, even if power is lost to facility. The nature of the emergency will determine the extent the emergency 3-day menu is implemented.

Valley Manor has a plan in place to minimize disruption from normal routines during an emergency by ensuring that there is sufficient food supply and staffing.

Emergency 3-Day Menu

Available at LTC home. Please contact Administrator for details.

Goal: "To mitigate any risk of acute decline related to energy and fluid intake".

Note: Available for all meals - Instant coffee/tea, Coffee Mate, sugar, powdered or UHT milk, nutritional supplements, fresh fruit, ginger ale and diet ginger ale.

Menu is created with the intention that a generator will provide up to 72 hrs of electrical power for small appliance (ie. Blender).

As per Act LTC4-05.14.07, the nature of emergency will determine the extent of adaptation that will be necessary.

If power, gas and water are unavailable, items will be heated on BBQ's, portable Burners and propane outside the building (If available). Potable water will be used to prepare all soups, crystals and milk. Disposable serving items will be used.

Use in stock supply of desserts as available and appropriate. Ensure Plus is to be used for all puree diets if there is no electricity to puree foods.

Portion sizes are all the same as regular diet during emergency. Serve extra water and/or reconstituted skim milk powder if available.

All beverages served as 250 mL to ensure adequate fluid intake of 1500mL per day, excluding supplement beverages.

Where an entrée is not available, provide a substitute of 235 mL Ensure Plus or 250 mL Carnation Instant Breakfast.

For Therapeutics Spreadsheets, Recipes and Sysco Order Codes - please refer to "3 Day Emergency Menu" binder located in dietary department.

Medication During an Emergency

During an emergency, Valley Manor Long Term Care Staff can access emergency pharmacy assistance through our vendor MediSystem.

A summary of the services provided by MediSystem and contact information can be found in Appendix C01-002:

- Will use existing network of pharmacies across the province to assist in meeting the needs during an emergency or disaster;
- In the event of a disaster, fire or other forced evacuation at the home, Pharmacy will work closely with the home to provide the following in a timely manner:
- Replacement and dispensing of all required medications
- Delivery of required medication to alternative locations
- Delivery and Printing of MAR Sheets and/or Prescriber's Medication Review
- Provide ongoing refills to the alternate location for the duration of the evacuation
- In the event the home receives residents evacuated from another home or the community they will make arrangements to dispense medications to these residents in blister cards, vials, or multi-dose packages for the required length of time.
- Pharmacies are equipped with security monitoring systems as well as safes for storage of antiviral medication and other high-security risk drugs;
- Includes a special section on antiviral and vaccine distribution and Administration;
- Protocols are in place to allow pharmacists to continue dispensing ongoing orders of medication in a situation without access to a physician; and

In the event of a widespread disaster, emergency situation or pandemic MediSystems will work with the government, public health and other organizations to collate, document and distribute needed medications as required.

SUBJECT:	**Food, Fluid and Medication Provision**	**POLICY #:**	**EMP01-011**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 1**
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Policy

Each long-term care home shall ensure that there are plans for food and fluid provision and to ensure all residents have timely access to all drugs that have been prescribed to them if an emergency response plan has been activated.

Food and Fluid Provision during an Emergency

Food and fluid provision during an emergency response plan activation will be in accordance with the emergency procedures detailed within G01-003.

Medication Provision during Outbreaks of a Communicable Disease or of Public Health Significance, Epidemics and Pandemics

Will be administered in accordance with the Emergency Response Plan and the Medication Management System.

Medication Provision during A Code Blue – Medical Emergency

Will be administered in accordance with the **Code Blue** Medical Emergency Response Plan.

Medication Provision during All Other Emergencies

Medication provision during an emergency response plan activation will be in accordance with the emergency procedures detailed within Appendix C01-002, and MediSystems Policies & Procedures. In the event of relocation, medications, MAR's and supplies will be prepared as required and delivered to the designated location by the pharmacy. Emergency contact information for MediSystems Pharmacy can be found in Appendix 'C' – Communication Plan.

Types of Emergencies That Are Most Likely to Affect Valley Manor Long Term Care:

Many hazards could threaten every day. These hazards have the capacity to cause social disturbances, human casualties and physical destruction.

Municipal Emergency Management team using the Hazard Identification and Risk Assessment (**HIRA**) matrix and referenced in Valley Manor Emergency Plan identifies the most likely health-related emergencies requiring a response as:

- Epidemic disease outbreak (e.g. Pandemic Influenza, SARS, etc.);
- Major transportation accidents;
- Terrorism;
- Severe Weather (e.g. tornados, high winds, ice storm, drought, flood, heat wave);
- Power grid/generator failure/communication failure (i.e. blackout).

Assumptions

- The possibility exists that an emergency may occur at any time without warning;
- In the event that an emergency exceeds the LTC centre's capabilities;
- External services and resources may be required;
- The resources identified as being available through the Township of Madawaska Valley Emergency Plan will be available.

EMERGENCY PLAN

The Emergency Plan is the operational framework for emergency management at the Valley Manor. When an emergency incident occurs the Valley Manor Emergency Management Plan is used as needed. The Plan identifies key personnel, their duties and responsibilities in the initial moments that an emergency occurs. Each of the sections has specific responsibilities. The Plan allows for a more coordinated and effective response and better accounting of personnel and resources. The Charge Nurse (CN) is in charge of the entire Plans structure. This person is assisted by a group who will be known as the appointed Staff Leads.

LOCKDOWN, SHELTER-IN-PLACE, HOLD AND SECURE

LOCKDOWN

Indicator:

This type of response action is used when the physical threat is already in the facility and measures need to be enacted to prevent the threat from accessing areas where potential victims are or may be, or to protect individuals from entering areas where the treat may be present.

Example- Active attacker inside the facility

*NOTE- The term Lockdown is generally associated with threats to schools however in certain circumstances it may be applied to Regional facilities.

Direction to Lockdown is usually initiated by emergency first responders at or near the site of the emergency.

Procedures for All Staff:

If it is safe to do so:

- **Call 9-1-1** and provide any information you can, such as location of attacker, number of employees etc.;
- Listen to instruction from emergency first responders;
- Remain in the lockdown response until police or security staff release you;
- If a fire alarm should sound during a full lockdown situation, do not automatically evacuate unless you smell smoke;
- Instructions may be given using the buildings PA system; and
- **DO NOT** open the door for anyone, except emergency personnel.

Wherever possible:

- Move to a safe area;
- Close and secure all doors and windows;
- Barricade doors with furniture or other available objects;
- Turn off lights;
- Keep away from exterior doors and windows;
- Silence cell phones;
- Remain silent; and
- Lay on the floor if gunshots are heard

Procedures for Administrator:

- Contact Municipal Emergency Management at 613-756-2747, and provide any details you can of the situation;
- You may be provided with additional information including direction.

SHELTER-IN-PLACE

Indicator:

This type of response is normally referred to when an environmental threat is present outside and it is not possible or advisable to evacuate the facility. This is usually in response to an air contaminates outside the building and keeping persons from unnecessarily putting themselves in medical danger.

Example: gas leak or chemical spill outside of the facility

Procedures for All Staff:

- Follow instructions from emergency responders;
- Encourage people to remain inside the building until the threat has passed;
- Notify Administrator, or designate, and the Nurse in Charge.

Wherever possible:

- Close and secure exterior doors;
- Close windows;
- Turn off HVAC system; and
- Proceed inside the building if it is safe to do so and if not already inside.

Procedures for Administrator:

- Contact Municipal Emergency Management at 613-756-2747and provide any details you can of the situation; and
- You may be provided with additional information including direction.

HOLD AND SECURE

Indicator:

This type of response in used when a serious environmental/physical threat is present outside of the facility or in the neighbourhood and prevention measures need to be enacted to protect individual(s) within the facility.

Example - an armed individual in the surrounding area

*NOTE: Direction to Hold and Secure is usually initiated by emergency first responders at or near the site of the emergency.

Procedures for All Staff:

- Follow instructions from emergency responders;
- Encourage people to remain inside the building until the threat has passed;
- Notify Administrator, or designate, and the Nurse in Charge.

Wherever possible:

- Proceed inside the building (if not already inside);
- Close and secure/lock exterior doors;
- Close windows and blinds; and
- Keep away from exterior doors and windows.

Procedures for CEO/Administrator:

- Contact Municipal Emergency Management at 613-756-2747and provide any details you can of the situation;
- You may be provided with additional information including direction.

SUBJECT:	**Emergency Alerts**	**POLICY #:**	**EMP01-012**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 1**
SECTION:	**Introduction**	**REFERENCES:**	
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Policy

In the event of an Emergency Alert broadcast affecting a LTCH, the in home Charge Nurse will ensure the building is aware and prepared (as applicable).

Description

Emergency alerts are created and sent by authorized emergency management organizations, such as police departments, Environment and Climate Change Canada, and provincial and territorial bodies. These potentially life-saving warnings, which are area-specific (geo-targeted), are known as emergency alerts. When an alert is issued, it is broadcast on television and radio and sent to mobile devices that are connected to a long-term evolution (LTE) network. They are typically issued for unique or fast forming extreme weather systems. The LTCH will follow the applicable emergency response plan and in the event the alert deals with weather outside of the Emergency Management Plan, the home should follow the instructions issued with the alert (as applicable) and initiate appropriate communication.

Types of Alerts

The National Public Alerting System is a federal, provincial, and territorial system that enables emergency management organizations across Canada to warn the public about imminent or possible dangers such as floods, tornados, hazardous materials, fires, and other disasters.

SUBJECT:	**Extreme Weather Plan**	**POLICY #:**	**EMP01-013**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 2**
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Purpose
The Extreme Weather Plan is a summary of emergency actions and response measures in support of the applicable **Code Green** or **Code Grey** Emergency Response Plans or any other extreme weather event. The Extreme Weather Plan Checklist is located in Appendix 'F' – Extreme Weather Plan.

Emergency Alerts
Emergency alerts are created and sent by authorized emergency management organizations, such as police departments, Environment and Climate Change Canada, and provincial and territorial bodies. They will give advance warning of extreme weather when possible.

Extreme Weather
Extreme events are occurrences of unusually severe weather or climate conditions that can cause devastating impacts on long-term care homes (LTCH) and surrounding communities. Weather-related extreme events are often short-lived and include heat or cold waves, winter storm warnings, wind, tornadoes and floods. Tornadoes and floods also have the capacity to be classified as natural disasters.

Natural Disaster
Natural Disaster means a natural occurrence, such as a flood, winter storm/blizzard, tornado, windstorm, or other event which threatens the public peace, health and safety of the people and/or damages and destroys public and private property.

Urgent Maintenance Services
See Appendix 'C' - Communication Plan to locate any of the following:
1. Urgent Services Contractors Suppliers Call List;
2. Disaster Plan
3. Call Back List
4. Fan Out List
5. Communication Log

Transportation Plan
See Appendix 'E' Transportation Plan if required to evacuate the facility and follow the Code Green Emergency Response Plan.

Food Fluid and Medication Provision
Will be provided as detailed in EMP01-011.

Staffing
If there is adequate advance notice of the anticipated event given (at least 24 hours) staff should make arrangements to ensure they are able to report for their scheduled shift. The LTCH will also call-in extra staff or alter shift times as required to prepare for the possible extreme weather event.

If an extreme weather event is impacting travel to and from the LTCH location and the greater community around the LTCH, arrangements (as applicable) will be made to:

1. Accommodate staff at the LTCH to stay beyond their scheduled shift with meal and rest areas if they are unable to leave the facility in a safe manner;
2. In the case of overnight accommodation, the LTCH may utilize ADP space, offices or other common locations. The LTCH's shall ensure mattresses and associated bedding (at a minimum) are available; and
3. Make arrangements for accommodations in the immediate vicinity of the LTCH with meal and rest areas if able to do so.

Emergency Response Plans

Code Grey Emergency Response Plans in the Emergency Management Plan (EMP) that detail staff response to extreme weather and/or natural disasters include:

1. Wind Warning;
2. Tornado Warning;
3. Flood Warning; and
4. Winter Storm Warning.

Code Grey Emergency Response Plans in the EMP detailing staff response to emergency situations affecting a LTCH that extreme weather may cause include:
1. Loss of Heat;
2. Loss of Cooling;
3. Loss of Water/Boil Water Advisory;
4. Loss of Electricity; and
5. CO (Carbon Monoxide)/Gas Leak.

Additional emergency responses within the EMP that may be activated by an extreme weather event include:
1. **Code Green** – Evacuation;
2. **Code Orange** – Community Disaster;
3. **Code Blue** – Medical Emergency; and
4. External Air Exclusion.

EMP01-014 Transportation Plan

TRANSPORT SUPPORT RESOURCES

If residents need to be transported in vehicles away from the site:

- Valley Manor Van;
- County of Renfrew Paramedic Services;
- Carefor (Barry's Bay, Pikwakanagan)
- Madawaska Valley Association for Community Living;
- Sunshine Coach; and
- Buses - Renfrew County Joint Transportation Consortium.

Classify residents in a category for transport:

Category 1: Those who may be cared for by next of kin living within a 30-minute drive could be contacted for short term care.
Category 2: Those who are bed-ridden or stretcher bound.
Category 3: Those who can walk with assistance.
Category 4: Those who are confined to wheelchairs.

At least one staff member accompanies residents during transport.

1. County of Renfrew Paramedic Services (CRPS):

- Works in conjunction with County of Renfrew Paramedic Service regarding the transport of residents to surrounding hospitals (if required);
- Determines the best mode of transport (VM Van, EMS, Private Transfer Services, Buses) for residents based on their general health and presenting conditions, along with the status of emergency calls within the Region;
- As required, CRPS staff will request additional Ambulances, Paramedics and Support vehicles and equipment be sent to the scene to assist with the evacuation. This may also include resources from outside the Valley Manor; and
- Transport non-ambulatory residents requiring medical care.

2. Carefor (Barry's Bay & Pikwakanagan):

- Transport ambulatory and non-ambulatory residents requiring medical care.
- Barry's Bay - 2 SUV's and one Wheelchair Van available.
- Pikwakanagan - 1 Wheelchair Van, one van, one car and one SUV.

Madawaska Valley Association for Community Living

- Transports non-ambulatory residents requiring minimal medical assistance. A nurse from the home may travel with the residents;
- A maximum of 4 wheelchairs per accessible van will be accommodated;

- Total number of vehicles available will be dependent on the number of Operators we are able to contact and call in.

4. Sunshine Coach:

- Transport ambulatory and non-ambulatory residents requiring medical care.
- Big bus accommodates. 4 wheelchairs & 10 ambulatory positions.
- Smaller vans able to transport 1 wheelchair & 2 to 3 ambulatory each.

5. Buses:

- **Brad Musclow -** Transport ambulatory residents on buses and vans providing they are available in the event of an emergency.
- **Holly Bus Lines -** Transport ambulatory residents on 28 passenger mini bus and vans providing they are available in the event of an emergency.

SUBJECT:	**Transportation Plan**	**POLICY #:**	**EMP01-014**
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Description

Ont. Reg. 246/22, s. 268 (4)2: Evacuation Plans for the Home, Including, At a Minimum;

i. A system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency (**Code Green** Emergency Response Plan),
ii. Identification of a safe evacuation location for which the licensee has obtained agreement in advance that residents, staff, students, volunteers and others can be evacuated to (Appendix 'D' - Reciprocal Relocation Agreements),
iii. A transportation plan to move residents, staff, students, volunteers and others to the evacuation location, and
iv. A plan to transport critical medication, supplies and equipment during an evacuation to the evacuation location to ensure resident safety.

Transportation Plan

In the event of the activation by a long-term care home (LTCH) of the **Code Green** Evacuation Emergency Response Plan;

a) The movement of residents, staff, and volunteers will be coordinated by the Administrator (or designate) to relocation facilities. They will contact the transportation provider(s) as noted in Appendix 'E' - Transportation Plan.
b) The movement of critical medication, supplies and equipment will be dependent on the ability to re-enter the LTCH.
c) If re-entry is deemed untenable; the pharmacy shall be contacted by the Administrator, DOC (or designate). Supplies and equipment will be pulled from local partners.
d) Valley Manor vehicles will be utilized to transport supplies and equipment.
e) Staff may be asked to transport themselves and drive their personal vehicle to the relocation site if it is at the LTCH and safely accessible.
f) Families may be utilized to transport residents under the direction of the Administrator (or designate).

Recovery – Employee Assistance Program

Incident Evaluation and Follow-Up

Within 30 days, after each significant emergency incident, a debrief session, led by the CN, will be held to examine the response. This critical evaluation, that will help improve future responses, is formalized using a **Debrief Checklist & Action Plan Report**. All relevant staff, residents and other entities involved should participate in the debrief session.

The Charge Nurse will send completed debrief reports to the Administrative Assistant to copy and place in the Emergency Drill Binder, as per instructions.

Any corrective actions will be tracked by Management throughout the year as debrief reports are provided.

RECOVERY PLANNING

The recovery plan establishes the responsibilities and resources necessary for the re-instatement of normal business operations. It is expected that the staff, residents and infrastructure are supported and encouraged to return to normal functioning as quickly and practically as possible. The transition from emergency response to recovery should be seamless. Recovery planning occurs before the emergency incident happens, during the emergency and after the emergency.

Pre-Incident Recovery Planning

- Services have been prioritized within the LTC centre based on whether they are essential or non-essential;
- Goods or services that must be delivered have been established;
- Collaboration with principal vendors regarding their Business Continuity Plans (BCP) has occurred;
- Acceptable delivery levels and maximum period of time the service can be disrupted without severe impact upon the organization has been established;
- Employee Assistance Program (EAP) is available to employees for crisis and supportive counselling as required; and
- Internal and external dependencies have been identified. External dependencies include such things as host sites, utilities, transportation and insurance providers. Internal dependencies include employee availability (see Emergency fan out list), organizational assets and resources.

During the Emergency Incident Recovery Planning

- Human needs, infrastructure and finance are monitored;
- Data is recorded for accountability and future reimbursement;
- Resources are monitored and managed. Resources that are needed to recover and how to get them have been identified; and

- Emergency Information is developed and released. Information is given to the public in a timely fashion (see Administrator Role of Media Relations Policy). If available during the Emergency event, the Administrator/CEO is responsible for media briefs.

Post-Emergency Incident Recovery

- Assess the impact, both short and long term;
- Return of or relocation of LTC centre evacuees;
- Connect employees with support and counselling services through EAP;
- Provide care to residents as a result of stress related to the emergency;
- Review compensation and financial management (includes donations);
- Post recovery analysis;
- Withdrawal of services (i.e. withdrawal of extra help given during the incident); and
- Assess intangible losses such as “loss of reputation or public confidence.

EMERGENCY PLAN MAINTENANCE

The Long-Term Director of Care with the home’s Administrator are accountable for having current Emergency Plans.

On-going Emergency Management Plan maintenance will be conducted to ensure the plan remains a useful tool for LTC management and staff.

Annual Review

Annual reviews are scheduled and facilitated by Management and completed by designated staff per the Administrator and Management Leadership Team.

Emergency Plan Updates

Changes to the Plan outside of the annual review may occur as a result of training exercises, emergency incidents, changes to the infrastructure or policy and procedure.

Change requests are sent to the Administrator for evaluation and impact to the home. Changes to documents are made with support by the Management team. Revised documents are reviewed by the Management Team for approval. Some may be reviewed by the appropriate Peer Groups.

Communicating Changes

Revised documents will be shared by email with a summary of the changes. The Administrative Assistant will replace documents in the Emergency Management Plan binders.

MANDATORY MINISTRY REPORTING OF EMERGENCY INCIDENTS

MLTC Critical Incident System Reports: Section 107 of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007, outlines responsibilities for reporting critical incidents to the Ministry of Long-Term Care.

The Director of the Ministry of Long-Term care is to be notified **immediately,** followed by completion of a Critical Incident System report for:

- An emergency, including fire, unplanned evacuation or intake of evacuees;
- An unexpected or sudden death, including a death resulting from an accident or suicide;
- A resident who is missing for three hours or more;
- Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing;
- An outbreak of a disease of public health significance or communicable disease as defined in the *Health Protection and Promotion Act*; and
- Contamination of the drinking water supply.

The Administrator and Director of Care are to be notified within one business day, followed by completion of a Critical Incident System report for:

- A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
- An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including:
  - a breakdown or failure of the security system;
  - a breakdown of major equipment or a system in the home;
  - a loss of essential services; or
  - flooding.
- A missing or unaccounted for controlled substance.
  Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition. See O. Reg. 79/10 section 107, (3.1).
- A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

Business Continuity Plans

Vendors Summaries of Business Continuity Plans

Cardinal Heath:

- They have invested in Kinaxis' Rapid Response software to help us generate options and choices for when something goes different than we had collectively planned.
- Specialized solution to store and manage procured products
  - Bulk buy savings
  - Auto-substitution flexibility with Cardinal Health or customer owned inventory
  - Storage benefits with increased space
  - Inventory expiry management
  - Cardinal Health Pandemic Storage Warehouse with over 1 million square feet

    - Customer owned inventory
- Logical unit of measure distribution platform that provides greater flexibility with order and delivery
    - Inventory level reduction
    - Auto-substitution flexibility with Cardinal Health or customer owned inventory
    - Reallocation of space and labor
    - Support customer owned inventory in local distribution center, while utilizing
    - Cardinal Health Pandemic Storage Warehouse for replenishment
    - Cardinal Health owned inventory

Medical Mart (Medline):

- Medline Industries, LP is headquartered in the Chicago area of the United States and; the company has over 27,000 employees worldwide and does business in over 125 countries, including dedicated manufacturing and distribution centres in North America and Europe.
- Service & Support in 8 key locations across Canada – from St John, Newfoundland to Delta, British Columbia
- Medline Canada 1M square feet of warehouse space, with 560+ employees and over 35,000 products available

ARJO:

- Arjo's products and services are sold in over 100 countries
- Approximately 6,500 employees worldwide
- Strong focus on mitigating costs while ensuring customer satisfaction
- Efficiency activities include fill rates, consolidation and more effective route and mode planning
- Less air freight due to optimized coordination of sales and supply
- Exploring options to secure long-term supply, incl. vertical integration opportunities
- Increased R&D activity and need to re-design to secure cost and availability
- Continued investments in roll-out of SEM scanner
- Structural implementation of the Provizio SEM scanner across facilities

Medication Vendor:

- Will use existing network of pharmacies across the province to assist in meeting the needs during an emergency or disaster;
- In the event of a disaster, fire or other forced evacuation at the home, Pharmacy will work closely with the home to provide the following in a timely manner:
- Replacement and dispensing of all required medications
- Delivery of required medication to alternative locations
- Delivery and Printing of MAR Sheets and/or Prescriber's Medication Review
- Provide ongoing refills to the alternate location for the duration of the evacuation
- In the event the home receives residents evacuated from another home or the community they will make arrangements to dispense medications to these residents in blister cards, vials, or multi-dose packages for the required length of time.
- Pharmacies are equipped with security monitoring systems as well as safes for storage of antiviral medication and other high-security risk drugs;
- Includes a special section on antiviral and vaccine distribution and Administration;

- Protocols are in place to allow pharmacists to continue dispensing ongoing orders of medication in a situation without access to a physician; and
- In the event of a widespread disaster, emergency situation or pandemic MediSystems will work with the government, public health and other organizations to collate, document and distribute needed medications as required.

These activities include directive regarding:

- Contacts, staffing, electrical power down, use of generators, telephone lines down, pharmacy computer down, adjudication/communication problems, medications/supplies unavailable or in short supply, delivery/transportation problems, credit cards/cash register down, water supply down, pharmacy closed;
- Includes a special section on antiviral and vaccine distribution and Administration;
- Influenza Outbreak information in our pharmacies which includes information on responding to seasonal influenza outbreaks;
- Dispensaries are stocked with Tamiflu year around for influenza Outbreaks;
- Protocols are in place to allow pharmacists to continue dispensing ongoing orders of medication in a situation without access to a physician;
- On a case-by-case basis resident's profile is reviewed by the pharmacist to safely eliminate the supply and or administration of non- critical meds at some point during a pandemic; and
- In the event of a widespread disaster, emergency situation or pandemic Medical Pharmacies will work with the government, public health and other organizations to collate, document and distribute needed medications as required.

Food and Beverage Vendor:

- Has created a continuity plan template to use in planning for an Emergency;
- They are committed to communicating as much information as possible to their customers as they formulate the detailed contents of the plan;
- An integrated approach between grocery and foodservice distributors is mapped to ensure a continuous flow of goods;
- Linked to key government agencies through their business association with the Canadian Council of Grocery Distributors who will orchestrate the allocation of resources to the area's most in need during the crisis;
- Provide a 3-day emergency menu for customers which will consist of regular and pureed texture choices as well as a wide variety of convenience and shelf stable products.

SUBJECT:	**Recovery - EAP**	**POLICY #:**	**EMP01-015**
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Emergency Impacts

An emergency can impact a long-term care home (LTCH) in many ways which in turn will dictate how recovery will look. For drills and minor emergency situations recovery is short term. For emergencies that impact mental or physical health, force relocation or impact buildings and infrastructure recovery may become medium to long term.

Recovery – Short Term

Debriefs are held for participants in the activation of an emergency response plan at the conclusion of each emergency. These debriefs are documented on the Emergency Drill Report and stored in the Testing of Emergency Plans binder and online.

Recovery – Medium and Long Term

Debriefs are held within 30 days of the activation of each emergency response plan and documented in the Manager meeting minutes.

If residents have been relocated, the infrastructure or LTCH has been damaged and the effects of the emergency continue to impact residents and staff the provision of resident care and health and safety of residents and staff shall be closely monitored.

If recovery is medium – long term, external stakeholders and government agencies will be involved in the response.

Residents

Any resident suffering adverse effects related to mental or physical health and requiring medical treatment due to an emergency situation will receive such treatment.

Staff

- Any staff suffering adverse effects related to physical health and requiring medical treatment due to a real emergency situation will receive such treatment; and
- Any staff suffering adverse effects related to mental health will be supported through the corporate Employee Assistance Program (EAP).

Recovery Plan Template - Appendix B14

EMP01-016 Emergency Resource Stockpiles

Resource Stockpile:

- The LTC facility should identify, maintain, and set aside a resource stockpile vital for each emergency response plan;
- This stockpile includes resources, supplies, personal protective equipment (PPE), and equipment necessary for emergency situations;
- At a minimum, the stockpile should include hand hygiene products, cleaning supplies, and other essential items; and
- Resources may also encompass materials like food, drugs, sanitation products, and non-material resources such as staff, transportation, funding, and information needed for implementing emergency plans.

Managing the Stockpile:

- Regular management of the resource stockpile is essential;
- A process should be in place to prevent required items from expiring; and
- Ensuring that stockpile items remain usable and up-to-date is critical.

National Emergency Strategic Stockpile (NESS)

You can reach us 24 hours a day, 7 days a week to submit a request by:

- Email: hpoc-cops@phac-aspc.gc.ca
- Telephone: 1-800-545-7661 **or** 613-952-7940.

SUBJECT:	**Emergency Resource Stockpiles**	**POLICY #:**	**EMP01-016**
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Policy

Long-term care home's (LTCH) are required to set aside the resources, supplies, personal protective equipment (PPE), and equipment vital for emergency response. At minimum, the stockpile will include hand hygiene products, cleaning supplies, PPE and a process to ensure that required resources, supplies, PPE, and equipment are not expired.

Description

Ont. Reg. 246/22 S. 268(4): The licensee shall ensure that the emergency plans provide for the following:

3. Resources, supplies, personal protective equipment and equipment vital for the emergency response being set aside and readily available at the home including, without being limited to, hand hygiene products and cleaning supplies, as well as a process to ensure that the required resources, supplies, personal protective equipment and equipment have not expired.

Emergency Resource Stockpiles

Emergency resources identified and embedded within the emergency response plans in the Emergency Management Plan will be maintained to provide an effective emergency response in maintaining the health and safety of building occupants. These resources are catalogued on the Resource Stockpile Checklist.

Valley Manor's Joint Health and Safety Committee (JHSC) will review the quarter's stockpile audit. The LTCH's Management Team will ensure resource stockpiles are maintained after the activation of an emergency response plan.

All resource stockpile audits conducted will be documented on the Resource Stockpile Checklist template located in Appendix 'G' - Emergency Resource Stockpiles. Completed Resource Stockpile Checklists will be stored in the Testing of Emergency Plans binder and with the applicable JHSC meeting minutes.

CHEMICAL SPILL

Ideally alternative processes/products should be used in place of hazardous chemicals however, this is not always possible and a spill of a hazardous chemical can create a hazard to the health of a home's occupants. There are two categories of spills that a home may be faced with including:

- A major chemical spill **-** any spill of a pollutant that creates a hazard to the health of a person (i.e.: a chemical that generates hazardous or toxic vapours, corrosive etc.) that occurs in a quantity that requires the response from an emergency service; and

- A minor Chemical Spill- any spill of a pollutant in a quantity that does not create a hazard to the health of a person other than the hazards associated with the safe handling of the product.

The emergency plans pertaining to a chemical spill emergency are detailed in the home's Emergency Management Plan, Index # EMP08-001 Chemical Spill Emergency Response Plan. These plans detail the actions staff must take once a chemical spill emergency is declared. It is important that all accountable staff are familiar with these plans to minimise the risk to the occupants of the home associated with this type of emergency.

SUBJECT:	**Hazard Identification Risk Assessment**	**POLICY #:**	**EMP01-017**
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Purpose

Hazard Identification and Risk Assessments (HIRAs) ensure that hazards and risks that may give rise to an emergency impacting the long-term care home (LTCH) are identified and assessed, whether the hazards and risks arise within the home or in the surrounding vicinity or community.

Description

A Hazard Identification and Risk Assessment (HIRA) is a tool that assists Managers through the analysis of which hazards pose the greatest level of risk in terms of how likely they are to occur and how great their potential negative impact on the LTCH may be. The goal of the HIRA is to address the following questions:

1. What hazards could impact my LTCH or surrounding area?
2. How frequently do they occur?
3. How severe can their impact be on residents, infrastructure, property, the environment, and staff?
4. Which hazards pose the greatest level of threat?

Documentation

The HIRA template and instructions are located in Appendix 'H' - Hazard Identification and Risk Assessments.
All completed HIRAs will be stored on site in the Administrator's Testing of Emergency Plans binder and centrally on the Managers Icon.

Review

All LTCH HIRAs will be reviewed annually or more frequently as required. New or evolving hazards identified as posing a risk to the LTCH will also be assessed by this method.

SUBJECT:	**Testing Requirements**	**POLICY #:**	**EMP02-001**
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Policy

Testing Of Plans

(2) The Administrator of the long-term care home (LTCH) shall ensure that the emergency plans are tested, evaluated, updated and reviewed with the staff of the home as provided for in regulation 246/22 s.268 (10) and with the test frequency detailed in this policy and Ontario Fire Code Division B s. 2.8.3.2 (1)

Annual Test

(a) On an annual basis test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies, violent outbursts, gas leaks, natural disasters, extreme weather events, boil water advisories, outbreaks of a communicable disease, outbreaks of a disease of public health significance, epidemics, pandemics and floods, including the arrangements with the entities that may be involved in or provide emergency services in the area where the home is located including, without being limited to, community agencies, health service providers as defined in the *Connecting Care Act, 2019*, partner facilities and resources that will be involved in responding to the emergency;
Test all other emergency plans at least once every three years, including arrangements with the entities that may be involved in or provide emergency services in the area where the home is located including, without being limited to, community agencies, health service providers as defined in the *Connecting Care Act, 2019*, partner facilities and resources that will be involved in responding to the emergency;

(b) Conduct a planned evacuation at least once every three years; and

(c) Keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

(11) If there is a conflict or an inconsistency between a provision of the fire code under the *Fire Protection and Prevention Act, 1997* and a provision of an emergency plan, the fire code prevails to the extent of the conflict or inconsistency.

Ont. Reg. 213/07: Ontario Fire Code, Division B

2.8.3.2. (1) Subject to Sentences (2), (3), (4) and (5), a fire drill shall be held for the supervisory staff at least once during each 12-month period.

Supervisory Staff

The training of staff is a critical step in Emergency Management to ensure the safety of not only residents but supervisory staff responding to the emergency. The Emergency Management Plan is developed to provide comprehensive emergency training for all supervisory staff within Valley Manor, in addition to fire safety training provided upon hire and at Step Ahead training sessions annually for staff and volunteers.

An equally important component of Emergency Management is regular testing of plans. Regular testing provides staff the opportunity for emergency response training, assists in determining whether designated staff can competently respond to the emergency and can be used to assess the effectiveness of the emergency response plans.

Responsibilities Administrator

1. Implementation of fire safety/emergency plans;
2. Ensure completion of testing of emergency plans as per the schedule in Appendix 'B';
3. Implement follow up actions identified as a result of a drill;
4. Distribute drill documentation pertaining to the drill to the Maintenance Manager and post on the Policy Icon; and
5. Maintain designated records in Testing of Emergency Plans binder as per EMP02-003.

Departmental Managers

1. Train and implement Fire Safety and Emergency Management Plans in each department and assist in plan implementation.

CEO and Maintenance Manager

1. Develop and or revise Fire Safety and Emergency Management Plans;
2. Ensure review and approval of emergency plan(s) by local authorities and the Divisional Leadership Team (DLT) as applicable;
3. Provide emergency plans updates or revisions;
4. Develop staff training and education programs;
5. Develop testing process and schedule;
6. Liaise with local authorities and community partners to ensure participation in drill(s), plan review and/or development; and
7. Prepare and conduct annual observed fire drills in conjunction with local Fire Services.

Maintenance Manager

1. Conduct monthly fire drills as detailed in the Emergency Management Plan and in accordance with the LTCH Administrator; and
2. Maintain all drill records and documentation in Testing of Emergency Plans binder as per EMP02-003.

Maintenance Manager and Executive Assistant to CEO

1. Assist with facilitating exercises as requested;
2. Coordinate staff training and education programs;
3. Facilitate training and staff education; and
4. Development of staff training and education programs

SUBJECT:	**Testing of Emergency Plans Schedule and Scenarios**	**POLICY #:**	**EMP02-002**
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Policy

All long-term care homes (LTCH) shall adhere to the following schedule in the testing of emergency plans. If a LTCH experiences a real event that activates an Emergency Response Plan outside of the testing schedule noted below; that event may serve as the required test as long as response, documentation, debrief and follow-up requirements are met.

Testing Of Emergency Plans Schedule

Please see Appendix 'B', B01 – Testing of Emergency Plans Schedule

Code Red Drills

Code Red drills are an important tool in emergency planning. They provide opportunities for comprehensive fire emergency response training; assist in determining whether staff can competently respond in accordance with the emergency fire and evacuation procedures in a timely manner; and can be used to assess the effectiveness of the emergency procedures under different fire scenario conditions.

Therefore, for the purpose of this Emergency Management Plan the procedures for conducting and documenting monthly **Code Red** drills as detailed in the Fire Safety Plan will be followed. They are detailed in EMP03-001.

Comprehensive Drills

Comprehensive drills involve partial - full activation of system(s) and staff responses.

Silent Drills

Silent drills do not involve any activation of system(s) and silent simulated staff responses.

Table Talk Drills

Table talk drills focus on facilitated discussion revolving around the activation of an emergency response plan and do not involve physical demonstration/simulation of the emergency response activities.

Drill Documentation

All real and/or tested emergency responses are documented on the Emergency Drill Report located in Appendix ‘A’.

Drill Facilitator Instructions

1. Ensure resources and equipment needed to conduct the exercise are available including the Emergency Drill Report;
2. Initiate the drill;
3. Have staff demonstrate their response according to their role and responsibilities;
4. Monitor drill and record observations on the Emergency Drill Report;
5. Conduct a debriefing with participants; and
6. Assemble the home’s management team for debriefing and follow up noting areas of concern and corrective action (if applicable).

Testing Of Emergency Plans Scenarios

The Testing of Emergency Plans Scenarios information is located in Appendix ‘B’, B02, and may be utilized in testing emergency plans. Questions are included to support emergency response objectives, staff response and discussion. Additional scenarios and questions may be used at the discretion of the LTCH.

	Annual Testing										3-Year Testing			
Month	Fire Day Shift	Fire Evening Shift	Fire Night Shift	Missing Resident	Loss of Essential Services			Medical Emergency	Violent Outburst	Intruder	Planned Evacuation	Bomb Threat	Community Disaster	Chemical Spill
					Loss of Water	Loss of Hydro	Loss of Heat							
Jan	Comprehensive Announced	Comprehensive Announced	Silent	√										
Feb	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Mar	Comprehensive Announced	Comprehensive Announced	Comprehensive Un-Announced											
Apr	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent		√									
May	Comprehensive Announced	Comprehensive Announced	Silent											
Jun	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											√
Jul	Comprehensive Announced	Comprehensive Announced	Silent					√						
Aug	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Sep	Comprehensive Announced	Comprehensive Announced	Comprehensive Un-Announced											
Oct	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent						√					
Nov	Comprehensive Announced	Comprehensive Announced	Silent											
Dec	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Jan	Comprehensive Announced	Comprehensive Announced	Silent	√										
Feb	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Mar	Comprehensive Announced	Comprehensive Announced	Comprehensive Un-Announced											
Apr	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent			√								
May	Comprehensive Announced	Comprehensive Announced	Silent						√					
Jun	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Jul	Comprehensive Announced	Comprehensive Announced	Silent					√						
Aug	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Sep	Comprehensive Announced	Comprehensive Announced	Comprehensive Un-Announced								√		√	
Oct	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Nov	Comprehensive Announced	Comprehensive Announced	Silent											
Dec	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Jan	Comprehensive Announced	Comprehensive Announced	Silent	√										
Feb	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Mar	Comprehensive Announced	Comprehensive Announced	Comprehensive Un-Announced											
Apr	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent				√							
May	Comprehensive Announced	Comprehensive Announced	Silent											
Jun	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent									√		
Jul	Comprehensive Announced	Comprehensive Announced	Silent					√						
Aug	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											
Sep	Comprehensive Announced	Comprehensive Announced	Comprehensive Un-Announced											
Oct	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent						√					
Nov	Comprehensive Announced	Comprehensive Announced	Silent											
Dec	Comprehensive Un-Announced	Comprehensive Un-Announced	Silent											

SUBJECT:	**Testing of Emergency Plans Binders**	**POLICY #:**	**EMP02-003**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 1**
SECTION:	**Introduction**	**REFERENCES:**	
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Policy

The home shall maintain 2 Testing of Emergency Plans binders on site; they will be located in the offices of the Administrator and Maintenance Manager.

CEO/Administrator's Testing of Emergency Plans Binder

The Administrator Testing of Emergency Plans binder shall be stored in the Administrators Office and will contain the following completed records:

1. Emergency Drill Reports (all);
2. Required Actions Checklists;
3. Resource Stockpile Audits;
4. Thirty Day Debrief minutes (Post activation of Emergency Preparedness Plan);
5. Communication and Collaboration Logs;
6. Hazard Identification and Risk Assessments (HIRAs); and
7. Attestations.

Maintenance Manager's Testing of Emergency Plans Binder

The Maintenance Manager's Testing of Emergency Plans binder shall be stored in the Maintenance Manager Office and will contain the following completed records:

1. Code Red Emergency Drill Reports; and
2. Staff Training Records

SUBJECT:	Code Red Fire Emergency Response Plan	POLICY #:	EMP03-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 4
SECTION:	Introduction	REFERENCES:	
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Policy

To ensure the safety of building occupants, a long-term care home (LTCH) will follow the **Code Red** – Fire emergency response procedures in the event of the activation of the fire alarm or the discovery of smoke or fire.

Procedure

Roles and responsibilities are detailed in this section and on the **Code Red** Fire Emergency Response Plan, Appendix 'A'.

Fire Drills

Fire drills will be planned, scheduled, carried out, documented and evaluated to ensure participation by all full-time staff and all Registered Nurses. It is the joint responsibility of the Administrator and Fire Safety Co-coordinator(s) to develop the annual schedule for fire drills, ensure the schedule is adhered to, and the following:

1. The drill schedule includes at least one drill per month per shift (days, afternoons, nights);
2. That 12 comprehensive drills are conducted per year, for the day shift. Announced drills will only be conducted when in home conditions dictate such notice;
3. That 12 comprehensive drills are conducted per year for the afternoon shift. Announced drills will only be conducted when in home conditions dictate such notice;
4. That two comprehensive drills and ten silent drills are conducted for the night shift. Additional staff will be scheduled to attend night shift comprehensive drills to monitor resident safety during drills with minimum staffing levels;
5. On occasion, in home conditions may dictate the need to hold a table talk drill in lieu of a comprehensive or silent drill;

6. All full-time staff and Registered Nurses have the opportunity to participate in a drill;
7. A range of alarm scenarios are developed, including areas of the building, type of fire, and type of device activated;
8. During announced comprehensive drills, the home's management team will monitor staff response in the unaffected areas of the home and conduct a debriefing with staff in those areas; and
9. On a quarterly basis a member of the management team will fill the role of Charge Nurse during a drill.

Procedure - Comprehensive Fire Drill

1. The Maintenance Manager will contact the Fire Department to advise that the home will be conducting a fire drill and ask that the home is taken out of service. The Maintenance Manager will advise the Fire Department that they will be receiving a call from the home during the drill from the Charge Nurse.
2. The Maintenance Manager will contact The Security Company (TSC) to advise that the home will be conducting a fire drill and ask that the home is taken out of service. The Maintenance Manager will advise FMC that the Fire Department will be receiving a call during the drill from the Charge Nurse.
3. The Maintenance Manager will switch off the AC power to the fire alarm system to test the system under standby battery power on a quarterly basis (January, April, July, and October). The Maintenance Manager will ensure that door system security systems are monitored during this process as applicable.
4. The Maintenance Manager may simulate the fire by any of the following means:
   a. Signal a red flashing lantern placed in the pre-selected area;
   b. Activating a smoke detector; or
   c. Inform a staff member that a fire exists and its location.
5. The first staff member to arrive at the scene will be expected to remove anyone in immediate danger, ensure the door is closed to confine the fire, activate the nearest pull station (if alarm not activated), communicate the location of the fire to responders and obtain a fire extinguisher placing it near the simulated fire location.
6. Other staff will respond to the fire drill as per their responsibilities.
7. Following the resetting of the fire alarm system and the announcement of the "all clear", a call will be made to the Fire Department that the drill is completed and to ask that the home is put back in service.
8. Following the resetting of the fire alarm system, the announcement of the "all clear", and the call to the Fire Department that the drill is completed; a call will also be made to TSC to indicate the drill has been completed and ask that the home is put back in service.
9. All drills will include a de-briefing session by the Charge Nurse with those in attendance. The de-briefing will be documented on the Emergency Drill Report.
10. A fire alarm can be counted as a fire drill as long as there is full response to the alarm and a full de-briefing is held and documented.

Procedure – Table Talk Fire Drill

1. Table talk drills are also conducted in addition to comprehensive fire drills. Similar to silent fire drills, table talk exercises are conducted in designated areas of a LTCH.

2. The major difference between a silent drill and table talk drill is that table talk drills do not involve physical demonstration/simulation of the emergency response activities.
3. Table talk drills involve facilitated discussion surrounding example fire scenarios.
4. Staff with assigned roles involved in the table talk drills must describe their proposed response to the given scenario.
5. The facilitator assesses the adequacy of the suggested response in relation to required actions and uses the opportunity to reinforce correct responses expected of staff.
6. On occasion in home conditions may dictate the need to hold a table talk fire drill.
7. Tabletop exercises are discussion-based sessions where team members meet in an informal, group setting to discuss their roles during an emergency and their responses to a particular emergency situation.
8. The Administrator, Maintenance Manager will fill the role of facilitator.
9. All drills will include a de-briefing session by the Charge Nurse with those in attendance. The de-briefing will be documented on the Emergency Drill Report.

Procedure – Silent Fire Drill

1. Silent fire drills are scheduled in addition to comprehensive drills.
2. These drills are conducted in designated areas of the LTCH for the purpose of ensuring that all staff participates in fire drills at a desired frequency.
3. Features of silent fire drills include the following:
   a. These drills do not involve the actual activation of the fire alarm system.
   b. Fire alarm system activation is only simulated.
4. Maintenance Manager or Managers monitor the emergency response of individuals in a specific area to a simulated or described fire scenario.
5. Participants involved in the area respond to the simulation in accordance with their roles and responsibilities.
6. The facilitator(s) assesses the adequacy of the suggested response in relation to required actions and uses the opportunity to reinforce correct responses expected of staff.
7. To avoid accidental activation of the fire alarm system during these exercises, the individual initiating and monitoring these drills takes appropriate steps to ensure that the drill remains silent by notifying personnel in the area in advance of the exercise.
8. All drills will include a de-briefing session by the Charge Nurse with those in attendance. The de-briefing will be documented on the Emergency Drill Report.

Documentation

1. All drills and alarms will be documented by the Charge Nurse on the Emergency Drill Report.
2. Any corrective actions will be documented.
3. The Emergency Drill Report will be available to the Administrator, Management Team, Maintenance Manager, Co-Chair of the Joint Health and Safety Committee (JHSC) as requested and applicable. The JHSC shall have Fire Safety as a standing agenda item and discuss drills at each meeting as applicable.
4. Documentation will also include maintaining a listing of staff in attendance at each

drill. This documentation will be maintained by the Administration Office staff. Administration Office staff will input staff attendance into SSC, copied to the testing binders and training spreadsheet.

5. The Maintenance Manager will be responsible for maintaining the original copy of all reports.
6. The Maintenance Manager shall be provided the original copy of all reports for in home records.
7. The list of staff attending alarms/drills will be analyzed by the Administration Office staff to develop a sub-list of staff who have not attended a drill or alarm in that calendar year.
8. On or about November 15 of each year, the sub-list will be analyzed to determine those staff that will not have the opportunity to attend a drill by the end of the year. Managers of these staff will be advised and must arrange an appropriate training opportunity or table talk exercise for these staff. The results of the table talk exercise will be provided to the Maintenance Manager and the participants will be added to the list of those attending a fire drill within the year.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

Immediately

1. An emergency within the meaning of section 268 of the *Fixing Long-Term Care Act, 2021* including fire, unplanned evacuation or intake of evacuees.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Red Responsibilities	POLICY #:	EMP03-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 3
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Responsibilities - Administrator

The Administrator will be responsible for the overall development and maintenance of the fire safety plan and all other emergency plans. Specifically, the Administrator is responsible for:

1. Coordinating fire safety efforts and/or concerns affecting the long-term care home with the Fire Safety Co-coordinator (as noted below);
2. Ensure emergency procedures are available in designated areas and updated accordingly, as well as staff responsibilities being posted in designated areas;
3. Ensure that managers are training all new staff when oriented to the home and that the home continues to update training to all staff and managers on an on-going annual basis;
4. Ensure Fan-Out List is kept up to date with all names and phone numbers;
5. Ensure residents' lists are updated and maintained by the Administration office;
6. Provision of alternate measures for safety of occupants during shutdown of fire protection equipment;
7. Arrange for external relocation centers and assess availability of equipment and supplies at these centers;
8. Maintain an updated staff listing and fan out list at personal residence.

Responsibilities – Maintenance Manager and Administrative Assistant to the CEO

The Maintenance Manager will be the designated Fire Safety Co-coordinator. Specifically, the they are responsible for:

1. Develop plans for testing of various sections of the Emergency Management Plan and, once approved, implement;
2. Ensure that minutes are taken at all departmental meetings dealing with the Emergency Management Plan;
3. Co-ordinate the fire drills to ensure standards are followed;
4. Review and update Emergency Management Plan Procedures for the Valley Manor when warranted and obtain approval from Chief Fire Officials;
5. Ensure community contacts are kept up to date with proper phone numbers/names;
6. Ensure that the annunciator panel is correct for the zones and locations;

7. Ensure that the re-set panel is labelled with instructions for the operation and procedures for resetting alarms;
8. Assist in training staff in emergency response, and help develop plans for such training;
9. Instruction of supervisory staff and other occupants so that they are aware of their responsibilities for fire safety and are able to implement the fire safety plan and all other emergency plans;
10. Testing of emergency generators on an on-going basis;
11. Control of fire hazards in the building;
12. Maintenance of building facilities provided to ensure safety;
13. Ensuring that the check, test and inspections as required by the Fire Code are completed on schedule and that records are retained for no less than two years;
14. Preparation of schematic diagrams, acceptable to the Chief Fire Official, showing type, location and operation of all building fire emergency systems;
15. Ensure that a schematic diagram, showing type, location and operation of all building fire emergency systems (e.g.: location of fire alarm control panel, shut off valves, annunciation and natural gas) is maintained;
16. Ensure that all exits are in proper working order;
17. Ensure the Transportation Plan is current in event of evacuation (as applicable);
18. Be familiar with relocation centers' services and facilities;
19. Maintain and establish required communication channels as part of Communication Plan;
20. Assist Administrator in ensuring proper security of premises;
21. Maintain an updated Maintenance Staff listing at personal residence; and
22. Ensure Reciprocal Relocation Agreements are current.

Responsibilities – Managers

Managers are responsible for training and the implementation of the fire safety plan and all other emergency plans in their department and to assist in the home's implementation. Specifically, the Managers are responsible for:

1. Being familiar with their role and the role of their staff as it pertains to the fire safety plan and all other emergency plans;
2. Designation and assignment of Charge Nurse and Assigned Staff Leads;
3. Ensuring all department personnel have been trained and educated on the use of the existing fire safety equipment and in the actions to be taken under the approved fire safety plan and all other emergency plans;
4. Know the operation of fire protection equipment, fire alarm system and fire extinguishers;
5. Maintain an updated staff listing and fan out list at personal residence;
6. Ensure that staff are called in when required;
7. Assist in coordinating and staffing reception area;
8. Be familiar with relocation centers' services and facilities;
9. Ensure a list is made of all staff on duty at time of alarm; and
10. Participate in all comprehensive **Code Red** drills for night staff to monitor resident safety during drills occurring with minimum staffing levels.

Responsibilities – All Staff

To ensure a safe environment and to ensure the safety of all building occupants, all staff shall be trained on their responsibilities and role as it pertains to the approved fire safety

plan and all other emergency plans before given any responsibility under these plans.

1. All staff shall receive an orientation on their role and responsibilities as it pertains to the approved fire safety plan and all other emergency plans at the time of hire.
2. All staff shall review their role and responsibilities as it pertains to the approved fire safety plan and all other emergency plans at least annually.
3. Specifically, all staff are responsible for:
    a. Knowing their role and responsibility as it pertains to the approved fire safety plan and all other emergency plans;
    b. Carrying out their duties as described within the emergency plans;
    c. Participating in the testing of emergency plans;
    d. The reporting of hazards or unsafe practices that diminish the fire safety systems or equipment within a home;
    e. Remaining on duty and implementing the emergency procedures should an emergency be activated during a shift change or while on a break;
    f. To assist with the control of fire hazards.

SUBJECT:	**Code Red Staff Roles**	**POLICY #:**	**EMP03-003**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 3**
SECTION:	**Introduction**	**REFERENCES:**	
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I Found the Fire

Remember "React"

R- Remove anyone in immediate danger
E- Ensure containment-close the door
A- Activate the nearest emergency pull station
C- Communicate the emergency; tell other responders exactly where the fire is
T- Try to extinguish the fire if safe to do so

Charge Nurse – After Hearing a Stage 1 Alarm

1. Put on a Charge Nurse emergency vest.
2. Check the annunciator panel for fire location.
3. Announce "**Code Red**" and the location of the fire three times slowly and clearly.
4. Call 911.
5. Assign Staff Leads and a scribe for the code event or drill.
6. Assign one staff to go to the front entrance to refuse entry to anyone and meet the emergency crews.
7. Go to the affected area.
8. Confirm the location of the fire.
9. Ensure resident and visitors are being evacuated from the affected area (fire zone).
10. Initiate emergency fan out system if required.
11. Note the location and number of residents that were unable to be evacuated.
12. Follow instructions from the emergency crews.
13. Activate stage two alarm if directed by emergency crews and follow **Code Green** instructions.

Charge Nurse - When Code Red Is Over

1. Reset fire alarm system-only after instructed to do so by emergency crews.
2. Reset door security systems.
3. Announce '**All Clear Code Red**' three times.
4. Assign staff to take residents back to their rooms and conduct head count.

5. Debrief with staff.
6. Complete and distribute Emergency Drill Report.

Appointed Staff Leads – The Fire Is In My Area

1. Return to your area by the safest route, if you are not already on the area.
2. Put on a Staff Lead emergency vest.
3. Confirm the location of the fire.
4. Tell staff to move residents and visitors to a location outside of the affected area (fire zone).
5. Tell staff to search rooms, remove any residents, close doors and use red indicator disks when the room is empty in the affected area (fire zone).
6. Tell staff to move med cart and resident charts, if safe to do so.
7. Follow instructions from the Charge Nurse and emergency crews.

Appointed Staff Leads – The Fire Is Not In My Area

1. Return to your area by the safest route, if you are not already on the area.
2. Put on a Staff Lead emergency vest.
3. Send one staff with Med Sleds to the affected area to assist with the evacuation [In the absence of other staff (ex. night shift) take Med Sleds and go to the affected area to assist with the evacuation of the affected area].
4. Tell staff to close windows and doors in your area.
5. Tell staff to clear carts and other equipment from hallways.
6. Tell staff to monitor doors.

All Other Staff – I Hear the Stage One Alarm and Code Red Fire Announcement

1. Shut off all equipment and appliances.
2. Listen for **Code Red** announcement.
3. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
4. If directly supervising residents report to the Assigned Staff Lead where you are.
5. Follow instruction from the Assigned Staff Lead.

Administrator – After Being Made Aware of a Code Red Fire

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of Charge Nurse if required.
3. Ensure Communication Plan is consulted and followed accordingly.

Managers – After Being Made Aware of a Code Red Fire

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. Follow instruction from the Assigned Staff Lead, Charge Nurse and emergency crews.
3. Assume the role of an Assigned Staff Lead if required.
4. Assume the role of the Charge Nurse if required.

All Staff

1. Remain calm and decisive.
2. For a stage two alarm follow code green instructions.
3. Close all windows in unaffected areas.

SUBJECT:	**Control of Fire Hazards**	**POLICY #:**	**EMP03-004**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 1**
SECTION:	**Introduction**	**REFERENCES:**	
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To ensure a safe environment within the home all staff will assist with the control of fire hazards. The following list of practices will be adhered to by all staff.

Procedures

1. If smoking is permitted, smoke in designated areas only.
2. Never empty ashtrays into garbage containers. Ashtrays must be emptied into containers provided for that use.
3. Do not use unsafe electrical appliances, frayed extension cords, extension cords or lamp wire for permanent wiring, and overloaded circuits. Report such situations to Maintenance and follow up with a Maintenance Requisition.
4. Do not leave articles such as carts, tables, chairs, boxes and other obstructions, in building halls, corridors, exits or stairwells.
5. Do not store any items within 18 inches of a ceiling or in a manner that will obstruct the sprinkler system from operating properly.
6. Do not store items in any service room for which the room was not intended to contain.
7. Do not block, nor obstruct fire protection equipment or exits. If you see this type of situation, correct it immediately and report it to your supervisor/manager.
8. Do not prop, wedge or tie fire separation doors open. If you see this type of situation, correct it immediately and report it to your supervisor/manager.
9. Rubbish and other combustible waste materials should not be allowed to accumulate in any area of the building, other than those specifically designed for that purpose. Particular attention must be paid to exits and corridors and stairwells.
   If you see this type of situation, correct it immediately and report it to your supervisor/manager.
10. Containers of waste materials shall be removed from the building as required
11. Combustible materials (saw dust, dust bane and other combustible absorbents) shall not be used to absorb spills of flammable or combustible liquids.
12. Greasy and oily rags, subject to spontaneous ignition, shall be deposited in a non-combustible receptacle without openings in the side and bottom and provided with a tightly fitting, self-closing lid.

Notify your Supervisor, Manager, or Administrator immediately when you discover a potential fire hazard.

SUBJECT:	Fire Alarms	POLICY #:	EMP03-005
MANUAL:	Emergency Management Plan	PAGE:	1 of 1
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Types of Fire Alarms

The fire alarm system is a two-stage alarm system, which has been designed to activate as follows:

First Stage Alarm (Alert Signal)

The first stage alarm is activated by a smoke detector, heat detector, flow switch or manual pull station. The fire alarm bells will ring slowly (20 beats per minute). During this stage, the **Code Red** Fire Emergency Response Plan will be activated as outlined in the Plan. Evacuate the affected area (fire zone).

Second Stage Alarm (Alarm Signal)

The second stage alarm will be manually activated if the fire is getting "out of control", all fire alarm bells will ring quickly during the second stage alarm (increased beats per minute). Upon initiation of the second stage alarm proceed with "**Code Green**" Evacuation Procedures" as outlined in the Plan. Evacuate the entire building.

Note: Activation of the second stage alarm will be initiated by authorized personnel only (e.g. the Charge Nurse as directed by the Chief Fire Official). To activate the second stage alarm, open fire pull station and insert second stage key and turn. Evacuation mode will start instantly once key is turned.

SUBJECT:	Fire Alarm System; Resetting, Detectors and Emergency Equipment	POLICY #:	EMP03-006
MANUAL:	Emergency Management Plan	PAGE:	1 of 1
SECTION:	Introduction	REFERENCES:	
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Fire Alarm System Reset

1. See Appendix 'J'

Fire Alarm System

1. The fire alarm system is a two-stage alarm system.
2. Manual fire alarm pull stations are located at every exit.
3. Bells are located throughout.
4. Sprinkler protection is throughout.

Types of Detectors

1. Smoke detectors are located in resident's rooms, throughout corridors and at the top of stairwells.
2. Smoke detectors are "fully addressable" providing exact location of an alarm.
3. Heat detectors are located in common spaces, dining rooms, other service rooms.

Other Emergency Equipment:

1. Emergency lighting is located throughout the building and powered by the emergency generator.
2. Fire extinguishers are located at all exits.
3. Fire blankets are located in the main kitchen, mechanical room and adjacent resident smoking areas.
4. Med Sled evacuation equipment is located at each resident home area.

SUBJECT:	Fire Extinguishers and Fire Blankets	POLICY #:	EMP03-007
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Introduction	REFERENCES:	
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Types of Fires

There are three types of fires:

1. Class A - wood, paper, fabric, rubbish, etc. – regular combustibles;
2. Class B - gasoline, oil, and grease – flammable liquids; and
3. Class C - electrical, motor, wiring, etc. – energized electrical.

Types and Usage of Fire Extinguishers and Blankets

Specific types of fire extinguishers are geared to specific types of fire. There are multiple types of fire extinguishers to fight fires. Careful attention must be paid to the type of fire when selecting the appropriate fire extinguisher.

How to Use a Fire Extinguisher

Remember “pass”

P- Pull out pin (twist the pin to break the seal).
A- Aim at the base of the fire.
S- Squeeze the handle.
S- Sweep back and forth at the base of the fire.

Multi-Purpose ABC Dry Chemical Fire Extinguisher

1. Red coloured cylinder, small ones have a short metal nozzle, and the larger ones have an attached hose with a nozzle on the end.
2. Used on Class A, B, and C fires.
3. Has a range of 5-20 feet.

Co_2 (Carbon Dioxide)

1. Red coloured cylinder, with an attached hose with a horn on the end.
2. May be used on Class B and C fires.
3. Has a range of 3-8 feet.

4. Warning- do not hold horn! Hold the hose with a plastic or wood handle.
5. When CO^2 releases, it can give a freezer burn.

K-Class Fire Extinguisher

1. Silver coloured cylinder with an attached rubber hose.
2. Used on cooking type fires usually associate with higher temperatures.
3. Initially activate extinguisher from a distance of not closer than ten ft.

Fire Blankets

1. Special fire blankets are located in the main kitchen, mechanical room and adjacent resident smoking areas.
2. A fire blanket is used to put out a fire on a person's clothing by smothering the fire.
3. Remove the blanket from the plastic bag; open the blanket completely.
4. Place the blanket over the victim by:
    a. Draping the blanket over your non-dominant arm (left arm if you are right-handed);
    b. Positioning the elbow of your arm with the blanket on the victim's nearest shoulder;
    c. Lay the blanket across the person, covering the complete body from neck down. This ensures that no smoke or gas will escape into the victim's face or airway; and
    d. Smooth out air pockets, moving from the victim's neck down toward the feet, to smother the fire.

Confining, Controlling & Extinguishing the Fire

This is primarily the responsibility of the Fire Services. The production of toxic fumes in buildings makes firefighting potentially dangerous, particularly if a large amount of smoke is being generated.

Only after ensuring everyone has evacuated the area, the alarm has been raised and the Fire Services have been notified, should an experienced person (familiar with fire extinguisher operation) attempt to extinguish a small fire.

This is a voluntary act.

Never attempt to fight a fire alone.

If it cannot be easily extinguished with the use of a portable fire extinguisher, leave the area and confine the fire by closing the door.
Leave the affected area (fire zone) and await the arrival of the Fire Services.

SUBJECT:	Room Indicators	POLICY #:	EMP03-008
MANUAL:	Emergency Management Plan	PAGE:	1 of 1
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Purpose

1. Red Room Indicators are used to indicate when a room has been searched and fully evacuated.
2. Indicators will be placed in all resident bathrooms throughout the home. The indicator is a round, one-inch red plastic disc, with a magnet on the back.

Procedure

1. During non-emergency conditions, (i.e. normal operations) the disc will be magnetically mounted on the interior hinge side of the bathroom door frame of a resident room and the interior hinge side of the door frame for all other rooms.
2. When an evacuation is initiated, the indicator is to be magnetically mounted on the exterior door hand side of the doorframe, approximately the same height as the hallway railing. This is to be done after residents, visitors or any other person is evacuated from the room. Close the door once the room is evacuated.
3. Use indicator when checking rooms that are empty (i.e. bedroom, housekeeping closet, utility rooms, tub room, washrooms, offices, etc.).

Maintenance of System

1. Housekeeping staff will ensure an indicator is present in every resident bathroom and other rooms in the home and will replace any missing or damaged indicators.
2. The Maintenance Manager will maintain an adequate supply of indicators for replacement when necessary

SUBJECT:	Fire Watch	POLICY #:	EMP03-009
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
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Purpose

To provide for active safety monitoring in the event of malfunction of the fire alarm system in any part of Valley Manor Long Term Care Home. In the event of any shutdown or failure of fire alarm/protection equipment and systems, or any part thereof, a fire watch will be implemented in the area or areas affected. The fire watch will be maintained and documented for the duration of the event.

All homes will have at least two portable radios, fully charged and ready, suitable for communication throughout the home for fire emergency use. Radios are located at the Nurses Station.

Fire Watch Procedure

In the event of the shutdown or failure of a fire alarm system/protection equipment and systems, or any part thereof, the procedures noted below are to be followed. Fire watch duties must be conducted on a 24-hour basis until the fire alarm system is fully back in service. At least one person must be assigned to fire watch duties.

Documentation

All Fire Watch duties will be documented on the Fire Watch Checklist located in 'Appendix A'.

Person Initiating Fire Watch

1. Notify the Fire Department, Administrator, and Maintenance Manager.
2. Notify all building occupants that the fire alarm system is not fully functional, specifically; the area(s) affected, and that a fire watch has been started for their protection and warning.
3. Ensure the person responsible for the fire watch has a phone or radio for communication.

4. Ensure all staff are aware that they must call switchboard or Charge Nurse who then calls 9-1-1 if an emergency arises, and the pull stations are not functioning.

Staff Responsible for Fire Watch:

1. Each staff on fire duty should have a suitable means of communication, a flashlight, pen, copy of fire watch duties and check list, and a key to provide entry to all rooms and spaces.
2. Check all unprotected parts of the building on an hourly basis for any fire risk condition.
3. Record his/her patrols of the building on the Fire Watch Checklist - (Appendix 'A').
4. If a fire is discovered in (one of) the affected area(s), the fire alarm must be sounded by pulling a fire pull station.
5. If the pull stations are not functional, notify the Charge Nurse who will then announce the alarm.
6. In the event of a total system shutdown, notify the Ministry of Long Term Care by completing the Critical Incident Report.

Conclusion of Fire Watch Condition:

1. Once fire protection equipment and systems are fully restored by the fire alarm service company and confirmation is received from them by the Charge Nurse of the building, the Charge Nurse will remove fire watch and notify the Fire Department, Administrator, and Maintenance Manager.
2. A general announcement is to be made, to inform all persons in the building of restoration of normal conditions.

SUBJECT:	Fire Zone Locations and Floor Plans	POLICY #:	EMP03-010
MANUAL:	Emergency Management Plan	PAGE:	1 of 1
SECTION:	Introduction	REFERENCES:	
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Fire Zones

1. A fire zone is an area between two fire doors.
2. If a fire occurs in one zone- this area is the first area to evacuate beyond the fire doors away from the fire.

Fire Zone Locations and Floor Plans

1. See Appendix 'I'

SUBJECT:	Code Green - Evacuation	POLICY #:	EMP04-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 5
SECTION:	Introduction	REFERENCES:	
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NOTE: All walkie talkies should be set to channel 20.

Policy

To ensure the safety and continued provision of services for residents a long-term care home (LTCH) will follow the **Code Green** - Evacuation Emergency Response Plan procedures located below and in 'EMP06' if a LTCH experiences an emergency situation forcing the complete evacuation of the home.

Authority to Order Evacuation

The CEO (or designate as authorized by the CEO), or the Charge Nurse in consultation with emergency crews has the authority to order a total building evacuation.

Circumstances Forcing an Evacuation

- Fire or smoke;
- Gas leak;
- Bomb threat;
- Occurrences outside the home, for example: Environmental spill or Toxic or flammable gas escape;
- Natural disaster, for example: Flood or Tornado;
- Major mechanical problems, for example: Loss of heat, Loss of water/boil water advisory or Loss of electricity; and
- Chemical Spill.

Procedure

Roles and responsibilities are detailed in this policy and on the **Code Green** Evacuation Emergency Staff Roles, EMP05-002.

Evacuation Signal

Evacuation of the building due to a **Code Red** emergency will be signaled by the Charge Nurse by activating the stage 2 alarm for the fire alarm system and followed by a "**Code**

Green" announcement.

1. The Charge Nurse will activate the stage 2 alarm by inserting the evacuation key into a nearby fire alarm pull station and turning the key to activate the stage 2 alarm.
2. Once activated, the stage 2 alarm for the fire alarm system will sound at a more rapid pace (120 strokes beats per minute (temporal pattern).
   An order to evacuate will follow any of the other emergency codes when the situation requires a full evacuation of the building. This will be communicated to the occupants of the building by the Charge Nurse by announcing "**Code Green**" over the public address system.

Sequence of Evacuation

In order to ensure a timely evacuation of residents the following sequence of evacuation will be followed if practical.

1. Residents in immediate danger;
2. Ambulatory residents;
3. Non-ambulatory residents, including wheelchair users; and
4. Resistive residents.

Guidelines

1. Evacuate away from the area of concern. Do not go through an unsafe zone.
2. Direct visitors to the nearest safe holding area.
3. Determine the best sequence for evacuating residents.
4. Ensure Red/White REMAR Tags are being used to identify rooms that have been evacuated Assess the most appropriate methods of evacuation for each resident.
5. All areas of the home may be used as temporary holding areas during a horizontal evacuation.
6. Do not use elevators during an evacuation due to a **Code Red** emergency unless directed by the Chief Fire Official.

Advanced Emergency Evacuation Techniques

During a **Code Green** Evacuation every effort shall be made to evacuate residents as quickly and safely as possible.
There are a number of advance emergency evacuation techniques that can be used to safely assist in the evacuation of residents requiring additional assistance including:

1. Gentle Persuasive Approach (GPA) techniques.
2. Emergency lifts and carries. Use training received and documented in Valley Manor Lifts Transfers and Back Care Program - Appendix A11-001, unless other wise instructed by emergency personnel. (OPP or Fire Dept.)
3. The use of evacuation aids.

Only staff trained in the use of advanced emergency evacuation techniques should be assigned to evacuate residents requiring additional assistance such as non-ambulatory or resistive residents.

Never use the resident's bed during an emergency **Code Green** evacuation.

Emergency Operations Centre

Immediately upon implementation of a **Code Green** evacuation, an Emergency Operations Centre (EOC) will be established at the Nurse's Station to control evacuation and communication.
The EOC establishes a safe area having ready access to major resident areas, ease of exit and surveillance of same, and access to major communication and life-safety system controls.
The reception area of the home will serve as the default location for the EOC.
In the event that the reception area is not a safe location the Charge Nurse (RN) will establish an alternate location for the EOC.

Communication

See Appendix 'C' Communication Plan.

Building Access

Access by friends and relatives and the public shall be prohibited during the emergency.

Emergency Management Plan

1. Evacuate an emergency management plan, if possible, to be referenced outside as needed.

Office Records

Office records are to be evacuated only as time and circumstances allow in the following order:

1. Cash and un-deposited cheques;
2. Receipt books; and
3. HR's personal files.
4. Zone clip board and first aid kit on top of small filling cabinet, and visitor log.

Resident Care Records

Resident Care Records must be evacuated with the resident in the following priority order:

1. Resident Chart Binders from the Nurse's Station, using the provided hockey bags;
2. Medication Record Sheets on medication carts (if any); and
3. Electronic Medical Administration Record (EMARS) and Electronic Treatment Administration Record (ETARS) documentation will be acquired from an alternate site (LTCH).

Resident Identification

Residents will be identified by the following:

1. Each resident should be wearing an identification resident specific triage sticker affixed to a wristband on evacuation.
2. The triage tags and wrist bands can be found at various exits and on clipboards behind

zone separating doors.
3. The identification of the resident should include the resident's name, their doctor and the resident's home area (RHA).

Medications

Please see the MediSystem Valley Manor Disaster Plan – Appendix 'C'.

Meeting Areas

Outside meeting areas will be established for each zone and administration area in the home. The outside meeting area established by the home should be:

1. Easily accessible from the home's emergency exits;
2. Easily accessible for emergency transportation;
3. Clear of egress for emergency crews responding to the home; and
4. Easy to monitor residents (clear of bushes, trees or other obstructions that hinder visually monitoring a group of residents with minimal staff).
5. Unless not accessible the facilities primary meeting area will be the top parking lot. Each zone will stay together at their designated area, marked with a sign saying "Gathering Place for Zone _ in Emergencies". If the top parking lot is not available the charge nurse and/or the emergency service provider, such as the fire chief, will appoint another safe area.

Primary Relocation Centers

See Appendix 'D' Reciprocal Relocation Agreements.

Emergency Transportation

See Appendix 'E' Transportation Plan.

Relocation Guidelines

1. Residents shall be relocated to receiving facilities in the order of priority as assessed by the Charge Nurse and in home staff. Those demonstrating increased anxiety, intolerance or medical need will be relocated first.
2. Handoff procedures between the evacuating and receiving home shall include staff from the evacuating facility remaining with each group of evacuated residents.
3. Resident emergencies during transport will be first responded to by staff on the transport and by calling 911 if required or the situation increases in urgency.
4. Infection control, information security and privacy shall be maintained at all times.
5. Psychosocial support will be offered throughout the emergency.
6. Staff shall be re-assigned to relocation facilities as part of their regular position for the duration of resident relocation.

Temporary Emergency Licenses

A Temporary Emergency License (TEL) is issued by the Director set out in section 115 of the *Fixing Long Term Care Act*, *2021* (FLTCA), either by email or letter, where there are emergency situations affecting a licensed LTCH that makes it necessary to move one or more residents from a "source home" to a "recipient home" to protect the health and safety of the residents.

A TEL is issued to a recipient home in two circumstances:

1. If residents are accommodated above the licensed capacity of a licensed LTCH.
2. At a New Stand Alone Temporary LTC Unit:

A TEL will be issued if residents are expected to be out of their source home for more than 24 hours. In the event of an emergency and temporary housing is needed, this temporary emergency license remains effective until such time as the source home is safe for residents to return (for a maximum term of up to a one year).
CEO (or authorized designate) will arrange Temporary Emergency Licenses as required.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response.

Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances;

Immediately

An emergency within the meaning of section 268 of the FLTCA, including fire, unplanned evacuation or intake of evacuees.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Green Staff Roles	POLICY #:	EMP04-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Introduction	REFERENCES:	
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Charge Nurse – After Being Told to Call Code Green

1. Put on the Charge Nurse emergency vest if you are not already wearing one.
2. Activate fire alarm system stage two alarm if evacuation is due to fire emergency.
3. Announce "**Code Green**" three times slowly and clearly.
4. Ensure emergency crews are on site. If not call 911.
5. Initiate the emergency Fan-Out system. If staff are called in, advise them they must check in with the Charge Nurse upon arrival.
6. Assign Staff Leads and a scribe for the code event or drill.
7. Ensure residents and visitors are being evacuated.
8. Ensure med carts and resident charts are being removed with the residents.
9. Follow instructions from the emergency crews.
10. Contact the relocation facility to request assistance (see Appendix 'D' - Reciprocal Relocation Agreements located in the Emergency Management Plan).
11. Contact the emergency transportation provider (see Appendix 'E' Transportation Plan located in the Emergency Management Plan)

Charge Nurse – When the Code Green Is Over

1. If **Code Green** was due to a **Code Red**; reset fire alarm system only after instructed to do so by the Fire Chief.
2. Reset door security systems.
3. Announce "**All Clear Code Green**" three times.
4. Assign staff to take residents back to their rooms and conduct head count.
5. Debrief with staff.
6. Complete and distribute Emergency Drill Report.

Assigned Staff Lead – After Being Made Aware of a Code Green Evacuation

1. Return to your area by the safest route, if you are not already on the area.
2. Put on an Assigned Staff Lead emergency vest.

3. Assign nonessential staff members to all exits using a facility map found in Appendix I02. All doors will be unlocked when fire alarm is activated. After the facility is completely evacuated send a staff member to collect the staff watching the exits.
4. Tell staff to ensure residents have identification triage wrist bands (with stickers affixed) on.
5. Remind staff of the designated meeting area outside.
6. Tell staff to evacuate residents and visitors using the nearest safe holding area.
7. Tell staff to search rooms, remove any residents, close doors and use red/white REMAR tags when the room is empty.
8. Tell staff to move med cart and resident charts, if safe to do so.
9. Ensure all residents from your area are accounted for and report any missing residents to the Charge Nurse immediately.
10. Follow instructions from the Charge Nurse and emergency crews.

All Other Staff – After Being Made Aware of a Code Green Evacuation

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. If directly supervising residents report to an Assigned Staff Lead where you are.
3. Follow instructions from the Assigned Staff Leads, Charge Nurse and emergency crews.
4. Help residents and visitors to the nearest safe holding area.
5. Use alternate exit if you encounter smoke or other danger.
6. For a vertical evacuation use med sleds or alternate evacuation techniques to evacuate non-ambulatory residents.
7. Go to the designated meeting area outside the building.
8. Stay with the residents from your area.
9. Front office staff collect your zone board and first aid kit off the top of the small filing cabinet and the visitor log to take with you.

Administrator - After Being Made Aware of a Code Green Evacuation

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of Charge Nurse in the emergency capacity roll, if required.
3. Ensure Communication Plan is consulted and followed accordingly.

Managers - After Being Made Aware of a Code Green Evacuation

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. Collect your departments staff schedule for attendance.
3. Follow instruction from the Assigned Staff Lead, Charge Nurse and emergency crews.
4. Assume the role of the Assigned Staff Lead if required.
5. Assume the role of the Charge Nurse in the emergency capacity roll, if required.
6. When appropriate each manager should call their Urgent Services Contractors and Suppliers for their department.

SUBJECT:	Code Yellow – Missing Resident	POLICY #:	EMP05-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 3
SECTION:	Introduction	REFERENCES:	
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Policy

Each Long Term Care Home (LTCH) must have an established practice to ensure an effective and thorough response is activated when a resident is missing. Therefore, to ensure the safety of residents, a LTCH will follow the **Code Yellow** Missing Resident Emergency Response Plan procedures located below if a resident is deemed missing. If a LTCH is equipped with a resident global positioning system (GPS) tracking system that shall be utilized first and foremost to locate the missing resident.

Search

If a resident is suspected missing, staff will:

1. Make an announcement on the public address system; "Mr./Mrs./MS _____ please return to your area". This is announced **3** times at one-minute intervals. If there is no response to the above announcement, repeat: "**Code Yellow**, Mr./Mrs./MS _____, Resident Home Area: _____;" "**Code Yellow**, Mr./Mrs./MS _____, Resident Home Area: _____."
2. Check the resident in/out board (sign out?).
3. Initiate a search of the Resident Home Area (RHA) and outside by staff. (Make sure walkie-talkies are charged and ready at all times)

At this point the search has been expanded to the entire home with a quick check around the parking areas outside the home. Staff will be assigned to conduct a search throughout the LTCH and outside using the check lists located in the Emergency Management Plan (EMP), Appendix 'A' - Seach Check Lists: Zone Check List & Exterior Check List. Staff to mark a ✓ in all rooms searched, time and initial, and mark a ✓ in all locked, inaccessible rooms, time and initial and return to the Command Center (Nurses Station). Start at one side and systematically search all areas. At the same time start an outside search. Staff to mark a ✓ in all outside areas searched, time and initial.

At no time shall staff be requested to use their cars to search in the community. If staff wish to leave the home to search off the property, they must report to the Charge Nurse to

get and leave a cell phone number so they can communicate with the home if the resident is found.

Emergency Operations Center (Nurses Station)

Immediately upon implementation of a "Code Yellow" - Missing Resident, an emergency operations center (EOC) will be established by the Charge Nurse. The reception area of the home will serve as the default location for the EOC.

Communication

See Appendix 'C' Communication Plan.

Role of Family

Inform them of the situation and request their assistance in possible places to search. Keep the family informed throughout the search and reassure them of all progress and effort being used in the search.

Role of Police

Upon their arrival Ontario Provincial Police – Killaloe Dept. Officers are to be provided with all information collected, including the resident's photo. The OPP Officers will assume command of the search and the Regional Staff shall assist as required and requested and may request to see any video surveillance that may be available on the homes surveillance system(s).

Resident Photo

Print resident photo – Photos are located in the Electronic Chart or in the hard copy photo album at the Nurse's Station.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.
All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response.

Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

Immediately

1. Critical Incidents.

2. For a resident who is missing three hours or more.
3. For any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

No Later than One Business Day

1. A resident who has been missing for less than three hours and who returns to the home with no injury or adverse change in any of the resident's conditions.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' - Communication Plan: Urgent Services Contractors Suppliers Call List.

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Charge Nurse – After Being Made Aware of a Missing Resident

1. Put on a Charge Nurse emergency vest.
2. Announce "**Code Yellow** - Mr./Mrs./MS_____ Resident Home Area_____"
3. Charge Nurse will assign a staff member to each zone to lead the search in immediate interior zones with the search check list, and assign 2 staff to outside of the facility, each going in the opposite direction. Remind Maintenance Manager to check Cameras.
4. Collect marked check lists from staff leads.
5. Assign a scribe for the code event or drill.
6. If the resident is still not found call 911 to request assistance.
7. Contact the family to inform them and ask for places that should be searched.
8. Initiate the emergency fan out system for your home if required.
9. Print resident photo.
10. Complete the **Code Yellow** Missing Resident Report, located in Appendix 'A'.
11. Assign a staff member to go and meet OPP at the front entrance.
12. Upon arrival provide OPP with all the information they require.
13. Report the incident to the Ministry of Long-Term Care (MLTC) (as required).

Charge Nurse – When Code Yellow Is Over

1. Inform family the resident is found.
2. Announce "**All Clear Code Yellow**" 3 times.
3. Report to the MLTC that the resident has been found (as required).
4. Update resident care plan (as required).
5. Complete and distribute Emergency Drill Report.

Assigned Staff Leads – After Being Made Aware of a Code Yellow Missing Resident

1. Return to your area by the safest route, if you are not already on the area.
2. Put on an emergency vest.
3. Hand out check lists of the area you are assigned to and tell staff to search all rooms including closets and under beds.

4. Tell staff to mark a ✓ in all rooms and outside areas searched, time and initial; and mark a ✓ in all locked or inaccessible rooms, time and initial and return to the Command Center (Nurses Station).
5. Once search is complete report to the Charge Nurse at the EOC with the zone check lists.
6. If resident is found report to the Charge nurse.

All Other Staff – After Being Made Aware of a Code Yellow Missing Resident

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the appointed Staff Lead.
2. If directly supervising residents report to the assigned Staff Lead where you are.
3. Follow instructions from the assigned Staff Lead.

Administrator - After Being Made Aware of a Code Yellow Missing Resident

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of Charge Nurse if required.
3. Ensure the Communication Plan is consulted and followed accordingly.

Managers - After Being Made Aware of a Code Yellow Missing Resident

1. Return to your assigned area by the safest route, if you are not already on the area and report to the assigned Staff Lead.
2. Follow instructions from the assigned Staff Lead, Charge Nurse, and emergency crews.
3. Check outside Cameras to see if resident can be seen on any of the footage.
4. Assume the role of the assigned Staff Lead if required.
   Assume the role of the Charge Nurse if required.

SUBJECT:	Code Grey Emergency Response Plans Overview	POLICY #:	EMP06.0-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 1
SECTION:	Introduction	REFERENCES:	
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Purpose of a Code Grey Emergency Response Plan

Code Grey Emergency Response Plans are divided into three categories:

- Building Emergency;
- Extreme Weather; and
- Extreme Weather/Natural Disaster.

The above emergency situations are grouped together under **Code Grey** as they all pose threats to residents, staff, vital infrastructure and systems within each building.

Staff shall respond according to the appropriate **Code Grey** Emergency Response Plan roles and responsibilities.

Special Weather Statements

If a Special Weather Statement is issued staff shall activate the appropriate **Code Grey** Emergency Response Plan. Staff shall follow any instructions for Special Weather Statements if it is a first-time occurrence or outside of any established **Code Grey** Response Plans in the Emergency Management Plan.

SUBJECT:	Code Grey – Additional Emergency Response Measures	POLICY #:	EMP06.0-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 4
SECTION:	Code Grey	REFERENCES:	
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Purpose

Additional Building Emergency Response situations, associated roles, responsibilities and testing are as noted below:

Resident Communication and Response System

- Each long-term care home (LTCH) has a portable resident communication and response system capable of being distributed into a resident's home area of up to 30 units.
- Additional mitigation measures on the failure of a resident communication and response system may include the calling in of extra staff and the placement of bells in resident rooms in addition to following Urgent Maintenance Services (Appendix 'C') protocol.

The Resident Communication and Response System will be inspected annually to ensure proper operation of the system under:

Testing - Nurse Call System (Prebooked in MaintenanceCare.com)

One person is required to verify incoming calls to:

- The nurse call annunciator panel (if applicable);
- The nurse call console (if applicable); or
- The nurse call marquis (if applicable) Staff pagers (if applicable).

Second designated person moves from room to room sending in a call from each:

- Bed station;
- Washroom pull station;
- Duty station (located in all common areas, corridors, family rooms, dining rooms etc.); or
- During each activation of a station check the following:

    - Dome light outside the room illuminates;
    - Call cord is in good condition;
    - Washroom/shower pull cords are not more than 6 inches from the floor;
    - Communicate from one person to another that the call has been received and verify the call designation;
- Repair or replace any components not working;
- Document work performed;
- Maintain records for no less than two years unless otherwise indicated.

Internal Building Flooding Finding the Flood

- Isolate water source if possible – shut-offs are commonly located under sinks and toilets – turn clockwise to shut off;
- If it is a small flood and can be corrected (i.e. plugged toilet, sink overflow) – stop water flow and clean up area;
- If it is a large flood and cannot be corrected (i.e. broken toilet, burst pipe), contact maintenance during business hours and the Charge Nurse shall follow Urgent Maintenance Services (Appendix 'C') protocol for after-hours response;
- Utilize floor machines and/or mops to clean/contain flooded areas as best as possible.

Building Services

- Arrange for repair and/or remediation of the system that caused flooding;
- Dispose of contaminated items that cannot be dried;
- Flooring that has been soaked by flood water should be removed and discarded
- Dispose of all insulation materials, drywall that have been exposed to flood water and cannot be thoroughly cleaned and dried;
- Ensure interior spaces are thoroughly dried;
- Arrange for mold remediation contractor if needed.

Environmental Services

- Clean the affected area.

Preventative maintenance will be completed annually on plumbing fixtures to ensure the proper operation as well as ensuring water conservation by preventing leaky or bypassing fixtures under:

External Air Exclusion

In the event of an external emergency (i.e. fire, chemical spill, etc.) affecting the indoor air quality of a Long Term Care home;

- The decision to shut down air handling units bringing fresh air into a home will be made by emergency crews, the Administrator (or designate), the Manager Long Term Care Facilities or Supervisor Building Services only;
- Building Services will be contacted and will arrange the shutdown of the applicable air handling units;
- Communication will be put out to the building regarding the disruption of service and expected timeline for resolution (if known);
- Residents and building temperatures will be monitored;

- Upon conclusion of the emergency all air handling systems will be re-instated.

Air Handling Unit Preventative Maintenance (Units Are Shut-Down and Operation Verified).

Testing - Air Handler Units (HVAC) (Prebooked in MaintenanceCare.com)

Preventative maintenance will be completed on all air handling units semi-annually to ensure compliance with current legislation and optimal efficiency of the equipment.

Semi Annually in accordance with the Semi-Annual Inspection for the Ventilation Systems and Prevention of Respiratory Illness for Residential facilities.

1. Disconnect, lock-out and tag energy source.
2. When performing maintenance on equipment where dust or organic material will be disturbed staff should wear appropriate personal protective equipment (i.e. respirator, N95 mask, eye protection etc.).

The Maintenance Manager will ensure that the following occurs:

1. Fans:
   (a) Clean buildup, dust, and dirt from fan blades.
   (b) Clean inside of fan housing and casing, noting structural irregularities, condition of insulation, loose bolts, foundation and vibration isolation.
2. Bearings: (With pillow blocks, sleeve or ball bearings)
   (a) Lubricate bearings, change oil, and perform pressure lubrication according to manufacturer's instructions. Take care not to over-lubricate.
   (b) Remove top housing and examine retainers and slings.
3. Drives: (Belt and direct)
   (a) Inspect for excessive belt wear indicating misalignment, overloading, or improper belt tension.
   (b) If belts are worn, they should be replaced to prevent untimely breakdown. (Multi-belt drives should be replaced in matched sets.) Adjust belt tension with a scale and straight edge.
   (c) Check rigid couplings for alignment on direct drives, and for tightness of assembly.
   (d) Inspect flexible couplings for alignment and wear.
4. Coils
   (e) Examine coils for leakage at joints and bends.
   (f) Clean coil exterior by brushing, vacuuming, blowing, or chemical cleaning.
   (g) Humidifiers (city water, spray, steam pan grids, etc.) will require additional attention to avoid scaling, odors, biological contaminants.
5. Freeze Protection and Controls
   (h) Check pitch of coil to drainage point and blow down with compressed air.
   (i) Inspect test controls, linkage and control motors used for freeze protection.
   (j) Clean face bypass dampers and lubricate damper operators.
   (k) Clean and lubricate as necessary.
6. Maintain records for a minimum of two years or as directed.

Testing - Exhaust Fans (Prebooked in MaintenanceCare.com)

Preventative maintenance will be performed on exhaust fans semi-annually to ensure compliance with legislation and optimal efficiency of the equipment.

Semi Annually in accordance with the Semi-Annual Inspection for the Ventilation Systems and Prevention of Respiratory Illness for Residential Facilities.

The Maintenance Manager will ensure the following is conducted semi-annually:

1. Disconnect, lock-out and tag energy source (refer to energy lock out policy).
2. Check over unit thoroughly. Look for signs of rust, corrosion or deterioration.
3. Check insulation, repair if needed.
4. Check structural members, vibration eliminators and flexible connections.
5. Check bearings, shaft, pulley, and alignment with motor (if vibration is excessive- check balance of motor).
6. Perform required lubrication as required.
7. Change/replace belts.
8. Maintain records for minimum of 2 years unless otherwise identified.

Food Preparation Equipment

- Failure of food preparation equipment will be addressed by completing a maintenance request being logged through MaintenanceCare.com icon on any computer at the home.

Cyber Security

In the event of a cyber-threat or cyber emergency affecting one or more Long Term Care homes;

- Those who become aware of the breach should report it immediately to;
  - A Manager during business hours;
  - The Charge Nurse after hours;
  - The Charge Nurse will then contact the Manager on Call.
- The Manager shall place an IT request by completing an IT request being logged through MaintenanceCare.com icon on any computer at the home.
- Notify the Administrator/CEO
- The Administrator will follow up with Risk Management (as applicable).

Documentation

All real emergency events shall be documented on the Emergency Drill Report located in Appendix ‘A’. Testing records as noted above also shall be kept in the Testing binders in both the Maintenance Office and the Main Office.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response.

SUBJECT:	Code Grey Building Emergency – Loss of Heat	POLICY #:	EMP06.1-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Grey	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
PAST REVISIONS:		RESPONSIBILITY:	
CURRENT REVISION:	June 2024	DISTRIBUTION:	

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Policy

To ensure the safety and continued provision of services for residents a long-term care home (LTCH) will follow the **Code Grey** - Building Emergency Loss of Heat Response Plan procedures located below and in EMP06.01-002 if a LTCH experiences a loss of heat.

Description

The loss or interruption of heat for a LTCH can affect the safety and provision of care/services for the residents of a home.

Loss of All Heating Systems

1. In the event that the heating system is not functional, immediate steps must be taken to conserve and preserve body heat.
2. All residents and staff should congregate in one area of the home (if possible), close all doors to other areas, and use all available blankets and bed clothing for warmth.
3. Develop a contingency plan to deal with a prolong shortage of heat on each unit.
   Emergency Operations Center
   Immediately upon implementation of a Code Grey-Building Emergency, an Emergency Operations Centre (EOC) will be established by the Charge Nurse. The Nurse's Station of the home will serve as the default location for the EOC.

Emergency Operations Center

Immediately upon implementation of a Code Grey-Building Emergency, an Emergency Operations Centre (EOC) will be established by the Charge Nurse. The Nurse's Station of the home will serve as the default location for the EOC.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances;

No Later than One Business Day

1. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including:
    a. A breakdown or failure of the security system,
    b. A breakdown of major equipment or a system in the home,
    c. A loss of essential services.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Grey Building Emergency – Loss of Heat Staff Roles	POLICY #:	EMP06.1-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Grey	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Charge Nurse – After Being Made Aware of a Loss of Heat

1. Put on a Charge Nurse emergency vest.
2. Announce "**Code Grey-Loss of Heat**" three times slowly and clearly.
3. Initiate the Protocol for Urgent Maintenance Services if required.
4. Initiate the emergency fan out system for your home if required.
5. Assign Staff Leads (if required) and a scribe for the code event or drill.
6. Go to the Emergency Operations Center (EOC) (Nurse's Station).
7. Assign staff to close non-resident area doors to conserve heat.
8. Assign staff to inventory emergency supplies (portable heaters).
9. Collect the inventory of surplus supplies from Assigned Staff Leads.
10. Assess residents at risk.
11. Assign staff to install portable heaters for residents at high risk.
12. Call in additional staff as required.
13. Notify residents and visitors of disruption of service (Disruption of Services Protocol).
14. Contact Ministry of Long-Term Care (MLTC) as required.

Charge Nurse - If the Situation Requires Relocation of Residents to another Facility

1. Determining relocation of residents will be authorized by the home's Administrator or emergency crews.
2. Activate & follow the **Code Green** Emergency Response Plan.

Charge Nurse – When Code Grey Loss of Heat Is Over

1. Announce "**All Clear Code Grey-Loss of Heat**" three times.
2. Debrief with staff.
3. Complete and distribute Emergency Drill Report.
4. Report to the MLTC as required.

Assigned Staff Leads – After Being Made Aware of a Code Grey Loss of Heat

1. Return to your area by the safest route, if you are not already on the area.
2. Put on the Assigned Staff Lead emergency vest.
3. Tell staff to close windows in your area.
4. Tell staff to inventory surplus supplies such as sheets, blankets.
5. Report to the Charge Nurse at the EOC with the inventory of surplus supplies if safe to leave residents.
6. Follow instruction from the Charge Nurse.

All Other Staff – After Being Made Aware of a Code Grey Loss of Heat

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. If directly supervising residents report to the Assigned Staff Lead where you are
3. Follow instruction from the Assigned Staff Lead.

Administrator - After Being Made Aware of a Code Grey Loss of Heat

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of the Charge Nurse if required.

Managers - After Being Made Aware of a Code Grey Loss of Heat

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. Follow instruction from the Assigned Staff Lead, Charge Nurse and emergency crews.
3. Assume the role of the Assigned Staff Lead if required.
4. Assume the role of the Charge Nurse if required.

Maintenance Manager - Code Grey Loss of Heat

1. Work to ensure systems are operational and/or repaired.
2. Ensure generator is in a state of readiness.
3. Ensure departmental emergency equipment and materials are in a state of readiness.

SUBJECT:	Code Grey Building Emergency – Loss of Water – Boil Water Advisory	POLICY #:	EMP06.2-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Grey	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Policy

To ensure the safety and continued provision of services for residents a long-term care home (LTCH) will follow the Code Grey - Building Emergency Loss of Water/Boil Water Advisory Response Plan procedures located below and in EMP06.2-002 if a LTCH experiences a loss, interruption and/or contamination of water services.

Description

The loss, interruption and/or contamination of water services for a LTCH can affect the safety and provision of care/services for the residents of a home.

The services that may be affected include fire protection systems (i.e. sprinkler systems, hose and stand pipe systems etc.), the preparation of meal service (i.e. equipment such as steamers, combi ovens, coffee machines and water-cooled refrigeration equipment will not function), and bathing or personal care for the residents.

There are varying interruptions that a home may be faced with such as:

- A planned shutdown or interruption of water services, which provides the home an opportunity to pre-plan for the event. A planned interruption or loss of water service may be initiated by the municipal water service provider due to repairs/upgrades of local water mains etc. A planned shutdown or interruption may also be scheduled by the home for maintenance or to make repairs/alterations to systems within the home.
- An emergency shutdown or loss of municipal water service that requires immediate actions to be taken by the home's staff.
- A potential contamination of the municipal water service that requires immediate actions to be taken by the home's staff.

Emergency Operations Center

Immediately upon implementation of a Code Grey-Building Emergency, an Emergency Operations Centre (EOC) will be established by the Charge Nurse. The Nurses Station of the home will serve as the default location for the EOC.

Loss of Water/Boil Water Advisory Required Actions Checklist

The checklists were developed to assist the Charge Nurse in determining the actions required to be taken and are located in Appendix 'A'. Additional actions may be required as dictated by the circumstances of the emergency, subsequently some actions may not be required.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances;

Immediately

1. An emergency within the meaning of section 268 of the Fixing Long-Term Care Act, 2021 including fire, unplanned evacuation or intake of evacuees.
2. Contamination of the drinking water supply.

No Later than One Business Day

1. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including;
    a. A breakdown or failure of the security system,
    b. A breakdown of major equipment or a system in the home,
    c. A loss of essential services.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Grey Building Emergency – Loss of Water – Boil Water Staff Roles	POLICY #:	EMP06.2-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 3
SECTION:	Code Grey	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Charge Nurse – After Being Made Aware of a Loss or Contamination of Water

1. Put on a Charge Nurse emergency vest.
2. Announce "**Code Grey-Loss of Water/Boil Water Advisory**" three times slowly and clearly.
3. Initiate the Protocol for Urgent Maintenance Services if required.
4. Initiate the Emergency Fan out System for your home if required.
5. Go to the Emergency Operations Centre (EOC).
6. Assign Staff Leads (if required) and a scribe for the code event or drill.
7. Review the Required Actions Checklists located in the Emergency Management Plan, (Appendix 'A') and determine appropriate action.
8. Assign staff to duties as described in the Required Actions Checklist (as required).
9. Notify residents and visitors of disruption of service.

Charge Nurse - If the Situation Requires Relocation of the Residents to Another Facility

1. Determining relocation of residents will be authorized by the home's Administrator or emergency crews.
2. Activate and follow the **Code Green** Emergency Response Plan.

Charge Nurse – When Code Grey Loss of Water/Boil Water Advisory Is Over

1. Announce "**All Clear Code Grey Loss of Water/Boil Water Advisory**" three times.
2. Assign staff to turn on and flush water lines throughout the home if required.
3. Ensure proper notification to required personnel that the emergency is over.
4. Collect the emergency supplies.
5. Audit remaining bottled water inventory and notify Food Services Manager so stock can be reordered.
6. Debrief with staff and residents.

7. Complete and distribute Emergency Drill Report.
8. Report to the Ministry of Long-Term Care, Public Health etc. as required.

Assigned Staff Leads– After Being Made Aware of a Code Grey Loss of Water/Boil Water Advisory

1. Return to your area by the safest route, if you are not already on the area.
2. Put on the Assigned Staff Lead emergency vest.
3. Report to the Charge Nurse at the EOC if safe to leave residents.
4. Follow instruction from the Charge Nurse.

All Other Staff – After Being Made Aware of a Code Grey Loss of Water/Boil Water Advisory

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. If directly supervising residents report to the Assigned Staff Lead where you are.
3. Follow instruction from the Assigned Staff Lead.

Administrator - After Being Made Aware of a Code Grey Loss of Water/Boil Water Advisory

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of the Charge Nurse if required.

Managers - After Being Made Aware of a Code Grey Loss of Water/Boil Water Advisory

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. Follow instruction from the Assigned Staff Lead, Charge Nurse and emergency crews.
3. Assume the role of the Assigned Staff Lead if required.
4. Assume the role of the Charge Nurse if required.

SUBJECT:	Code Grey Building Emergency – Loss of Electricity	POLICY #:	EMP06.3-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 3
SECTION:	Code Grey	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Policy

To ensure the safety and continued provision of services for residents, a long-term care home (LTCH) will follow the **Code Grey** Building Emergency Loss of Electricity Emergency Response Plan procedures located below and in EMP06.3-002 if a LTCH experiences a loss of electricity.

Description

Each LTCH has an emergency backup generator to supply power to critical systems and equipment in the event of a loss of electricity. The home's emergency generator is diesel powered.

The emergency generators at Valley Manor will provide power for critical systems such as:

- Fire alarm systems;
- Door security systems;
- Nurse call systems;
- Heating, Ventilation, Air Conditioning (HVAC) systems;
- Lighting systems;
- Dietary equipment;
- Refrigeration equipment; and

In addition to the emergency generator each home maintains a supply of emergency equipment including flashlights, batteries, extension cords, portable battery backup, as well as portable generators (or have access to portable generators located at other LTCH) that will be distributed by staff as required.

Emergency Operations Centre

Immediately upon implementation of a Code Grey Building Emergency, an Emergency

Operations Centre (EOC) will be established by the Charge Nurse. The Nurse's Station of the home will serve as the default location for the EOC.

Loss of Electricity Required Actions Checklists

The checklists were developed to assist the Charge Nurse in determining the actions required to be taken and are located in Appendix - A05 and F02. Additional actions may be required as dictated by the circumstances of the emergency, subsequently some actions may not be required.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances;

Immediately

1. An emergency within the meaning of section 268 of the *Fixing Long-Term Care Act, 2021* including fire, unplanned evacuation or intake of evacuees.

No later than one business day

1. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including:
   a. A breakdown or failure of the security system;
   b. A breakdown of major equipment or a system in the home; or
   c. A loss of essential services.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Grey Building Emergency – Loss of Electricity Staff Roles	POLICY #:	EMP06.3-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 3
SECTION:	Code Grey	REFERENCES:	
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Charge Nurse– after being made aware of a loss of electricity

1. Put on a Charge Nurse emergency vest.
2. Announce "**Code Grey Loss of Electricity**" three times slowly and clearly.
3. Initiate the protocol for Urgent Maintenance Services if required.
4. Initiate the emergency fan out system if required.
5. Go to the Emergency Operations Centre (EOC).
6. Assign Staff Leads (if required) and a scribe for the code event or drill.
7. Review the Required Actions Checklists (Appendix - A05 and F02) located in the Emergency Management Plan and determine appropriate action:
   - If nurse call system is not functional assign staff to monitor residents; or
   - If door security system is not functional assign staff to monitor doors;
8. Assign staff to duties as described in the Required Actions Checklists (as required);
9. Notify residents and visitors of disruption of service.
10. Activate the Contingency Staffing Plan(s) if required.

Charge Nurse - if the situation requires relocation of the residents to another facility

1. Determining relocation of residents will be authorized by the home's Administrator or emergency crews.
2. Activate and follow the **Code Green** Emergency Response Plan if evacuating.

Charge Nurse- when Code Grey loss of electricity is over

1. Ensure that magnetic locks are reset.
2. Verify the door security, fire alarm and nurse call systems are operational.
3. Ensure a head count is completed for each resident area.
4. Collect the emergency supplies issued to staff such as flashlights, batteries, extension cords, etc.
5. Ensure that therapeutic mattresses are re-inflated.
6. Announce '**All Clear Code Grey Loss of Electricity**" three times.

7. Debrief with staff and complete and distribute Emergency Drill Report.
8. Report to the Ministry of Long-Term Care as required.

Assigned Staff Lead – after being made aware of a Code Grey loss of electricity

1. Return to your area by the safest route, if you are not already on the area.
2. Put on an Assigned Staff Lead emergency vest.
3. Tell staff to get emergency supplies (flashlights, extension cords etc.).
4. Tell staff to identify residents with oxygen (O_2) and air surfaces, and ensure equipment is plugged in.
5. Report to the Charge Nurse at the EOC if safe to leave residents.
6. Follow instruction from the Charge Nurse.

All Other Staff – after being made aware of a Code Grey loss of electricity

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. If directly supervising residents report to the Assigned Staff Lead where you are.
3. Follow instruction from the Assigned Staff Lead.

Administrator - after being made aware of a Code Grey loss of electricity

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of the Charge Nurse if required.

Managers - after being made aware of a Code Grey loss of electricity

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. Follow instruction from the Assigned Staff Lead, Charge Nurse and emergency crews.
3. Assume the role of the Assigned Staff Lead if required.
4. Assume the role of the Charge Nurse if required.

Maintenance Manager- Code Grey loss of electricity

1. Work to ensure systems are operational and/or repaired.
2. Ensure generator is in a state of readiness and always has a fuel supply of at least 75% full.
3. Ensure departmental emergency equipment and materials are in a state of readiness by using the “Emergency Power Supply Inventory” checklist (A05-001).

SUBJECT:	Code Grey Building Emergency – CO (Carbon Monoxide)- Gas Leak	POLICY #:	EMP06.4-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Grey	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Policy

To ensure the safety and continued provision of services for residents, a long-term care home (LTCH) will follow the **Code Grey** Building Emergency CO (Carbon Monoxide)/Gas Leak Emergency Response Plan procedures located below and in EMP06.4-002 if a LTCH experiences a CO or natural gas leak emergency.

Description

Carbon monoxide is a colourless, odourless, tasteless, toxic gas; usually the product of incomplete combustion from a fuel fired appliance.

Natural gas is odourless in its pure state. An odorant is added to give natural gas a distinctive rotten egg smell.

Symptoms of carbon monoxide and / or natural gas exposure

Exposure to CO or natural gas can cause a number of serious symptoms including flu-like symptoms such as headaches, nausea and dizziness, as well as confusion, drowsiness, loss of consciousness and even death.

Signs of a natural gas leak

- Sight - Damaged connections to natural gas appliances.
- Sound - Hissing or whistling.
- Smell - A distinctive rotten egg or Sulphur-like odour.

Ventilation

During a **Code Red** (fire emergency) it is important to close windows and doors in unaffected areas to prevent the spread of fire and or smoke from entering these areas.

During a **Code Grey** CO (Carbon Monoxide)/Gas Leak the opposite is true. Opening windows and doors in unaffected areas will ventilate these areas and prevent any potential carbon monoxide from spilling over and accumulating in these spaces.

Carbon Monoxide Detectors

Carbon monoxide detectors have been installed in areas of the home where fuel burning appliances/equipment have been located and adjacent resident sleeping areas. In some homes the detectors have also been installed within the resident room.

If a CO detector detects a dangerous level of CO, the red alarm light-emitting diode (LED) will flash, the detector will emit a loud alarm pattern (four quick beeps, five second pause and repeats) and the digital display will indicate the level of CO present in the form of parts per million (PPM).

- Low levels - Generally below 50 PPM.
- Mid-levels - Generally between 50 PPM to 100PPM.
- High levels - Generally above 100PPM.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix ‘A’.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

No later than one business day

1. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including:
   a. A breakdown or failure of the security system,
   b. A breakdown of major equipment or a system in the home,
   c. A loss of essential services, or
   d. Flooding.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry’s method for after-hours emergency contact. Contact information can be found in Appendix ‘C’ Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Grey Building Emergency – CO (Carbon Monoxide) Gas Leak Staff Roles	POLICY #:	EMP06.4-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Grey	REFERENCES:	
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All Staff - I discovered the alarm or leak and/or smell natural gas

1. Remove or evacuate any residents or visitors from the affected area.
2. Ensure containment – close the door(s).
3. Tell staff to report the alarm to the Charge Nurse.
4. If no other staff are nearby, go to the closest location to find a staff member and then return to the area.
5. Open windows or doors to ventilate the unaffected areas.
6. Follow instructions from the Assigned Staff Lead.

Charge Nurse– after being made aware of a CO (carbon monoxide) alarm or presence of natural gas

1. Put on the Charge Nurse emergency vest.
2. Announce "**Code Grey CO/Gas Leak**" and the location of the alarm three times slowly and clearly.
3. Go to the affected area.
4. Confirm the alarm and/or presence of gas.
5. Assign Staff Leads (if required) and a scribe for the code event or drill.
6. Ensure resident and visitors have been removed from affected areas.
7. Call 911.
8. Ensure windows and doors are opened to provide ventilation in the unaffected areas.
9. Assign one staff to the front entrance to meet the emergency crews.
10. Initiate the protocol for Urgent Maintenance Services if required.
11. Initiate the emergency fan out system if required.
12. Follow instructions from emergency crew.

Charge Nurse - if the situation requires relocation of the residents to another facility

1. Determining relocation of residents will be authorized by the home's Administrator or

emergency crews.
2. Activate and follow the **Code Green** Emergency Response Plan.

Charge Nurse - when Code Grey CO/gas leak is over

1. Announce "**All clear Code Grey CO/Gas Leak**" three times.
2. Assign staff to take residents back to their rooms and conduct head count.
3. Debrief with staff.
4. Complete and distribute Emergency Drill Report.

Assigned Staff Leads– after being made aware of a Code Grey CO (carbon monoxide)/gas leak in my area

1. Return to your area by the safest route, if you are not already on the area.
2. Put on an Assigned Staff Leads emergency vest.
3. Confirm the location of the alarm.
4. Ensure residents and visitors have been removed from the affected area.
5. Follow instructions from the Charge Nurse and emergency crews.

Assigned Staff Leads – after being made aware of a Code Grey CO (carbon monoxide)/gas leak outside of my area

1. Return to your area by the safest route, if you are not already on the area.
2. Put on an Assigned Staff Leads emergency vest.
3. Send a staff member to the affected area to assist (in the absence of other staff (ex. night shift) go to the affected area to assist).
4. Tell staff to open windows and doors in your area.

All Other Staff – after being made aware of a Code Grey CO (carbon monoxide)/gas leak

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. If directly supervising residents report to the Assigned Staff Lead where you are.
3. Follow instruction from the Assigned Staff Leads.

Administrator - after being made aware of a Code Grey CO (carbon monoxide)/gas leak

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of the Charge Nurse if required.

Managers - after being made aware of a Code Grey CO (carbon monoxide)/gas leak

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. Follow instruction from the Assigned Staff Lead, Charge Nurse and emergency crews.
3. Assume the role of an Assigned Staff Lead if required.
4. Assume the role of the Charge Nurse if required.

SUBJECT:	Code Grey Extreme Weather – Loss of Cooling	POLICY #:	EMP06.5-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 3
SECTION:	Code Grey	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Policy

To ensure the safety and continued provision of services for residents, a long-term care home (LTCH) will follow the Code Grey Extreme Weather Loss of Cooling Emergency Response Plan procedures located below and in Appendix 'B' if a LTCH experiences a loss of mechanical cooling system(s) leading to a rise in building temperatures above 26° C and resident duress or discomfort according to the Heat Related Illness Prevention and Management Plan (Ont. Reg. 246/22).

Heat Related Illness Prevention and Management Plan

The Heat Related Illness Prevention and Management Plan for the home shall be implemented every year during the period from May 15 to September 15, and it shall also be implemented:

- Any day on which the outside temperature forecasted by Environment Canada for the area in which the home is located is 26°C or above at any point during the day; and
- Anytime the temperature in an area in the home measured by the licensee in accordance with Ont. Reg. 246/22 reaches 26°C or above, for the remainder of the day and the following day.

Heat Warning – Environment Canada

A Heat Warning is issued by Environment Canada when two or more consecutive days of daytime maximum temperatures are expected to reach 31°C or warmer and nighttime minimum temperatures are expected to fall to 20°C or warmer, or;

A heat warning is issued when two or more consecutive days of humidex values are expected to reach 40°C or higher. This may also be communicated as a heat advisory by other issuing agencies.

Cooling Areas

In the event of system failure impacting resident comfort and central air conditioning is not available in one or more areas of the LTCH, separate designated cooling areas for every 40 residents will be established.

The resident home area dining rooms will serve as the default resident cooling areas (as required) until cooling systems are functional and/or air temperatures begin to drop. The LTCH may consider other areas for cooling areas as long as capacity does not exceed 40 residents.

If central air conditioning is not available in one area of the home, residents will be relocated to areas of the home where cooling systems are maintaining legislated temperatures.

Each LTCH shall have a spare stock of air conditioners on site with more units available at other LTCH's if required.

Emergency Operations Centre

Immediately upon implementation of a **Code Grey** Building Emergency, an Emergency Operations Centre (EOC) will be established by the Charge Nurse. The Nurse's Station of the home will serve as the default location for the EOC.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

No later than one business day

1. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including:
a. A breakdown or failure of the security system,
b. A breakdown of major equipment or a system in the home,
c. A loss of essential services.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Grey Extreme Weather – Loss of Cooling Staff Roles	POLICY #:	EMP06.5-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Grey	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Charge Nurse – after being made aware of indoor temperatures rising above 26 degrees Celsius or of a cooling system failure

1. Put on a Charge Nurse emergency vest;
2. Confirm temperature;
3. Announce "**Code Grey Loss of Cooling**" three times slowly and clearly;
4. Initiate the Protocol for Urgent Maintenance Services;
5. Initiate the emergency fan out system for your home if required;
6. Assign Staff Leads (if required) and a scribe for the code event or drill.
7. Go to the Emergency Operations Centre (EOC) (Nurse's Station);
8. Assign staff to prepare portable air conditioners for the areas where mechanical cooling system(s) have failed and residents are experiencing duress;
9. Continually assess residents at risk;
10. Prepare cooling area on resident's home area dining room (or alternate location);
11. Move at risk residents to cooling area if the space they are in is unable to be cooled;
12. Call in additional staff as required;
13. Notify residents and visitors of disruption of service;
14. Contact the Ministry of Long-Term Care (MLTC) as required.

Charge Nurse - if the situation requires relocation of residents to another facility

1. Determining relocation of residents will be authorized by the home's Administrator or emergency crews;
2. Activate and follow the **Code Green** Emergency Response Plan. **Charge Nurse – when Code Grey loss of cooling is over**
3. Announce '**All Clear Code Grey-Loss of Cooling**" three times;
4. Debrief with staff;
5. Complete and distribute Emergency Drill Report;
6. Report to the MLTC as required.

Assigned Staff Leads– after being made aware of a Code Grey loss of cooling affecting your area

1. Return to your area by the safest route, if you are not already on the area;
2. Put on an Assigned Staff Lead emergency vest;
3. Tell staff to ensure windows are closed in your area;
4. Tell staff to monitor residents;
5. Report resident status;
6. Establish cooling area as directed;
7. Follow instruction from the Charge Nurse.

Assigned Staff Leads– after being made aware of a Code Grey loss of cooling outside of your area

1. Return to your area by the safest route, if you are not already on the area;
2. Put on an Assigned Staff Lead emergency vest;
3. Tell staff to ensure windows are closed in your area;
4. Tell staff to monitor residents;
5. Report resident status;
6. Follow instruction from the Charge Nurse.

All Other Staff – after being made aware of a code grey loss of cooling

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead;
2. If directly supervising residents report to the Assigned Staff Lead where you are;
3. Follow instruction from the Assigned Staff Lead.

Administrator - after being made aware of a Code Grey loss of cooling

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of Charge Nurse if required.
3. Ensure Communication Plan is consulted and followed accordingly.
4. Ensure Extreme Weather Plan is consulted and followed accordingly.
5. Ensure the Heat Related Illness Prevention and Management Plan for and Hot Weather Guidelines are active and in place.

Managers - after being made aware of a Code Grey loss of cooling

1. Ensure staff are aware of responsibilities.
2. Ensure departmental equipment required for the emergency response is in a state of readiness.
3. Assume the role of Assigned Staff Lead or Charge Nurse if required.

Maintenance Manger - Code Grey loss of cooling

1. Work to ensure systems are operational and/or repaired.
2. Ensure generator is in a state of readiness.
3. Ensure departmental emergency equipment and materials are in a state of readiness.

SUBJECT:	Code Grey Extreme Weather – Winter Storm Warning	POLICY #:	EMP06.6-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Grey	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Policy

To ensure the safety and continued provision of services for residents, a long-term care home (LTCH) will follow the **Code Grey** Extreme Weather Winter Storm Warning Emergency Response Plan procedures located below and in Appendix 'B' if a LTCH experiences a winter storm warning or blizzard warning.

Description

A Winter Storm Warning is issued by Environment Canada when severe and potentially dangerous winter weather conditions are expected, including;

A major snowfall (25 cm or more within a 24-hour period) or a snowfall warning (15cm or more within a 12-hour period) combined with other cold weather precipitation types such as: freezing rain, strong winds, blowing snow and/or extreme cold. Blizzard conditions may be part of an intense winter storm, in which case a blizzard warning is issued instead of a winter storm warning.

Emergency Operations Centre

Immediately upon implementation of a **Code Grey** Extreme Weather, an Emergency Operations Centre (EOC) will be established by the Charge Nurse. The Nurse's Station of the home will serve as the default location for the EOC.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

No later than one business day

1. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including:
   a. A breakdown or failure of the security system,
   b. A breakdown of major equipment or a system in the home,
   c. A loss of essential services.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Grey Extreme Weather – Winter Storm Warning Staff Roles	POLICY #:	EMP06.6-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
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Administrator (or designate) - after being made aware of a Code Grey winter storm warning being issued

1. Announce "**Code Grey Winter Storm Warning**" to the building.
2. Assume the role of Charge Nurse if required.
3. Ensure Communication Plan is consulted and followed accordingly.
4. Ensure Extreme Weather Plan is consulted and followed accordingly.

Administrator (or designate) - when the Code Grey winter storm warning is over

1. Debrief with staff and residents, complete and distribute Emergency Drill Report.
2. Announce "**All Clear Code Grey: Winter Storm Warning**" to the building.

Managers - after being made aware of a Code Grey winter storm warning

1. Ensure staff are aware of responsibilities.
2. Ensure departmental equipment required for the emergency response is in a state of readiness.
3. Assume the role of Assigned Staff Lead or Charge Nurse if required.

Maintenance Manager - after being made aware of a Code Grey winter storm warning

1. Ensure systems are operational.
2. Ensure generator is in a state of readiness.
3. Ensure departmental emergency equipment and materials are in a state of readiness.

Charge Nurse – after being made aware of Code Grey winter storm warning

1. Monitor residents and systems.
2. If the situation increases in urgency put on the Charge Nurse vest and respond accordingly.

3. Prepare for the activation of other emergency codes and respond accordingly, i.e. loss of electricity.
4. Initiate the Protocol for Urgent Maintenance Services if required and /or outside of business hours.
5. Initiate the emergency fan out system for your home if required.
6. Assign Staff Leads (if required) and a scribe for the code event or drill.
7. Prepare portable heaters for distribution if needed.
8. Notify residents and visitors of disruption of service if any systems fail.

Charge Nurse- when the Code Grey winter storm warning is over

1. Ensure proper notification to required personnel that the emergency is over (as needed).
2. Collect emergency supplies as needed.
3. Report to the Ministry of Long-Term Care, Public Health etc. as required.

Assigned Staff Lead – after being made aware of a Code Grey winter storm warning

1. Ensure exterior windows and doors are securely closed in your area.
2. Monitor residents for comfort and safety.
3. Ensure residents are not accessing exterior areas impacted by winds.
4. Report to Charge Nurse or management any areas where systems seem to not be functioning or where wind is entering the building or causing damage.
5. If the situation increases in urgency put on an Assigned Staff Leads vest and respond accordingly.

All Other Staff – after being made aware of a Code Grey winter storm warning

1. Ensure exterior windows and doors are securely closed in your area.
2. Monitor residents for comfort.
3. Ensure residents are not accessing exterior areas impacted by winds.
4. Report to Assigned Staff Lead, Charge Nurse or management any areas where systems seem to not be functioning, or where snow is entering the building or causing damage.

SUBJECT:	Code Grey Extreme Weather – Natural Disaster – Tornado Warning	POLICY #:	EMP06.7-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
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Policy

To ensure the safety and continued provision of services for residents, a long-term care home (LTCH) will follow the **Code Grey** Extreme Weather/Natural Disaster Tornado Warning Emergency Response Plan procedures located below and in Appendix 'B' if a LTCH is located in a geographic area that a tornado warning has been issued for.

Description

Tornadoes are rotating columns of high winds. Tornadoes can be hard to predict and can move up to 70 km/hour and leave a long path of destruction including uprooted trees, overturned cars, and demolished houses. Beware of flying debris. Even small objects such as sticks and straw can become dangerous.

Tornado Watch – Issued when conditions are favourable for the development of severe thunderstorms with one or more tornadoes. Tornado watches are also issued when the possibility of cold core funnel clouds is likely, and poses a threat to people on the ground. If there is a land spout on the ground, a tornado warning will be issued.

Tornado Warning – Issued when one or more tornadoes are occurring in the area specified or rotation is detected on weather radar, or when someone spots a supercell, tornado or a land spout on the ground. The exact location of the tornado or storm will be given in the statement.

Warnings are issued when severe weather is either imminent or occurring.

Tornado warning signs

1. Severe thunderstorms.
2. An extremely dark sky, sometimes highlighted by green or yellow clouds.
3. A rumbling or whistling sound similar to the sound of a freight train.

4. A funnel cloud at the rear base of a thundercloud, often being a curtain of heavy rain or hail.

Emergency Operations Centre

Immediately upon implementation of a **Code Grey** Extreme Weather/Natural Disaster, an Emergency Operations Centre (EOC) will be established by the Charge Nurse. The Nurse's Station of the home will serve as the default location for the EOC.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

Immediately

1. An emergency within the meaning of section 268 of the Fixing Long-Term Care Act, 2021 including fire, unplanned evacuation or intake of evacuees.

No later than one business day

1. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including:
   a. A breakdown or failure of the security system,
   b. A breakdown of major equipment or a system in the home,
   c. A loss of essential services, or
   d. Flooding.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Grey Extreme Weather – Natural Disaster – Tornado Warning Staff Roles	POLICY #:	EMP06.7-002
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Charge Nurse – after being made aware of a declared tornado warning

1. Put on a Charge Nurse emergency vest.
2. Announce "**Code Grey Tornado Warning**" three times slowly and clearly to the building.
3. Go to the Emergency Operations Centre (EOC).
4. Initiate the emergency fan out system if required.
5. Assign Staff Leads (if required) and a scribe for the code event or drill.
6. Initiate the Extreme Weather Plan 'Appendix F' if the warning is not imminent.
7. Establish communication with each resident home area.
8. Ensure residents are moved away from windows into central areas of the building.
9. Ensure windows and doors are closed throughout the building.
10. Prepare for loss of electricity.
11. Call 911 if a tornado impacts the home.
12. Shelter in place until the tornado warning has ended.
13. Follow instructions from emergency crews if they are on site.

Charge Nurse - if the situation requires relocation of the residents to another facility

1. Determining relocation of residents will be authorized by the home's Administrator or emergency crews.
2. Activate and follow the **Code Green** Emergency Response Plan.

Charge Nurse - when the Code Grey tornado warning has ended

1. Return residents to their rooms if able.
2. If the home has been affected, initiate other Emergency Response Plans as needed.
3. Complete and distribute Emergency Drill Report.

Assigned Staff Leads – after being made aware of a Code Grey tornado warning

1. Return to your area by the safest route, if you are not already on the area.
2. Put on an Assigned Staff Lead emergency vest.
3. Tell staff to move residents into hallways and central areas of the building away from skylights, windows and exterior walls. Use bathrooms if needed.
4. Tell staff to close all windows and doors, including fire doors.
5. Keep residents aligned in an orderly fashion to continue moving to alternate areas if necessary.
6. Prepare for loss of electricity.
7. Follow instructions from the Charge Nurse and emergency crews if they are on site.

All Other Staff – after being made aware of a Code Grey tornado warning

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. If directly supervising residents report to the Assigned Staff Lead where you are.
3. Follow instruction from the Assigned Staff Leads.

Administrator - after being made aware of a Code Grey tornado warning

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of the Charge Nurse if required.
3. Ensure Communication Plan is consulted and followed accordingly.
4. Ensure Extreme Weather Plan is consulted and followed accordingly.

Managers - after being made aware of a Code Grey tornado warning

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Leads.
2. Follow instruction from the Assigned Staff Leads, Charge Nurse and emergency crews.
3. Assume the role of the Assigned Staff Lead if required.
4. Assume the role of the Charge Nurse if required.

SUBJECT:	Code Grey Extreme Weather – Natural Disaster – Wind Warning	POLICY #:	EMP06.8-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Grey	REFERENCES:	
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Policy

To ensure the safety and continued provision of services for residents, a long-term care home (LTCH) will follow the **Code Grey** Extreme Weather/Natural Disaster Wind Warning Emergency Response Plan procedures located below and in Appendix 'B' if a LTCH is located in a geographic area that a wind warning has been issued for.

Description

A wind warning is issued by Environment Canada for sustained winds of 70 km/h or more and/or gusts to 90 km/h or more

Preparing for the wind warning

1. Ensure staffing levels are appropriate.
2. Ensure windows and doors are secure.
3. Ensure loose items around the exterior of the building are secure.
4. Ensure garbage enclosures are secure.
5. Staff should avoid parking near trees where possible.

After the wind warning

1. Ensure all systems are functioning as intended.
2. Ensure there is no damage to the exterior of the building.

Emergency Operations Centre

Immediately upon implementation of a **Code Grey** Extreme Weather/Natural Disaster, an Emergency Operations Centre (EOC) will be established by the Charge Nurse. The Nurse's Station of the home will serve as the default location for the EOC.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

Immediately

1. An emergency within the meaning of section 268 of the *Fixing Long-Term Care Act, 2021* including fire, unplanned evacuation or intake of evacuees.

No later than one business day

1. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including:
    a. A breakdown or failure of the security system,
    b. A breakdown of major equipment or a system in the home,
    c. A loss of essential services, or
    d. Flooding.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Grey Extreme Weather – Natural Disaster – Wind Warning Staff Roles	POLICY #:	EMP06.8-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
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Administrator (or designate) - after being made aware of a wind warning being issued

1. Announce "**Code Grey Wind Warning**" to the building.
2. Assume the role of Chief Warden if required.
3. Ensure Communication Plan is consulted and followed accordingly.
4. Ensure Extreme Weather Plan is consulted and followed accordingly.

Administrator (or designate) - when the Code Grey wind warning is over;

1. Debrief with staff and residents, complete and distribute Emergency Drill Report.
2. Announce "**All Clear Code Grey Wind Warning**" to the building.

Managers - after being made aware of a Code Grey wind warning

1. Ensure staff are aware of responsibilities.
2. Ensure departmental equipment required for the emergency response is in a state of readiness.
3. Assume the role of Assigned Staff Lead or Charge Nurse if required.

Maintenance Manager - after being made aware of a Code Grey wind warning

1. Ensure systems are operational.
2. Ensure generator is in a state of readiness.
3. Ensure departmental emergency equipment and materials are in a state of readiness.

Charge Nurse– after being made aware of a Code Grey wind warning

1. Monitor residents and systems.
2. If the situation increases in urgency put on the Charge Nurse vest and respond

accordingly.
3. Prepare for the activation of other emergency codes and respond accordingly, i.e. loss of electricity.
4. Initiate the Protocol for Urgent Maintenance Services if required and /or outside of business hours.
5. Assign Staff Leads (if required) and a scribe for the code event or drill.
6. Initiate the emergency fan out system for your home if required.
7. Prepare portable heaters for distribution if needed.
8. Notify residents and visitors of disruption of service if any systems fail.

Charge Nurse - when the Code Grey wind warning is over;

1. Ensure proper notification to required personnel that the emergency is over (as needed).
2. Collect emergency supplies as needed.
3. Report to Ministry of Long-Term Care, Public Health, etc. as required.
4. Assigned Staff Lead – after being made aware of a Code Grey wind warning.
5. Ensure exterior windows and doors are securely closed in your area.
6. Monitor residents for comfort and safety.
7. Ensure residents are not accessing exterior areas impacted by winds.
8. Report to Charge Nurse or management any areas where systems seem to not be functioning or where wind is entering the building or causing damage.
9. If the situation increases in urgency put on the Assigned Staff Lead vest and respond accordingly.

All Other Staff – after being made aware of a Code Grey wind warning

1. Ensure exterior windows and doors are securely closed in your area.
2. Monitor residents for comfort.
3. Ensure residents are not accessing exterior areas impacted by winds.
4. Report to Assigned Staff Lead, Charge Nurse or Management any areas where systems seem to not be functioning, or where wind is entering the building or causing damage.

SUBJECT:	**Code Black – Bomb Threat**	**POLICY #:**	**EMP07-001**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 3**
SECTION:	**Code Black**	**REFERENCES:**	
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Policy

To ensure the safety and continued provision of services for residents, a long-term care home (LTCH) will follow the **Code Black** Bomb Threat Emergency Response Plan procedures located below and in Appendix 'B' if a LTCH experiences a bomb threat.

Description

A bomb threat is defined as a threat to detonate an explosive or incendiary device to cause property damage, death, or injuries, whether or not such a device actually exists. All bomb threats are to be taken seriously.

Although very few bomb threats are real, a threat of this nature must be taken seriously. Generally speaking, anyone actually wishing to do harm by placing a bomb at a location usually will not call to provide warning however, this is not always the case and it must be assumed that any threat received is an actual threat.

If received by mail

The first person to read the document will immediately protect it for fingerprints, notify the Administrator (or designate) and/or the Charge Nurse. Do a quick visual inspection of your area. Do not touch or move suspicious objects. Do not use radios or cell phones as they can trigger an explosive device.

If received by telephone

The person receiving the call shall use the **Code Black** Alarm Report located at each landline business related phone and in Appendix 'A' to help summarize the following information:

1. Record the time of the call.

2. Establish the location of the bomb if possible and when it was placed.
3. Establish when the bomb is set to go off, ask if it is an electrical or mechanical device.
4. Ask why the bomb was put here, (i.e. personal, property, etc.).
5. Endeavour to establish the origin of the call (background noises, traffic, equipment, voices, weather).
6. Endeavour to determine the language dialect or distinguishing feature of the caller's voice.
7. Ask questions that might assist in identifying the caller i.e. "What is your name?"
8. Endeavour to determine the caller's state of mind, (i.e. calm, irrational, rational, intoxicated, etc.).
9. Endeavour to establish the sex and approximate age of the caller.
10. Complete **Code Black** Alarm Report as the call is in progress.
11. Dial 911; inform of bomb/threatening call.
12. Forward the **Code Black** Alarm Report to the Administrator (or designate) and/or the Charge Nurse.

Answer all questions in the report as fully as possible during the phone call. Write down as much detail as possible. Remember that strong emotions will accompany this type of threat and it is easy to forget details you might have observed. Stay calm and try to obtain as much information about the bomb and about the caller as possible.

Emergency Operations Centre

Immediately upon implementation of a **Code Black**, an Emergency Operations Centre (EOC) will be established by the Charge Nurse. The Nurse's Station of the home will serve as the default location for the EOC.

Role of Police

1. Police will respond to the LTCH after the 911 call is placed. They may arrive quietly as to not draw any more attention to the situation.
2. Police will be limited in the LTCH search since they are not familiar with the LTCH's floor plan and equipment; and would not know what was foreign or normal. Staff may be required to assist in a visual search of the building with police due to their familiarity with the LTCH.
3. The police should be informed of extremely vulnerable areas - both inside and outside the LTCH (i.e. fuel storage, electrical sources, etc.).
4. If a bomb or suspected bomb is found, it then becomes the complete responsibility of the police department to deactivate it or remove it to where it can be safely detonated.

Evacuation (Code Green)

Evacuation is not required unless:
1. Police order it.
2. A suspicious item is found.
3. The caller has indicated the location and/or time of explosion.
4. If a bomb or suspected bomb is found, police will instruct staff to evacuate residents in the immediate vicinity of the bomb.
5. If an evacuation is ordered follow **Code Green** Evacuation procedures.

6. After a decision has been made with regard to the evacuation route, the area will be evacuated. The shortest route may not necessarily be the safest. This will be the police decision, assisted by the Charge Nurse.

Media communication

1. Staff at the LTCH should **NOT** speak with the media.
2. Any communication to the media will be handled according to Corporate Policy, in consultation with the police.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances;

Immediately

1. An emergency within the meaning of section 268 of the Fixing Long-Term Care Act, 2021, including fire, unplanned evacuation or intake of evacuees.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	**Code Black – Bomb Threat Staff Roles**	**POLICY #:**	**EMP07-002**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 2**
SECTION:	**Code Black**	**REFERENCES:**	
ORIGINAL ISSUE:	**February 2023**	**APPROV. AUTH:**	
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Charge Nurse – after being made aware of a bomb threat

1. Put on a Charge Nurse emergency vest.
2. Call 911.
3. Announce "**Code Black**" three times slowly and clearly.
4. Assign Staff Leads (if required) and a scribe for the code event or drill.
5. Initiate the emergency fan out system if required.
6. Go to the Emergency Operations Centre (EOC).
7. Investigate the severity of the threat.
8. Assign a staff member to go and meet emergency crews at front entrance.

Charge Nurse - if the location of the bomb is known

1. Announce "**Code Green**" three times.
2. Follow **Code Green** Emergency Response Plan.

If the location of the bomb is not known

1. Instruct staff to search the building looking for anything suspicious, hand out check lists of the zones —visual search only.
2. Tell staff to mark a ✓ in all rooms searched, time and initial; and mark a ✓ in all locked or inaccessible rooms, time and initial and return to the Command Center (Nurses Station).
3. Provide police with floor plans noting the areas checked.
4. Follow instructions from emergency crews including activating **Code Green** Emergency Response Plan.

Charge Nurse when Code Black bomb threat is over

1. Announce "**All Clear Code Black**" three times.
2. Debrief with staff.
3. Complete and distribute Emergency Drill Report.

Assigned Staff Leads– after being made aware of a Code Black bomb threat

1. Return to your area by the safest route, if you are not already on the area.
2. Put on an Assigned Staff Lead vest.
3. Tell staff to ensure residents have identification wrist bands on.
4. Tell staff to prepare to move resident charts and med carts.

Assigned Staff Lead - if instructed to search the building

1. Hand out Search Check Lists (Appendix A) of your area and tell staff to conduct a visual search of all rooms including closets and under beds.
2. Staff should look for anything suspicious, i.e. back packs, suspicious packages etc.
3. Tell staff to mark a ✓ in all rooms searched, time and initial; and mark a ✓ in all locked or inaccessible rooms, time and initial.
4. Once search is complete report to the Charge Nurse at the EOC with the marked floor plans.

All Other Staff – after being made aware of a Code Black bomb threat

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. If directly supervising residents report to the Assigned Staff Lead where you are.
3. Follow instruction from the Assigned Staff Lead.

Administrator - after being made aware of a Code Black bomb threat

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of the Charge Nurse if required.
3. Ensure Communication Plan is consulted and followed accordingly.

Managers - after being made aware of a code

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. Follow instruction from the Assigned Staff Lead, Charge Nurse and emergency crews.
3. Assume the role of the Assigned Staff Lead if required.
4. Assume the role of the Charge Nurse if required.

SUBJECT:	Code Brown – Chemical Spill	POLICY #:	EMP08-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 4
SECTION:	Code Brown	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Policy

To ensure the safety and continued provision of services for residents, a long-term care home (LTCH) will follow the **Code Brown** Chemical Spill Emergency Response Plan procedures located below and in Appendix 'B' if a LTCH experiences a chemical spill. The chemical spill response will meet current standards as defined by the Ministry of Environment and any other current legislation.

Description

Chemical spills are the uncontrolled release of a hazardous chemical, either as a solid, liquid or a gas.

These spills need to be minimized as much as possible. If a chemical spill should occur, a quick response with a stocked chemical spill kit will help minimize potential harm to personnel, equipment and laboratory space.

Emergency Spill Kits

Each home will maintain at least one well-prepared emergency chemical spill kit to manage and control a spill.

The chemical spill kit will contain the following:

1. **Instructions:** Instructions for the use of the spill kit.
2. **Granular Absorbent**: An effective granular absorbent material helps clean up spills with ease. It absorbs liquids and prevents them from spreading further.
3. **Boom Socks**: Highly-absorbent boom socks are useful for containing and absorbing larger spills. They can be placed around the spill area to prevent it from spreading. (At least 5 - 3 inch x 4 foot absorbent socks. At least 1 – 3 inch x 8 foot absorbent sock).
4. **Mats and Pillows**: Include absorbent mats and pillows specifically designed for leaks and drips. These can quickly soak up liquids and minimize slip hazards. (At least 50 – 15 inch x 19 inch absorbent pads).
5. **Personal Protective Equipment (PPE)**: Ensure that the spill kit contains appropriate

PPE for keeping people safe during cleanup. This includes two sets of goggles (eye protection), disposable aprons, & two sets of chemical resistant gloves.

6. **Rubber sheeting:** Rubber sheeting large enough to cover a catch basin or storm sewer gate.
7. **Disposable Bags:** A quantity of 4-millimeter disposable bags and cable ties to collect and dispose of contaminated materials.
8. **Caution Tape:** One roll of caution tape.
9. **Portable Container**: Use a sturdy container to store the spill kit. It should be easy to carry and accessible in case of emergencies.

The Administrator will ensure the location(s) of the emergency chemical spill kit(s) will be in a place determined by the home that allows easy access for staff in a **Code Brown** Chemical Spill. The location(s) of the emergency spill kit(s) will be communicated to the Joint Health and Safety Committee (JHSC) of the home and all other staff.

The JHSC will inspect the emergency chemical spill kit(s) as part of their regular inspection cycle. Spill Kit Inspection Checklist can be found in Appendix "B".

Building Services will be responsible for maintaining the contents of the emergency chemical spill kit(s). All staff will be responsible to report to the Maintenance Manager any materials and quantities that have been used from the kit(s).

If the spill is a "major spill" and affects the health or safety of any occupants in the home, Emergency Medical Services (EMS) and Fire Services will be notified to respond by calling 911.

If the spill requires additional resources for remediation (spills that require the assistance from a qualified contractor for containment and clean up) see Call Back List, Appendix 'C'.

Note: Proper PPE shall be worn by all staff when handling any contaminated material in any of the above situations and according to Safety Data Sheet (SDS) requirements.

Minor Chemical Spill Indoors

1. The Safety Data Sheets must be consulted prior to handling any contaminated material.
2. Eliminate all ignition sources if the spill is flammable.
3. If possible, stop the flow at the source.
4. Contain the spill and do not allow the spill to spread or migrate. This can be done by:
    i. Placing "absorbent socks", obtained from the emergency spill kit, around the spill.
    ii. Placing the rubber sheeting, obtained from the emergency spill kit, over floor drains or storm drains etc.
5. Remove other materials, or equipment from the path of the spill.
6. Soak up spill with absorbent padding, obtained from the emergency spill kit.
7. Place all contaminated materials in the bags provided in the emergency spill kit.
8. If the spill is water soluble, wash the area with warm soapy water to remove any residue.
9. Contact Maintenance for disposal of contaminated materials and to replenish the emergency spill kit.
10. Complete an Employee Incident Report.

Major Chemical Spill Indoors

1. Evacuate the affected area.
2. Notify the Charge Nurse.
3. Wait in a safe area for the Charge Nurse to report to the scene.
4. Do not allow unauthorized persons to enter the contaminated area.

Chemical Spill Outdoors

1. Notify the Charge Nurse.
2. The Material Safety Data Sheets must be consulted prior to handling any contaminated material.
3. Eliminate all ignition sources if spill is flammable liquids.
4. If possible, stop the flow at the source.
5. Contain the spill and do not allow the spill to spread or migrate. This can be done by:
    a. Placing “socks”, obtained from the emergency spill kit, around the spill.
    b. Diking with earth/soil or other material.
    c. Placing the rubber sheeting, obtained from the emergency spill kit, over storm drains, sewer manholes etc. to prevent contaminating ground water or sewer system.
6. Remove other materials, or equipment from the path of the spill.
7. Soak up spill with absorbent padding, obtained from the emergency spill kit.
8. Place all contaminated materials in the bags provided in the emergency spill kit.

First Aid – Always Consult Safety Data Sheet

Eye Contact:

If a chemical has been splashed into the eyes, immediately wash the eye and inner surface of the eyelid with copious amounts of water for 15 minutes. Check for and remove any contact lenses at once. Seek medical attention immediately.

Ingestion:

Consult SDS or call Ontario Poison Center (OPC) 24/7 at 1-800-268-9017. Follow directions and seek medical attention immediately.

Minor Skin Contact:

Promptly flush the affected area with water and remove any contaminated clothing. If symptoms persist after washing, seek medical attention.

Major Skin Contact:

If chemicals have been spilled over a large area of the body, quickly remove all contaminated clothing and rinse body with water. Seek medical attention immediately. Note: Remember that for some chemicals, effects resulting from exposure may not become apparent until hours or days later. Consult the SDS for any chemical to which someone has been exposed, even if no immediate injury is apparent.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

If the spill is not exempt from the reporting guidelines as noted in Appendix 'A', owners of pollutants reporting spills are required to contact the Spills Action Centre by telephone:

- 416-325-3000
- Toll-free: 1-800-268-6060
- TTY: 1-855-889-5775

CEO should be prepared with the following information:

- Their name and phone number;
- Name and phone number of the person or company in control of the product spilled;
- Date, time and location of the spill;
- Duration of the spill (if known) and whether the spill is ongoing;
- Type and quantity of pollutant spilled, including hazard level or toxicity information;
- Source of the spill and information on the cause;
- Description of adverse effects;
- Environmental conditions that affect the spill (weather, traffic, etc.);
- Actions being taken to respond;
- Other agencies and parties responding.

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances;

No later than one business day

1. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including;
   a. A breakdown or failure of the security system,
   b. A breakdown of major equipment or a system in the home,
   c. A loss of essential services, or
   d. Flooding.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Brown – Chemical Spill Staff Roles	POLICY #:	EMP08-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Brown	REFERENCES:	
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Charge Nurse – After being made aware of a chemical spill

1. Put on the Charge Nurse emergency vest.
2. Announce "**Code Brown**" and the location of the spill three times slowly and clearly.
3. Go to the affected area.
4. Confirm the location of the spill.
5. Ensure resident and visitors have been removed from the affected area.
6. Call 911 if necessary.
7. Call spill response contractor if necessary.
8. Assign Staff Leads (if required) and a scribe for the code event or drill.
9. Assign one staff to go to the front entrance to meet the emergency crews.
10. Initiate the emergency fan out system if required.
11. Follow instructions from emergency crews.

Charge Nurse - When Code Brown is over

1. Announce "**All Clear Code Brown**" three times.
2. Report the spill if required.
3. Assign staff to take residents back to their rooms and conduct head count.
4. Debrief with staff.
5. Complete and distribute Emergency Drill Report.

Assigned Staff Leads– After being made aware of a Code Brown chemical spill that is in my area

1. Return to your area by the safest route, if you are not already on the area.
2. Put on the Assigned Staff Lead emergency vest.
3. Confirm the location of the spill.
4. Get the Safety Data Sheet.
5. Ensure residents and visitors have been removed from the affected area.
6. Tell staff to get the emergency spill kit.
7. Follow instructions from the Charge Nurse and emergency crews.

Assigned Staff Lead– After being made aware of a Code Brown chemical spill that is not in my area

1. Return to your area by the safest route, if you are not already on the area.
2. Put on the Assigned Staff Lead emergency vest.
3. Send a staff member to the affected area to assist.

All Other Staff – After being made aware of a Code Brown chemical spill

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. If directly supervising residents report to the Assigned Staff Lead where you are.
3. Follow instruction from the Assigned Staff Lead.

Administrator - After being made aware of a Code Brown chemical spill

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of the Charge Nurse if required.

Managers - After being made aware of a Code Brown chemical spill

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. Follow instruction from the Assigned Staff Lead, Charge Nurse and emergency crews.
3. Assume the role of the Assigned Staff Lead if required.
4. Assume the role of the Charge Nurse if required.

SUBJECT:	Code Orange – Community Disaster	POLICY #:	EMP09-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code Orange	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
PAST REVISIONS:		RESPONSIBILITY:	
CURRENT REVISION:	June 2024	DISTRIBUTION:	

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Policy

To ensure the safety and continued provision of services for residents, a long-term care home (LTCH) will follow the **Code Orange** Community Disaster Emergency Response Plan procedures located below and in EMP09-002 if a LTCH experiences an influx of residents being relocated from another facility that has had to evacuate.

Description

Code Orange Community Disaster is an influx of residents or patients from another facility due to a community disaster, facility disaster etc.

Due to the influx of additional people menus may need to be changed or altered during the emergency.

Each home is to having sleeping arrangements for the number of residents they have identified they can accommodate in the LTCH's Reciprocal Relocation Agreement.

The CEO (or designate) will ensure the evacuating facility has obtained temporary licenses as required by the Ministry of Long Term Care.
The CEO (or designate) will be responsible for announcing "**All Clear Code Orange**" once all residents or patients have returned to their home facility at the conclusion of the emergency.

Emergency Operations Centre

Immediately upon implementation of a **Code Orange** Community Disaster, an Emergency Operations Centre (EOC) will be established by the Charge Nurse. The Nurse's Station of the home will serve as the default location for the EOC.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill

Report located in Appendix ‘A’.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances;

Immediately

1. An emergency within the meaning of section 268 of the *Fixing Long-Term Care Act, 2021* including fire, unplanned evacuation or intake of evacuees.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry’s method for after-hours emergency contact. Contact information can be found in Appendix ‘C’ Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Orange – Community Disaster Staff Roles	POLICY #:	EMP09-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 3
SECTION:	Code Orange	REFERENCES:	
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Charge Nurse – after being made aware of a community disaster

1. Put on a Charge Nurse emergency vest, located in the Nurse's Station.
2. Announce "**Code Orange**" three times slowly and clearly.
3. Go to the Emergency Operations Centre (EOC) at the Nurse's Station.
4. Assign Staff Leads (if required) and a scribe for the code event or drill.
5. Initiate the emergency fan out system if required.
6. Call in additional staff if required.
7. Collect surplus inventory info from staff reporting from other resident home areas.
8. Assign staff to prepare a receiving area.
9. Assign staff to prepare:
    - Extra sheets and blankets;
    - Mattresses and beds;
    - Towels and face cloths;
    - Incontinence products;
    - Hygiene supplies;
    - Emergency identification wrist bands.

Charge Nurse - when residents/patients arrive

1. Assign staff to ensure each person has identification, record everyone on the Emergency Reception Registration Log (Appendix F03)
2. Assign staff to review each person's medical records if available, if not available interviewing each person or care giver responsible for the person.
3. Document each resident's needs.
4. Assign staff to take and record each person's vitals.
5. Complete and distribute Emergency Drill Report.

Note: The CEO (or designate) will be responsible for announcing "**All Clear Code Orange**" once all residents or patients have been relocated from the receiving long-term care home (LTCH) at the conclusion of the emergency.

Assigned Staff Leads (on each zone) – after being made aware of a Code Orange community disaster

1. Return to your area by the safest route, if you are not already on the area.
2. Tell staff to inventory surplus supplies in the area you are assigned to:
   - Sheets, blankets, pillows;
   - Face clothes, towels;
   - Incontinence products;
   - Mattresses, empty beds.

Send available staff to the EOC to report surplus supply inventory to the Charge Nurse

Maintenance Manager – after being made aware of a Code Orange community disaster

1. Inspect home for damage if necessary and document on the Damage Assessment Checklist (Appendix F04)

All Other Staff – after being made aware of a Code Orange community disaster

1. If not directly supervising residents, return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. If directly supervising residents, report to the Assigned Staff Lead where you are.
3. Follow instruction from the Assigned Staff Lead.

CEO -after being made aware of a Code Orange community disaster

1. Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
2. Assume the role of the Charge Nurse if required.

Managers - after being made aware of a Code Orange community disaster

1. Return to your assigned area by the safest route, if you are not already on the area and report to the Assigned Staff Lead.
2. Follow instruction from the Assigned Staff Lead, Charge Nurse, and emergency crews.
3. Assume the role of the Assigned Staff Lead if required.
4. Assume the role of the Charge Nurse if required.

SUBJECT:	**Code White – Violent Outburst**	**POLICY #:**	**EMP10-001**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 7**
SECTION:	**Code White**	**REFERENCES:**	
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Policy

To ensure the safety and security of residents, staff and visitors, staff will follow the **Code White** Violent Outburst Emergency Response Plan procedures located below and in Appendix 'B' if Valley Manor experiences a violent outburst.

Description

A violent outburst is a violent expression of feeling and/or an outburst of anger.

Common Law Duty – S.39, Fixing Long Term Care Act, 2021

"Common Law Duty

39 (1) *Nothing in this Act affects the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others.*

Restraining by physical device under common law duty

39 (2) *If a resident is being restrained by a physical device pursuant to the common law duty referred to in subsection (1), the licensee shall ensure that the device is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied.*

Restraining by administration of drug, etc., under common law duty

39 (3) *A resident may not be restrained by the administration of a drug pursuant to the common law duty referred to in subsection (1) unless the administration of the drug is ordered by a physician or other person provided for in the regulations.*

Same

39 (4) *If a resident is being restrained by the administration of a drug pursuant to the common law duty referred to in subsection (1), the licensee shall ensure that the drug is*

used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied."

1.1 Purpose

Early recognition and intervention in potentially violent outbursts or situations are key to crisis prevention. This plan is not limited to Residents; it may be used for any aggressive / violent individuals. In the event of rapidly escalating behavioral aggression, activating a **Code White** will provide:

- a standard response for staff to manage "acting out" individuals
- necessary support to maintain or regain control of the situation
- the means to minimize risk of injury to Residents, visitors, physicians, staff and volunteers
- structure for notifying other staff working in the home of the incident
- assistance to the "acting out" individual to regain control of their behaviour

Staff are encouraged to call a **Code White** when they feel threatened, and de-escalation techniques are ineffective. Proactively calling a **Code White** to ensure the safety of staff and Residents will not be subject to repercussions. A Resident's cognitive abilities are not a determining factor when calling a **Code White**. All staff must be aware of the Resident's plan of care related to responsive behaviours and the Resident's violence risk assessment.

1.2 Proactive Measures to Prevent a Code White

- The clinical team will utilize preventative planning through behaviour profiling to understand how the Resident interacts, communicates; and expresses protective or defensive behaviour in response to specific triggers.
- All clinical staff must remain vigilant for early indicators of an individual in crisis: anxiety, agitation or defensiveness and intervene safely and effectively in order to avert the crisis and minimize risk of assaultive behaviour.
- Staff's responses to the behaviours of an individual in crisis that incorporate the Gentle Persuasive Techniques from the GPA training sessions will provide the basis for consistent and effective intervention strategies.

1.3 Gentle persuasive Approaches to Dementia Care (developed by: AGE Inc.)

- Ensure only 1 staff member is communicating with the individual displaying responsive behaviours.
- Stay calm, confident and self-controlled
- Keep communications simple, short and clear
- Avoid arguments and power struggles
- Assign others to relocate Residents and others in order to isolate the individual experiencing catastrophic responsive behaviour
- Attempt to remove possible triggers i.e. bright lights, loud noise (TV, radio), an audience
- Stay at least a leg-length away from the defensive/protective individual
- Don't let the individual get between you and an exit from the room
- Don't try to handle the situation alone; request assistance from team members in the immediate vicinity
- Remain professional; if unable to stay professional, delegate the lead role to

another team member. Do not retaliate with anger or aggression, respond with unconditional positive regard
- If attempts to defuse the individual are unsuccessful and sufficient staff are not at hand, initiate a **Code White** response by having someone call Reception ext. 221 during regular office hours, or the Nurse's Station after hours at ext. 235.

Valley Manor will provide information on responsive behaviours and incorporate a review of the Code White response plan to all new staff. Periodic GPA training is provided.

1.4 Glossary

GPA: Gentle Persuasive Approach to dementia care: Responding to an individual with responsive behaviours.

Code White Response
A **Code White** may be initiated if there is escalating aggression and/or a threat of violence/assault made by an individual that is believed to be serious and imminent, and the immediate staff and resources are insufficient to de-escalate the individual and respond safely and effectively.

Acting Out Individual
An individual demonstrating a total loss of control, which results in a physical acting-out episode. This is defined in the Crisis Prevention Institute's Crisis Development Model as the third level of Crisis Development Behaviour. It is preceded by level one; anxiety and level two; defensiveness. The fourth and last stage is tension reduction.

Captain
A clinical staff member in the area where the **Code White** occurs, who has knowledge of the individual and the necessary therapeutic intervention skills (e.g. GPA training).
The Captain maintains a therapeutic and least restrictive approach to defuse the crisis incident. The level of response by staff or outside source will be determined by the Charge Nurse at the time of the incident.

The Captain can be:
- The Nurse in charge
- The first person on the scene
- Any team member with the confidence and competence in handling crisis situations, such as the BSO PSW
- The team member who has the best rapport with the acting out individual

The Captain's duties include:
- Assess the situation
- Plan the intervention
- Direct or cue the other team members
- Communicate with the acting out individual.

Code Manager
The Code Manager is a clinician (Director of Care, Nursing Coordinator or Delegate) who supports the Captain, and assists with coordination of the overall intervention. He/she may determine, as directed by or in consultation with the Captain:

- The number of staff needed and redirect others back to their work areas;
- The medication to be brought to the scene;
- Assignment of specific duties to other staff;
- Determine if Police are required, contact Reception and provide brief detail
- When the code is over and when to call Reception for the All Clear announcement.
- Facilitation of a formal post-incident debriefing

Code White Response Team
The responders to **Code White** will consist of a team of trained inter-professional staff (e.g. clinical staff, Director of Care, Nursing Coordinator, BSO PSW / Delegate) who will work together to effectively de-escalate or respond to an individual who is aggressive.

Control
The degree of influence required to maintain the safety of the individual under extreme circumstances or when there is reason to believe the individual has lost personal control (mentally, physically or in terms of their behaviour) to the extent where intervention is necessary.

Personal Safety Techniques
Maneuvers taught to all GPA trained staff to protect others and the acting out individual from injury when behaviour escalates to the physical level.

Chemical Restraint
Using medication, ordered by a physician, to temporarily reduce unmanageable responsive behaviour exhibited by a Resident. This will assist with calming overly aggressive or agitated behaviour. Chemical restraints are any form of psychoactive medication used, not to treat illness, but to intentionally inhibit a particular behaviour or movement. (College of Nurses, 2009).

Incident Debriefing
A group or individual discussion regarding the **Code White** incident response. It is an opportunity to provide support and education to responding staff and assess the impact and safety of staff and Residents following a Code White. This may occur immediately after the incident. Based on the circumstances of the incident, a more in-depth debriefing may also occur in the days following the incident.

1.5 Code to be used in Case of a Need for Extra Resources

All attempts to defuse a situation involving an individual whose behaviour is escalating rapidly into an “acting out” phase have been exhausted by staff on hand and it is perceived that the attending staff involved in a violent incident may not be able to safely and effectively defuse the situation, or:

- A threat of violence / assault made by an individual is perceived as serious and imminent and the immediate personnel and resources are insufficient to respond safely and effectively.
- It is necessary to impose emergency restraint on an individual(s) who is displaying “acting out” behaviour and adequate staffing is not at hand.

1.6 Authority to Declare a Code White

A Code White may be called by:

- Any staff member who is involved in a violent incident or is in the immediate area and who determines extra personnel and / or resources are required immediately

1.7 Activation of Code White

- The staff member who advises reception to call a Code White shall provide the location (Resident Home Area or area where the incident is taking place).
- The receptionist will immediately announce **Code White** and the area three (3) times in succession over the public address system.

1.8 Two way radios

- When two way radios are utilized please use **channel 20.**

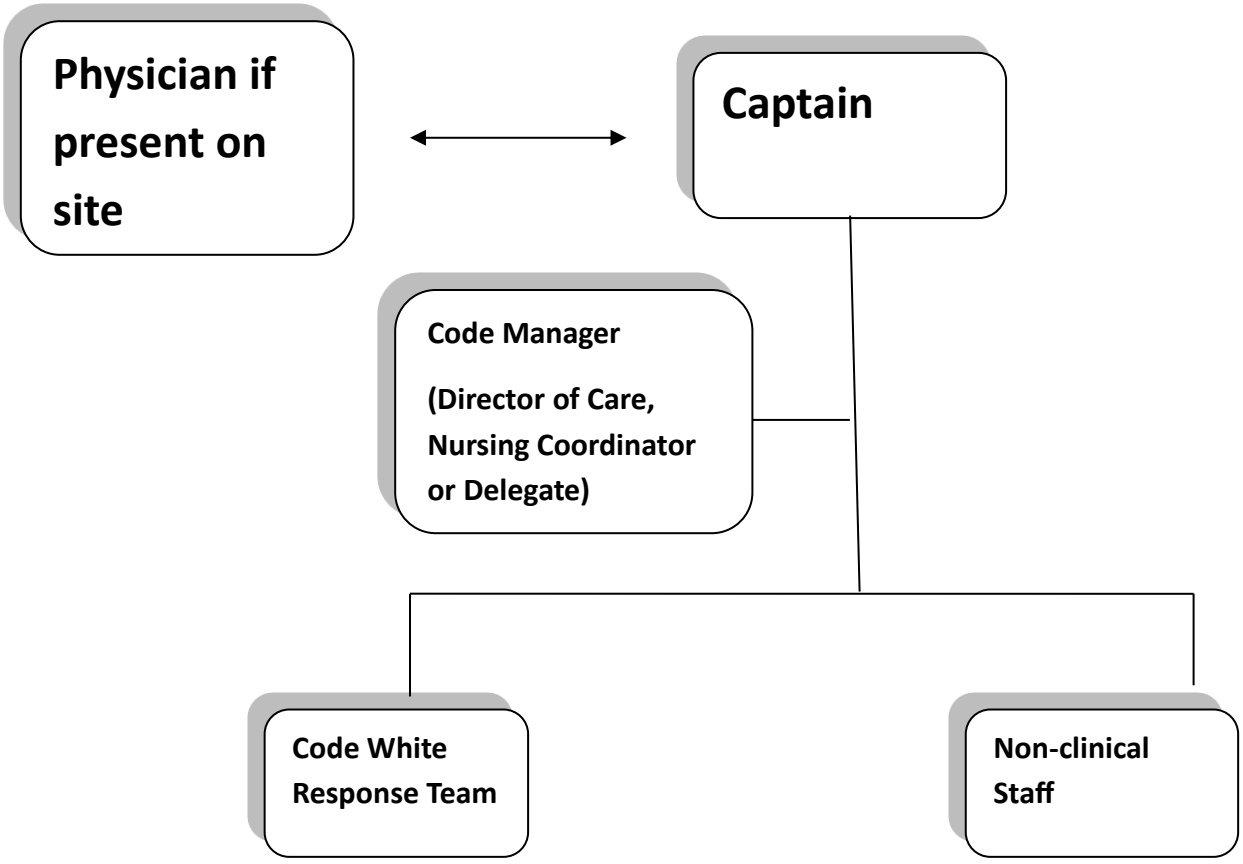
2.0 Incident Management System

Specific responsibilities may be assigned to appropriate staff to ensure interdepartmental coordination during an emergency to facilitate direction and control of response and recovery actions.

The assigned roles that may be established during a **Code White** include:

- The Captain – has the primary role to direct the team during the **Code White** and to communicate with the person in crisis
- Code Manager – supports the Captain
- Attending Physician – assessment and treatment if necessary
- Onsite Clinical staff – follow direction from the Captain
- Non-clinical staff responders – assist with isolating the area (closing door, redirecting visitors and Residents from the incident area, etc.)

Incident Management System



2.1 Procedure if you are aware of an acting out incident or there is an urgent need for extra personnel and / or resources:

- **in most instances the Captain is the first Code White Response Team member on the scene; any team member with the confidence and competence in handling crisis situations; and/or the team member who has the best rapport with the acting out individual.**

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A01'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances;

1. If the Code White is related to a resident(s), the incident must be documented in progress notes of any resident involved. An analysis will be completed to identify any precipitating factors prior to the incident, the type of behavior exhibited, a summary of the crisis situation, witnesses.
2. If the resident has negative outcomes or is transferred to hospital the Critical Incident Form must be completed and submitted.
3. An Employee Incident Report must be completed if any injuries were incurred and submitted to the employee's respective manager.
4. Immediately after the **Code White** has been declared 'All Clear' the Charge Nurse will meet with the respondents to the violent outburst to debrief and complete the **Code White** Violent Outburst Debrief Tool located in Appendix 'A01', including a listing of staff responding to the **Code White** and the outcome.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	**Code White – Violent Outburst Staff Roles**	**POLICY #:**	**EMP10-002**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 5**
SECTION:	**Code White**	**REFERENCES:**	
ORIGINAL ISSUE:	**February 2023**	**APPROV. AUTH:**	
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Code White Response Team

The **Code White** Response Team consists of:

Weekdays

- PSW(s) from the Resident Home Area
- Registered Nurse in charge
- Registered Practical Nurse from home area
- NCC & DOC or Designate
- Ancillary (non-clinical) staff in the area (Housekeeping, Maintenance, etc.)

Evenings, weekends and holidays

- PSW(s) from the Resident Home Area
- Registered Nurse in Charge
- Ancillary (non-clinical) staff in the area (Housekeeping, Maintenance, etc.

Nights

- Registered Nurse in Charge
- One or more PSWs

Procedure if you are aware of an acting out incident or there is an urgent need for extra personnel and / or resources:

- **in most instances the Captain is the first Code White Response Team member on the scene; any team member with the confidence and competence in handling crisis situations; and/or the team member who has the best rapport with the acting out individual.**

- The staff member who makes the assessment that the **Code White** is to be called will direct someone to **dial ext 221 or ext 235** providing:
- Name and title
- Location

- Nature of emergency (**Code White**)
- If a weapon is involved or suspected, request that the Police be notified immediately, and identify the weapon if possible
- Staff will initiate such procedures to assist the individual in crisis to regain self-control by implementing Gentle Persuasive Approach (GPA) to provide safety for the staff and individual

Response & Recovery

1.0 Response - Upon Receiving the Code White Notification

1.1 Captain

- Assess the situation and plan the intervention to defuse the immediate crisis incident
- Ensure someone has dialed ext 221 or ext 235 and has provided their name and location (zone or area where the incident is taking place), the nature of the incident, and information regarding weapons involved, if any.
- Direct or assist in implementing sanctioned procedures so as to deescalate and defuse the critical or potentially critical incident
- Communicate any known Resident de-escalation preferences or potential escalating triggers
- Communicate all known medical, emotional/psychological, physical, or psychiatric risk factors of the Resident in crisis
- If the acting out individual is not a Resident determine the best course of action to deescalate
- Implement such “Emergency Restraint Procedures” as necessary to temporarily maintain the acting out individual as safely as possible
- Disengage from the incident if the intervention is ineffective or if cued by the Code Manager

1.2 Code Manager (Director of Care, Assistant Director of Care / Delegate)

- Assess the situation and receive direction and input from the Captain to assist with the intervention
- In consultation with the Captain, brief all staff upon arrival and delegate duties:
  - Retrieve and assist with mechanical/chemical restraints (if needed)
  - Clear the area of potentially dangerous objects
  - In a professional manner, ensure other Residents are re-directed from the immediate area
  - In a professional manner, ensure visitors and family members are re- directed from the immediate area
- In consultation with the Captain, determine the number of staff needed and redirect others back to their work areas once enough have arrived to provide an appropriate response
- Prompt Captain to disengage from the incident if they are no longer effective in being able to defuse or de-escalate the individual and delegate another responder to the role.

1.3 Physician

- The Attending Physician if on site will respond according to the level of risk
- Be aware of the occurrence or provide direction for care via phone
- If emergency restraint is initiated provide direction to continue / discontinue emergency restraint procedures

1.4 All Staff

- All assigned staff with the approval of the Charge Nurse / Delegate, that can safely leave their area, will respond to a Code White
- Non-clinical staff will assist where and when required (i.e. open doors, keep corridors clear, etc.)
- Those who respond to a Code White should report to and take direction from the Captain and staff who are most familiar with the individual
- When responding avoid surging into the area in large numbers, it may only escalate the situation (i.e. move quickly to the location but walk in).
- Proceed to the location of the incident and provide assistance as requested
- Accept direction from the Captain or Code Manager:
- In a professional manner, ensure other clients, non-essential staff, visitors and family members are re-directed from the area to prevent unnecessary injury
- Remove any potential hazards in the environment
- When dealing with a person, and at the instruction of the Captain and / or Code Manager may physically restrict the acting out individual's movements
- Assist in the restraint process as needed under the direction of the Captain and/or Code Manager

1.5 Reception/Nurses Station

- When advised to do so announce "Code White (location)" three times in succession over the public address system
- If requested to do so, notify the Police (911)
- **Do not use the term Code White, instead say "violent episode" and briefly explain**
- **Include any information regarding weapons involved**

2.0 Recovery - Upon Notification That the Crisis Has Concluded

2.1 Captain

- In consultation with the Code Manager (Program Manager / Nursing Supervisor / Delegate), determine that the staff and acting out individual are safe and the Code White can be declared all clear
  - Ensure the receptionist is advised to call Code White – All Clear
- Initiate care for the Resident by ensuring the following actions are taken:
  - Brief clinical assessment of the physical and mental status of the person involved in the incident
- Report the incident in SafeT-Net with flags to the Service and / or Corporate Risk

Manager, Occupational Health & Safety and Emergency Management, Security & Life Safety
- Review legislative requirements for reporting of incident
- Report incident to Ministry of Long Term Care or other agencies, as required

2.2 Code Manager (Director of Care, Nursing Coordinator or Delegate)

- Supplement the incident report by speaking to the Captain
- Facilitate a formal post-incident debriefing with staff and Residents and incorporate the debriefing outcome in with the OH&S Committee
- Watch for signs of critical incident stress and encourage staff to seek assistance via the Employee Assistance Program (EAP)

2.3 Physician

- Provide follow up care for the person(s) involved

All Staff

- Ensure the individual in crisis is appropriately assessed and restrained if required
- Initiate observation, documentation and reports as appropriate to the situation
- Those involved in the incident may take some “time out” to regain personal composure before returning to work, if necessary
- Participate in a formal incident debriefing session following the incident
- Watch for signs of critical incident stress and encourage one another to contact the HR Manager or a Supervisor. Utilize the EAP if necessary and debrief with others.

2.5 Reception/Nurses Station

- Announce over the public address system three times, “Code White, All Clear”

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix ‘A01’.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

1. The incident must be documented in progress notes identifying any precipitating factors prior to the incident, the type of behavior exhibited, a summary of the crisis situation, a listing of staff responding to the **Code White** and the outcome.

2. If the resident has negative outcomes or is transferred to hospital the Critical Incident Form must be completed and submitted.
3. An Employee Incident Report must be completed if any injuries were incurred and submitted to the employee's respective manager.
4. Immediately after the **Code White** has been declared 'All Clear', the Charge Nurse will meet with all parties to the "Code White Violent Outburst" to debrief and complete "**Code White Violent Outburst"** Debrief Tool located in Appendix 'A01'.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Blue – Medical Emergency	POLICY #:	EMP11-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 4
SECTION:	Code White	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
PAST REVISIONS:		RESPONSIBILITY:	
CURRENT REVISION:	June 2024	DISTRIBUTION:	

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Policy

In the event of a medical emergency, the Charge Nurse will be immediately notified to report to the area to provide the appropriate assessment and response to the situation. Cardiopulmonary resuscitation (CPR) will be provided by staff certified and competent in CPR.

Consent must be obtained from the capable resident or the resident's substitute decision maker (SDM) if the resident is incapable when any treatment is being proposed.

Purpose

To ensure that the wishes of the capable resident or incapable resident's SDM are met if a resident suffers a cardiac arrest, which meets the criteria for resuscitation.

Background

Residents who reside in a long-term care home may experience a medical emergency from time to time. The current treatment plan, which can include medical directives, reflects the most recent plan for which consent was received.

Visitors and staff may occasionally experience a medical emergency. CPR will most commonly be initiated unless the individual's wishes are known that CPR should not be started.

Definition

Cardiopulmonary Resuscitation (CPR)

An emergency lifesaving procedure that is done when someone's breathing or heartbeat has stopped. CPR is designed to sustain breathing and heartbeat and combines rescue breathing and chest compressions to restore blood flow to someone suffering from cardiac arrest.

Cardiac Arrest

The unexpected loss of heart function in a person (heart stops beating) related to a variety of causes, such as heart disease, suffocation, drug overdose, stroke, electrocution, or injury.

Medical Emergency

There is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk if the treatment is not administered promptly, of sustaining serious bodily harm. May include, but not limited to: cardiac arrest, respiratory arrest, burn, and fracture, loss of consciousness, chest pain, allergic response, choking, asthma attack, cerebral vascular accident (CVA), and seizure.

Respiratory Arrest

The sudden and complete cessation of breathing.

Code Blue emergency involves a resident

1. The first responder (staff/visitor who discovers the resident) will:
   a) Initiate a **Code Blue;**
   b) Request emergency assistance;
   c) Remain with the resident and wait for instructions from the Charge Nurse.
2. All RNs on duty will respond immediately to a "**Code Blue**" paging. If the **Code Blue** occurs on an RPN's unit, the unit RPN will also respond immediately to a "**Code Blue**" paging.
3. The Charge Nurse (whoever arrives first – when the Charge Nurse arrives, they will take over the **Code Blue** response) will:
   a) Assess the resident to determine unresponsiveness, including the following:
      - The environment:
        - Assess the visibility and safety of the situation prior to responding.
      - Level of consciousness:
        - Response to voice, touch or painful stimuli;
        - Papillary response;
        - Unconscious.
      - Airway:
        - Presence of respiration;
        - Presence of foreign object in the mouth or airway.
      - Breathing:
        - Respiration rate, depth and character.
      - Circulation:
        - Presence of carotid pulse, strength and rhythm;
        - Presence of hemorrhage;
        - Skin colour, temperature, moisture.
4. In the event that it involves a resident, the Charge Nurse will initiate CPR if vital signs are absent and if:
   - The resident's last known capable wishes to receive CPR are known and documented in Point Click Care;

- The resident's wish is not documented but the SDM has provided informed consent for CPR during notification of the emergency;
- It is an emergency situation and there is no information on record for the resident's wishes, SDM consent or the information is not available.

5. The Charge Nurse will assign a staff member to initiate a call to 911:
   - Provide as much privacy to the individual as able;
   - Notify the SDM of the current situation and status of the resident;
   - Notify the attending physician/nurse practitioner and Director of Care (DOC) as required;
   - The Director of Care (DOC)/Administrator or designate will notify the Ministry of Long-Term Care, if applicable;
   - Initiate the required report to the Ministry of Long-Term Care (MLTC) as required.
6. In the event that it involves a resident, the Charge Nurse will not initiate CPR if vital signs are absent and if:
   - The capable residents expressed and/or documented wishes indicate no CPR that apply to this particular situation;
   - The resident is currently incapable and the SDM communicates the residents previously expressed capable wishes for no CPR and these wishes apply to this particular situation;
   - The resident exhibits obvious signs of death (death as determined by physical assessment, i.e. cardiac and respiratory vital signs have ceased);
   - There is current, documented and consent to plan of treatment that includes no CPR or the attending physician/nurse practitioner has ordered no CPR following notification of intent to the capable resident/incapable resident's SDM (within a reasonable amount of time) to ensure they are not opposed to the decision not to initiate emergency measures and CPR;
   - Upon direction of an attending physician/nurse practitioner that CPR will not benefit the resident and is not part of the treatment plan.

Note: If the resident is deceased, follow the after-death procedure check list and RDN protocol.

Code Blue emergency involves a staff/student/visitor/contract worker

1. In the event that the emergency situation involves a staff/student/visitor/contract worker.
2. Based upon the assessment of the situation the Charge Nurse may direct that 911 is to be contacted and initiate immediate assistance, if safe to do so.
3. Provide as much privacy to individual as able.
4. Notify next of kin as able or requested.
5. Notify Administrator/DOC as soon as possible.
6. In the event that the situation involves the Registered Nurse, the Registered Practical Nurse will provide the direction for the **Code Blue** situation. In the event that an RPN is not working the shift, a HCA/PSW may contact 911 directly.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix ‘A’.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Once situation is stabilized, initiate reports to MLTC and Ministry of Labour as required. Contact information can be found in Appendix ‘C’ Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Blue – Medical Emergency Staff Roles	POLICY #:	EMP11-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 2
SECTION:	Code White	REFERENCES:	
ORIGINAL ISSUE:	February 2023	APPROV. AUTH:	
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Charge Nurse– after being made aware of a medical emergency

1. Put on a Charge Nurse emergency vest.
2. Announce "**Code Blue**" and the location of the victim three times slowly and clearly.
3. Assign staff member to meet emergency crews at main entrance.
4. Assign Staff Leads (if required) and a scribe for the code event or drill.
5. Go to the location of the victim.

If the victim is a resident

1. Consult the resident's last known wishes documented in Point Click Care (PCC) to determine the response.
2. Call 911 if required.
3. Assign Staff Leads (if required) and a scribe for the code event or drill.
4. Provide as much privacy to the victim as possible.
5. Notify the Substitute Decision Maker as required.
6. Notify the attending physician/nurse practitioner as required.
7. Notify the Director of Care as required (DOC).
8. Notify the Ministry of Long-Term Care (MLTC) as required.
9. Initiate the required report to the MLTC as required.

Charge Nurse– if the victim is a staff/visitor/contractor

1. Call 911 if required.
2. Assign Staff Leads (if required) and a scribe for the code event or drill.
3. Provide as much privacy to the victim as possible.
4. Notify next of kin as required.
5. Notify Administrator, Director of Care as soon as possible.
6. Initiate required reports which may include critical incident report, Ministry of Labour, MLTC.

Charge Nurse- when Code Blue medical emergency is over:

1. Announce '**All Clear Code Blue**" three times.
2. Debrief with staff.
3. Complete and distribute Emergency Drill Report.

RN/RPN – after being made aware of a Code Blue medical emergency:

1. Report to the location of the **Code Blue.**

RN/RPN - If the victim is a resident:

1. Consult the resident's last known wishes documented in PCC to determine the response.
2. Conduct an assessment of the situation including:
   a. The victim's airway, breathing and circulation;
   b. The victim's level of consciousness;
   c. The environment.
3. Provide medical assistance as required.

RN/RPN - if the victim is a visitor/staff/contractor:

1. Conduct an assessment of the situation including:
   a. The victim's airway, breathing and circulation;
   b. The victim's level of consciousness;
   c. The environment;
   d. Provide medical assistance as required.

All Other Staff – finding the victim

1. Initiate **Code Blue** by announcing "**Code Blue**" and the location of the victim three times slowly and clearly.

2. Request emergency assistance of the closest staff member to stay with victim. The staff member will then initiate the **Code Blue** by announcing "**Code Blue**" and the location of the victim three times slowly and clearly.
   Return to the location of the victim and offer as much comfort and reassurance to the victim until the Charge Nurse arrives.

SUBJECT:	Code Silver – Active Shooter / Armed Intrusion	POLICY #:	EMP12-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 5
SECTION:	Code Silver	REFERENCES:	
ORIGINAL ISSUE:	March 2024	APPROV. AUTH:	
PAST REVISIONS:	June 2024	RESPONSIBILITY:	
CURRENT REVISION:	March 2025	DISTRIBUTION:	

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POLICY:

In the event of an intrusion by an armed person, or an active shooter situation, **Code Silver** procedures will be enacted to prompt an appropriate response in accordance with the location's **Code Silver** Emergency Plan.

Note: **Code Silver** will not result in other team members coming to assist, as it is designed to keep people away from harm. Police will be contacted as soon as **Code Silver** is called. When a **Code Silver** is initiated, all team members will make every reasonable effort to protect themselves, residents, visitors, and others in their immediate area, following the procedures set out below.

PURPOSE

1. To provide a standard response for staff to obtain assistance in managing episodes involving a **Code Silver – Active Shooter / Armed Intrusion**.
2. To preserve the safety of staff, residents and visitors.
3. To communicate an episode of an armed intruder to other staff members working in the building.
4. To assist the attacker to regain control over their behaviour.
5. To ensure a debrief occurs following every activation of the plan and to evaluate areas for improvement.

Medical Response During an Active Shooter/Armed Intrusion Situation

In all likelihood, it will be impossible and completely unsafe for nursing staff or Emergency Medical Services (paramedics) to respond to the location of an armed intruder situation until the Police arrive and/or the armed intruder is incapacitated.

Guidelines for Survival of an Active Shooter/Armed Intrusion Situation

Quickly determine the most reasonable way to protect your own life. Remember that residents and visitors are likely to follow the lead of staff and managers during an armed intruder situation.

- Be aware of your environment and any possible dangers
- Take note of the two nearest exits in any location you are in
- If you are unable to leave the incident location for whatever reason:
  - If you are in an office, stay there and secure the door
  - If you are in a hallway, get into a room and secure the door
  - Consider the difference between cover and concealment. Cover will protect from gunfire and concealment will merely hide you from the view of the shooter. Choose the best space that is available quickly.
- **As a last resort and only when your life is in imminent danger**, attempt to take the armed intruder down. When the intruder is at close range and you cannot flee, your chance of survival is much greater if you try to incapacitate him/her.

Key Messages for Staff

***Think about your area of work and the areas you travel through. If you saw a gun, heard gunshots or an overhead announcement for Code Silver Lockdown, where would you exit or hide quickly?

When you are safely hidden; call to notify Charge Nurse or Management of an armed intruder situation if it hasn't already been announced. This allows them to make an overhead announcement and notify police via 911.

"Code Silver Lockdown" and the location will be announced. This warns everyone in the building. Lockdown is a universal term. Schools and daycares practice lockdown procedures routinely. If resident & visitors are familiar with the term lockdown, they will hide when they hear the announcement.

Staff will keep themselves safe, and if possible, a couple people will proceed to the entrances to assist police in responding quickly by directing them to the shortest route to the armed intruder.

Do not use social media to post updates on the status of the incident. The active shooter or person with a dangerous weapon may be monitoring social media and you may inadvertently give them useful information.

PROCEDURE:

Response Options During an Active Shooter/Armed Intrusion Situation:

1. **Run** (Evacuate) – If there is an accessible escape path, attempt to evacuate the location.
2. **Hide** – If evacuation is not possible, find a place to hide where armed intruder is less likely to find you.

3. **Fight** (take action against the armed intruder) – **As a last resort and only when your life is in imminent danger**, attempt to disrupt and/or incapacitate the armed intruder.

Additional Emergencies During a Code Silver Lockdown

Should the fire alarm be activated, a Code Red will not be announced immediately. There will be a discussion with the Charge Nurse regarding the location of alarm origin and the last known location of perpetrator and the potential for a false alarm.

The Charge Nurse will issue instructions to Reception on how to manage the alarm e.g. usual response with "Code Red (location)" or no response with a "Please disregard fire alarm" overhead page. If there is to be a response, appointed personnel will proceed as safely as possible to the location through the Charge Nurse/Law Enforcement instruction. Reception will provide instructions to 911 for safe location for arrival of fire services to proceed into facility.

Should other alarms sound, there must be a discussion with the Charge Nurse/Law Enforcement before proceeding.
Should calls be received for other emergency codes, overhead pages will not be issued until the caller ID is noted, recorded and a discussion with Charge Nurse as to how to proceed is conducted.

Incident Command Centre

In all likelihood, the Incident Command Centre will not be established until the Police have neutralized the armed intruder and cleared the scene for entry.

- When safe to do so, establish the Incident Command Centre
- Ensure Incident Command Centre is locked and secure
- Ensure that Reception personnel are aware of the location and contact number for the Incident Command Centre
- Key personnel may need to be contacted by email or text

Upon Arrival of Police

Notes Regarding the Arrival of Police:

The objective of Police when they respond to an armed intruder situation is to stop the armed intruder as soon as possible. Officers will proceed directly to the area in which the last shots were heard, if any.

- Police Officers may:
  - Be wearing normal uniforms or tactical gear, helmets, etc.
  - Be armed with rifles, shotguns and/or handguns
  - Use chemical irritants or incapacitating devices (e.g. pepper spray, stun grenades, Tasers, etc.) to control the situation
  - Shout commands and may push individuals to the ground for their safety

The first officers to arrive to the scene will not stop to help injured persons.
Expect rescue teams comprised of additional officers and emergency medical personnel

to follow the initial officers. These rescue teams will treat and remove any injured persons. They may also call upon able-bodied individuals to assist in removing the wounded from the area.

Once you have reached a safe location you will likely be held in that area by Police until the situation is under control and all witnesses have been identified and questioned. Do not leave the safe location until Police have instructed you to do so.

All Staff

Police Officers will be responding with the intent to use deadly force. Ensure you do not present yourself as a threat to them:

- Remain calm and follow Officers' instructions
- Put down any items in your hands (e.g. bags, jackets, etc.)
- Immediately raise your hands and spread your fingers
- Keep your hands visible at all times
- Avoid making quick movements toward Officers, such as attempting to hold on to them for safety
- Avoid pointing, screaming and/or yelling
- Do not stop to ask Officers for help or direction when evacuating, just proceed in the direction from which Officers are entering the area
- Once you are in a safe area, remain there until dismissed by the Police
- The most important pieces of information to give Police are:
  - Location of the armed intruder
  - Number of intruders, if more than one
  - Physical description of the armed intruder(s)
  - Number and type of weapons held by the intruder(s)
  - Number of potential victims at the location

Upon Notification That the Crisis Has Concluded

Charge Nurse:

- Prepare for team debriefing
- Consider that large areas of the Home may be designated as crime scenes and as a result could be unavailable to staff until Police are able to complete their investigation
- Ensure that all documentation is collected for debrief preparation
- Participate in a team debriefing

All Clear – Declaring Return to Normal Operations

- In consultation with Police officials, determine whether the crisis has concluded, that it is safe to resume normal operations and authorize the reception to announce the "Code Silver - All Clear".
- Implement a course of action to manage a major disruption of the Home's routine

- Consider that large areas of the Home may be designated as crime scenes and as a result could be unavailable to staff until Police are able to complete their investigation
- Arrange for a debrief session with involved staff
- Arrange a Critical Incident Stress Debriefing (EAP[4]) for involved staff

**4 "EAP" is an Employee Assistance Program available free of charge to staff of Valley Manor through the HR department.*

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A01'.
All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

1. The incident must be documented in progress notes identifying any precipitating factors prior to the incident, the type of behavior exhibited, a summary of the crisis situation, a listing of staff responding to the Code Silver and the outcome.
2. If the resident has negative outcomes or is transferred to hospital the Critical Incident Form must be completed and submitted.
3. An Employee Incident Report must be completed if any injuries were incurred and submitted to the employee's respective manager.
4. Immediately after the Code Silver has been declared 'All Clear' the Charge Nurse will meet with the respondents to the "Code Silver Active Shooter / Armed Intruder" to debrief and complete the Code Silver Active Shooter / Armed Intruder Debrief Tool located in Appendix 'A01'.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Sliver - Active Shooter / Armed Intrusion Staff Roles	POLICY #:	EMP12-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 4
SECTION:	Code Silver	REFERENCES:	
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CURRENT REVISION:	June 2024	DISTRIBUTION:	

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All Staff - Upon Realizing There is Potential for an Active Shooter / Armed Intrusion

RUN (Evacuate) – If there is an accessible escape path, attempt to evacuate the location. Be sure to:

- Have an escape route and plan in mind
- Leave the area, removing residents and visitors, once possible
  - Leave your belongings behind
  - Help others escape, if possible
  - Prevent others from entering an area where the armed intruder may be
- If you have access to a Valley Manor phone announce "**Code Silver – Active Shooter/Armed Intrusion**" 3 times over the PA system when you are safe

HIDE

- If evacuation is not possible, take cover and hide in a room. Lock or barricade yourself inside
- Your hiding place should:
  - Be out of the armed intruder's view
  - Provide protection if shots are fired in your direction (i.e. an office with a closed and locked door)
  - Do not trap yourself or restrict your options for movement if possible
- To prevent an armed intruder from entering your hiding place:
  - Lock the door
  - Block the door with heavy furniture
- Silence your cell phone
- Turn off any sources of noise (e.g. radios, televisions, etc.)
- Hide behind large objects (e.g. cabinets, desks, etc.)
- Remain as quiet as possible
- Dial **911** to provide notification of the emergency – If you do not have access to the Home's telephone extensions but have a cell phone, you may use it to call **911**
- If you cannot speak leave the line open and allow the dispatcher to listen

- State area and/or room number clearly. Provide details of situation:
- Location of the armed intruder and dangerous weapon
- Number of intruders, if there is more than one
- Physical description of the armed intruder(s)
- Number and type of weapons held by the armed intruder(s)
- Number of potential victims at the location
- **Do Not** attempt to confront the armed intruder if you can evacuate or hide
- If evacuation and hiding are not possible:
  - Remain calm
  - Dial **911** to provide notification of the emergency

FIGHT **- Only as a last resort and only if your life is in imminent danger** attempt to disrupt and/or incapacitate the armed intruder by:

- Acting as aggressively as possible against him/her
  - Throwing items and improvising weapons
  - Yelling
  - Committing to your actions
- If others are available, work together to distract and attack the assailant as fiercely as possible

All Staff - Reminders

- **Do not approach the incident area**
- Do not use social media to post updates on the status of the incident. The armed intruder may be monitoring social media and you may inadvertently give them useful information

All Staff - Upon Notification That the Crisis Has Concluded

- If you witnessed the armed intruder situation you will need to provide a statement to the Police
- Large areas of the Home may be designated as crime scenes and as a result could be unavailable to staff or residents until Police are able to complete their investigation
- Those involved in the incident may take some "time out" to regain personal composure before returning to work, if necessary
  - Victims may need to seek assistance for psychological distress from the Emergency Department. For applicable incidents, the Sexual Assault and Family Violence program may be contacted for consultation
- Participate in an incident debriefing session following the incident
- Watch for signs of critical incident stress and encourage one another to contact the Occupational Health & Safety Department for assistance, as needed

Charge Nurse– after being made aware of an Active Shooter / Armed Intrusion

- Establish the Incident Command Centre once able to
- Assign Staff Leads; assign staff to monitor cognitively impaired residents.
- If you are the person witnessing the armed intruder situation respond using – "**All Staff**" scenario above.
- If you are not the person witnessing, and the emergency has not been announced, announce "Code Silver" and the location three times slowly and

clearly if possible

- Call 911 if possible (When speaking to Police **do not** use term **Code Silver Lockdown**. Instead say "**Active Shooter/Armed Intrusion**").
- Provide the following information to Police, if known:
  - Location of the armed intruder
  - Number of armed intruders, if there is more than one
  - Physical description of the armed intruder(s)
  - Number and type of weapons held by the armed intruder(s)
  - Number of potential victims at the location
- Notify DOC and CEO if possible
- Where possible, monitor ring cameras and document the movements and actions of the armed intruder. Relay information about the armed intruder's current location and actions to the Incident Command Centre when requested, otherwise, keep the phone line and radio channel clear.

Charge Nurse - when Code Silver is over

- Announce "All Clear - Code Silver" three times.
- Document the incident as required
  - Progress notes;
  - Critical Incident;
  - Employee incident;
  - Debrief Tool "A01".
  - Complete and distribute Emergency Drill Report.
  - In consultation with the Administrator/Delegate determine the need for a Critical Incident Stress Debriefing (EAP) for involved staff
- If required, arrange a Critical Incident Stress Debriefing (EAP) for involved staff ASAP

"EAP" is an Employee Assistance Program available free of charge to staff of Valley Manor through the HR department.

Administrator - after being made aware of a Code Silver Active Shooter / Armed Intrusion

- Assist the Charge Nurse with carrying out the duties of the Charge Nurse.
- Assume the role of the Charge Nurse in the emergency capacity roll if required

Managers - after being made aware of a Code Silver Active Shooter / Armed Intrusion

- Follow instruction from the Assigned Staff Lead, Charge Nurse and emergency crews.
- Assume the role of the Assigned Staff Lead if required.
- Assume the role of the Charge Nurse in the emergency capacity roll if required.

Additional Emergencies During a Code Silver Lockdown

- Should the fire alarm be activated, do not issue overhead page for Code Red immediately. If possible, discuss with the Charge Nurse location of alarm origin and to determine last known location of perpetrator and potential for false alarm.
- **Provide information to 911 that an armed intruder event in is progress and**

that the fire department should take direction from the police.

- Should other alarms sound, there must be a discussion with the Charge Nurse/Law Enforcement before proceeding. Should calls be received for other emergency codes, overhead pages will not be issued until the caller ID is noted, recorded and a discussion with Charge Nurse as to how to proceed is conducted.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A01'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director of LTC is informed in as much detail as is possible under the following timelines and in the associated circumstances:

1. The incident must be documented in progress notes identifying any precipitating factors prior to the incident, the type of behavior exhibited, a summary of the crisis situation, a listing of staff responding to the Code Silver and the outcome.
2. If the resident has negative outcomes or is transferred to hospital the Critical Incident Form must be completed and submitted.
3. An Employee Incident Report must be completed if any injuries were incurred and submitted to the employee's respective manager.
4. Immediately after the Code Silver has been declared 'All Clear' the Charge Nurse will meet with the respondents to the "Code Silver Active Shooter / Armed Intruder" to debrief and complete the Code Silver Active Shooter / Armed Intruder Debrief Tool located in Appendix 'A01'.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Purple - Lockdown/Threatening Visitor/Hostage Situation	POLICY #:	EMP13-001
MANUAL:	Emergency Management Plan	PAGE:	1 of 5
SECTION:	Code Silver	REFERENCES:	
ORIGINAL ISSUE:	March 2024	APPROV. AUTH:	
PAST REVISIONS:	June 2024	RESPONSIBILITY:	
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POLICY

To ensure the safety and security of residents, staff and visitors, a long-term care home (LTCH) will follow the **Code Purple – Lockdown/Threatening Visitor/Hostage Situation** Emergency Response Plan.

Description

A hostage situation will have occurred when a person(s) barricades themselves into an area and/or unlawfully confines, imprisons, or forcibly seizes another person(s) or for the purpose of gaining a perceived negotiating advantage, or in the case of sexual confinement, for obtaining sex from the “hostage”.

***The Police will at all times assume command of any hostage situation.**

PURPOSE

1. To provide a standard response for staff to obtain assistance in managing episodes involving a **Code Purple – Lockdown/Threatening Visitor/Hostage Situation**.
2. To preserve the safety of staff, residents and visitors.
3. To communicate an episode of a Threatening Visitor to other staff members working in the building.
4. To assist the Threatening Visitor to regain control over their behaviour.
5. To ensure a debrief occurs following every activation of the plan and to evaluate areas for improvement.

Authority to Declare

Anyone who believes that a “Hostage Situation” exists shall notify the Charge Nurse or delegate of the details. After approval from Administrator/Delegate, the Charge Nurse will announce **Code Purple** over the home public address system.

Incident Command Centre

Upon receiving notice of a hostage situation Charge Nurse will immediately establish an Incident Command Centre. The Charge Nurse will assume command and coordinate the response activities.

After normal business hours

Upon receiving notice of a hostage situation the Charge Nurse, with the help of the Assigned Staff Leads, will immediately establish an Incident Command Centre and assume command of the situation until the OPP arrives. Upon receiving notice of a hostage situation, the Charge Nurse will immediately contact the Killaloe OPP to request assistance.

The Charge Nurse must be prepared to transfer command to a higher authority (Police, CEO).

Measures to Prevent Being Taken as a Hostage

- Be aware of, anticipate and avoid danger
- Report persons who are suspicious or believed dangerous
- Avoid unsafe, dark, secluded areas
- Trust your instincts (i.e. maintain a safe distance from a person who makes you nervous)
- Do not interfere with a hostage situation
- Do not give anything to an aggressor (i.e.: coffee, food, cigarettes, etc.). These are important tools for Police negotiations
- Do not make deals with an aggressor

Guidelines for Survival of a Hostage

- Try to recognize the purpose for which you have been taken. You will have to make a personal decision as to what your best odds for survival are, keeping in mind the potential state of mind of your captor(s)
- Terrorists and mentally unstable persons are unpredictable and often lack remorse for their actions
- A hostage situation is most often the result of an aggressor's perception that there is no other way; this is their last and greatest effort to attain some goal
- If you decide your best odds for survival are to resist capture, it must be before the aggressor gains control of you
- In general, be a good hostage
- Remain calm
- Breathe deeply and slowly
- Mentally place yourself somewhere else that you would rather be
- Don't be a hero, because high adrenaline and anxiety levels make for unpredictable responses:
    - Do not show or attempt physical resistance once captured
    - Cooperate and follow instructions

    - Behave, as you would have another behave if the roles were reversed
    - Avoid sudden or threatening movement or gestures of any kind
    - Do not make threats of retaliation, deals, or promise rewards
    - Try to maintain a low profile and not underplay the aggressor's role
- Maintain effective communication with the aggressor
    - Allow the aggressor to initiate conversation
    - Do not argue
    - Avoid political or controversial topics
    - Talk on the same level as the aggressor, using the same diction, recognizing their apparent educational background; do not talk up or down
    - Speak more slowly than the aggressor to help calm them down
    - Do not offer suggestions to the aggressor
- Establish yourself as a person, making it difficult for the aggressor to harm you:
    - If possible, do not allow your head to be covered
    - Maintain your dignity
    - Project a positive self-image
    - Maintain eye contact when spoken to, but avoid drawing attention to yourself by staring
    - Use your first name
- Empathize with the aggressor. Let them feel you understand why they are doing this
- Befriend the aggressor
- Hostages should try to stay together:
    - To provide each other with mutual support
    - To aid rescuers in the identification between the aggressor(s) and the hostages in the event of a Police assault
- Don't refuse food, water and rest
- Be patient. It may appear as if nothing is happening, but the Police and Home Administration are collaborating to rescue you unharmed as quickly as possible.
- Be observant. In the event of release, your information is of great importance to the Police:
    - How many aggressor(s) are there?
    - What kind of weapons are they using?
    - What are they saying and doing?
    - Do they appear extremely agitated and nervous or absolutely calm?
    - Do they seem to be showing sympathy towards the hostages?
    - Are escape routes available to you, in the event that the opportunity for escape presents itself or if a rescue is made?
- Trust the Police:
    - They will minimize your importance to the aggressor(s), but are actually trying to save your life
    - They will try to prolong the situation beyond the first hours or so, in the course of standard calming and control procedures, the longer the situation goes on, the better the chances that it will end peacefully
    - If you are permitted to speak on the telephone, be careful what you say. Be prepared to answer "YES" or "NO" to questions asked by the Police.

- In the event of a Police assault, fall to the floor to get out of the line of fire and to distinguish the aggressor(s) from the hostages. Stay down and keep your hands on your head and do not make any sudden moves.
- If you find that you have been taken for sexual purposes, you will have to make a personal decision as to whether to passively or actively resist:
    - Passive resistance is most often recognized as the safest choice to avoid possible retaliation:
        - Verbalize your unwillingness to be assaulted
        - Use minimal physical resistance (i.e.: pushing their hands, crossing your legs), but do not resort to higher levels of force, basically making difficult for the attacker to attain their goal
    - Active resistance is not considered the safest choice. It is recognized, however, that active resistance can aid in psychological recovery. Resistance may result in retaliation, so your decision to fight at this point must be without doubt or hesitation:
        - Fight for your life
        - Use improvised weapons from the immediate environment
        - Use the aggressor's body's weak points (i.e.: genitals, eyes, throat) to your advantage

PROCEDURE:

Guidelines for Staff Who Are Not Hostages

The Police will handle negotiations with captors; they have trained staff to handle these situations. If Home staff must enter into negotiations with the captor(s) pending the arrival of the Police, use the following guidelines:

- Have negotiations conducted by "junior-rank" staff in order to allow delaying tactics, such as "I'll ask" or "I'll seek clarification"
- Meet demands with "I will do my best". Never say "no"
- Do not give drugs under any circumstances to the captor(s) until approved by the Administrator or the Police, **unless it is necessary medication for a hostage**
- Every effort should be made to regain control of the situation by peaceful means
- Leave the decisions to the Police and Administration
- Do not follow orders given by a captor unless under conditions of duress or to save lives
- If the aggressor is a resident or otherwise known to staff, staff are to contact any clinical staff who are familiar with and have some influence over, the person involved in the hostage incident. This is to be done whether or not the aggressor requested it

All Clear – Declaring Return to Normal Operations

- In consultation with Police officials, determine whether the crisis has concluded, that it is safe to resume normal operations and authorize the reception to announce the "**Code Purple - All Clear**" three times.
- Implement a course of action to manage a major disruption of the Home's routine

- Consider that large areas of the Home may be designated as crime scenes and as a result could be unavailable to staff until Police are able to complete their investigation
- Arrange for a debrief session with involved staff
- Arrange a Critical Incident Stress Debriefing (EAP[4]) for involved staff and arrange for professional councillors to be on site following the event.

**4 "EAP" is an Employee Assistance Program available free of charge to staff of Valley Manor through the HR department.*

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A01'.
All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances;

1. If a resident is involved the incident must be documented in progress notes. Identify any precipitating factors prior to the incident, the type of behavior exhibited, a summary of the crisis situation, a listing of staff responding to the **Code Purple** and the outcome.
2. If the resident has negative outcomes or is transferred to hospital the Critical Incident Form must be completed and submitted.
3. If a staff member is injured, an Employee Incident Report must be completed and submitted to the employee's respective manager.
4. Immediately after the **Code Purple** has been declared 'All Clear', the Charge Nurse will meet with all parties to the "Lockdown/Active Threatening Visitor" to debrief and complete the "**Code Purple Lockdown/Threatening Visitor/Hostage**" Debrief Tool located in Appendix 'A01'.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	Code Purple - Lockdown/Threatening Visitor/Hostage Situation Staff Roles	POLICY #:	EMP13-002
MANUAL:	Emergency Management Plan	PAGE:	1 of 4
SECTION:	Code Purple	REFERENCES:	
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All Staff - Upon Realizing There is a Lockdown/Threatening Visitor/Hostage Situation

Person/Staff Witnessing the Hostage Situation

1. Remove yourself from the area. If safe to do so, move residents and other staff to a safe location away from the incident, and notify the Charge Nurse of the situation.
2. Advise residents and visitors to return to/remain in their rooms until the crisis no longer exists.
3. Observe and note, as much as possible, what the aggressor(s) says and does
    - No staff person shall endanger their own person, but shall focus on the containment of the incident and on the safety of the residents, visitors, volunteers and staff in the affected area until additional assistance has arrived.
    - If there is any sign of actual danger or violence to any person do not attempt any action

All Staff - Upon Hearing Code Purple Being Announced Overhead

All Home Staff in the Affected Area

1. Cease all unnecessary activity
2. Remove yourself from the area. If safe to do so, move residents and other staff to a safe location away from the affected area

All Staff that are Not in the Affected Area

- **Do not** approach the Code Purple area
- Continue with normal duties, unless directed otherwise (ie. Code Purple Announcement)

All Staff - Upon Notification That the Crisis Has Concluded

- Be prepared to provide a written statement for Police if requested or required.
- Be prepared to complete an investigation template for the facility
- Advise residents and visitors that the crisis no longer exists
- Refer any inquires from media or the general public surrounding the crisis to the CEO/Administrator
- Resume normal duties

Charge Nurse – Upon Notification of Code Purple - Lockdown/Threatening Visitor/Hostage Situation

1. Establish the Incident Command Centre
2. Assign Staff Leads; assign staff to monitor cognitively impaired residents.
3. Notify, or request another staff member to notify, the Killaloe OPP,
   Provide the following information, where possible:
   - Name of aggressor(s):
   - Description of aggressor(s):
   - Number of Hostages:
   - Weapons involved:
   - Location Details (i.e. Resident room, corridor, office, room number, etc.):
     (When speaking to Police **do not** use term "Code Purple", instead state "**Hostage Situation**")
4. Receive status report/discuss initial action plan with staff
5. If not on site: Notify: CEO and DOC
6. Prepare to provide a situational report to the Administrator
7. Be prepared to transfer command to a higher authority (e.g. Police/Administrator)
8. Consult with Police on threat severity
9. Determine evacuation needs and prepare to make recommendations
10. If anyone is released from a hostage situation remove him/her from the area immediately and take him/her to an isolated area to be debriefed and provided with medical attention, as necessary

Charge Nurse - All Clear – Code Purple is Over

1. In consultation with Police officials, determine whether the crisis has concluded, that it is safe to resume normal operations and authorize the reception or delegate to announce the "**Code Purple - All Clear**" 3 times.
2. Implement a course of action to manage a major disruption of the Home's routine, if necessary
3. Arrange for a debrief session with involved staff
4. Document the incident as required
   - Progress notes;
   - Critical Incident;
   - Employee Incident;
   - Debrief Tool.
   - Complete and distribute Emergency Drill Report.
5. In consultation with the Administrator/Delegate determine the need for a Critical Incident Stress Debriefing (EAP) for involved staff

- If required, arrange a Critical Incident Stress Debriefing (EAP) for involved staff ASAP

**"EAP" is an Employee Assistance Program available free of charge to staff of Valley Manor through the HR department.*

Managers - after being made aware of a Code Purple Lockdown/Threatening Visitor/Hostage Situation

- Follow instruction from the Charge Nurse, Assigned Staff Leads and emergency crews.
- Assume the role of the Assigned Staff Lead if required.
- Assume the role of the Charge Nurse in the emergency capacity roll if required.

Administrator - after being made aware of a Code Purple - Lockdown/Threatening Visitor/Hostage Situation

- Support the Charge Nurse in the emergency capacity roll.
- Assume the role of the Charge Nurse in the emergency capacity roll if required

Additional Emergencies During a Code Purple Lockdown

- Should the fire alarm be activated, do not issue overhead page for Code Red immediately. If possible, discuss with the Charge Nurse the location of alarm origin and to determine last known location of perpetrator and potential for false alarm.
- **Provide information to 911 that a Lockdown/Threatening Visitor/Hostage Situation is in progress and that the fire department should take direction from the police.**
- Should other alarms sound, notify Maintenance by telephone/pager for management and/or discussion with Charge Nurse
- Should calls be received for other emergency codes, do not issue overhead page to deploy staff. Note caller ID and or internal extension and record. Discuss with the Charge Nurse as to how to proceed, should the Charge Nurse wish to issue the overhead page.

Documentation

All real and simulated emergency events shall be documented on the Emergency Drill Report located in Appendix 'A01'.

All formal activations of Emergency Response Plans shall include a formal debrief and review of the response plans within 30 days of the conclusion of the emergency. This debrief shall be documented separately from the original emergency response. Completed Emergency Drill Reports shall be logged in the Testing of Emergency Plans binder for a period of two years.

Reporting

Every licensee of a LTCH shall ensure that the Director is informed in as much detail as is possible under the following timelines and in the associated circumstances:

1. The incident must be documented in progress notes identifying any precipitating factors prior to the incident, the type of behavior exhibited, a summary of the crisis situation, a listing of staff responding to the **Code Purple** and the outcome.
2. If the resident has negative outcomes or is transferred to hospital the Critical Incident

Form must be completed and submitted.

3. An Employee Incident Report must be completed if any injuries were incurred and submitted to the employee's respective manager.
4. Immediately after the **Code Purple** has been declared 'All Clear', the Charge Nurse will meet with all parties to the "Lockdown/Active Threatening Visitor" to debrief and complete the "**Code Purple Lockdown/Threatening Visitor/Hostage**" Debrief Tool located in Appendix 'A01'.

Report Submission

Where a licensee is required to make a report immediately as identified above and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. Contact information can be found in Appendix 'C' Communication Plan – Urgent Services Contractors Suppliers Call List.

SUBJECT:	**Outbreaks – Communicable Disease, Public Health Significance, Epidemics and Pandemics**	**POLICY #:**	**EMP14-001**
MANUAL:	**Emergency Management Plan**	**PAGE:**	**1 of 8**
SECTION:	**Code White**	**REFERENCES:**	
ORIGINAL ISSUE:	**February 2023**	**APPROV. AUTH:**	
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Policy

All reasonable actions to reduce risk to residents, staff and visitors will not await scientific certainty. The policy abides by the precautionary principles of where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat. As such, the long-term care homes (LTCH) will always ensure an abundance of caution.

Purpose

To ensure a coordinated response that ensures the safety of all residents, staff, families and visitors of a LTCH, in the event that the home is faced with an outbreak of a communicable disease, outbreak of a disease of public health significance, epidemic or pandemic.

Procedure

Activation of the Emergency Response

Upon notification of a pandemic threat level change, the regional Medical Officer of Health (MOH) or Emergency Management Ontario may declare or recommend the activation of local emergency response plans.
The Premier may declare a provincial emergency in response to the arrival and/or spread of a pandemic influenza virus.

The local public health unit may declare an outbreak of a communicable disease and/or of public health significance in response to infection cases in the home that exceeds predicted amount.

Termination of an Emergency Response

The Premier of Ontario may, at any time, terminate a municipal declaration of emergency.

The local public health unit may declare an outbreak of a communicable disease and/or of public health significance over in consultation with the LTCH. Public Health will use the most current available epidemiological data and best practices/guidance documents to determine when an outbreak can be declared over. The local medical officer of health retains the final authority to determine if an outbreak is over.

Preparation of the Regional Emergency Response

Each LTCH will conduct annual drilling and testing of the home's plan for responding to infectious disease outbreaks in collaboration with local Public Health Units (PHU) and health partners.

- Results of these annual drills and tests are reported to the Ministry of Long-Term Care (MLTC) and PHU as part of the compliance and inspection regime.

Each home will post their infectious disease outbreak plan, any other relevant plans and the contact information of the Administrator to the Niagara Region website.

Evaluation of Emergency Response

Within 30 days of the emergency response being declared over, the LTCH will complete an evaluation of the emergency plan and ensure that all entities that have been involved in the emergency response are provided an opportunity to offer feedback.

Recovery from Emergency Response

The LTCH will debrief residents and their substitute decision maker(s) (SDM) (if any), staff, volunteers and students after the emergency.

The LTCH will resume normal operations in the home following the emergency unless otherwise instructed by the local PHU, MOH or MLTC.

Outbreak Management Team

- Infection Control Coordinator (IPAC) Lead;
- Back Up IPAC Lead;
- Administrator (CEO);
- Director of Care (DOC);
- Public Health;
- Registered Staff;
- Medical Director;
- Medisystem Consultant Pharmacist;
- Nursing & CQI Coordinator;
- Maintenance Manager;
- Supportive Services Manager.

Upon Activation of Emergency Response

Responsible	Action/ Task

Infection Control Coordinator (IPAC) Lead or Designate	• Initiate Outbreak Management Guide provided by the Ministry
	• Lead outbreak management for the LTCH
	• Briefs team of pandemic condition as reported by Public Health
	• Provide IPAC training to staff, residents and visitors at the outset and during any infectious disease outbreak
	• Ensure isolation precautions are being followed
	• Conduct audits for PPE usage, IPAC measures, cleaning & disinfection, hand hygiene and any other audits deemed necessary
	• Carry out infectious disease surveillance in LTCHs and analyze the resulting data
	• Consult with local Public Health Unit about potential outbreaks in LTCHs and provide PHUs with information on the infected individuals
	• Communicate with staff, residents and visitors about measures in place and any policy/procedure changes.
	• Ensures control measures are in place as per the direction of Public Health (e.g. screeners, screening tables)
	• Ensures the set up at entrance surveillance to prevent persons with symptoms of illness identified from entering the home. The monitor will use a case finding surveillance tool as directed by Public Health, the MOH or MLTC.
	• The monitor shall use personal protective equipment (PPE) as required
	  ○ Restrict access to only approved entrances (ex. one for all staff & visitors to enter)
	• Work with local Public Health Unit and Registered Nursing staff to plan to cohort residents to avoid transmission of infection with appropriate staffing for each cohort and include a plan for moving residents to another site or sites (“decanting”) if cohorting measures are deemed unlikely to contain an outbreak
	  ○ LTCHs will review relocation agreements with community partners annually
	• Collaborates with local PHU to make provision for safe, in-person access to residents by essential caregivers
	• Determines in collaboration with Public Health if public gatherings, programs or special events should be cancelled

	• Audit home's stockpile of PPE and other necessary supplies and check that they are not expired • Ensure PPE is available to all staff and visitors as appropriate • Collaborate with Dietary, Housekeeping and Laundry (DHL) manager to select disinfectants to be used for resident care equipment, supplies, devices, and contact surfaces • Monitors the proper use of PPE • Monitors N95 mask fit testing status for all staff • Monitors influenza or other novel immunization for staff and residents • Ensures hand hygiene is practiced by all staff, residents, visitors and volunteers • Create, maintain and audit resident immunization records • Conduct immunization clinics for residents and staff as required • Administer and document staff immunizations and screening tests in accordance with policies and procedures and legislative and regulatory requirements • Facilitate annual drilling and testing of home's plan for responding to infectious disease outbreaks • Participate in the annual review of the pandemic plan • Monitor PPE in storage – swap out items close to expiration date and use those before expiring – in col • Expired PPE may be used for educational purposes • Expired PPE should not be used unless the manufacturer was contacted to use beyond expiry date in extreme PPE shortages • Ensures that there are alternates planned for each manager in case of illness • Ensures communication to key stakeholders (families, staff, physicians, pharmacy, other LTC homes, Nurse Practitioner, student placements, service providers and local hospitals) • Monitor MOH and/or MLTC directives, guidance documents and update policies and procedures as required • Provide IPAC education, at minimum, annually for all staff
Responsible	**Action/ Task**
CEO/Administrator	• Provides regular, proactive, timely communication with residents and their families, SDM's, essential caregivers, etc:

	○ At the outset of any infectious disease outbreak ○ During an outbreak, including proactive updates regarding the status of the home in general ○ Whenever new management is introduced ○ In response to requests for information ○ When the outbreak/emergency is declared over • Sets specific communication briefs/meeting times and locations with team • Reviews staffing plan to ensure adequate staffing levels with potential for increased staffing on hand to provide additional assistance for increased care needs • Ensures each department has the required supplies available • Keeps Director of Seniors Services informed of any influenza activity • Ensures home maintains a four-week pandemic stockpile of PPE and other necessary items with sufficient supply to respond during an outbreak
Responsible	**Action/ Task**
DOC	• Meets with nursing staff to ensure all staff are aware of expectations • Works with Public Health for heightened surveillance • Ensures nursing supplies are available for at least four weeks • Reviews and prepares for adequate staffing levels • Collaborates with Pharmacy for medication education, intervention and supplies • Ensure annual drilling and testing of the home's plan for responding to infectious disease outbreaks is occurring
Responsible	**Action/ Task**
Registered Nursing Staff	• Conduct daily active surveillance to identify resident cases • Initiates isolation precautions as required if resident cases meet case definitions • Obtains testing specimens as per requirements set by MLTC, local PHU. MOH, etc. (i.e. nasopharyngeal, etc.) • Provide regular, proactive and timely communication/ updates regarding the health

	status of affected residents including significant changes • Follow outbreak measures outlined in IPAC policies or other specific policies as required • Ensure resident cohorting is being practiced and isolation precautions are being followed • Contact supplier for release of required pandemic supplies (Nursing Admin. Assistant)
Responsible	**Action/ Task**
Medical Director	• Continually assess the impact on quality of life of the residents and work with relevant health partners to make adjustments as necessary in the event residents are confined to their rooms • Physically attend to residents when needed and within 24 hours of the request for care • Review and approve medical directives for novel immunizations, prophylaxis medication, and/or treatments
Responsible	**Action/ Task**
Manager of Recreation & Volunteers	• Meet with programs staff to ensure all staff is aware of expectations • Communicate with volunteers and hairdresser(s) about IPAC measures, outbreak status, etc. regularly • Monitor current planned activities for possible rescheduling • Reassign staff to other duties as required, dependent on adequate staffing levels • Ensure regular virtual visits between residents and their families are available during an outbreak • Oversee screener(s) if applicable
Responsible	**Action/ Task**
Support Services Manager	• Meets with DHL staff to ensure all staff are aware of expectations • Heightened cleaning and disinfecting to prevent the spread of infection in high touch areas • Ensures supplies for all departments are available for at least seven days • Plan for the provision of meals to staff if working extended hours • Collaborate with IPAC program manager when discussing new products for disinfection

Responsible	Action/ Task
Maintenance Manager	• Determine engineering controls such as containment (closing resident home areas), increased monitoring of HVAC and possible adjustments to Building Automation Systems (BAS) to decrease recirculation of air with common spaces
Responsible	**Action/ Task**
Nursing and CQI Coordinator	• Supports the home management team with surveillance, monitoring and planning • Supports the front-line staff with care planning
Responsible	**Action/ Task**
Office Lead/ Office Assistant	• Supports the home management team with inputting vaccination data into related portals as required (ex. COVAX), and shares info with IPAC Lead
Responsible	**Action/ Task**
IPAC Lead and Public Health	• Update/revise IPAC assessments to support homes with surveillance and monitoring • Offer support services for staff who experience distress during the emergency (Employee and Family Assistance Program – EFAP)
Responsible	**Action/ Task**
Resident and Family Support Worker (Essential Caregivers)	• Support residents, visitors, families, staff, etc. who experience distress during the emergency

Additional Measures

Isolation Beds

The Home will make every attempt to ensure residents who require isolation are provided a private accommodation unless they are able to be cohorted with a roommate.

In the event a resident requires isolation for an illness and they cannot be isolated in their own resident room, St. Martha's room shall be used as the isolation room.

Staff Cohorting

The Home will make every attempt to ensure staff are cohorting to one unit and one home for the duration of the outbreak. In the event of low staffing levels, the home may work in collaboration with the local PHU to determine if they may break cohorting to ensure adequate staffing levels.

If possible, exposed staff that are able to continue to work (ex. test-to-work) should remain caring for symptomatic cases on a daily basis and avoid transferring to an unaffected unit/floor during the outbreak.
If possible, assign staffing to either look after ill residents and others looking after well residents.

Allied health professionals (e.g. physiotherapists, recreational therapists, etc.) should be cohorted to the outbreak unit where possible, or provide care on non-outbreak units before entering the outbreak unit (preferably on a one-on-one basis).

Resident Cohorting

Residents should be cohorted according to their infective status:

- Symptomatic positive with symptomatic positive;
- Asymptomatic positive with asymptomatic positive;
- Symptomatic negative with symptomatic negative;
- Asymptomatic negative with asymptomatic negative.

Residents will be cohorted to the unit for the duration of the outbreak. If dining resumes, residents will be cohorted to tables in the dining room within the same cohort.

Staffing Contingency Plans

Refer to G01-002

Staff Exposures

Staff who meet outbreak definition should not return to the facility for the duration of their isolation period, as determined by the cause of the infection, unless under extreme staffing shortages where a test-to-work method is implemented with additional public health measures.

If it has been determined that the staff member acquired an occupational illness, the Ministry of Labour will be contacted.

Managing Symptomatic Residents

Registered staff will keep the attending physician or nurse practitioner up-to-date on resident's who are symptomatic and/or have tested positive for the infection. Registered staff will follow direction from the practitioner to determine what treatment options will be prescribed (ex. Tamiflu for confirmed influenza outbreak, Paxlovid for COVID-19, etc.)

Managing Symptomatic Staff

Staff who are symptomatic and/or have tested positive will remain out of the workplace until their period of isolation is complete.

In extreme staffing shortages, homes will follow direction from the MOH, MLTC, and/or local public health unit to determine if test-to-work can be facilitated – preference for staff who are asymptomatic and isolating due to work-place exposure.

Staff will follow direction from their primary prescriber and/or Medical Director for treatment options depending on the type of infection (ex. Tamiflu).