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APPROVED BY:		**REVIEWED DATE:** July 26, 2022

The purpose of the Emergency Plan is to provide the Home team with protocols on how to deal with common types of emergencies, whether they occur within the Home or in the surrounding vicinity or community

The plan is used to educate staff, visitors, volunteers and contract service providers on universal codes, types of emergencies, evacuation and relocation protocols.

It provides clear delineation of roles in the event of an emergency situation.

The Emergency Plan is developed in consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to the emergency.

The Emergency Plan identifies and assesses hazards and risks that may give rise to an emergency impacting the Home, whether the hazards arise within the Home or in the surrounding vicinity or community.

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SUBJECT: ACTIVATION AND EVALUATION OF EMERGENCY PLAN	**PAGE:** 1 OF 2
	ORIGINAL DATE: April 30, 2010
APPROVED BY: Hansons	**REVISED DATE:** July 26, 2022

STANDARD:

1. The Emergency Plan or a component of the plan emergency plan will be activated in response to an internal or external emergency and/or disaster.

PROCEDURE:

1. The Emergency Plan will cover the activation of the plan, lines of authority, communication plan and roles and responsibilities of the staff.

2. The Emergency Plan will be activated in response to any of the Emergency Code listing in policy A-15.

3. The appropriate internal and external authorities are notified in accordance with the procedures listed in the Emergency Codes.

4. The internal and external communication plan is activated when an emergency situation arises.

Testing the Emergency Plan:

1. The Home must test the following emergency codes on an annual basis on all three shifts:
   - Code Blue
   - Code Green
   - Code Green Stat
   - Code Orange
   - Code Yellow
   - Code White
   - Code Brown
   - Code Black
   - Priority Code

2. Code Red must be tested on a monthly basis on all three shifts.

3. The Emergency Phone list must be tested on an annual basis.

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PLEASE NOTE: The testing of these emergency plans must involve making arrangements with community agencies, partner facilities and resources that will be involved in responding to these emergencies.

4. All other components of the emergency plan must be tested at least every three (3) years, including making arrangements with community agencies, partner facilities and resources that will be involved in responding to these emergencies.

5. The Home must conduct a planned evacuation at least every three (3) years.

Evaluation:

1. The Home must evaluate the emergency plan within 30 days of an emergency being declared over, after each instance that an emergency plan has been activated, if risk or situation changes and annually should the plan not have been activated. The Emergency plan must be updated based on the evaluation.

2. All emergency contact information must be reviewed and updated at least annually.

3. The Home must keep a written record of the testing of all emergency codes including the planned evacuation and changes made to improve the Emergency Plans.

OUTCOMES:

1. There is evidence that the Emergency Plans are activated in response to the emergencies.

2. There is evidence that the evaluation of the plans is in accordance with legislative requirements.

ADDITIONAL REFERENCES:

1. FLTCA 2021 and Regulation 246/22, section 268 and 269 – Emergency Plans.

2. CARF Standards

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SUBJECT:	EMERGENCY CODES	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. All staff, residents, volunteers, students, contracted services and families will have an orientation to universal codes.

2. All staff to achieve proficiency through provisions of ongoing education and practical application of universal codes.

PROCEDURE:

1. Education on universal emergency codes will be provided to all employees at a minimum annually.

2. A review of universal codes will be done as part of the employee performance review.

3. Introduction to universal codes for residents and families will occur on admission and during orientation for new employees, volunteers, students and contract service providers.

4. Staff will have an opportunity to apply learned knowledge through testing of components of the emergency plan on an annual basis. Note: Code Red is practiced monthly on each shift

5. Universal codes will be used to announce the type of emergency over the P/A system.

6. A list of the Universal Codes is posted on each floor and at the back of all staff identification cards.

7. The following are Universal Codes, by which specific disaster types are identified.

Code Black:	Bomb Threat
Code Blue:	Cardiac Arrest and Medical Emergency
Code Red:	Fire
Code Yellow:	Missing Resident
Code White:	Violent Resident
Code Orange:	External Disaster
Code Green:	Horizontal Evacuation
Priority Code:	Intruder Alert
Code Brown:	Chemical Spill
Code Silver:	Person with a Weapon

SECTION:	INTRODUCTION	**INDEX I.D.:** EPM A-15
SUBJECT:	EMERGENCY CODES	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. 100% adherence to universal codes.

2.All new staff, residents, families, volunteers, students and contract services providers have received orientation to Universal Codes

ADDITIONAL REFERENCES:

1. Fire Department
2. Ontario Fire Code
3. Home's Policies and Procedures

SECTION:	RESOURCES	**INDEX I.D.:** EPM B-05
SUBJECT:	LIST OF CONTACTS	**PAGE:** 1 OF 3
		ORIGINAL DATE: January 19, 2001
APPROVED BY:		**REVISED DATE:** JULY 26, 2022

A. **EMERGENCY EXTERNAL RESOURCE AGENCIES:**

Fire Department - 911

Ambulance Service - 911

Police - 911

Transit Commission (TTC) - 416-393-4636

Chartered Buses:

Healeys Transportation 613-283-3518

Howard Travel 613-342-9211

Lanark County - 613-264-8256

Priority Patient Transfer 1-866-561-7787

Quality Patient Transfer 613-547-8034

Taxi Services:

Access Taxi - 613-283-1441

B. OTHER EXTERNAL RESOURCES AGENCIES:

Gallipeau Centre:
Location for relocating residents
following evacuation 613-284-9916

Hilltop Manor:
Location for retirement residents following evacuation 613-296-4707

SECTION:	RESOURCES	**INDEX I.D.:** EPM B-05
SUBJECT:	LIST OF CONTACTS	**PAGE:** 2 OF 3
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D. WHOM TO CALL:

Problem	Call	Telephone Number
Loss of power	Hydro One	(24 hr. Emergency) 1-800-434-1235
Loss of water/flood (sewers)	Public Works	(24 hr. Emergency) 613-284-8065
Gas Leak	Enbridge Gas	1-877-873-7467
Loss of communication	Bell Canada	310-BELL
Toxic Spill, Radiation or Community Disaster	Police and Fire Departments	911 911 911
Fire Alarm/Fire Panel Indicator	Advanced Alarms	613-283-6238 #0773
	Fire Department (Non Emergency)	613-283-5869

E. MISCELLANEOUS:

Ministry of Health and Long Term Care

- Main Line: 613-327-8952 (8:00 am to 5:00 pm)
- Emergency After Hours: 1-888-999-6973

SECTION:	RESOURCES	**INDEX I.D.:** EPM B-10-05
SUBJECT:	BUILDING RESOURCES FIRE EQUIPMENT	**PAGE:** 1 OF 5
		ORIGINA DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

A. **DESCRIPTION OF BUILDING:**

NAME:	**Broadview Nursing Centre**
ADDRESS:	210 Brockville St Smiths Falls, Ontario, K7A 3Z4
TELEPHONE:	(613) 283-1845
TYPE OF FACILITY:	Long Term Care Home
NUMBER OF FLOORS:	One
NUMBER OF ROOMS:	Twenty Nine (29) bedrooms, plus service rooms and offices
NUMBER OF RESIDENTS:	Fifty One (51)

B. **AUTOMATIC EXTINGUISHING SYSTEM: (connected to Fire Alarm System)**

LOCATION:	Food Preparation Area - Kitchen
NAME OF COMPANY:	Automatic Sprinkler Corp
MODEL:	Range Guard
TYPE:	Wet chemical 4 Gal Wet
COVERAGE:	gas range

LOCATION OF PULL HANDLE: exit door from kitchen

TYPE OF FUEL FOR COOKING: Gas

NOTE: **In case of fire, gas and electricity must be shut off manually.**
Main gas shut off is located in

SECTION:	RESOURCES	**INDEX I.D.:** EPM B-10-05
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FIRE EXTINGUISHING SYSTEM: **(CONT'D)**

C. COMMUNICATION SYSTEM:

TYPE: Edwards Speakers

MODEL: ESA 2000

SPEAKERS: Location: Three (3) on North Zone
Three (3) on South Zone
Every 2nd landing North

EMERGENCY VOICE COMMUNICATION:

Unlock fire panel using key hanging in the maintenance room. Open the panel. Push the "All Call" button. Pick up the microphone. Voice Communication cannot be used on the initial fire alarm, while bells are ringing for a minimum of 30 seconds.

Announce in a clear voice Code Red on Zone___, three (3) times. Repeat announcement three (3) times as soon as location has called with exact location, announce Code Red on Zone___, Room ____.

After completion of announcement, release the microphone push button, return microphone to panel, fire tones will resume sounding on all floors.

POWER DISRUPTION:
1. Emergency Voice Communication System will function in house.
2. To access outside of Long Term Care Home use the emergency phone at the reception desk.

FIRE FIGHTERS PHONES: At north and south exits on all floors.
Key accessed. Key to open Fire Phones – inside Fire Hose cabinets. If key is not available break glass to access.

ANNUNCIATOR PANEL LOCATION: Maintenance room.

F. FIRE ALARM AND DETECTION SYSTEM:

NAME OF SERVICE COMPANY: Advanced Alarms
Telephone: 613-283-6238

MODEL: EST3X-SFS1B

TYPE:

SECTION:	RESOURCES	**INDEX I.D.:** EPM B-10-05
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PRIMARY POWER: 110V A.C.

BACK UP POWER: 2 12 Volt Battery

LOCATIONS OF PANEL: Maintenance Room

LOCATION OF ANNUNCIATOR PANEL: Nurses Station

F. **FIRE ALARM AND DETECTION SYSTEM:** (cont'd)

LOCATION OF PULL STATIONS:

1. All exit doors.
2. Dining room
3. Mechanical Room
4. By all exits

LOCATION OF SPEAKERS: 1. Each zone Four (4) emitting a ring when alarm is activated. .

20 tones/minute for 1st stage.
120 tones/minute for 2nd stage.

LOCATION OF HEAT DETECTORS: Kitchen and in the hallways.

LOCATION OF SMOKE DETECTORS: Located in all corridors, resident rooms, lounges, dining areas and service areas.

HOW TO RESET ALARM SYSTEM:

1. Reset activated Pull Station first:
   Insert flat screw driver, turn counter-clockwise, snap pull bar back into position, restore switch to down position and close pull station. Ensure station is closed.

2. Main panel is in the Main Lobby. To reset main panel:
   Open panel door, push button labelled reset. Should the alarm resume signalling on same zone, check the activated pull station to ensure that it was properly reset, then on main panel push alarm silence, then push the reset button. Should the alarm begin signalling on a different zone, thoroughly check the cause before resetting.

SECTION:	RESOURCES	**INDEX I.D.:** EPM B-10-05
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H. FIRE DEPARTMENT ACCESS:

Access: Building face accessible from parking lot and driveway along east side and north-west side of the building.

Fire Route Posting: There is a Fire Route posted along the north lot

I. FIRE PUMP:

LOCATION: Electrical Room, all hallways

J. FIRE SEPARATIONS: (fire rating 1 1/2 hours)

LOCATION: The fire separations are located at the entrance to the west wing

MODE OF OPERATION: The self closing doors in the fire separation areas are held open by the hold open devices that release when the fire alarm is activated.

K. SPRINKLERS:

SYSTEM: Wet System

COVERAGE: Entire building

CONTROL VALVES: Maintenance Room.

SIAMESE LOCATION:

FIRE DEPARTMENT CONNECTION: Sprinkler valves are supervised by fire alarm system which is monitored by the Advanced Alarms, telephone (613) 283-6238 (I.D. 0773).

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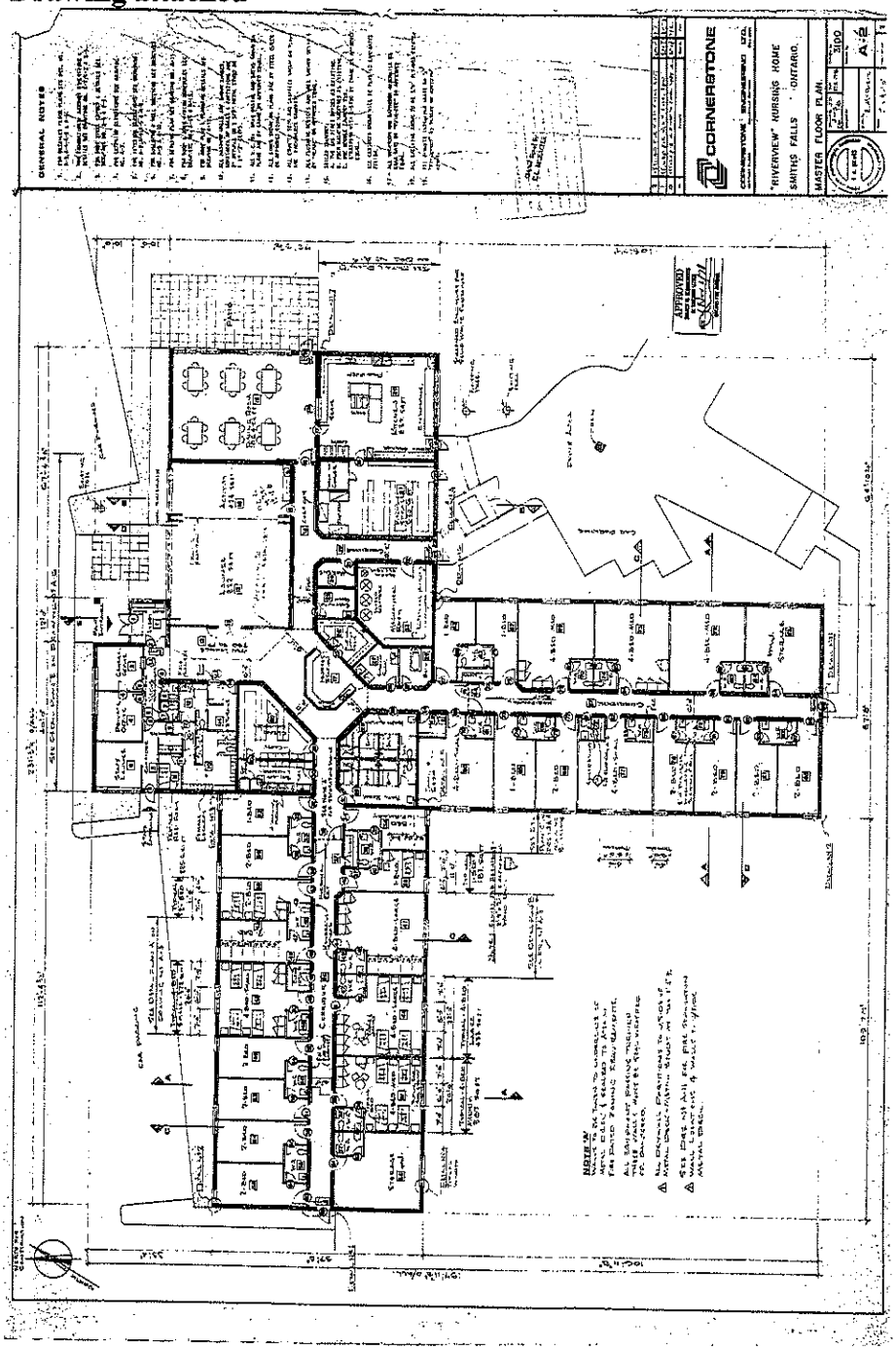
L. **STANDPIPE HOSE CABINETS:**

LOCATION:	Standpipe outlets with hose cabinet and hoses are located on the north side and south side of all floors.
CONTROL VALVE:	The main control valve is located in the Mechanical room
SIAMESE LOCATION:	
FIRE DAMPERS:	All vertical ducts passing through floors and all ducts passing through a fire separation are provided with U.L. labelled "FIRE DAMPERS". All fire dampers close when temperature reaches approximately 165 F.
HOSE:	Seventy-five (75) feet poliflex # 502MTL
NOZZLES:	WILCO HN-4-L (adjustable fog and straight stream).
FIRE DEPARTMENT CONNECTION:	Connector 2-1/2.

SECTION:	RESOURCES	**INDEX I.D.:** EPM B-10-10
SUBJECT:	BUILDING RESOURCES FIRE EXITS	**PAGE:** 1 OF 7
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** March 1, 2022

Floor Drawing attached



SECTION: CODE RED	**INDEX I.D.:** EPM C-01
SUBJECT: INTRODUCTION TO FIRE PLAN	**PAGE:** 1 of 2
	ORIGINAL DATE: March 3, 2014
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

Introduction

Even though this Fire Safety Plan may be approved by the Local Fire Services, it does not in any way relieve the owner, the lessee, or the management, of their responsibilities as set out under the Ontario Fire Code. The Fire Protection and Prevention Act states that "every person who contravenes any provision of the Fire Code and every director or officer of a corporation who knowingly concurs in such contravention is guilty of an offence and on conviction is liable to a fine of not more than $50,000.00 for an individual or $100,000.00 for a corporation or to imprisonment for a term of not more than one year or both.

The Local Fire Services may require this plan, or parts thereof, once approved, to be resubmitted if there are any changes to occupancy or use, if there is any change in standards, if the Fire Safety Plan has not been kept current or up-to-date, or because the Chief Fire Official judges the current Fire Safety Plan as no longer being acceptable.

The Chief Fire Official is to be notified regarding any subsequent changes in the approved Fire Safety Plan.

The approved Fire Safety Plan will be located within an approved Fire Safety Plan box in the main entrance lobby Fire Safety Plan box in accordance with the Local By-law# 186-2004.

Fire safety is an important responsibility for everyone. However, the consequences of inadequate fire safety planning are especially serious for anyone involved in a group setting for persons receiving institutional care who may be vulnerable due to illness or infirmity. Patients/residents depend on the knowledge, skills and training of the **supervisory staff** in providing and maintaining a fire safety environment.

Procedures contained in a Fire Safety Plan must be designed specifically for each building. In a fire emergency, if followed properly, the procedures should reduce the risk to life safety for all patients, residents, visitors and staff in the building. To be effective however, a Fire Safety Plan requires the following:

- Commitment by management and **supervisory staff** to fire safety
- A willingness by management to promote fire safety
- Knowledge of the building
- Knowledge of the fire safety protection equipment
- A clear understanding of the procedures and how to implement them properly
- Co-operation of **supervisory staff** to enhance the fire safety of patients/residents

SECTION: CODE RED	**INDEX I.D.:** EPM C-01
SUBJECT: INTRODUCTION TO FIRE PLAN	**PAGE:** 2 of 2
	ORIGINAL DATE: March 3, 2014
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

All **institutional facility owners**, managers and administrator should have a copy of the Fire Code, Ontario Regulation 388/97, as amended, and the Fire Protection and Prevention Act, 1997. Copies of these documents are available at Publications Ontario, 880 Bay Street, Toronto, M7A 1N8, 1-800-668-9938.

The Fire Code is a provincial regulation made under Part IV of the Fire Protection and Prevention Act, 1997. The Fire Code states that the **owner** is responsible for carrying out "all provisions of the Code".

In a court of law, the definition of "owner" could be interpreted to mean the person whose name is on the title, executive officer of a corporation owning the building, an administrator, a night supervisor/manager or even a maintenance supervisor/manager. Penalties for non-compliance by an individual can be as high as $50,000 per conviction and or imprisonment for up to one year in jail. Penalties for corporations are a maximum of $100,000 per offence.

Owners, managers, administrators and supervisors of **institutional facilities** should be intimately familiar with their responsibilities under the Fire Code since contravention of any provision can result in a penalty as listed above.

As required by Section 2.8 of the Fire Code, the **owner** of an **institutional facility** is responsible for the preparation of a Fire Safety Plan. In most cases, the Fire Safety Plan can be prepared by an experienced building or maintenance supervisory/manager in conjunction with the manager of the facility. Buildings with elaborate emergency systems may require the assistance of a fire protection consultant. After the plan has been prepared, it must be submitted to the **Chief Fire Official** for **approval**.

Once **approved**, the **owner/designate** is responsible for implementing the Fire Safety Plan and training all staff in their respective duties. It is also the **owner's** responsibility to ensure that all visitors and staff are informed of what to do in case of fire or when the fire alarm sounds. During a fire emergency, a copy of the **approved** Fire Safety Plan shall be available for responding fire department. This may be delivered by hand or, provided in a location **approved** by the **Chief Fire Official**, such as a security lock box at the main entrance to the building. This lock box, if **approved**, shall contain the Fire Safety Plan, master keys and schematic diagrams for the building.

Your Fire Safety Plan is a unique document that must be prepared specifically for your building. All of the procedures in the plan must provide staff with the guidance necessary to ensure the safe evacuation of the patients/residents and visitors from the building.

SECTION:	CODE RED	**INDEX I.D.:** EPM C-05
SUBJECT:	CODE RED - GENERAL	**PAGE:** 1 OF 3
		ORIGINAL DATE: January 19, 2001
APPROVED BY:		**REVIEWED DATE:** JULY 26, 2022

STANDARD:

1. Emergency Code Red will be used:

   a) To alert all occupants when a fire is discovered.
   b) When conducting fire drills.
   c) When there is a suspicious event that may lead to a fire (i.e.: smoke, smelling something burning).

PROCEDURE:

PLEASE REMEMBER

Pulling the alarm is the quickest way to get help
THE FIRST RESPONSIBILITY IS THE SAFETY OF THE RESIDENTS

A. IF YOU DISCOVER A FIRE/SMOKE:

Call out "**CODE RED**" and fire location; and

R - Remove Residents from immediate area;
E - Ensure windows and doors are closed
A - Activate Alarm
C - Call Code Red and location (3 times)
T - Try to extinguish fire (if possible)

B. IF YOU HEAR THE ALARM:

1. Check pull station located at the end of each hall to see if activated on your unit.

2. Initiate room to room search. Assign a staff member to each hall. All rooms to be checked as follows:

   - Close windows
   - Check closets
   - Check bathrooms
   - Close doors

SECTION:	CODE RED	**INDEX I.D.:** EPM C-05
SUBJECT:	CODE RED - GENERAL	**PAGE:** 2 OF 3
		ORIGINAL DATE: January 19, 2001
APPROVED BY:		**REVIEWED DATE:** JULY 26, 2022

- Note location of residents

C. YOU ARE LOOKING FOR SIGNS OF FIRE

1. **Supervisor is to check:**

   - Utility room
   - Tub room
   - Resident Lounge
   - Staff Washroom

2. When search is complete continue to patrol halls looking for signs of fire or smoke and reassuring residents.

3. If you hear the alarm and are not in your area:
   - Listen for the fire location over the voice communication system.
   - Return to your area, using the stairs (opposite stairwell from fire zone).
   - Follow directions of person in charge.

4. Receptionist or person assigned to fire assignment is responsible for announcing location of fire, calling 911, retrieving the elevator to the main floor, and directing fire department to fire scene.

5. All areas in the home will:
   - Resume normal duties/activities **only** after the all clear is announced.
   - The person in charge in each area completes a fire drill report noting areas that require follow up and gives to Nurse Manager as soon as possible. The report is signed by the ESS Manager and Executive Director.

6. Fire alarm to be reset after a drill by authorized personnel **only.** In the event that it is a false alarm **DO NOT SILENCE OR RESET THE ALARM.** Fire Department will conduct total search and determine when to reset the fire alarm.

7. The alarm system has two tones these are:
   - Loud beeping sound – 1st stage general alarm at 20 times per minutes.
   - Continuous rapid sound – 2nd stage alarm at 120 times per minutes which means initiate vertical evacuation by listening and following instructions.

SECTION:	CODE RED	**INDEX I.D.:** EPM C-05
SUBJECT:	CODE RED - GENERAL	**PAGE:** 3 OF 3
		ORIGINAL DATE: January 19, 2001
APPROVED BY:		**REVIEWED DATE:** JULY 26, 2022

OUTCOME:

1. Code Red is used each time there is a drill or fire.

2. A systematic check of each unit/area is conducted as per procedure every time there is a fire alarm.

ADDITIONAL REFERENCES:

1. Ontario Fire Code Rules & Regulations.

2. Home's Policies & Procedures.

SECTION: CODE RED	**INDEX I.D.:** EPM C-05-05
SUBJECT: CODE RED - AT RECEPTION	**PAGE:** 1 OF 2
	ORIGINAL DATE: May 01, 2002
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. All staff will:

   a) Demonstrate in-depth knowledge of his/her role during a code red at reception.
   b) Attend mandatory fire safety education at a minimum annually to enhance comprehension of practices in the facility.
   c) A fire drill/code red for reception will be held at a minimum annually on all shifts to allow for practice.

PROCEDURE:

A. IF YOU DISCOVER A FIRE/SMOKE AT RECEPTION, STAFF INITIATE & FOLLOW R.E.A.C.T. PROCEDURES:

1. The Receptionist/delegate calls out "**CODE RED, RECEPTION**" to elicit assistance & alert nearby staff, while evacuating residents to the exterior of the building through lobby exit doors.

2. If possible, the Evacuation Binder(s), the Wanderers' Binder, and the Visitors' Sign-In Book are relocated to a safe area.

3. The Receptionist/delegate pages **"Code Red, Reception"** three times, using the fire panel annunciator.

4. The Receptionist/delegate calls **911** to brief the Fire Department on the particulars of the emergency situation.

B. IF YOU HEAR A PAGE FOR CODE RED AT RECEPTION, STAFF IN ALL OTHER AREAS INITIATE & FOLLOW R.E.A.C.T. PROCEDURES:

1. The person in charge of each unit/area assigns one staff to monitor the exit doors.

2. Dietary staff will come to main reception area.

SECTION: CODE RED	**INDEX I.D.:** EPM C-05-05
SUBJECT: CODE RED - AT RECEPTION	**PAGE:** 2 OF 2
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PROCEDURE (cont'd):

3. The Maintenance Person/delegate proceeds to the north side of the building, through the parking lot and ensures that Fire Routes are clear and places yellow Caution tape around the entrance perimeter to warn visitors/the community of danger. He/she directs the Fire Department to the fire scene upon arrival using the entrance/exit door through the parking lot.

4. Receptionist/delegate on duty will ensure that residents are moved to safe location passed the fire barrier doors and accounted for.

OUTCOME:

1. Code Red is used each time there is a drill or fire.

2. A systematic check of each unit/area is conducted as per procedure every time there is a fire alarm.

ADDITIONAL REFERENCES:

1. Ministry of Health Program Standards (1011-01 M3.3, M3.10).

2. Ontario Fire Code Rules & Regulations.

3. Facility's Policies & Procedures.

SECTION:	CODE RED	**INDEX I.D.:** EPM C-10-05
SUBJECT:	ROLES AND RESPONSIBILITIES ROLE OF ADMINISTRATOR	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Administrator will:
   a) Demonstrate in-depth understanding of his/her role during a Code Red.

   b) Attend mandatory fire safety education at a minimum annually to enhance comprehension of practices in the facility.

PROCEDURE:

1. Upon hearing Code Red, Administrator goes to command post located at reception in main lobby.

2. Ensures that receptionist/delegate carries out his/her responsibilities.

3. Maintains constant communication with DOC/delegate and is kept apprised of emergency situation.

4. Apprises Emergency Services of situation and takes direction from Emergency Services.

5. If the Administrator/delegate determines the need for vertical evacuation an announcement is made to prepare for Code Green Stat.

6. If Code Green Stat or total evacuation is ordered, ensures that fan out protocol has been initiated.

7. Elicits the help of other facilities as needed.

8. Ensures that families are kept apprised of situation.

9. Ensures that fire area is sealed and that burned material is not discarded.

10. Have staff who discovered the fire or who were in the area before or during the fire make written independent statements on what they observed and did.

11. Completes CIS Report for Ministry of Health.

12. Ensures that relocation of residents is occurring as per emergency plan and that families are kept informed.

13. Ensures that receiving facilities are aware of emergency.

SECTION:	CODE RED	**INDEX I.D.:** EPM C-10-05
SUBJECT:	ROLES AND RESPONSIBILITIES ROLE OF ADMINISTRATOR	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
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14. Prepares Media release and contacts appropriate outside services (i.e. Ministry of Health).

15. Following total evacuation the Administrator/delegate will ensure:
    a) Families/responsible parties are contacted and made aware of evacuation proceedings.
    b) A notice is posted at facility entrance listing necessary information and contact phone numbers.
    c) Appropriate arrangements are made to maintain ongoing security of evacuated premises.
    d) Continued provision of care at level provided prior to evacuation (help with staffing at relocation sites and visit relocation sites regularly).

16. Debriefing meeting after emergency to determine:
    a) Loss of life.
    b) Extent of damage.
    c) Location of each resident/staff.
    d) Assistance required from external sources.
    e) Length of time it will take facility to resume normal operations.
    f) Need to release further media statements.
    g) Need for trauma counseling for staff and Residents.

    Please Note: In the absence of the Administrator, the Director of Care/delegate takes over the role of the Administrator.

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

OUTCOME:

1. There is demonstrated evidence through practice that the Administrator understands his/her role in an emergency situation.

ADDITIONAL REFERENCES:

1. Fire Code-Statutes/Regulations.

2. Home's Policies & Procedures

SECTION: ROLES & RESPONSIBILITIES **INDEX I.D.:** EPM C-10-10

SUBJECT: ROLE OF DIRECTOR OF CARE **PAGE:** 1 OF 2

ORIGINAL DATE: June 1, 2000

APPROVED BY: Karen **REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Director of Care will:

   a) Demonstrate in-depth understanding of his/her role during a code red.

   b) Attend mandatory fire safety education at a minimum annually to enhance comprehension of practices in the facility.

PROCEDURE:

1. Upon hearing Code Red, go directly to fire scene.

2. Assess Leadership at fire scene. If Nurse Manager/Unit Supervisor/Nurse Manager has not taken charge take charge by putting on fire vest and directing all activities at fire scene.

3. If Nurse Manager/Unit Supervisor has taken charge and is in control of fire scene, follow his/her directions.

4. Ensure that staff is using REACT.

5. Ensure that residents are removed to safety

6. Rooms are evacuated as per Code Red procedures. Evacuation signs used to identify vacant rooms have been utilized.

7. Report to Fire Department upon their arrival at the fire scene. Update on action(s) taken; exact location of fire and extent of evacuation.

8. Follow Code Green and Code Green Stat when evacuating residents from fire scene and other units.

9. Ensure critical resident information is evacuated, if possible (i.e. clinical charts).

10. Assign a Nurse(s) to the designated triage area(s).

11. Communicate with Executive Director and or delegate at "Command Post" in lobby to keep apprised of fire situation. Use fire phone to do this.

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-10
SUBJECT: ROLE OF DIRECTOR OF CARE	**PAGE:** 2 OF 2
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

12. Ensure that triaging is taking place as per protocol and that paramedics are kept informed of urgent cases for prompt transfer to nearby acute centers.

13. Ensure that assigned staff are accounting for all residents and that logs are being completed.

14. Ensure that once fire unit is evacuated that all areas are sealed to prevent residents/staff/visitors from re-entering area(s).

15. Following total evacuation, the Director of Care / designate will:

    a) Ensure the suspension of all regular work schedules in a disaster situation.
    b) Rework the schedule to reflect the changed needs/location of residents.

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

OUTCOME:

1. There is evidence of applied knowledge through practice in a fire situation.

ADDITIONAL REFERENCES:

1. Fire Code

2. Home's policy and procedures.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-15
SUBJECT:	ROLE OF NURSE MANAGER(S)/ IN CHARGE NURSE	**PAGE:** 1 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. All Nurse Managers (full and part time) will demonstrate an in-depth understanding of his/her role during a Code Red.

2. Attend mandatory fire safety education sessions yearly.

PROCEDURE:

1. Upon hearing **Code Red** the Nurse Manager will respond to the fire area.

2. Assess leadership at fire scene.

3. If Unit Supervisor has not taken charge put on fire vest and take charge.

4. If Unit Supervisor has taken charge and is in control of fire scene, follow his/her directions.

5. Ensure that staff follow REACT and rooms are evacuated as per **Code Red** procedures.

6. Notify Executive Director and Director of Care as soon as possible, giving them a full report of location of fire and action taken.

7. Follow direction of Director of Care.

8. Complete reports as needed.

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

EVENING NURSE MANAGER AND NIGHT IN CHARGE NURSE:

If In-charge of building and there is no Reception, Nurse Manager/IC Nurse must:

A. **ON HEARING THE ALARM:**

1. Report to main floor fire panel using stairs.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-15
SUBJECT:	ROLE OF NURSE MANAGER(S)/ IN CHARGE NURSE	**PAGE:** 2 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

2. Check location of fire on alarm panel.

3. Announce over voice communication system using Code Red Zone___, three (3) times.

4. Call fire department (call 911). Give address: BROADVIEW NURSING CENTRE 210 Brockville St. If call received from the fire area, relay the information to the Fire Department but do not wait for a call. Notify and confirm the alarm with Monitoring Company. For Fire Drills call the Alarm Monitoring Company **(613) 283-6238 Code 0773** and the Smiths Falls Fire Department 283-5869 before the drill.

5. Direct Fire Department upon their arrival.

6. Initiate the fan out calling system in order to notify key personnel of the emergency/disaster, which is located in the Evacuation binder.

7. Be prepared to evacuate "evacuation information binder, face sheet binder, visitor's sign-in binder and wanderers' binder.

8. Upon completion of the drill/fire, notify the fire department and alarm monitoring company to ensure fire alarm is operational.

9. Reset mag locks.

10. Do not allow residents or visitors to go upstairs before "all clear" is announced.

11. Page "Code Red all clear" three (3) times when told to do so by fire department, or Person In-Charge after a drill.

12. Update evacuation information. Refer to G-15-20 for details.

B. **PAGING PROTOCOL:**

When the Fire Alarm panel (EST 3 system) receives a first stage fire alarm the audible will sound at the Alert Rate throughout the building. When the system receives the first alarm, the paging system switch **will not** operate immediately. There will be a 30 second inhibit period.

1. Open Fire Alarm panel doors, using fire panel keys located in the lock box at Reception.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-15
SUBJECT:	ROLE OF NURSE MANAGER(S)/ IN CHARGE NURSE	**PAGE:** 3 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

2. Identify fire zone indicated on Fire Panel. Fire zone will be illuminated.

3. Pick-up telephone and press page then number 2 and number 1 and then speak

8. **START TO PAGE: CODE RED fire site) , CODE RED (fire site),**

   CODE RED (fire site)

   Example: Code Red Zone 2

9. Open lobby doors for Fire Department.

10. Remain at Fire Alarm panel and direct Fire Department to fire site.

11. Supervise residents in lobby, keep area clear for Fire Department and keep visitor out of the building.

12. Page **"CODE RED ALL CLEAR"** three (3) times when instructed by the Fire Department.

OUTCOME:

1. There is evidence of applied knowledge through practice in a fire situation.

ADDITIONAL REFERENCES:

1. Fire Code.

2. Home's policy and procedures.

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-20
SUBJECT: ROLE OF UNIT SUPERVISOR(S)	**PAGE:** 1 OF 3
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

To ensure the safety and security of all staff, residents, visitors, students and volunteers in the event of a fire.

PROCEDURE:

PLEASE NOTE:

On Evenings and Nights when there is no Receptionist these responsibilities are carried out by the Nurse Manager/Charge Nurse.

A. IF THE FIRE IS IN YOUR AREA:

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

Begin and continue calling out "Code Red" while you **REACT**.

Please remember: the first responsibility is the safety of the residents.

1. Reflective vest donned by Unit Supervisor or person in charge of the floor, **only on the fire floor.**
2. Take charge and delegate the staff to do the following:
3. Day and Evening staff will use the fire phone to communicate Code Red and exact location of fire to main floor.
4. Evacuate all residents from immediate fire area.
5. Contain fire – after fire area is evacuated, close windows and doors. Place a towel or blanket at the base of the floor to prevent smoke from escaping the effected room.
6. Evacuate residents in rooms across hall and on either side of immediate fire area to safe area. Example:

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-20
SUBJECT: ROLE OF UNIT SUPERVISOR(S)	**PAGE:** 2 OF 3
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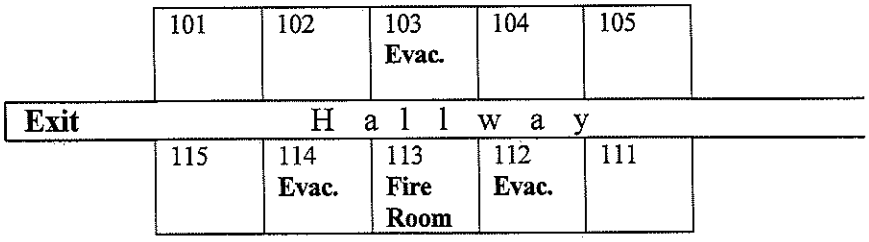

7. Remaining rooms – residents may stay in rooms with doors and windows closed. Evacuate to safe area if danger threatens.

8. Extinguish only if knowledge of proper use and safe to do so.

9. Vacant signs – display on empty rooms.

10. Clear halls of all equipment and residents.

11. Assign a staff member to monitor stairwell doors until magnetic doors locks are reset.

12. Electrical equipment – turn off all fans, radios, computers, televisions, etc. – leave the lights on.

13. Account for all staff, visitors and residents using a current resident list.

14. Keep residents calm.

15. Be prepared to evacuate:
    - Resident list
    - MARS and TARS, where applicable. If using E-Mar, information will be available on the internet.

16. After the all clear has sounded, open the doors and resume normal activities.

17. The person in charge completes the Unit Fire Drill Report and submits to the Nurse Manager or IC.

B. <u>IF THE FIRE IS NOT IN YOUR AREA:</u>

On hearing the alarm:

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-20
SUBJECT: ROLE OF UNIT SUPERVISOR(S)	**PAGE:** 3 OF 3
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

1. Listen for fire location over voice communication system.

2. Return to your area using the opposite stairs.

3. Follow direction of the person in charge of the unit or take charge of the floor and provide specific directions to staff.

4. Close all doors and windows – residents may stay in their rooms.

5. Vacant signs – display on empty rooms.

6. Clear halls of all equipment and residents.

7. Electrical Equipment – turn off all fans, televisions, computers, radios, etc. Leave lights on.

8. Account for all residents, staff and visitors using a current resident list.

9. Keep residents calm.

10. One staff member to monitor the Zone 2 and one staff member to monitor Zone 3 to ensure residents stay in rooms and no signs of fire are evident.

11. Be prepared to evacuate:
    - Resident list
    - MARS and TARS, where applicable. If using E-Mar, information will be available on the internet.

C. <u>ALL AREAS IN THE HOME:</u>

1. After the all clear has sounded, open the doors and resume normal activities.

2. The person in charge in each area completes the Unit Fire Drill Report and submits it to Nurse Manager or IC.

<u>OUTCOME:</u>

1. All Unit Supervisors respond appropriately to Code Red and lead staff, residents and visitors to safety.

<u>ADDITIONAL REFERENCES:</u>

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-25
SUBJECT:	ROLE OF PERSONAL SUPPORT WORKER	**PAGE:** 1 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** JULY 26, 2022

STANDARD:

1. The Personal Support Worker will:
   a) Demonstrate in-depth knowledge of his/her role during a Code Red.

   b) Attend mandatory fire safety education and fire drills at a minimum annually to maintain knowledge of current practices.

PROCEDURE:

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat

A. IF THE FIRE IS IN YOUR AREA:

Begin and continue calling out "CODE RED" while you **REACT**.

Please remember the first responsibility is the safety of the residents.

B. IF THE FIRE IS NOT IN YOUR AREA:

On hearing the alarm:

1. Listen for fire location over the voice communication system.
2. Return to your area,.
3. The PSW on Nights Fire Assignment must report to the fire location.
4. Close all doors and windows – resident may stay in rooms.
5. Vacant Signs – display only on empty rooms.
6. Clear halls of all equipment and residents.
7. Electrical equipment – turn off all fans, televisions, computer, radios.
8. Account for all residents on the floor using master list including visitors and staff.

9. Keep resident(s) calm.

10. One Personal Support Worker to monitor ZONE 2 and ZONE 3 for signs of fire.

11. Await further direction from Unit Supervisor.

C. **"SHOULD** the Supervisor be away from the floor when a fire is discovered or the alarm sounds, PSW discovering Fire assumes the role of Supervisor, takes charge and assigns duties until relieved by Supervisor, management or the Fire Department."

These duties are:

Take charge and delegate staff to do the following.

1. Reflective vest donned by person in charge of unit, only on the fire floor.

2. Pull the fire alarm and call down to reception with the exact location of the fire using the red fire phone only on days and evenings shift.

3. Evacuate all residents from immediate fire area to safe area.

4. Contain the fire - after fire area is evacuated, close doors and windows. Place a towel or blanket at the base of the door to prevent smoke from escaping the effected room.

5. Evacuate residents in rooms across the halls and on either side of immediate fire area to a safe area. Example:

	115	114	113 **Evac.**	112	111
Exit			H a l l w a y		
	101	102 **Evac.**	103 **Fire Room**	104 **Evac.**	105

6. Remaining rooms – residents may stay in rooms with doors and windows closed. Evacuate to safe area if danger threatens.

7. Extinguish - only if knowledge of proper use and safe to do so.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-25
SUBJECT:	ROLE OF PERSONAL SUPPORT WORKER	**PAGE:** 3 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** JULY 26, 2022

8. Vacant Signs - display only on empty rooms.

9. Clear halls of all equipment and residents.

10. Be prepared to evacuate.

OUTCOME:

1. All Personal Support Workers will respond to Code Red and follow REACT.

ADDITIONAL REFERENCES:

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EMP C-10-30
SUBJECT:	ROLE OF FOOD SERVICES MANAGER	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Food Services Manager will:
   a) Demonstrate in-depth understanding of his/her role during a code red.
   b) Attend mandatory fire safety education at a minimum annually to enhance comprehension of practices in the facility.

PROCEDURE:

NOTE: **If at any time during the fire you determine resident/staff safety is at risk you Initiate code green or code green stat.**

A. IF THE FIRE IS IN YOUR AREA:

1. Upon hearing Code Red, return to the kitchen and take charge
2. Ensure that staff are using REACT.
3. Ensure that residents are moved to safety.

B. IF FIRE IS NOT IN YOUR AREA:

1. Upon return to the kitchen:
   a) Ensure equipment is in off position, windows and doors closed.
   b) Assign staff to monitor residents in the area.
   c) Direct dietary aide(s) to fire scene.
   d) Follow directions as given by person in charge.
2. Following total evacuation the Food Services Manager will:
   a) Ensure that he/she arrange for the provision of hot beverages and snacks to residents, staff, volunteers, fire fighters, police and ambulance personnel.
   b) Assign staff to assist with evacuation.

OUTCOME:

1. There is evidence of applied knowledge through practice in a fire situation.

ADDITIONAL REFERENCES:

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EMP C-10-35
SUBJECT:	ROLE OF DIETARY STAFF	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY: Parsons		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure that there is a process and plan for the safety of all residents in the event of fire.

2. Residents will be removed from emergency, safety, calmly and efficiently to a designated relocation area.

3. All dietary staff is responsible and accountable for understanding and demonstrating ongoing competence in all relevant aspects of safety in the event of fire.

PROCEDURE:

1. **On discovering a fire/smoke**:

   REACT

2. **On hearing the alarm:**
   a) Listen for fire location over the voice communication system.
   b) Return to your area, using the stairs.
   c) Follow direction of the person in charge.

3. **If the fire is in your area:**
   a) Pull the fire alarm.
   b) Turn off all electrical equipment
   c) Turn off all gas
   d) Ensure passage ways are clear
   e) Shut all fire doors in kitchen
   f) Remove all residents from danger.
   g) Attempt to extinguish fire – use only BC rated portable extinguisher on grease fire.

   For the dietary exhaust hood extinguishing system:
   a) Remove pin in head of extinguisher.
   b) Rotate red lever clockwise.

NOTE: **If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.**

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EMP C-10-35
SUBJECT:	ROLE OF DIETARY STAFF	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

4. **If the fire is not in your area:**
   a) Turn off all electrical equipment including fans.
   b) Turn off all gas.
   c) Ensure all passageways are clear.
   d) Shut all fire doors to kitchen.
   e) Assign dietary person to go directly to fire scene and report to person in charge for further instructions.
   f) Assign dietary person to call both elevators to main floor and put them in-service.

   * Since members may vary due to meal/non-meal times, the decision will be based on:

   a) Number of residents in main dining room at the time.
   b) Anticipation of visitors and further residents arriving in the dining area.
   c) Possibility of need to evacuate residents from main dining room.

   - Remaining staff to report to command post.

OUTCOME:

1. Dietary staff to follow established protocols in response to code red.

ADDITIONAL REFERENCES:

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-40
SUBJECT:	ROLE OF ENVIRONMENTAL SERVICES MANAGER	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Environmental Services Manager will:
   a) Have good understanding and knowledge of fire code, fire equipment, fire alarm system and fire safety protocols.
   b) Demonstrate in-depth knowledge of his/her role during a code red.
   c) Attend mandatory fire safety education and fire drills a minimum annually to maintain knowledge of current practices.

PROCEDURE:

A. ON DISCOVERING A FIRE/SMOKE:

Follow **R E A C T**

NOTE: **If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.**

B. IF FIRE IS NOT IN YOUR AREA:

1. Report to fire scene with extinguisher.
2. Follow directions from person in charge.
3. Check exhaust system to ensure it has been shut-off when alarm activated.
4. After the all clear – assist with resetting the alarm.
   a) Check fire panel to make sure it is functioning.
   b) Check exhaust / ventilation system to make sure they are functioning.
   c) Check Mag Lock system to ensure it has been re-set.
5. Follow-up on recommendations contained in the fire drill report.

OUTCOME:

1. The Environmental Services Manager demonstrates applied knowledge through practice in a fire situation.
2. Demonstrates knowledge of fire safety equipment.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-40
SUBJECT:	ROLE OF ENVIRONMENTAL SERVICES MANAGER	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

3. Documentation of all fire safety logs as per fire code.

ADDITIONAL REFERENCES:

1. Fire Code

2. Home's policies and procedures

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-45
SUBJECT: ROLE OF HOUSEKEEPING STAFF	**PAGE:** 1 OF 1
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. Housekeepers will:
   a) Demonstrate in-depth knowledge of his/her role during a code red.
   b) Attend mandatory fire safety education and fire drills a minimum annually to maintain knowledge of current practices.

PROCEDURE:

A. ON DISCOVERING A FIRE/SMOKE:

Follow **R E A C T**

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

B. IF THE FIRE IS IN YOUR AREA:

1. Remove housekeeping cart and place in janitor closet/safe area.

2. Report to the person in-charge for further instructions.

C. IF THE FIRE IS NOT IN YOUR AREA:

1. Remove your housekeeping cart and any other housekeeping equipment from the hallways.

2. Report to the Unit Supervisor for further instructions.

OUTCOME:

1. Housekeeper(s) demonstrates applied knowledge through practice in a fire situation.

2. Staff readiness for fire emergency.

ADDITIONAL REFERENCES:

1. Fire Code.

2. Home's policies and procedures.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-50
SUBJECT:	ROLE OF LAUNDRY STAFF	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Laundry Aide will:
   a) Demonstrate in-depth knowledge of his/her role during a code red.

   b) Attend mandatory fire safety education and fire drills a minimum annually to maintain knowledge of current practices.

PROCEDURE:

A. ON DISCOVERING A FIRE/SMOKE:

Follow **R E A C T**

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

B. IF THE FIRE IS IN YOUR AREA:

1. Turn off all equipment and fans.
2. Close all doors in your area, including laundry chute doors.
3. Evacuate – remove yourself and all other persons from the fire area, close doors as you exit.
4. Activate the alarm using the nearest pull station.
5. Use the nearest fire phone to inform reception of the exact location.
6. Extinguish – only if you know proper procedure and it is safe to do so.

C. IF THE FIRE IS NOT IN YOUR AREA:

1. Listen for location of fire over voice communication system.
2. Return to your area using the stairs.
3. Turn off all equipment and fans.
4. Close all doors.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-50
SUBJECT:	ROLE OF LAUNDRY STAFF	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

5. Report to command post.

OUTCOME:

1. Laundry aide demonstrates applied knowledge through practice in a fire situation.

ADDITIONAL REFERENCES:

1. Fire Code
2. Home's policies and procedures

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-55
SUBJECT: ROLE OF MAINTENANCE STAFF	**PAGE:** 1 OF 2
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Maintenance staff will:
   a) Demonstrate in-depth knowledge of his/her role during a code red.
   b) Attend mandatory fire safety education and fire drills a minimum annually to maintain knowledge of current practices.

PROCEDURE:

A. ON DISCOVERING A FIRE/SMOKE:

Follow **R E A C T**

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

B. IF THE FIRE IS IN YOUR AREA:

1. Remove yourself and fire logbook from the fire area, close doors as you exit.
2. Activate the alarm using the nearest pull station.
3. Inform reception with the exact location of fire using the nearest fire phone.
4. Follow instructions from the person in charge of the fire.

C. IF THE FIRE IS NOT IN YOUR AREA:

1. Ensure driveways, entranceways are free of obstacles.
2. Proceed to the fire area and follow direction of person in-charge.

D. SPECIFIC RESPONSIBILITIES

1. After the FIRE/DRILL assist the Nurse Manager/In-Charge Nurse in resetting the fire alarm system and mag lock system.
2. Monitor fire route for easy access for emergency vehicles.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:**	EPM C-10-55
SUBJECT:	ROLE OF MAINTENANCE STAFF	**PAGE:**	2 OF 2
		ORIGINAL DATE:	June 1, 2000
APPROVED BY:		**REVIEWED DATE:**	July 26, 2022

OUTCOME:

1. Maintenance staff demonstrates applied knowledge through practice in a fire situation.

ADDITIONAL REFERENCES:

1. Fire Code
2. Home's policies and procedures.

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-55
SUBJECT: ROLE OF MAINTENANCE STAFF	**PAGE:** 1 OF 2
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Maintenance staff will:
   a) Demonstrate in-depth knowledge of his/her role during a code red.
   b) Attend mandatory fire safety education and fire drills a minimum annually to maintain knowledge of current practices.

PROCEDURE:

A. ON DISCOVERING A FIRE/SMOKE:

Follow **R E A C T**

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

B. IF THE FIRE IS IN YOUR AREA:

1. Remove yourself and fire logbook from the fire area, close doors as you exit.
2. Activate the alarm using the nearest pull station.
3. Inform reception with the exact location of fire using the nearest fire phone.
4. Follow instructions from the person in charge of the fire.

C. IF THE FIRE IS NOT IN YOUR AREA:

1. Ensure driveways, entranceways are free of obstacles.
2. Proceed to the fire area and follow direction of person in-charge.

D. SPECIFIC RESPONSIBILITIES

1. After the FIRE/DRILL assist the Nurse Manager/In-Charge Nurse in resetting the fire alarm system and mag lock system.
2. Monitor fire route for easy access for emergency vehicles.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-55
SUBJECT:	ROLE OF MAINTENANCE STAFF	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. Maintenance staff demonstrates applied knowledge through practice in a fire situation.

ADDITIONAL REFERENCES:

1. Fire Code
2. Home's policies and procedures.

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-60
SUBJECT: ROLE OF RECEPTION	**PAGE:** 1 OF 4
	ORIGINAL DATE: January 19, 2001
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure that there is a process and plan for the safety of all residents in the event of fire.

2. Residents will be removed from emergency, safely, calmly and efficiently to a designated relocation area.

3. All reception staff is responsible and accountable for understanding and demonstrating ongoing competence in all relevant aspects of safety in the event of a fire.

4. Reception staff will attend mandatory fire safety education and fire drills a minimum annually to maintain knowledge of current practices.

PROCEDURE:

NOTE: **On Evenings and Nights when there is no Receptionist these responsibilities are carried out by the Nurse Manager or In Charge.**

A. **ON DISCOVERING THE FIRE/SMOKE:**

Follow **R E A C T.**

B. **ON HEARING THE ALARM:**

1. Return to your area using the stairs.

2. Check location of fire on alarm panel.

3. Announce over voice communication system using Code Red on Zone 3 or Zone 2, three (3) times.

4. Call fire department (call 911). Give address: BROADVIEW NURSING CENTRE, 210 Brockville St If call received from the fire area, relay the information to the Fire Department but do not wait for a call. Notify and confirm the alarm with Monitoring Company. For Fire Drills call the Alarm Monitoring Company **(613) 283-6238 (I.D. # 0773)** and the Smiths Falls Fire Department **(613)283-5869** before the drill.

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-60
SUBJECT: ROLE OF RECEPTION	**PAGE:** 2 OF 4
	ORIGINAL DATE: January 19, 2001
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

5. Repeat step 3. Staff at the fire scene will call Reception with the exact location of the fire and Reception will page the exact location. Listen carefully for this.

6. Direct Fire Department upon their arrival.

7. At the direction of the Administrator or designate initiate the fan out calling system in order to notify key personnel of the emergency/disaster.

8. Be prepared to evacuate "evacuation information binder, face sheet binder, visitor's sign-in binder and wanderers' binder.

9. Upon completion of the drill/fire, notify the fire department and alarm monitoring company to ensure fire alarm is operational.

10. Reset mag locks.

11. Do not allow residents or visitors to go upstairs before "all clear" is announced.

12. Page "Code Red all clear" three (3) times when told to do so by fire department, or Person In-Charge after a drill.

13. Update evacuation information. Refer to G-15-20 for details.

C. **PAGING PROTOCOL:**

When the Fire Alarm panel (EST 3 system) receives a first stage fire alarm the audible will sound at the Alert Rate throughout the building.
When the system receives the first alarm, the paging system switch **will not** operate immediately. There will be a 30 second inhibit period.

1. Open Fire Alarm panel doors.

2. Identify fire zone indicated on Fire Panel. Fire zone will be illuminated.

3. Pick-up paging microphone, press and hold the tab button located on the side of the microphone.

4. Press the button marked **ALL CALL.** A light will illuminate.

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-60
SUBJECT: ROLE OF RECEPTION	**PAGE:** 3 OF 4
	ORIGINAL DATE: January 19, 2001
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

5. **PAGE EXACT LOCATION: CODE RED (fire site exact location), CODE RED (fire site exact location),**

   CODE RED (fire site exact location)

   Example: Code Red Zone 2 , Room 127

6. Open lobby doors for Fire Department.

7. Remain at Fire Alarm panel and direct Fire Department to fire site.

8. Supervise residents in lobby, keep area clear for Fire Department and keep visitor out of the building.

9. Page "**CODE RED ALL CLEAR**" three (3) times when instructed by the Fire Department.

OUTCOME:

1. Reception staff follow established protocols in response to Code Red.

ADDITIONAL REFERENCES:

1. Fire Code.

2. Home's policies and procedure.

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-65
SUBJECT: ROLE OF PROGRAMS MANAGER	**PAGE:** 1 OF 2
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Programs Manager will:
   a) Demonstrate in-depth understanding of his/her role during a code red.
   b) Attend mandatory fire safety education at a minimum annually to enhance comprehension of practices in the facility.

PROCEDURE:

A. IF THE FIRE IS IN YOUR AREA:

1. Upon hearing Code Red, return to the programs department and take charge.
2. Ensure that staff are using REACT.
3. Ensure that residents are moved to safety.

NOTE: **If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.**

B. IF FIRE IS NOT IN YOUR AREA:

1. Upon hearing Code Red, go directly to fire scene.
2. Follow directions as given by Unit Supervisor (or Director of Care) in charge of fire.
3. Ensure that staff are using REACT.
4. Ensure that residents are moved to safety.
5. Rooms are evacuated as per Code Red procedures. Evacuation signs used to identify vacant rooms have been utilized.
6. Fire Department to determine if further evacuation measures are to commence.
7. Follow Code Green and Code Green Stat when evacuating residents from fire scene and other units.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-65
SUBJECT:	ROLE OF PROGRAMS MANAGER	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

8. Following total evacuation the Programs Manager will:
   a) Ensure the suspension of all regular work schedules in a disaster situation.
   b) Rework the schedule to reflect the changed needs/location of residents.

   NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

OUTCOME:

1. There is evidence of applied knowledge through practice in a fire situation.

ADDITIONAL REFERENCES:

1. Fire Code.

2. Home's policy and procedures.

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EMP C-10-70
SUBJECT: ROLE OF PROGRAMS STAFF	**PAGE:** 1 OF 2
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD

1. To ensure there is a process and plan for the role of program staff in emergency fire procedures.

2. Programs employees are responsible and accountable for understanding and demonstrating ongoing competence in all aspects of programs emergency fire procedures.

3. The safety of the residents is always the first responsibility.

PROCEDURE:

1. On discovering fire and or smoke:

   Follow **REACT.**

2. If fire is in your area take charge:
   a) Evacuate all residents from the programs location to a safe area
   b) Close the doors
   c) Notify reception of the fire location
   d) Account for all residents in the program you are running
   e) Clear the halls of all equipment
   f) Turn off all electrical equipment
   g) Provide reassurance to residents as needed
   h) Attempt extinguishing if it is safe to do so

3. If fire is not in your area and you are in the programs room:
   a) Close all doors and windows
   b) Clear halls of equipment
   c) Turn off all electrical equipment
   d) Be prepared to evacuate
   e) After the all clear has sounded resume normal activities

   NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

4. If not in a program, upon hearing alarm, listen for fire location announcement and use opposite stairs.

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EMP C-10-70
SUBJECT:	ROLE OF PROGRAMS STAFF	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

5. Immediately report to your unit and follow the instructions of the person in charge.

6. Person in charge to complete the fire drill checklist and submit it to the Nurse Manager or In Charge.

OUTCOME:

1. All programs staff to follow appropriate emergency fire procedures.

ADDITIONAL REFERENCES:

SECTION:	ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-80
SUBJECT:	ROLE OF VOLUNTEERS	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure that there is a process and plan for volunteer emergency fire procedures.

2. All volunteers are responsible for understanding and demonstrating ongoing competence in all relevant aspects of emergency fire procedures.

PROCEDURE:

1. On discovering fire or smoke **REACT**.

2. On hearing the alarm:
   a) Listen for announcement of the fire location
   b) If not in a program with the residents report to the front lobby via accessible stairwells, for further instructions.
   c) If in a program with residents reassure residents as needed, help staff in charge upon their direction – if prefer not to help move to the lobby via accessible stairwells

   NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

OUTCOME:

1. All volunteers are safe and help residents in accordance with their personal comfort zone.

ADDITIONAL REFERENCES

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-85
SUBJECT: ROLE OF OFFICE STAFF	**PAGE:** 1 OF 2
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. Administrative/Nursing Assistant and bookkeeper will respond according to REACT procedures in the event of a fire/fire alarm.

PROCEDURES:

A. ON DISCOVERING A FIRE/SMOKE:

1. R E A C T

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green or code green stat.

B. ON HEARING THE ALARM:

1. Listen for the fire location over the voice communication system.
2. Return to your area

C. IF THE FIRE IS NOT IN YOUR AREA:

1. Report to, command centre in lobby (Office staff may be re-directed by facility fire marshal to other locations within the facility as needed)
2. Ensure residents are escorted to the Residents' Lounge.
3. Ensure lobby is cleared.
    a) **Prepare to move records to safety.**

OUTCOMES:

1. Results of fire drills/false alarms/fire reports indicate that office staff respond appropriately to Code Red.
2. There is evidence that fire Drills are held in the office area a minimum of once a year.

SECTION: ROLES & RESPONSIBILITIES	**INDEX I.D.:** EPM C-10-85
SUBJECT: ROLE OF OFFICE STAFF	**PAGE:** 2 OF 2
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

3. There is evidence that orientation of new office staff includes REACT and above procedure.

ADDITIONAL REFERENCES:

SECTION:	CODE BLUE	**INDEX I.D.:** EPM D-05
SUBJECT:	CODE BLUE – GENERAL	**PAGE:** 1 OF 4
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. Code Blue will be used to:
   a) Alert individuals in the facility of a medical emergency and to provide a systematic approach of responding to it.
   b) A medical emergency is defined as a cardiac and/or respiratory arrest, choking, convulsive seizure, acute chest pain, respiratory distress, syncope and/or any other situation where clinical assistance is needed.
   c) When a Code Blue is called the following emergency plan for a Code Blue is activated.

PROCEDURE:

1. Upon discovering the emergency:
   a) Pull the nearest call bell and alert nearby staff by shouting **Code Blue**,
   b) Stay with the person,
   c) If no response to the call bell of the call for help, go to nearest phone and page **"CODE BLUE"**, floor number and location, then return to the resident and begin assessment and/or resuscitation

2. Upon hearing the page for **"CODE BLUE"**:
   a) Unit Supervisors are to respond to a Code Blue
   b) The Nurse Manager/In-Charge Nurse on duty will go immediately to the code area and direct it until ambulance personnel arrive, followed by the Director of Care and the Clinical Practice Coordinator.

3. The Nurse Manager/Unit Supervisor on duty will direct the code and ensure appropriate resuscitation endeavors or direct
   a) 911 to be called.
   b) A PSW will be assigned to put elevator on service and wait for ambulance on main floor (after reception hours).

4. Unit supervisor on floor where code is will:
   a) Complete transfer form and give complete report to ambulance attendants prior to transfer to hospital.
   b) Notify the substitute decision-maker.
   c) Inform physician of transfer. If transfer occurs after office hours, notify the on-call physician and leave a note to ensure the attending physician is notified the following day by the day Unit Supervisor.

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SUBJECT:	CODE BLUE – GENERAL	**PAGE:** 2 OF 4
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d) The Nurse Manager/In-Charge Nurse or Clinical Practice Coordinator will ensure that all emergency equipment is replenished/cleaned following the emergency (i.e. oxygen tanks, suction machines).

If the medical emergency is an event of chocking, follow the protocol below:

CHOCKING EVENT

STANDARD:
All PSWs and Registered Staff will respond immediately and appropriately to incidents of choking, including the management of residents following a choking episode.

DEFINITION:
Foreign-body airway obstruction (choking)
Foreign-body obstruction of the airway may be either partial or complete. Abdominal thrusts (the Heimlich maneuver) are recommended for relieving foreign-body airway obstruction in the conscious adult.

CLINICAL SIGNS:
Weak, ineffective cough, high pitched noises on inspiration; respiratory distress; inability to speak or breath; cyanosis; hand at the throat (universal choking sign).

PROCEDURE:

Should a choking event occur, Personal Support Worker (PSW) shall:

1. Initiate steps to clear the airway of obstruction of a conscious resident by encouraging the resident to cough.

2. The Personal Support Worker must immediately call for assistance by notifying the Registered staff supervising the mealtime.

Registered Staff shall:

1. Assess the resident and airway, and determine if the resident can speak, cough, or expel air.

2. Registered Staff/Designate must CALL CODE BLUE

3. Determine if the resident is experiencing partial or complete obstruction.

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4. If the resident is experiencing complete obstruction call 911

Partial Obstruction

1. Encourage the resident to cough to clear the obstruction

2. Closely monitor the resident's ability to produce an effective cough

3. Ensure that the resident has relieved the obstruction

Complete Obstruction

A. Conscious Resident:

1. Clear the vicinity of where the event is occurring of all other residents and any other hazards or obstacles.

2. Follow first aid care and perform abdominal thrusts and delegate available staff to CALL CODE BLUE.

3. Stand behind the resident; wrap your arms around the resident's waist, and proceed as follows:
   - Make a fist with one hand, placing the thumb side of the fist against the resident's abdomen in the midline, slightly above the navel and well below the xiphoid process. Grasp the fist with your other hand.
   - Press your fist into the resident' abdomen with a quick upward thrust. Each new thrust should be a separate and distinct maneuver.
   - Continue until the obstruction is cleared, help arrives, or the resident becomes unresponsive.

B. Unconscious Resident:

- If not in bed, lower the resident safely to the floor and initiate CODE BLUE if not done previously and follow expected procedures, including determining the appropriate use of CPR.
- Call 911 and notify other responsible parties including the physician and power of attorney.

Note: Every dining room is equipped with a suction machine and can be used based on the registered staff's assessment.

Follow up Care:

1. Inform MD of choking incident

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2. Monitor vitals for 72 hours, including monitoring of temperature, shortness of breath, cough, difficulty swallowing, and pain in the chest and neck.

   NOTE: Performing abdominal thrust and chest compressions has the potential to cause serious internal injury, including ruptures or laceration of abdominal or thoracic viscera, so resident must be examined for injuries.

3. Send referral to dietician, and review with MD whether SLP assessment is required

4. Review and revise the resident's plan of care where necessary.

OUTCOME:

1. Designated person(s) respond to code blue with assigned equipment.

2. Code blue is carried out consistent with policies and procedures.

3. Resident will receive immediate and appropriate care when experiencing partial or complete airway obstruction.

ADDITIONAL REFERENCES:

1. Home's Policies and Procedures

2. CNO Standards of Practice

3. CPR Standards of Practice

SECTION:	CODE WHITE	**INDEX I.D.:** EPM E-05
SUBJECT:	CODE WHITE - GENERAL	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. Emergency Code White will be used to attain immediate assistance in a situation related to violent/outbursts/behaviours.

2. The following emergency plan will be activated when faced with violent/outbursts/behaviours

PROCEDURE:

1. Call out "Code White". Unit staff to respond immediately to area of concern.

2. Remove Residents/Visitors from immediate area.

3. Announce "Code White", floor number and location, e.g. "Room 104".

4. Return to resident, ensure environment is safe. Using principles noted in the Responsive Behaviour Philosophy Program Responsive Behavioural to attempt to diffuse the situation.

5. Nurse Managers and Behaviour Support Manager must always respond to Code White.

6. Once situation is assessed then:
   a) If able to diffuse violent behaviours, stay with resident, provide reassurance and assess contributing factors. Document on MDPN's interventions and outcomes.

   b) If unable to diffuse violent behaviours notify physician to determine need for a form 1 and call 911 for emergency response. Notify substitute decision maker, family, Director of Care/Executive Director. Complete CIS report and document strategies on MDPN's.

OUTCOME:

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1. Code White is used every time when immediate response is needed to manage violent/aggressive behaviors.

ADDITIONAL REFERENCES:

1. LTCHA and Regulation 79/10 – Responsive Behaviours (section 53 in the Regulation) and altercations and other interactions between residents (section 54 and 5.55 in the regulation).

2. Responsive Behaviour Philosophy Program

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SUBJECT:	CODE YELLOW - GENERAL	**PAGE:** 1 OF 18
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STANDARD:

1. Code yellow will be used:

   a) upon discovering a resident is missing after all possibilities of the whereabouts (i.e. out with family member or in the smoking area) of the missing resident have been ruled out

   b) To systematically search for a missing resident.

2. The following emergency plan will be activated each time a resident is discovered missing.

3. The search grid checklist will be initiated upon discovery of a missing resident.

PROCEDURE:

1. The Unit Supervisor/delegate, after ruling out all possibilities of the whereabouts of the missing resident, will page **"Code Yellow, (name of the missing resident, room number (#)" e.g. "Code Yellow, Mrs. Smith, Room 113"**.

2. All unit staff on each Resident Home Area (RHA) will conduct a search of the unit in an organized fashion:
   a) In each room, on/under beds;
   b) In each bathroom;
   c) Utility rooms;
   d) Linen Closets;
   e) Stairwells;
   f) Elevators

3. When conducting a search of a floor the search grid checklist must be completed and signed by the staff members completing the search.

4. Assigned unit staff members will start the search at each end of the unit and search toward the middle of the hallway then continue to the opposite end ensuring that each room has been searched twice. Stairwells will then be searched.

5. All other staff will receive direction from the Nurse Manager/Unit Supervisor or Designate on what their role will be during the code yellow procedure.

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6. The Nurse Manager will delegate one person to search the outdoor perimeter of the Home and one staff member from a unit or management team member to search the main floor and basement in co-ordination with the Nurse Manager\delegate. The Nurse Manager or designate will assign someone to conduct an elevator search. When conducting an elevator search:

   The elevators are to be brought down to the main floor and put on service with the doors open.

7. The Nurse Manager or designate will assign staff to conduct the main floor. The main floor search will be conducted in the following manner:

   a) Starting in the lobby, the staff will search all offices and rooms in a systematic fashion. The staff will unlock all offices etc. and relock the doors once the search is completed. Once the search is completed all doors on the main floor will be locked.

   b) The staff members will search the bathrooms and relock the doors once the search is completed, and

   c) The staff members will search all the other areas on the main floor.

8. **Each Unit Supervisor will call the Nurse Manager to indicate:**

   a) Search Completed;
   b) Resident found/not found.

9. If resident not found, staff on each floor will alternate sides of unit and search again.

10. **Each Unit Supervisor will call the Nurse Manager to indicate**

    a) Second search Completed.
    b) Resident found/not found

11. **All search grid checklists are returned to the Director of Care or Nurse Manager as soon as the search of the area(s) is completed.**

12. If the resident is not found the Nurse Manager/ delegate will notify the substitute decision maker, Police Department, Ministry of Health (by completing and submitting a critical incident through the Critical Incident System (CIS) or calling after hour number), physician, Director of Care and the Executive Director.

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13. The Unit Supervisor completes the Risk Incident in PCC. Follow up and additional actions are documented in the electronic progress notes. The Nurse Manager/delegate can access the resident's picture in PCC including other relevant clinical information.

14. When the resident is not found within twenty-four (24) hours, the Executive Director shall determine the appropriate course of action to be taken. (i.e.: arrange for press release, involve public assistance.)

15. **When the resident is found, the Nurse Manager/delegate will notify:**

    a) Police,
    b) Ministry of Health Long Term Care,
    c) Substitute Decision Maker,
    d) Executive Director,
    e) Director of Care,
    f) Physician, and
    g) All units and departments.

16. The Resident's condition will be assessed by registered staff and documented with follow-up as required. The plan of care is updated to ensure it reflects the resident's current condition and any interventions to ensure residents safety.

OUTCOME:

1. There is evidence that code yellow procedure is utilized when a resident is confirmed as missing.

2. Search is conducted in accordance with policy and procedure.

ADDITIONAL REFERENCES:

1. Resident Care and Services Manual, Critical Incident Policy, Policy ID E-45.

2. Home's policy and procedure

3. The LTCHA 2007 and Regulation 79/10

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CODE YELLOW REPORT

Date: _____

Name of Missing Resident: _____

Missing Resident Room Number: _____

Initiation time of Code Yellow: _____

Name of person initiating Code Yellow: _____

Time Resident Found: _____

Location of Where Resident was Found: _____

1. Was Code Yellow announced three times over PA System? □ Yes □ No
2. Did the Unit Supervisor report missing resident to the nurse manager/delegate? □ Yes □ No
3. Did the Unit Supervisor assign staff to conduct search? □ Yes □ No
4. Did the Nurse Manager/delegate conduct a search of the main floor □Yes □No
5. Did the Nurse Manager/delegate assign a staff to conduct a search of the outdoor perimeter? □ Yes □ No
6. Were all the search grid checklists handed in to the Nurse Manager/delegate? □ Yes □ No
7. Areas where the search grid ckeclists lists indicate that they were not checked, were rechecked following the search procedure outlined in this policy? □ Yes □ No
8. Debriefing conducted with staff? □ Yes □ No

Signature of Person Completing Report: _____

Signature of Director of Care/Delegate: _____

MAIN FLOOR SEARCH GRID

Date: _____ **Time:** _____

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1st Search (Staff Initials)	2nd Search (Staff Initials)	Area Searched
		South Stairwell
		Dining Room
		Kitchen
		Food Services Manager Office
		Dry Storage Area
		Dairy Fridge
		Meat Fridge
		Vegetable Freezer
		Meat Freezer
		Milk Fridge
		Receiving Area
		Meat Dish Storage Room
		Kitchen storage room and Dairy Fridge
		Main Floor Lobby Area
		Bistro
		Reception Area
		Nursing Administrative Assistant Office
		Nurse Manager Office
		Director of Care Office
		Social Worker Office
		RAI Coordinator Office
		Executive Director Office
		Resident Washroom
		Bookkeeper's Office
		Spare Office
		Boardroom
		Staff Washroom
		Kitchenette area
		North Stairwell

Reviewed by Director of Care/delegate:_____ **Date:** _____

OUTDOOR PERMITER SEARCH GRID

Date: _____ **Time:** _____

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1st Search (Staff Initials)	2nd Search (Staff Initials)	Area Searched
		Parking Lot
		Smoking Area
		Garden Area
		Shed #1
		Shed #2

Reviewed by Director of Care/delegate:_____ **Date:** _____

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UNIT 2 SEARCH GRID

Date: _____ **Time:** _____

When searching resident rooms ensure that all closet doors are opened and checked inside as well as all resident washrooms.

1st Search (Staff Initials)	2nd Search (Staff Initials)	Area Searched
		SOUTH SIDE
		101
		102
		103
		104
		Shower Room
		Supply Closet
		105
		106
		107
		108
		109
		110
		Dirty Utility Room
		NORTH SIDE
		111
		112
		113
		Medication room
		Resident Lounge
		114
		115
		116
		117
		118
		119
		120
		121
		Tub Roomx2
		122

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		123
		124
		125
		126
		127
		128
		129

Reviewed by Director of Care/delegate:_____ **Date:** _____

SECTION:	CODE GREEN/CODE GREEN STAT	**INDEX I.D.:** EPM G-05
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STANDARD:

1. There is a systematic plan in place to evacuate Residents from immediate danger in the event of an impending emergency disaster.

2. All employees are responsible for understanding the use of code green in the event of a disaster/emergency situation.

3. The emergency plan is initiated when the decision to evacuate residents is made.

PROCEDURE:

1. Code green (horizontal evacuation) - All residents to be horizontally evacuated to a safe area beyond the fire barrier doors on the same floor.

2. Person in charge pages code green, unit and designated area (i.e. code green, north side to south side).

3. Once the emergency plan to evacuate has been initiated the Home must:

   a) Start the Home process as per the emergency plan and procedures
   b) Use the Ministry of Long Term Care Emergency Evacuation Guide to ensure they are following the MoLTC administrative process outlined in the guide (see links below).

   The guide will:
   1. identify the process of transmitting information;
   2. provide materials to complete during the evacuation process;
   3. provide information regarding licences, specifically temporary emergency licences; and
   4. outline the terms and conditions under which the ministry will license eligible beds and reimburse LTC Homes for eligible expenses related to the admission and accommodation of residents during emergency evacuations from existing LTC Homes or the community.

   In addition, the guide will describe:
   - the issuance of Temporary Emergency Licence(s), with applicable licence conditions (more information under licensing below), which typically includes a condition that

the Director may revoke the licence effective on the day that the affected resident(s) are all discharged from the Recipient Home(s);

- information on the provision of applicable funding; and
- the necessary permission under s. 104(3) of the LTCHA (BIA approval) in respect of the temporarily closed beds, and to the associated BIA Agreement to be created, effective until the day when the Source Home/Beds re-opens and the Temporary Emergency Licence is revoked or surrendered.

NOTE: If at any time during the fire you determine resident/staff safety is at risk you initiate code green stat.

OUTCOME:

1. There is evidence that all residents, employees and other occupants are safely evacuated from the disaster area.

2. All Ministry forms have been completed and the Ministry of Long Term Care has been contacted to coordinate temporary emergency placements and potential licences.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-05, Types of Evacuation policy

2. Emergency Plan Manual, Policy ID # B-10-15, Diagrams and Schematics

3. Ministry of Long Term Care – Instructions, Information and Materials – The Guide on the Policy, Process, and Procedures during Emergency Evacuations – Instructions, Information and Materials (English)
https://www.ltchomes.net/LTCHPORTAL/Content/Snippets/Emergency%20Evacuation%20Policy%20(EN).pdf

4. Ministry of Long Term Care – Instructions, Information and Materials – The Guide on the Policy, Process, and Procedures during Emergency Evacuations – Instructions, Information and Materials (French)
https://www.ltchomes.net/LTCHPORTAL/Content/Snippets/Emergency%20Evacuation%20Policy%20(FR).pdf

5. Evacuation Placement Process (English):
https://www.ltchomes.net/LTCHPORTAL/Content/Snippets/Evacuation%20Placement%20Process%20(EN).pdf

SECTION:	CODE GREEN/CODE GREEN STAT	**INDEX I.D.:** EPM G-05
SUBJECT:	CODE GREEN GENERAL	**PAGE:** 3 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVISED DATE:** July 26, 2022

6. Evacuation Placement Process (French):
https://www.ltchomes.net/LTCHPORTAL/Content/Snippets/Evacuation%20Placement%20Process%20(FR).pdf

7. Evacuation Placement Form (English):
https://www.ltchomes.net/LTCHPORTAL/Content/Snippets/Emergency%20Placement%20Form%20(Appendix%20B).docx

8. Evacuation Placement Form (French):
https://www.ltchomes.net/LTCHPORTAL/Content/Snippets/Emergency%20Placement%20Form%20(FR).docx

9. Overview of Temporary Emergency (TE) Licence and Beds In Abeyance (BIAs) (English):
https://www.ltchomes.net/LTCHPORTAL/Content/Snippets/Overview%20of%20Temporary%20Emergency%20(TE)%20Licence%20and%20Beds%20in%20Abeyance%20(BIAs)%20(EN).pdf

10. Overview of Temporary Emergency (TE) Licence and Beds In Abeyance (BIAs) (French):
https://www.ltchomes.net/LTCHPORTAL/Content/Snippets/Overview%20of%20Temporary%20Emergency%20(TE)%20Licence%20and%20Beds%20in%20Abeyance%20(BIAs)%20(FR).pdf

SECTION:	CODE GREEN/CODE GREEN STAT.	**INDEX I.D.:** EPM G-10
SUBJECT:	CODE GREEN STAT GENERAL	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There is a systematic plan in place to evacuate residents from the disaster area vertically to a safe area.

2. All employees are responsible for comprehending the use of the code green stat in the event of a disaster/emergency situation.

PROCEDURE:

1. Code green stat to be used to completely evacuate residents from disaster area in a vertical downward direction and may involve one unit/department or the whole building.

2. Person in charge pages code green stat, unit and designated area (i.e. code green stat floor 2 using north stairwell to main dining room)

3. Follow procedure outlined in EPM G-15-10.

OUTCOME:

1. There is evidence that all residents, staff and other occupants are safely evacuated from the disaster area.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-05, Types of evacuation policy

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-05
SUBJECT:	TYPES OF EVACUATIONS	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure that there is an appropriate plan to evacuate the building that is dependent on various situations / developments.

2. To promote the safe and effective evacuation of residents in the event of an impending emergency/disaster.

3. All employees are responsible and accountable for understanding the types of evacuations and the use of each type in a disaster / emergency situation.

PROCEDURE:

1. There are four types of emergency evacuation procedures that can be initiated in our facilities and they are as follows:

   a) **Code Red** – this includes the evacuation of the room in which the fire originated, and the rooms on either side, and directly across the fire location. This evacuation will be announced over the voice communication system as **"CODE RED",** followed by the exact location of the fire as indicated on the fire panel in the main lobby.

   Extended Evacuations

   b) **Code Green - Horizontal Evacuation** – this includes the complete evacuation of disaster area to a designated safe area **on the same floor.**

   c) **Total Evacuation** – this involves total evacuation of all persons in the facility. **This will be indicated by the sounding of the stage two evacuation alarm** (i.e. a rapid continuous ring). Total evacuation is initiated at the discretion of the Fire Department and/or the Administrator/Delegate or Person in charge.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-05
SUBJECT:	TYPES OF EVACUATIONS	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. There is evidence that all residents and employees are safely evacuated from the building in the event of emergency/disaster.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # A-15, Universal Codes.
2. Emergency Plan Manual, Policy ID # G-15-10 Order of Evacuation

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-10
SUBJECT:	ORDER OF EVACUATION	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure that there is a process in place to ensure orderly, safe and expedited evacuation of residents and staff in the event of an emergency/disaster.

2. All employees are responsible and accountable for understanding and demonstrating ongoing competence in the order of evacuation in the event of a disaster/emergency.

PROCEDURE:

Code Red Evacuation:

1. Code Red is initiated by the person discovering the fire (REACT).

2. Evacuation of fire location and rooms to either side and directly across the fire location.

Code Green Evacuation:

1. Code Green is initiated by the person in charge of the floor upon escalation in the status of the emergency/disaster.

2. This includes complete evacuation of the disaster area (i.e. department/unit) to a designated safe area of the building on the **same floor**.

Total Evacuation:

1. Total evacuation is initiated at the discretion of the Fire Department and/or the Administrator/Delegate in a crisis or impending danger situation (stage 2 alarm).

2. Total evacuation will be conducted in an orderly and timely fashion as announced over the voice communication system by the designated personnel.

3. The order of total evacuation will be determined by location, severity and the extent of disaster/emergency situation and various options/methods of evacuation may be utilized as safe and appropriate.

OUTCOME:

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-10
SUBJECT:	ORDER OF EVACUATION	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
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1. There is evidence all residents are evacuated from disaster/emergency situation.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-05, Types of evacuations.
2. Emergency Plan Manual, Policy ID # A-15, Universal Codes.
3. Emergency Plan Manual, Policy ID # Diagrams and Schematics.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-15
SUBJECT:	EVACUATION LOG	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure that there is a policy and procedure for tracking the relocation sites of residents in an evacuation situation.

2. To maintain a record of family contacts for future reference.

PROCEDURE:

1. Person in charge assigns staff member(s) to complete the evacuation log(s).

2. Process of completing the evacuation log:
   a) Utilize Evacuation Log form provided in disaster bag.
   b) Ensure that all residents are accounted for upon completion of the Evacuation Log(s).
   c) Initiate communication with substitute decision maker noting each successful contact made

3. Person in charge will ensure that:
   a) Evacuation Log is completed
   b) All substitute decision makers have been contacted.

OUTCOME:

1. There is evidence that all residents are accounted for and substitute decision maker notified.

REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-50, Communication with Substitute Decision Maker policy.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-15	
SUBJECT:	EVACUATION LOG	**PAGE:** 2 OF 2	
		ORIGINAL DATE: June 1, 2000	
APPROVED BY:		**REVIEWED DATE:** July 26, 2022	

NAME	RELOCATION SITE	METHOD OF TRANSPORT	TIME	RECORDS SENT		SUBSTISTUTE DECISION MAKER NOTIFIED		COMMENTS
				YES	NO	YES	NO	

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-20
SUBJECT:	EVACUATION INFORMATION BINDER	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To have a policy and procedure in place to ensure the effective and efficient retrieval of emergency information during an evacuation.

2. All employees are responsible and accountable for understanding and completing their respective parts of the Evacuation Information Binder.

PROCEDURE:

1. The Evacuation Information Binder will always be kept at reception and contain the following information:
   a) Staff list
   b) Resident list
   c) Face sheets
   d) Emergency contact list
   e) Nursing complement
   f) Dietary / Environmental Services schedules
   g) Recreation outing lists
   h) Evacuation Log sheets

2. Receptionist / delegate will remove Evacuation Information Binder from the premises in an evacuation situation.

3. Receptionist / delegate will remove Visitor / Volunteer Sign-In Book in an evacuation situation, and wanderer's binder.

4. To ensure that the Evacuation Information Binder is complete and current:
   a) Staff lists will be updated at least quarterly
   b) Resident lists will be updated when there are new admissions
   c) Admission face sheets will be inserted into the Evacuation Information Binder within 24 hours of admission and reviewed for changes at least quarterly
   d) Emergency contact list will be updated as necessary to reflect changes
   e) Dietary / Environmental Services Managers will submit all schedules daily
   f) Programs staff will ensure that reception has accurate and complete outing lists
   g) Reception will ensure that there are sufficient Evacuation Log Sheets in the Evacuation Information Binder to allow for complete tracking of all residents in the facility

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-20
SUBJECT:	EVACUATION INFORMATION BINDER	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. Quality management activities illustrate complete and accurate information is maintained.

REFERENCES:

SECTION: EVACUATION	**INDEX I.D.:** EPM G-15-25
SUBJECT: EMERGENCY IDENTIFICATION - TAGGING OF RESIDENTS	**PAGE:** 1 OF 1
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To promote easy identification of residents during an emergency situation/evacuation.
2. To assist in triage and relocation of residents to designated sites as appropriate.
3. To ensure that all residents are accounted for in the event of a disaster/emergency.
4. To provide relevant medical information to assist in the appropriate placement and ongoing care needs of residents.

PROCEDURE:

1. An alphabetized binder of current Resident Face Sheets located at reception will be utilized to identify residents in the event of a total evacuation.
2. The physical safe evacuation of the residents remains the priority and where it is not possible tagging will be done once residents have been evacuated to the safe designated area.
3. The triage area will be set-up such as to accommodate efficient identification and tagging of residents.

OUTCOME:

1. All residents are accurately identified for appropriate placement.
2. Face sheet binders are kept current as evidenced by the results of regular review of internal processes.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-30, Triage – Assessment of Residents.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-30
SUBJECT:	TRIAGE - ASSESSMENT OF RESIDENTS	**PAGE:** 1 OF 4
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure that there is a process in place to ensure orderly, rapid **assessment** of all residents to determine the need for medical treatment and appropriate placement in the event of an emergency/disaster.

2. To provide a mechanism of rating residents for priority of treatment and transportation in the event of a disaster/emergency.

3. All Registered Nurses / Registered Practical Nurses are responsible and accountable for understanding and demonstrating ongoing competence in the triage procedure and process.

PROCEDURE:

1. The assessment for triage categorization is to be performed by the person(s) assigned in charge of the triage area (usually RN, RPN). The incumbent will don the orange triage vest and orange baseball cap located in the evacuation bag. Two orange pylons identify the triage area.

2. The assessment of each resident/individual should not take more than 30 seconds per person.

3. The assessment includes:
   a) Asking the individual/resident where it hurts in order to determine level of awareness and main complaint.
   b) Observing for any obvious signs of bleeding/trauma
   c) Assessing the ventilatory and circulatory status of the **unconscious residents.**

4. The Triage Nurse/Delegate does not provide treatment **except** in the following conditions/circumstances:
   a) Individual/resident is bleeding profusely and will surely die unless immediate treatment is provided.
   b) The resident's airway is severely compromised.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-30
SUBJECT:	TRIAGE - ASSESSMENT OF RESIDENTS	**PAGE:** 2 OF 4
		ORIGINAL DATE: June 1, 2000
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5. The Nurse/Delegate assigns the resident to the following international categories based on her assessment:

A. First Priority (Red)

a) Immediate medical attention is required
b) The individual is critical and their condition is probably deteriorating
c) Transportation to hospital via ambulance is required.

B. Second Priority (Yellow)

a) Prompt medical attention is required
b) Individual is in serious but stable condition
c) Individual can sustain a wait of approximately 30 minutes to two hours without hospital intervention provided stabilization occurs on-site.

C. Third Priority (Green)

a) Individual transportation to hospital can be delayed.
b) Individual is ambulatory

D. Last Priority (Black)

a) Individual is not alive.

E. Stable Non-Urgent (White)

a) Individual does not require medical interventions awaiting transportation to relocation center.

6. Time permitting, document assessments on the appropriate face sheets tagged to resident.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-30
SUBJECT:	TRIAGE - ASSESSMENT OF RESIDENTS	**PAGE:** 3 OF 4
		ORIGINAL DATE: June 1, 2000
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Contents of Evacuation Bag

- Orange vest (labeled "TRIAGE IN–CHARGE" front and back)
- 2 Flashlights
- 2 treatment kits
- Gloves
- 6 large ABD pads
- 3 rolls adhesive tape
- cue card
- 4 reflective blankets
- 4 Clipboard, **with** supply of evacuation log sheets & pens attached.
- Extra pens

- **LAMINATED CUE CARD- orange – Triage Area:**
  Check - ABC's (airway, breathing, circulation)
  - gross bleeding
  RED – priority #1 - stat
  YELLOW – priority #2 – within 30 minutes
  GREEN – priority #3 - stable
  BLACK – deceased
- **BASEBALL CAPS LABELLED IN-CHARGE** – Orange, Red, Yellow, Green

MARKING EMERGENCY & HOLDING AREAS

Pylons will be kept in designated areas with evacuation bags.

Emergency Area:
2 RED
2 YELLOW
2 GREEN
2 WHITE

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-30
SUBJECT:	TRIAGE - ASSESSMENT OF RESIDENTS	**PAGE:** 4 OF 4
		ORIGINAL DATE: June 1, 2000
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TREATMENT KITS

1. Stethoscope X2
2. Gloves
3. 1 bottle normal saline
4. Pressure dressings
5. Tape
6. Scissors
7. Airways
8. Alcohol wipes
9. Band-aids

OUTCOME:

1. Appropriate assessment for the need for care, treatment and transportation of individual in the event of emergency disaster.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-35, Triage Area Set-Up and Responsibilities.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-35
SUBJECT:	TRIAGE AREA SET-UP AND RESPONSIBILITIES	**PAGE:** 1 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. A nearest safe location to the disaster/emergency is selected as the triage area.

2. The location selected facilitates access of emergency personnel and minimizes the need to carry for any distances.

3. Triage area should be sheltered and provide sufficient light to observe and assess the victims.

4. The triage area should be consolidated to allow for easy identification of **Red** tagged and **Yellow** tagged individuals/residents in need of urgent medical intervention/treatment.

5. The triage area should be set-up to allow for early treatment and intervention of residents/individuals requiring the same.

PROCEDURE:

1. Establish and identify triage area and priority holding areas.

2. Assign at least one staff member to each area. The non-injured may be handled by non-nursing personnel if none is available.

3. Co-ordinate to ensure all necessary supplies and emergency kits are delivered to the triage site(s).

4. The role of the person (s) assigned to each area includes:
   a) Providing emotional support/reassurance to the individuals
   b) Preventing individuals/residents from wandering away
   c) Keeping out all unnecessary personnel/visitors
   d) Keeping individuals away from people receiving treatment
   e) Identifying and logging all individuals
   f) Directing arriving emergency personnel to the most severely injured
   g) Providing emergency care/treatment as necessary
   h) Assisting with transportation of individuals/residents to re-locate to care sites

5. Maintain ongoing communication with command post/person in charge of disaster to await for further directions.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-35
SUBJECT:	TRIAGE AREA SET-UP AND RESPONSIBILITIES	**PAGE:** 2 OF 3
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OUTCOME:

1. Effective triage and ongoing care of individuals/residents in the event of emergency/disaster.

REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-30, Triage - Assessment of Residents policy

** NOTE: see attached Schemata of a suggested triage set-up.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-35
SUBJECT:	TRIAGE AREA SET-UP AND RESPONSIBILITIES	**PAGE:** 3 OF 3
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Insert Schemata of a suggested triage set-up

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-40
SUBJECT:	CONTACTING STAFF	**PAGE:** 1 OF2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. A systematic process will be in place to contact staff quickly in an emergency situation.

2. Each Department Head/Managers will have a designated group of staff to contact in an emergency situation.

PROCEDURE:

1. All Department Heads/Managers are to receive a designated section of the staff phone list to contact in case of an emergency.

2. The Receptionist shall update the Bookkeeper emergency fan-out phone list at a minimum quarterly and redistribute to Department Heads/Managers with each change.

3. The Administrative/Nursing Assistant shall update the nursing fan out list at a minimum quarterly and/or after the Home has hired new staff so that it is as accurate as possible. The list will also be redistributed to Department Heads/Managers with each change.

4. All Department Heads/Managers are to keep their lists in an appropriate place, one at their residence, the other to be carried with them.

5. The emergency fan-out phone list which includes a list of staff who are able to respond in an emergency is posted at Reception in the evacuation binder.

   The list is classified according to response time, ie.
   a) Response Time – Fifteen minutes or less.

   b) Response Time – Fifteen to thirty (15-30) minutes

   c) Response Time – Thirty (30) minutes or less.

   d) Response Time – Thirty to sixty (30-60) minutes.

   e) Response Time - Over sixty (60) minutes.

   In a crisis situation, the Nurse Manager initiates the specific contact procedure.

6. The emergency fan-out phone list must be tested on an annual basis.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-40
SUBJECT:	CONTACTING STAFF	**PAGE:** 2 OF2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. Emergency fan-out phone list is reviewed monthly and updated if necessary.
2. Dept Heads/Managers receive an updated emergency call list at a minimum quarterly.
3. Emergency fan-out phone list is tested on an annual basis.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-45, Specific Contact Procedures policy.
2. Emergency fan-out phone list.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-45
SUBJECT:	SPECIFIC CONTACT PROCEDURE	**PAGE:** 1 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The specific contact procedure is initiated to contact staff in a systematic and prompt manner.

2. All Department Heads/Managers are familiar with their contact responsibilities and respond accordingly during an emergency situation.

PROCEDURE:

IMPORTANT NOTE: **If unable to reach first contact proceed with subsequent call(s) until person to person contact is made.**

1. The Nurse Manager on duty initiates fan-out procedure and contacts the Administrator/delegate.

2. The Administrator contacts
   a. The Director of Care

3. The Director of Nursing contacts the
   a. The Administrative/Nursing Assistant
   b. The Bookkeeper

4. The Administrative/Nursing Assistant:
   a. Contacts those staff residing less than fifteen (15) minutes away from the Home
   b. Contacts those staff residing fifteen (15) to thirty (30) minutes away from the Home
   c. Reports to person in charge of emergency to determine the need for further human resources.
   d. Contacts those staff residing thirty (30) to sixty (60) minutes away from the Home, as required
   e. Contacts those staff residing more than sixty (60) minutes away from the Home, as required

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-45
SUBJECT:	SPECIFIC CONTACT PROCEDURE	**PAGE:** 2 OF 3
		ORIGINAL DATE: June 1, 2000
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5. The Bookkeeper contacts all other key personnel as follows:
   a. Contacts the other Nurse Manager(s)/Associate Nurse Manger and the full-time Receptionist.
   b. Department Heads
      i. Programs Manager/Volunteer Coordinator
      ii. Social Services Coordinator
      iii. Environmental Services Manager & Supervisor
      iv. Food Services Manager & Supervisor
      v. Staff Development Coordinator/Quality Improvement Lead
   c. Medical Director and Attending Physicians
   d. Director of Care of sister Homes
   e. External Resources & Others
      i. Enbridge Gas
      ii. Hydro
      iii. Water
      iv. Dietician
      v. Gordon Food Service

6. The flow diagram (page 3) illustrates the fan-out procedure.

OUTCOME:

1. Fan-out program is activated as soon as an emergency situation occurs.

2. Fan-out program is implemented as per facility procedures.

ADDITIONAL REFERENCES:

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-45
SUBJECT:	SPECIFIC CONTACT PROCEDURE	**PAGE:** 3 OF 3
		ORIGINAL DATE: June 1, 2000
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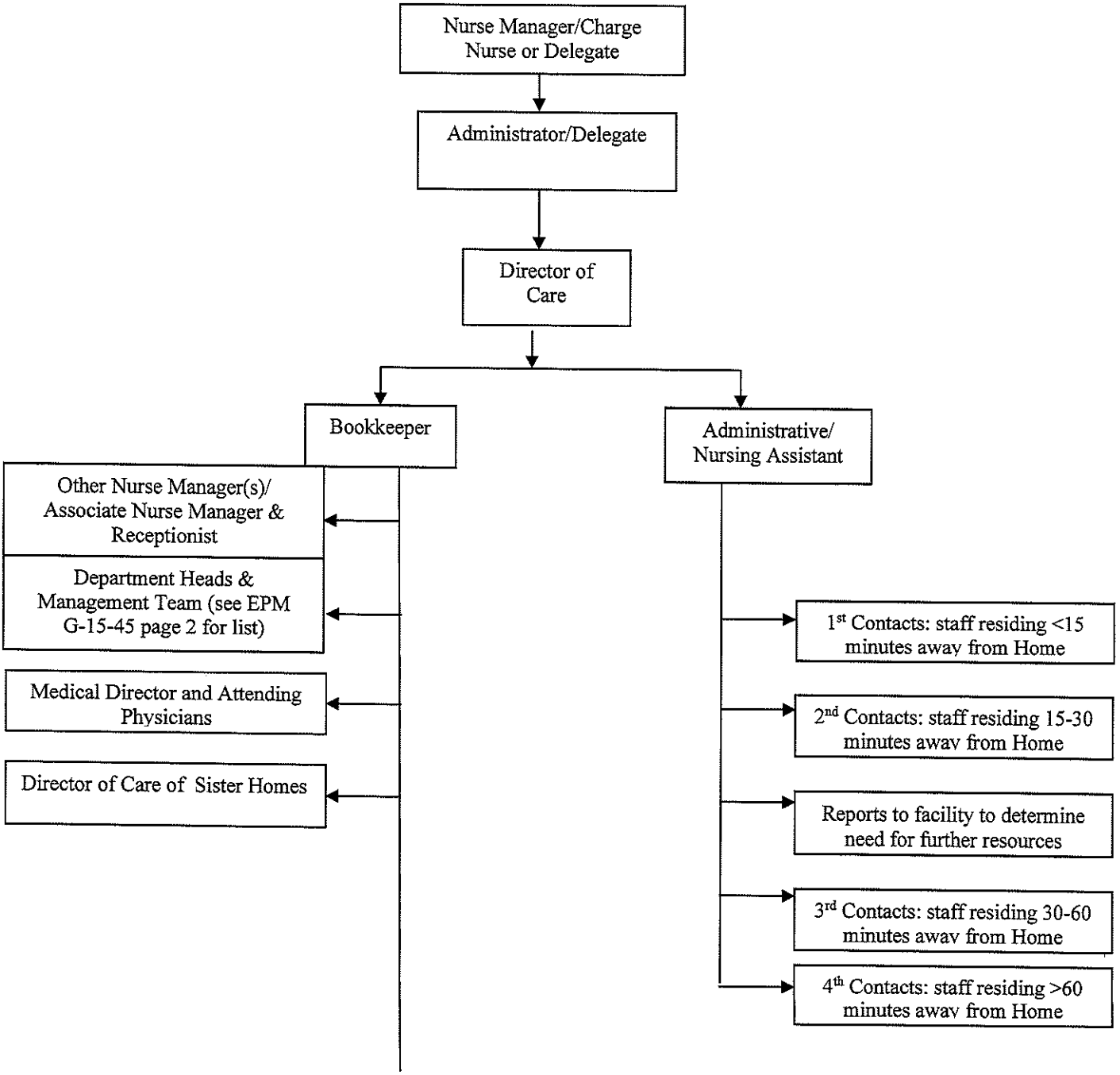
SPECIFIC CONTACT PROCEDURE:



SECTION:	EVACUATION	**INDEX I.D.:** EMP G-15-50
SUBJECT:	COMMUNICATION WITH SUBSTITUTE DECISION MAKER	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure there is a policy and practice for contact and communication with substitute decision makers in a timely fashion.

2. Administrator / designate to delegate staff to contact substitute decision maker.

PROCEDURE:

1. Administrator / designate will delegate staff to make the necessary phone calls.

2. When establishing initial contact with substitute decision maker convey emotional support and reassurance that safety and well being of the resident is our number one priority.

3. When substitute decision maker are contacted (in a disaster / emergency situation) they have to be notified of:
   a) Type of emergency
   b) Time of emergency
   c) Current status and / or location of resident
   d) Mechanism in place for access to updated information

OUTCOME:

1. Effective / efficient communication with substitute decision maker in emergency / disaster situation.

ADDITIONAL REFERENCES:

1. Residents Profile on PointClickCare

2. Face sheets Binder

SECTION: EVACUATION	**INDEX I.D.:** EPM G-15-55
SUBJECT: COMMUNICATION WITH MEDIA	**PAGE:** 1 OF 1
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure there is a process and plan for initiating and maintaining ongoing contact with the media in an emergency / disaster situation.

2. Administrator is accountable and responsible for communicating with the media as the need arises.

3. All media contact is referred to Administrator.

PROCEDURE:

1. Administrator initiates or responds to media inquiries during an emergency / disaster.

2. Administrator provides a standardized press release as appropriate.

OUTCOME

1. Effective, efficient and responsible communication with the media in an emergency / disaster situation.

ADDITIONAL REFERENCES:

1. List of media telephone numbers and contacts.

2. Leadership and Governance Manual, Dealing with News Media/Public Relations Policy, Policy ID # A-15.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-60
SUBJECT:	PROCEDURE FOLLOWING TOTAL EVACUATION	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure that there is a policy and practice for appropriate procedures to undertake following a total evacuation.

2. Security of building, well-being of relocated residents and necessary communication with families / responsible parties will be maintained.

PROCEDURE:

1. Designated person in charge of emergency (i.e. fire dept. / police) will conduct following inspection of physical premises:

    a) Ensure all electrical equipment is turned off
    b) Ensure heat / air conditioning is turned off
    c) Ensure that all evacuated areas are sealed off, secured and barricaded as required
    d) Ensure that all windows are closed, all doors are locked

2. Administrator / designate will:

    a) Ensure that substitute decision makers are contacted and made aware of evacuation proceedings
    b) Ensure that a notice is posted at facility entrance listing necessary information and contact phone numbers
    c) Ensure that appropriate arrangements are made to maintain ongoing security of evacuated premises
    d) Ensure continued provision of care and help with staffing at relocation sites and visit relocation sites regularly

3. Director of Care / designate will:

    a) Ensure the suspension of all work schedules in a disaster situation
    b) Rework the schedule to reflect the changed needs / location of residents

OUTCOME:

1. There is evidence that resident safety and building security is maintained.

SECTION:	EVACUATION	**INDEX I.D.:** EPM G-15-60
SUBJECT:	PROCEDURE FOLLOWING TOTAL EVACUATION	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-40, Contacting Staff policy.
2. Emergency Plan Manual, Policy ID # G-15-50, Communication with Substitute Decision Maker policy.
3. Emergency Plan Manual, Policy ID # G-15-55, Communication with Media policy.

SECTION:	RELOCATION	**INDEX I.D.:** EMP G-20-05
SUBJECT:	RELOCATION PROCEDURES	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure there is a process and plan for the reception of residents, in the event of an internal/external emergency disaster, that promotes resident and staff safety.

2. All employees are responsible and accountable for understanding and demonstrating ongoing competence in all relevant aspects of relocation procedures as a condition of ongoing employment.

3. The Administrator or delegate is responsible and accountable for initiating the relocation procedures.

PROCEDURE:

1. Administrator/delegate conveys decision to relocate residents.

2. Administrator/ delegate contacts delegated relocation site(s).

3. Administrator / delegate initiates triage procedures.

4. Administrator/ delegate determines and arranges appropriate mode of transport to delegated relocation site based on individual needs of residents.

5. Food Services Manager / delegate contacts contracted food services provider to initiate plan for alternate food delivery service at relocation site.

6. Director of Care / delegate to coordinate appropriate staffing to ensure continuity of care services at the delegated relocation site.

7. Administrator / delegate assigns individual(s) to accompany, receive and supervise evacuees at the delegated reception site.

8. Director of Care/ delegate coordinates the transfer of critical supplies and health records to the delegated reception site.

9. Director of Care/ delegate to advise personal physicians, specialists and next of kin of resident relocation to delegate site.

SECTION:	RELOCATION	**INDEX I.D.:** EMP G-20-05
SUBJECT:	RELOCATION PROCEDURES	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. Residents are relocated as per above procedures.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-30, Triage - Assessment of Residents
2. Emergency Plan Manual, Policy ID # B-05, List of Contacts.
3. Emergency Plan Manual, Policy ID # H-05, Code Orange – General.

SECTION:	MOCK EVACUATION	**INDEX I.D.:** EPM G-25-05
SUBJECT:	TESTING OF DISASTER AND EMERGENCY PLANS	**PAGE:** 1 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Emergency Plan will be tested in accordance with the following procedure.

DEFINITIONS:

Disasters and emergencies include a variety of hazardous situations that may occur inside or outside the Home. These include, but are not limited to, fires, natural disasters, biochemical and bomb threats, chemicals spills, radiation exposure, threats of personal violence, power failures.

PROCEDURE:

1. The Home must test the following emergency plans on an annual basis on all three shifts:
    a. Code Blue
    b. Code Green
    c. Code Green Stat
    d. Code Orange
    e. Code Yellow
    f. Code White
    g. Code Brown
    h. Code Black
    i. Priority Code

PLEASE NOTE: The testing of these emergency plans must involve making arrangements with community agencies, partner facilities and resources that will be involved in responding to these emergencies.

2. Code Red must be tested on a monthly basis on all three shifts.

3. The emergency fan-out list must be tested on an annual basis.

4. All other components of the emergency plan must be tested at least every three (3) years, including making arrangements with community agencies, partner facilities and resources that will be involved in responding to these emergencies.

5. The Home must conduct a planned evacuation at least every three (3) years.

6. The Staff Development Coordinator will develop a yearly schedule for the testing of disaster and emergency plans.

SECTION:	MOCK EVACUATION	**INDEX I.D.:** EPM G-25-05
SUBJECT:	TESTING OF DISASTER AND EMERGENCY PLANS	**PAGE:** 2 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

7. The Staff Development Coordinator plans and prepares staff for the mock disaster and testing of emergency plans.

8. The mock evacuation checklist will be used during the mock disaster plan exercise to ensure all areas are covered.

9. The Staff Development Coordinator will complete an Emergency Exercise Report following the testing of each emergency plan/code. The completed report with corrective actions is to be submitted to the Executive Director for review.

10. During the planned evacuation, observers are given various responsibilities. An Assessor Questionnaire is given to observers to document observations made during the testing of disaster and emergency plans.

11. A debriefing takes place after completion of the all exercises to evaluate strengths, weaknesses and identify areas for improvement.

12. Recommendations from all mock exercises are forwarded to the Infection Prevention and Control/Emergency Management Team for review.

13. The Infection Prevention & Control/Emergency Management Team completes the Emergency Exercise Report of all the mock exercises. Report to include the following:
    a) Date of mock
    b) Type of disaster and/or emergency plan
    c) Planning phase
    d) Evaluation (strengths, weaknesses)
    e) Recommendations made at time of debriefing
    f) Action plan to address recommendations.

14. The Emergency Exercise report is submitted to the Leadership Team for review and approval with input into the action plan, as appropriate.

15. The Infection Prevention & Control/Emergency Management Team will ensure the contracts with relocation sites are renewed at a minimum every three (3) years.

SECTION:	MOCK EVACUATION	**INDEX I.D.:** EPM G-25-05
SUBJECT:	TESTING OF DISASTER AND EMERGENCY PLANS	**PAGE:** 3 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. There is documented evidence that the emergency plans are tested in accordance with the legislation requirements as noted in this policy.

2. There is documented evidence that the planned evacuation is tested at least every three (3) years.

3. Staff and volunteers follow proper procedures during the mock disaster and emergency plans.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy I.D. G-25-10, Mock Evacuation Checklist policy.

2. Emergency Plan Manual, Policy I.D. G-25-15, Assessor Questionnaire policy.

3. Forms Manual, Emergency Exercise Report.

4. CARF Standards.

5. LTCHA and Regulations 79/10, section 230 – Emergency Plans.

SECTION:	MOCK EVACUATION	**INDEX I.D.:** EPM G-25-10
SUBJECT:	CHECKLIST	**PAGE:** 1 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. Mock evacuation checklist is used and completed when planning a mock emergency.

PROCEDURE:

1. The Infection Prevention & Control/Emergency Management Team follows all the steps in the mock evacuation checklist.

2. Checklist is completed and included with Emergency Exercise report.

OUTCOME:

1. A mock evacuation checklist is completed each time a component or all components of the emergency plan are tested.

ADDITIONAL REFERENCES:

1. Forms Manual, Emergency Exercise Report.

SECTION:	MOCK EVACUATION	**INDEX I.D.:** EPM G-25-10
SUBJECT:	CHECKLIST	**PAGE:** 2 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

Tasks	Comments	Date Completed
1. Meeting with Infection Prevention & Control/Emergency Management Team to determine type of disaster and/or emergency plan.		
2. Check policy and procedure manual: - Emergency Plan Manual.		
3. Consider and plan for possibility of real emergency (code blue) during exercise.		
4. Update staff fan-out list.		
5. Letter to EMS (Police, Fire, and Ambulance).		
6. Renew relocation agreements.		
7. Review roles and responsibilities in event of fire/evacuation with all key personnel.		
8. Plan scenario and script.		
9. Identify residents and/or "shadow residents".		
10. Recruit volunteers - shadow residents - video		
11. Arrange assessors - Fire - Police - Ambulance - Other Facilities - Students - Corporate Office		
12. Prepare participation badges.		
13. Prepare badges for shadow residents.		
14. Consent forms.		
15. Determine staffing needs.		
16. Assign triage staff to triage area.		
17. Prepare pylons for triage/treatment areas.		
18. Forms for triage and record of transfer of evacuated residents.		
19. Develop questionnaires for assessors.		
20. Blankets – available.		
21. Traffic control.		
22. Arrange lunch.		
23. Arrange debriefing – all participants		
24. Check evacuation bag(s).		

SECTION:	MOCK EVACUATION	**INDEX I.D.:** EPM G-25-10
SUBJECT:	CHECKLIST	**PAGE:** 3 OF 3
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

Tasks	Comments	Date Completed
25. Education – all staff regarding roles / responsibilities and type of mock disaster and/or emergency plan.		
26. Prepare emergency face sheets for evacuees.		
27. Prepare for sending medications / MAR with evacuees.		
28. Communication - General Staff Meeting - Memo to all staff - Nursing Agencies - Physicians - Lab, Pharmacy, etc. - Residents - Sign for lobby and community - Residents'/Family Council - Billing information - Letters → reallocation → EMS		
29. Invite Medical Director to attend.		
30. Brief volunteers and assessors in advance of and morning of mock evacuation.		
31. Thank you letters to all participants.		
32. Emergency Exercise Report is completed.		
33. Communicate results of mock evacuation.		
34. Inform Ministry of Health of mock evacuation.		

Date Completed By: _____

SECTION:	MOCK EVACUATION	**INDEX I.D.:** EPM G-25-15
SUBJECT:	ASSESSOR QUESTIONAIRE	**PAGE:** 1 OF 3
		ORIGINAL DATE: May 01, 2002
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To ensure a checklist is used during a mock disaster plan exercise.

PROCEDURE:

1. The checklist is given to observers at the time of the mock disaster plan exercise.

2. The observers include but not limited to the following people: Administrator /delegate, Directors of Care/delegate, Nurse Managers, Dietary Supervisors and Environmental Services Managers from the sister facilities, Police, Ambulance, Fire Department, Public Utilities and employees from all departments

3. All observers are to provide feedback of the exercise at the debriefing session after the mock disaster plan exercise using the checklist and recommendations.

OUTCOME:

1. There is evidence that an observer's checklist is completed each time all components or one component of the emergency plan is tested.

ADDITIONAL REFERENCES:

SECTION:	MOCK EVACUATION	**INDEX I.D.:** EPM G-25-15
SUBJECT:	ASSESSOR QUESTIONAIRE	**PAGE:** 2 OF 3
		ORIGINAL DATE: May 01, 2002
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OBSERVERS CHECK-LIST

#	CRITERIA	Yes	No	N/A	COMMENTS
1	Was the Fire Department called prior to the exercise?				
2	Was the Alarm Monitoring Company called prior to the exercise?				
3	Could you hear the announcement for code_____ clearly over the P.A system? Was it announced three times?				
4	Did staff initiate and follow correct protocol for code ?				
5	Was the exact location of the Code_____ paged 3 times by reception/delegate				
6	If code red is being tested, did staff initiate R.E.A.C.T?				
7	Was the correct Pull Station used?				
8	Did Fire doors close?				
9	Were all Bedroom/office doors closed?				
10	Did all Bedroom/office doors latch properly?				
11	Was evacuation practiced correctly on the unit and down the stairwell?				
12	Was there a smooth traffic flow down the stairwell?				
13	Were all evacuees triaged and accounted for?				
14	Were the evacuation bags and face sheet binders taken to triage scene?				
15	Were the MARS brought to the triage scene by the unit supervisor?				
16	Was there evidence of a 30 second assessment done by the triage nurse at the triage scene?				
17	Did the triage nurse delegate responsibilities to staff for assessments, tagging, logging of the evacuees and monitoring of the holding areas?				
18	Were the treatment/holding areas clearly marked and the assigned personnel clearly identified?				

SECTION:	MOCK EVACUATION	**INDEX I.D.:** EPM G-25-15
SUBJECT:	ASSESSOR QUESTIONAIRE	**PAGE:** 3 OF 3
		ORIGINAL DATE: May 01, 2002
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

#	CRITERIA	Yes	No	N/A	COMMENTS
19	Were the evacuees in the appropriate holding areas (red, yellow, green, white and black)?				
20	Was the Executive Director/delegate at reception to direct emergency personnel/incoming staff to the disaster and/or triage area(s)?				
21	Were Evacuation Logs completed at the triage scene and returned to the Executive Director/delegate?				
22	Were evacuees appropriately transferred to other locations?				
22	Are service agreements renewed annually with receiving facilities for evacuees (Catering, Red Cross, Nursing Agencies,)?				
23	Were logs completed for the location of the evacuees upon arrival to the receiving facility?				
24	Was the Fire Alarm System reset?				
25	Was the Alarm Monitoring Company and Fire Department called after the exercise?				
26	Was an **"All Clear"** paged over the P.A. System following Code_____ ?				

SECTION:	CODE ORANGE	**INDEX I.D.:** EPM H-05
SUBJECT:	CODE ORANGE - GENERAL	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. Code Orange is an external disaster. A code orange is announced to alert employees that an adverse event has occurred outside of the home that may affect the operations of the home.

2. The Home activates the following emergency plan when a Code Orange is called.

PROCEDURE:

1. The Administrator or designate upon being notified of an external event will establish communication with the governing agency to determine if a code orange is warranted. Possible Governing agencies may include (but not limited to) Fire, Police, Health authorities on a Regional, Provincial or Federal level.

2. On request, the Charge Nurse or designate will announce **"Code Orange Alert"** to advise employees of a potential change in operations. **"Code Orange"** or **"Code Orange Confirmed"** will be used to advise employees that there has been a change to normal business practices.

3. A command centre will be established to coordinate communication with all employees. The command center in conjunction with the governing agency will determine what alterations to normal business practices are required. This will include implementing existing emergency polices as well as following any guidelines set out by the governing agency.

4. The Administrator or designate will determine what reporting may be required as well as what polices may need to be implemented. See H-05-05 'Code Orange Decision Tree' for guidelines.

OUTCOME:

1. Code Orange is announced; a communication plan is implemented and required policies are implemented.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy I.D. # H-05-05, Code Orange – Decision Tree

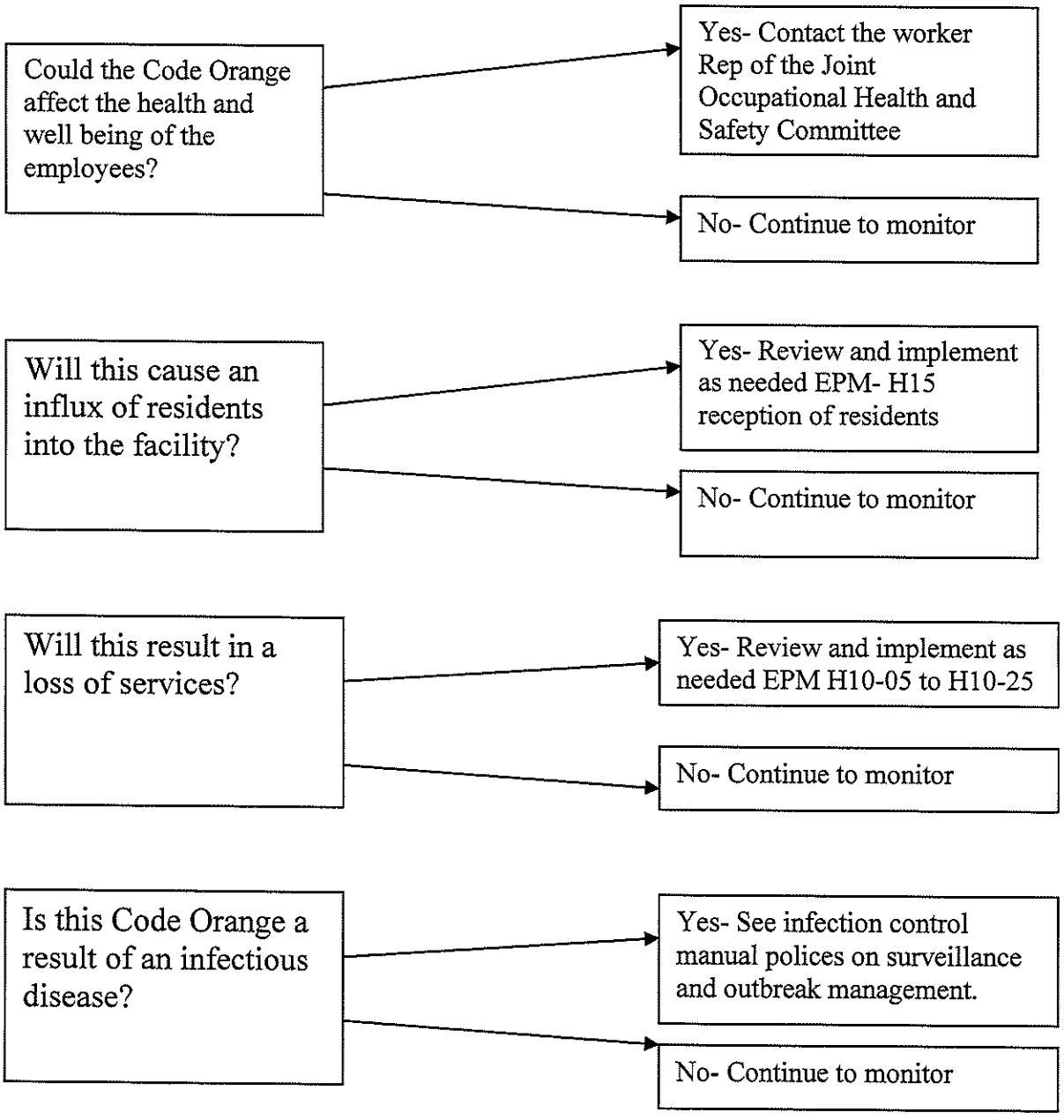
SECTION: CODE ORANGE **INDEX I.D.:** EPM H-05-05

SUBJECT: CODE ORANGE – DECISION TREE **PAGE:** 1 OF 1

ORIGINAL DATE: February 7, 2007

APPROVED BY: **REVIEWED DATE:** July 26, 2022

CODE ORANGE- DECISION TREE



SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-05
SUBJECT:	INTERRUPTION OF DIETARY SERVICES (LOSS OF ESSENTIAL SERVICES)	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Home shall have in place a plan and be prepared to deal with an interruption in Food Services in a way that minimizes disruption to the residents.

PROCEDURE:

1. In the event of loss of the Dietary Services, food for residents will be purchased in the ready form from outside sources and served in disposable containers.

2. Juice, milk and cereals are to be purchased in portioned pack containers.

3. Individually wrapped muffins, cookies and cakes are to be used in the place of bread.

OUTCOME:

1. No disruption of meal service to residents during interruption of dietary services.
2. Contingency protocol followed.
3. All key people have knowledge and understanding of contingency protocol.

ADDITIONAL REFERENCES:

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-10
SUBJECT:	LOSS OF HYDRO (LOSS OF ESSENTIAL SERVICE)	**PAGE:** 1 OF 8
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The Home will have in place a protocol and be prepared to deal with an incident of loss of hydro in a way that minimizes disruption to the residents and staff.

PROCEDURE:

1. In the event of a total loss of power, contact the Local Public Utilities and determine the anticipated duration of the power loss. If the phones do not activate when the hydro is out, the call must be made using the activation cellular phone and/or a personal cell phone.

2. In the event that power is to be restored quickly, no further action need be taken.

3. **If the loss of power occurs during cold weather,**
   - Ensure that all windows and exterior doors are closed.
   - Obtain additional blankets from storage and use as necessary to keep residents warm.
   - If gas supply is still available, supply residents with hot beverages as needed.
   - Keep vacant room doors closed to minimize loss of heat.
   - If temperatures drop to unacceptable levels and/or power supply will not be restored for an extended period of time, initiate evacuation (see Evacuation, G-15-05, G-15-10).

4. **If the loss of power occurs during hot weather**
   - Ensure all residents are receiving adequate fluids to maintain hydration
   - Monitor for signs of heat related complications such as heat stroke (refer to Hot Weather Related Illness Policy (Resident Care and Services Manual, policy G-20)).

NOTE:
Homes with emergency generator will supply power for essential services as follows:

- **ELECTRICAL ROOM:** Nothing on generator
- **LIGHTING** Corridor ceiling lights, one at each end of the hallway and one at the fire

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-10
SUBJECT:	LOSS OF HYDRO (LOSS OF ESSENTIAL SERVICE)	**PAGE:** 2 OF 8
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

separation door.

- **MAIN FLOR LIGHTING AND ELECTRICAL ON GENERATOR:** The lobby, lounge, and each dining room has one emergency light each.

- power outage is wide spread in the community, other services may be affected. For additional emergency procedures refer to the following policies:

  - Loss of Natural Gas (EPM H-10-15)
  - Loss of Water (EPM H-10-20)
  - Loss of Communication (Telephone System) (EPM H-10-25)
  - Withdrawal of Service/No staff Available (EPM H-10-35)
  - Interruption of Dietary Services (EPM H-10-05)
  - For additional supplies, access the emergency kit.
    - Extension cords (2/unit)
    - Radio (battery operated)
    - First aid kit
    - Flashlights/Laterns (6, additional to what is currently stored)
    - Blankets – 50
    - Batteries – varies sizes
    - Medi-wipe
    - Gowns – 2 cases
    - Gloves – 2 cases
    - Isagel – 1 case of small bottles
    - Thermometer Probe Covers – 2 sleeves
    - Goggles – 6
    - Surgical Face Masks – 1 case
    - N-95 masks
    - Outbreak Notices, precautions and forms

DURING THE EMERGENCY, IT IS IMPERATIVE TO BE KEPT INFORMED (VIA BATTERY OPERATED RADIO) OF THE CITY'S EMERGENCY PLAN FOR FURTHER DIRECTIVES OR EVACUATION ORDERS.

5. When power is restored, ensure that the mag locks are reset.

6. Use the checklists attached to facilitate routine checks for safety.

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-10
SUBJECT:	LOSS OF HYDRO (LOSS OF ESSENTIAL SERVICE)	**PAGE:** 3 OF 8
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. Key people have knowledge and understanding of protocol.
2. Protocol is followed when there is loss of hydro.

ADDITIONAL REFERENCES:

1. Loss of Hydro Checklist
2. Loss of Hydro Checklist – unit Supervisor

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-10
SUBJECT:	LOSS OF HYDRO (LOSS OF ESSENTIAL SERVICE)	**PAGE:** 4 OF 8
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

Loss of Hydro Checklist - Unit Supervisors

Area reviewed	Completed			Comments
	Yes	No	N/A	
UNIT SUPERVISOR				
Initiate a head count of all residents on the unit and document on resident list (used for code red)				
Account for all unit staff and record names below				
Residents on air mattress assessed and alternate measures implemented (resident placed in chair, extra mattress brought to unit)				
Resident on G-feed assessed to ensure battery is charged				
Resident's on oxygen assessed and switched to portable O2 tank if necessary				
Fridge temperatures monitored				
Air temperatures monitored				
All windows and exterior doors checked to ensure they are closed				
Vacant rooms kept closed to minimize loss of heat				
Q15 minute safety checks initiated				
If call bell system is not on generator ensure staff are doing continuous rounds for safety				
Extra blankets made available to residents				
Extra disposable supplies on hand for peri- care				
Warm beverages offered to residents				
Flashlights located and are in use				
If loss of power during hot weather				
Residents are receiving adequate fluids to maintain hydration				
Heat risk assessment list retrieved and reviewed with staff and activate heat risk policy				
All residents monitored for signs of heat related				

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-10
SUBJECT:	LOSS OF HYDRO (LOSS OF ESSENTIAL SERVICE)	**PAGE:** 5 OF 8
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

Area reviewed	Completed			Comments
	Yes	No	N/A	
complications (Heat stroke)				
Air temperatures taken and documented q30 minutes				
Move residents to cooler area of the home if needed (basement)				

Name of Unit Supervisor and designation: _____

Date/Time: _____

Observations:

_____

_____

_____

Please forward completed checklist to DOC/delegate

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-10
SUBJECT:	LOSS OF HYDRO (LOSS OF ESSENTIAL SERVICE)	**PAGE:** 6 OF 8
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

Loss of Hydro Checklist

Area reviewed	Completed			Comments
	Yes	No	N/A	
EXECUTIVE DIRECTOR/DELEGATE				
Hydro contacted for update stated following:				
Notified following re: outage • Alarm monitoring company • MOH Initial time:_____ Outage over: _____ • Medical Director • VP of Operations or delegate • HCSS • Frequent announcements for staff, residents, and visitors to provide information and direction.				
Generator functioning properly				
eMar/Server/Computers and back-up running				
Carbon monoxide detector(s) plugged into emergency electrical outlets				
Vaccine fridges monitored and protocol followed				
Dietary: • Review of menu • Arrange with sister facilities in regards to Hot soups/beverages • GFS informed and to have freezer truck on				

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-10	
SUBJECT:	LOSS OF HYDRO (LOSS OF ESSENTIAL SERVICE)	**PAGE:** 7 OF 8	
		ORIGINAL DATE: June 1, 2000	
APPROVED BY:		**REVIEWED DATE:** July 26, 2022	

standby • Initiate emergency record temperature log for fridge and freezer (q1hour checks)				
Verify that emergency outlets are functioning				
DOC/Delegate follow up to ensure:				
Head count of all residents in facility conducted and documented on resident list				
Head count of all staff in the Home conducted. (Attach roster)				
Residents on Air mattress assessed and alternate measures implemented (resident placed in chair, extra mattress brought to unit)				
Resident on G-feed assessed to ensure battery is charged				
Residents on oxygen assessed and switched to portable O2 tank if necessary				
Vaccine Fridge temperatures monitored q30 minutes				
Air temperatures monitored q30 minutes				
Water temps monitored q30 minutes				
All windows and exterior doors checked to ensure they are closed				
Vacant rooms kept closed to minimize loss of heat				
If call bell system is not on generator – staff to be conducting continuous rounds If call bell system is on generator – q15 minute checks to be completed				
Extra blankets brought to the unit				
Extra disposable supplies on hand for peri- care				
Warm beverages offered to residents				
Flashlights located and are in use				
Suction machine charged				
If loss of power during hot weather				
Residents are receiving adequate fluids to maintain hydration				

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-10	
SUBJECT:	LOSS OF HYDRO (LOSS OF ESSENTIAL SERVICE)	**PAGE:** 8 OF 8	
		ORIGINAL DATE: June 1, 2000	
APPROVED BY:		**REVIEWED DATE:** July 26, 2022	

Heat risk assessment list to be generated and reviewed with unit staff				
Residents monitored for signs of heat related complications (Heat stroke)				
Air temperatures taken and documented q30h				
Transfer residents to cooler areas i.e. basement				
Ensure all windows and window curtains are closed				
ONCE POWER IS RESTORED				
Check all steam tables				
Replenish all emergency supplies				
Reset maglocks				
Check HVAC, boiler, mechanical room etc. for equipment functioning properly				
Continue to monitor fridge/freezer temps for 12 hours				
Call monitoring company				
Update VP of Operations or delegate				

Name:_____ Date/Time: _____

Observations:

_____

_____

_____

_____

_____

Please forward completed checklist to DOC/delegate for review and to be attached to Emergency Report

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-15
SUBJECT:	LOSS OF NATURAL GAS (LOSS OF ESSENTIAL SERVICES)	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There will be a protocol in place to deal with an incident of loss of natural gas in a way that minimizes disruption to the residents and staff.

2. Ensure the well being of the residents and staff in case of a loss of natural gas.

PROCEDURE:

1. In the event of loss of gas, contact local Gas Company (Enbridge Consumer's Gas) in order to determine expected duration of shutdown.

2. In the event that the supply of gas will be restored quickly, no further action need be taken.

3. **In the event that loss of gas is to be restored in a reasonable period of time:**

   3.1 Suspend operation of laundry and dishwashing services in order to conserve hot water for residents' use.

   3.2 For emergency feeding of residents, see **"Interruption of Dietary Services".**

4. In the event that gas supply is not to be restored for an extended period of time, initiate **Total Evacuation** (see Evacuation).

OUTCOME:

1. Key staff have knowledge and an understanding of protocol for loss of natural gas.

2. Staff adhere to protocol.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Interruption of Dietary Services, Policy ID # H-05

2. Emergency Plan Manual, Relocation Procedure, Policy ID # G-20-05

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-20
SUBJECT:	LOSS OF WATER (LOSS OF ESSENTIAL SERVICES)	**PAGE:** 1 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To have a protocol in place to deal with an incident of loss of water which would allow for minimal disruption to the Home.

2. To have access to an adequate supply of water in the case of an emergency.

PROCEDURE:

1. In the event of a complete loss of water, contact local Public Utilities in order to determine expected duration of shutdown.

2. In the event that water services will be returned to normal quickly, no further action need be taken.

3. **In the event that water supplies will not be available for several hours, the following procedure is to be followed:**

   3.1 Milk and fruit juices are to be used to meet the needs of residents.

   3.2 Laundry and dishwashing operations and regular resident bathing shall be discontinued for the duration of the shortage.

   3.3 Disposable hand wipes will be obtained through Nursing Office for personal care.

   3.4 Water required for emergency care of the residents may be obtained from the water tanks located in the boiler room. Water used for this purpose must be allowed to cool before use, as tank temperatures are normally 60° Celsius.

4. **Minimize the use of toilets during the period of shortage. Remember that a toilet can be flushed only once after water supply to building is cut off.**

5. **In the event that water supplies will not be returned to normal for an extended period of time, initiate contact with pre-planned emergency water sources:**

   5.1 Gordon Food Service (905) 670-8605

6. In the event that water supplies will not be returned to normal indefinitely, initiate **Total Evacuation** (see Evacuation).

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-20
SUBJECT:	LOSS OF WATER (LOSS OF ESSENTIAL SERVICES)	**PAGE:** 2 OF 2
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. Access to external water sources.

2. All key people have knowledge and understanding of protocol to follow when there is loss of water.

ADDITIONAL REFERENCES:

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-25
SUBJECT:	LOSS OF COMMUNICATION (TELEPHONE SYSTEM)	**PAGE:** 1 OF 1
		ORIGINAL DATE:
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There is a plan and process to effectively manage care and service delivery during a temporary loss of telephone communication.

PROCEDURE:

1. In the event of loss of regular telephone services, utilize the Home's emergency back-up phone located with activities and contact Bell Telephone service at 310-BELL, notify them of the disruption in service and request immediate emergency repairs.

2. If the Home's emergency back-up phone and the FAX machine is inoperative, utilize the nearest community pay telephone or a personal cell phone or send out an email message to families and staff providing Activation Cell phone number (613)285-8216 as they will be able to transfer the calls to the home.

3. The same procedure is to be followed to obtain ambulance service or medical services, during the period of emergency.

4. Staff will be requested to run messages to all floors/departments.

OUTCOME:

1. Staff demonstrate knowledge and follows protocol in the event of loss of telephone communication.

2. All staff knowledgeable of alternative procedures in the event of loss of regular telephone service.

ADDITIONAL REFERENCES:

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-30
SUBJECT: EXTERNAL AIR EXCLUSION	**PAGE:** 1 OF 3
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There is a process for the immediate shutdown of all air handling and air exchange systems to restrict the entry of external contaminated air.

2. All activities and/or systems that create an exchange of air between the facility and the external environment will be shut down immediately in the event of toxic hazardous emissions in the community.

PROCEDURE:

1. External Air Exclusion will be used to identify the need to implement the external air exclusion policy.

2. Notify the Administrator, Director of Care or delegate and Environmental Services Manager immediately upon being informed of the situation.

3. Page "External Air Exclusion" three times.

4. Employees in each department must immediately securely close all windows to the outside.

5. All doors to the outside must be closed. Entering and exiting the building will be confined to the "air-lock style" doors allowing the first set of doors to close before the second set opens to reduce air exchange.

   NOTE: DO NOT DE-ACTIVATE FIRE EMERGENCY EXITS.

6. Turn off all air conditioners and air conditioning systems.

7. Shut down bathroom/toilet fans.

8. Shut down stove fume hoods, dishwasher fans, dryer fans etc.

9. Close down air circulation and exhaust fans that draw air from or exhaust air to the outside.
   Location: roof (in electrical room), basement, main floor, outside building, laundry
   Access: roof, basement-Master Key; ESM, Housekeeping, maintenaince key box,
   Shut Down: Pull breaker to close manually

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-30
SUBJECT: EXTERNAL AIR EXCLUSION	**PAGE:** 2 OF 3
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

OUTCOME:

1. In the event of a toxic gaseous leak in the community, all air exchange systems are shut down immediately.

2. All employees will be familiar with the External Air Exclusion procedure.

3. All valves and equipment will be clearly marked and instructions posted in close proximity.

ADDITIONAL REFERENCES:

1. Hanna, James A.; Disaster Planning. CHA Press, Ottawa, Ontario, 1995.

2. Standards for LTC Organizations CCHSA, 1996(pg.sup-38).

3. Emergency Plan Manual, Policy ID # B-10-15, Building floor plans and schematics

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-30
SUBJECT: EXTERNAL AIR EXCLUSION	**PAGE:** 3 OF 3
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

Drawings attached

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** H-10-35
SUBJECT: WITHDRAWAL OF SERVICE/ NO STAFF AVAILABLE	**PAGE:** 1 OF 1
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There is a plan to provide for the delivery of essential care and services in the event of withdrawal or interruption of services.

PROCEDURE:

1. Employees already in the building will remain on duty in an emergency situation until relieved or other instructions are received.

2. The Nurse Manager/Person In-Charge will call in additional Supervisors, the Director of Care and the Administrator, if not already in the building. Supervisors will remain on duty during the course of the emergency or until other instructions are received.

3. The Ministry of Health must be informed of the problem. The Admninistrator/delegate will be responsible for this.

4. Each Department Head will contact off duty staff and arrange for them to get to work if at all possible. This may entail arranging car pools or other transportation to get the staff to the building.

5. Relatives, agency personnel and volunteers are to be called if the situation warrants.

6. If the situation warrants, residents shall be discharged to their own families where possible. The Administrator shall determine when the situation warrants this.

OUTCOMES:

1. There is evidence of provision of essential care/services in an emergency situation

2. Phone numbers and travel time of all employees is current and readily available (Fan-Out-System)

ADDITIONAL REFERENCE:

1. Emergency Plan Manual, Policy ID # G-15-45, Fan-Out Protocol policy

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-40
SUBJECT: PRIORITY CODE	**PAGE:** 1 OF 3
	ORIGINAL DATE: March 20, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The priority-intruder alert will be used to:
   a) Initiate an appropriate effective response to the presence of an unauthorized person(s) in the home.

2. The following emergency plan is activated in the event of a priority-intruder alert.

PROCEDURE:

1. The Receptionist will ensure that all visitors sign in and out.

2. Anyone unfamiliar or found loitering in the home will be approached by staff in a non-confrontational and professional manner.

3. Ascertain whom they are visiting and whether they require any assistance.

4. Once the nature of the visit has been determined, advise the visitor it is the policy of the Home that all visiting personnel register at the reception desk. If they have not registered at reception, ask them to return to reception to register. If the person demonstrates an unwillingness to cooperate advise them that the Home will call the Police upon refusal to comply.

5. Two staff members will accompany the person(s) to reception (providing that they are willing to cooperate).

6. If an unauthorized individual:
   a) is not recognized and
   b) refuses to follow direction, or
   c) becomes argumentative, or
   d) has no purpose for being in the nursing home, or
   e) looks suspicious

   Advise the nearest Registered staff or management staff member so they can initiate a Priority Code (i.e. to alert everyone that there is an intruder in the building). If the Registered staff or management staff is not readily available, initiate the Priority Code yourself. Document a full description of the individual.

7. Page **PRIORITY CODE**: use the nearest telephone to make your announcement.

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-45
SUBJECT: FACILITY LOCKDOWN	**PAGE:** 1 **OF** 5
	ORIGINAL DATE: October 20, 2005
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There is a process for a facility lockdown in situations that constitute life-threatening events and where evacuation of the Home could be fatal. This includes a scenario of an active shooting in the neighbourhood or on the Home's property.

2. Two levels of lockdown will be used to initiate the most appropriate and effective response to keep residents, staff, and others safe in the event of a serious threat and/or violent incident.

3. Specific actions taken by Home personnel will depend on the specifics of the situation. Any action taken depends on several factors, including the level of threat and the advice/ directive of emergency personnel. In general a "prevent, secure, preserve, and submit" strategy is implemented.

FIRST STEP IS PREVENTION:

1. Receptionist will encourage all visitors to sign in and out.

2. All exterior doors are locked after the receptionist leaves.

3. Building safety checklists are being completed daily and any deficiencies that will affect resident care or safety will be reported to the Administrator and/or Environmental Services Manager.

4. Anyone unfamiliar or found loitering in the Home will be approached by staff in a non-confrontational and professional manner. If anyone unfamiliar is found loitering in the immediate area around the Home, staff will alert the nearest registered or management staff member so that they can assess the situation.

THERE ARE TWO LEVELS OF LOCKDOWN:

Hold and Secure: means that all movement in and out of the building is restricted, however movement within the building is not restricted. The external danger near the building poses no immediate threat to the residents, staff, and others unless they leave the building.

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-45
SUBJECT: FACILITY LOCKDOWN	**PAGE:** 2 **OF** 5
	ORIGINAL DATE: October 20, 2005
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

Lockdown: refers to the most serious response to a threat to residents, staff, and others inside the building, on building property, or on property in immediate proximity to the building. The danger poses an immediate and serious threat to everyone in the building or on the property. The lockdown minimizes visibility and shelters/isolates residents, staff, and others in the safest possible location within the Home given the specifics of the situation.

HOLD and SECURE PROCEDURE:

1. Hold and Secure will be used to identify the need to implement a response to a threat in the general vicinity of the Home (but not inside the Home, on building or adjacent property).

2. Notify the Administrator, Director of Care or delegate and Environmental Services Manager immediately upon being informed of the emergency situation.

3. Page "Attention all Staff - Implement Hold and Secure measures immediately". Repeat the page three times.

4. Call 911 to ensure that emergency personnel are apprised of the situation and will maintain communication on the status of the situation.

5. Residents/staff and visitors outside but close to the main door should be quickly escorted inside the building. Residents should be returned to their unit.

6. Employees in the reception area or person in charge of the building/delegate will immediately ensure that all exterior doors are locked.

7. All movement in and out of the Home is restricted, except for access by emergency personnel. Entrance/exit by others is determined on a case by case basis at the discretion of the person in charge.

8. Activities and resident/staff movement within the Home can continue as in normal circumstances.

9. The Administrator/designate will remain in communication with emergency services personnel and communicate instructions and updates to staff and occupants as appropriate.

10. Family members will be kept informed as much as possible and reunited with residents as soon as the Hold and Secure is lifted and it is safe to do so. During the time of Hold and

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-45
SUBJECT: FACILITY LOCKDOWN	**PAGE:** 3 **OF** 5
	ORIGINAL DATE: October 20, 2005
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Secure, family members should also be advised to keep informed by listening to the radio or monitoring the situation on television.

11. All doors to the outside must remain locked until an all clear is announced. Entering and/or exiting the building will be prohibited unless otherwise advised by Administrator/delegate or Emergency Services personnel.

12. Once the Administrator/designate receives word from emergency personnel that the danger has passed, the Administrator/designate will authorize a page "Hold and Secure Lifted, All Clear". The page will be repeated three times.

13. Ensure that a debriefing meeting is held, and a report filed.

LOCKDOWN PROCEDURE:

1. Lockdown will be used to identify the need to implement a response to a serious threat to residents, staff, and others inside the Home, on the building's property or on property in close proximity to the Home.

2. Notify the Administrator, Director of Care or delegate and Environmental Services Manager immediately upon being informed of the emergency situation.

3. Page "Attention all staff – Implement Lockdown procedures immediately". Repeat the page three times.

4. Call 911 to ensure that emergency personnel are apprised of the situation and will maintain communication on the status of the situation.

5. Residents/staff and visitors outside but close to the main door should be quickly escorted inside if time permits. Wherever possible, residents should be returned to their unit.

6. Employees in the reception area or person in charge of the building/delegate will immediately ensure that all exterior doors are locked.

7. All movement in and out of the Home is restricted, except for access by emergency personnel.

8. Employees in each department must immediately securely close all windows and interior doors and dim the lights, if possible.

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-45
SUBJECT: FACILITY LOCKDOWN	**PAGE:** 4 **OF** 5
	ORIGINAL DATE: October 20, 2005
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9. Staff to encourage residents and visitors to remain calm and as silent as possible.

10. All residents must be kept in their rooms or other areas that are as far away from the threat as possible. This will vary depending on the specifics of the situation (i.e. act of terrorism, an active shooter or other violence, etc.) and the direction of emergency personnel/Executive Director/designate.

11. Staff will accompany residents to the nearest room/designated location if they are not able to safely and quickly reach their own room.

12. Registered staff and department heads/designates are responsible for accounting for all residents and staff.

13. In case of an active shooter or an individual with any type of weapon, implement the Code Silver procedures (Refer to Policy ID # H-10-85, Code Silver - Person With A Weapon) immediately.

14. The Administrator/designate will remain in communication with emergency services personnel at the scene and communicate instructions and updates to staff and occupants as appropriate.

15. Family members will be kept informed as much as possible and reunited with residents as soon as the lockdown is lifted, and it is safe to do so. During the time of crisis, family members should also be advised to keep informed by listening to the radio or monitoring the situation on television.

16. All doors to the outside must remain locked until an all clear is announced. Entering and/or exiting the building will be prohibited unless otherwise advised by administrator/delegate or Emergency Services personnel.

17. Once the Administrator/designate receives word from emergency personnel that the danger has passed, the Executive Director/designate will authorize a page "Facility Lockdown Lifted, All Clear". The page will be repeated three times.

18. Ensure that a debriefing meeting is held and a report filed.

OUTCOME:

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-45
SUBJECT: FACILITY LOCKDOWN	**PAGE:** 5 **OF** 5
	ORIGINAL DATE: October 20, 2005
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1. In the event of a threat in the community or to the Home itself, the most appropriate level of response (Hold and Secure or Lockdown) is implemented immediately.

2. All employees will be familiar with the Hold and Secure and Facility Lockdown procedure.

3. The Home will hold a practice of the Hold and Secure and Lockdown procedures a minimum of annually.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # H-10-40, Priority Code

2. Emergency Plan Manual, Policy ID # B-10-15, Building floor plans and schematics

3. Emergency Plan Manual, Policy ID # H-10-85, Code Silver: Person with Weapon

4. Toronto Police Community Relations Liaison Officer

5. Toronto District School Board, Threats to School Safety Procedures

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-50
SUBJECT: NATURAL GAS LEAK	**PAGE:** 1 **OF** 3
	ORIGINAL DATE: September 9, 2008
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There is a systematic plan in place to respond to a natural gas leak to protect residents, staff, and the public from immediate danger.

2. All employees are responsible for understanding the use of Code Red, Code Green, Code Green Stat, Total Evacuation, and External Air Exclusion, in the event of a natural gas leak.

PROCEDURE:

NOTE: Natural gas is colourless, odourless, and non-poisonous. It can become highly explosive when combined with air and an ignition source. In high concentrations asphyxiation can occur. A strong odorant, mercaptan, which smells like rotten eggs is deliberately added by the supplier so that even the smallest amount of escaped gas can be detected by smell.

IF YOU SMELL GAS and SUSPECT A LEAK:

1. Evacuate the immediate area and alert others to leave the area. Take those in need of help with you, if possible. Otherwise, provide their location to emergency responders.

2. Notify the person in charge of the building.

3. Call 911 immediately if a gas leak is suspected.

NOTE: Do not call from the affected area (See Safety Tips below).

4. Call Enbridge Gas immediately at the 24 hour emergency number.

   - 1 – 866 – 763 – 5427 (1 – 866 – SMEL GAS)

NOTE: Do not call from the affected area (See Safety Tips below).

5. For an **internal gas leak**: open doors and windows in the surrounding area to provide ventilation.

   For an **external gas leak**: close all windows, doors, and ventilation systems (See external air exclusion policy and procedure H – 10 – 30).

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-50
SUBJECT: NATURAL GAS LEAK	**PAGE:** 2 **OF** 3
	ORIGINAL DATE: September 9, 2008
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

6. In the event of a fire follow Code Red policies and procedures in the Emergency Plan Manual.

7. In the event of need to evacuate follow Code Green, Code Green Stat, and Total Evacuation policies and procedures, as deemed necessary and/or as directed by the person in charge.

8. In the event of partial or total building evacuation, evacuees must be taken a safe distance from the Home:

   - Well out of the way of first emergency responders (fire, police, ambulance, and Enbridge Gas personnel)
   - Safe distance as directed by the fire department

NOTE: safe distance is contingent upon the size of pipe and the gas pressure

SAFETY TIPS: If You Smell Gas Indoors or Outdoors or Are Near a Gas Leak

- Do not use a telephone or cell phone in the vicinity of the gas smell (phones can create a source of ignition sufficient to ignite gas fumes).
- Do not turn any electrical switches, appliances, or computers on or off (electrical equipment can create a source of ignition sufficient to ignite gas fumes).
- Do not smoke, use lighters, or matches.
- Do not start any motors or motor vehicles near the gas leak.
- Avoid use of elevators.
- In the event of fire - do not use water on fires that involve natural gas.
- Ensure that internal natural gas lines are clearly marked with a yellow tag.
- Ensure that personnel in charge of the building know where the external natural gas shut off valve is located.

OUTCOME:

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-50
SUBJECT: NATURAL GAS LEAK	**PAGE:** 3 **OF** 3
	ORIGINAL DATE: September 9, 2008
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

1. There is evidence that all residents, employees and other occupants will be safely evacuated from the disaster area in the event of a natural gas leak.

2. The Fire Department and/or Enbridge Gas will test the internal air quality/gas levels and determine when it is safe for residents, staff, and public to reenter the building or a specific area of the building.

ADDITIONAL REFERENCES:

1. Enbridge Gas: www.enbridge.com

2. WHMIS Binder: Material Safety Data Sheet (MSDS) for Natural Gas

3. Emergency Plan Manual Section C: Code Red

4. Emergency Plan Manual Section G: Code Green/Code Green Stat

5. Emergency Plan Manual Section B: Diagrams and Schematics

6. Emergency Plan Manual, Policy ID # H-10-30, External Air Exclusion Policy

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-55
SUBJECT: CARBON MONOXIDE (CO)	**PAGE:** 1 **OF** 6
	ORIGINAL DATE: June 18, 2009
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There is a systematic plan in place to protect residents, staff, and the public from immediate danger in the event of suspected or detected emission of carbon monoxide (CO) gas above safe levels

2. All employees are responsible for understanding the use of Code Red, Code Green, Code Green Stat, and Total Evacuation in the event of actual or suspected carbon monoxide emissions

3. Commercial carbon monoxide detectors (CSA approved) are installed in specified areas of the Home (kitchen, laundry room, boiler room)

4. Equipment is inspected and tested to ensure proper functioning and acceptable air quality

NOTE:

Carbon monoxide is a colorless, odorless, and tasteless gas, making it almost impossible to detect. It can be produced by gas or oil furnaces, space and water heaters, clothes dryers, ovens, wood stoves, and other appliances that run on fossil fuels such as wood, gas, oil, diesel, propane, or coal

Carbon Monoxide vapors are highly flammable and can create a fire and explosion hazard. The explosion hazards are at certain concentrations (reference 1)

Carbon monoxide is classified in the Workplace Hazardous Materials System (WHMIS) as Class D: Poisonous and Infectious Material, Division 1: Materials Causing Immediate and Serious Toxic Effects, Subdivision A: Very Toxic Material

Although everyone is at risk, senior citizens and people with heart and lung problems are at greater risk. If an area is very well sealed or not well ventilated, the levels of carbon monoxide in the air may easily rise to deadly levels

WARNING SIGNS of CARBON MONOXIDE EXPOSURE/POISONING

Low Concentrations: shortage of breath on moderate exertion; slight headache; nausea; dizziness (reference 1)

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Higher Concentrations: severe headache; mental confusion; dizziness; impairment of vision and hearing; collapse or fainting on exertion (reference 1)

Extreme Concentrations: unconsciousness; coma; death (reference 1)

The fatal concentration of carbon monoxide depends on the length of exposure, air turnover, exertion, etc. Levels above 300 parts per million (ppm) for more than 1 -2 hours can lead to death, and exposure to 800 ppm (0.08%) can be fatal after an hour (reference 13)

PROCEDURE:

1. Commercial CSA approved Carbon Monoxide Alarms will be installed in the following locations: kitchen, laundry room, boiler room.

   NOTE: The higher the level or concentration of CO, measured as parts per million (ppm), the faster the alarm sounds. Levels are set in accordance with CSA standards.
   70 ppm: alarm response time of 60 -240 minutes
   150 ppm: alarm response time of 10 – 50 minutes
   400 ppm: alarm response time of 4 – 15 minutes

2. Each Carbon Monoxide Alarm will be checked and tested (using the test buttons) monthly by the Maintenances staff in accordance with the manufacturer's instructions. Additionally, the alarm monitoring company will inspect and test each carbon monoxide alarm (including use of a simulated test with a hand held meter) a minimum of annually.

   NOTE: Life expectancy of the CO detector is 5 -6 years

3. A carbon monoxide detector/alarm control panel with the capability to be triggered by any one of the carbon monoxide alarms in the Home will be installed in a central, clearly visible location at Reception. The alarm will sound in the individual area (kitchen, laundry, or boiler room) if CO levels exceed specific levels and will sound at Reception regardless of the specific location of the CO alarm. Maintenance staff will check and test the control panel a minimum of every 2 months.

   NOTE: The control panel alarm is fitted with a rechargeable battery that will continue to operate the alarm for 48 – 60 hours in the event of a power surge or power failure. The battery should be changed every 5 years in accordance with the installation date noted on the control panel. If the control panel alarm sounds, refer to step # 5 below. If the trouble signal on the control panel lights up notify maintenance and/or contact the installation/service company at (905) 277-2975. During investigation to determine the

cause of the alarm sounding, the control panel alarm can be silenced and then reset once an all clear is given. After resetting the alarm panel, ensure that the only light on is the green power light

4. Arrange and document regular safety inspection of equipment (ovens, stoves, steamer, gas appliances, boiler, etc.) in accordance with Technical Standards and Safety Authority (TSSA) standards

5. If the **Carbon Monoxide Alarm Sounds** the following steps must be taken:

- Immediately notify the person in charge of the building
- Notify Environmental Services Manager/Maintenance immediately. After hours maintenance on-call number is as follows: (647) 285-1795
- Call 911 immediately if anyone in the area is experiencing signs and/or symptoms of carbon monoxide exposure(see Warning Signs page 1 above)
- Open doors and windows in the surrounding area to increase ventilation, if required
- Shut off any problematic equipment/appliance in the specific area where the alarm was triggered (kitchen, laundry room, boiler room). Maintenance will contact the 24 hour service repair company as appropriate:
  - Kitchen equipment contact : Inter-City Food Equipment Inc. (416) 283 - 5515
  - Laundry appliances contact: Harco (905) 890 - 1220
  - Boiler room equipment contact: Naylor (905) 764 – 0913
- Call Enbridge Gas immediately if any gas odour is detected (natural gas leaks can contribute to carbon monoxide emissions). The 24 hour emergency number is

  1 – 866 – 763 – 5427 (1 – 866 – SMEL GAS)

Note: Please refer to Emergency Plan Manual (H -10 -50)

- If necessary, evacuate the identified area and alert others to leave the area. Take those in need of help with you, if possible. Otherwise, provide their location to emergency responders

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:**	EPM H-10-55
SUBJECT:	CARBON MONOXIDE (CO)	**PAGE:**	4 **OF** 6
		ORIGINAL DATE:	June 18, 2009
APPROVED BY:		**REVIEWED DATE:**	July 26, 2022

- In the event of need to evacuate follow Code Green, Code Green Stat, and Total Evacuation policies and procedures, as deemed necessary and/or as directed by the person in charge

- In the event of partial or total building evacuation, evacuees must be taken a safe distance from the Home:

  - Well out of the way of first emergency responders (fire, police, ambulance, and Enbridge Gas personnel)
  - Safe distance as directed by the fire department

  NOTE: safe distance is contingent upon the levels of carbon monoxide determined by the fire department and/or the gas company

- Return of evacuees to the area/Home will be on the direction of Emergency Services personnel based on the return to safe CO air quality levels from their detection meters

SAFETY TIPS:

- Install a carbon monoxide detector in areas that may present a hazard in order to recognize the presence of this deadly gas before a serious situation develops
- Ensure that all carbon monoxide detectors are in good working order (test the unit at least once monthly)
- Ensure that the carbon monoxide alarm system is in good working order
- Ensure that all appliances are in good working order and area properly vented according to manufacturer's recommendations and regulatory requirements
- Immediately report any warning signs so that additional testing for carbon monoxide levels can be quickly arranged, as appropriate
- Keep chemicals such as butane, rubbing alcohol, and nail polish remover away from the carbon monoxide detector as these products can affect the sensing device which could lead to false alarms
- Be familiar with the following sources of CO: (reference 2)
  - A defective chimney
  - Improperly installed gas appliances
  - Car running in attached garage
  - Barbeque used in an enclosed area
  - Gas or wood burning fireplace
  - Corroded or disconnected vent pipe, valves, etc.
  - Blocked vent

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-55
SUBJECT:	CARBON MONOXIDE (CO)	**PAGE:** 5 **OF** 6
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- Cracked heater exchange
- Portable heater fueled by gas, propane or kerosene

OUTCOME:

1. Promotion of safety in the workplace and prevention of accidents from harmful levels of carbon monoxide
2. All residents, employees and other occupants will be safely evacuated from the disaster area in the event of carbon monoxide levels exceeding safe levels
3. All equipment and appliances that have the potential to emit carbon monoxide gas are inspected according to TSSA standards and are tested on a regular basis
4. There is system for regular preventative maintenance of equipment to ensure its proper functioning
5. Ventilation equipment and systems to prevent the buildup of harmful gases in the air are installed and functioning properly
6. Carbon Monoxide detectors are installed in targeted locations and are Canada Safety Association (CSA) approved
7. Carbon monoxide detectors have an automatic recharging battery back up component
8. The carbon monoxide alarm system is installed and functioning properly
9. Staff respond appropriately if the carbon monoxide alarm sounds
10. The Fire Department and/or Enbridge Gas test the internal carbon monoxide levels and determine when it is safe for residents, staff, and public to reenter the building or a specific area of the building if evacuation was necessary.

ADDITIONAL REFERENCES:

1. Canada Safety Council
2. Canadian Standards Association (CSA)
3. Technical Standards and Safety Authority (TSSA)

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-55
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4. Occupational Health and Safety Act
5. Enbridge Gas: www.enbridge.com
6. City of Toronto, Emergency Services: Police, Fire and Ambulance
7. WHMIS Binder: Material Safety Data Sheet (MSDS) for Carbon Monoxide Gas
8. Emergency Plan Manual Section C: Code Red
9. Emergency Plan Manual Section G: Code Green/Code Green Stat
10. Emergency Plan Manual Section B: Diagrams and Schematics
11. Emergency Plan Manual, Policy ID # H -10 -50, Natural Gas Leak policy
12. Canadian Centre for Occupational Health and Safety

13 Carbon Monoxide Detector Manufacturer's Instructions

14. Safety Emporium, Laboratory and Safety Supplies, the MSDS Hyper Glossary

SECTION: EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-60
SUBJECT: CODE BROWN - CHEMICAL SPILL	**PAGE:** 1 **OF** 3
	ORIGINAL DATE: October 8, 2009
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There is a systematic plan in place to respond to a chemical spill to protect residents, staff, and the public from immediate danger.

2. All employees are responsible for understanding the use of Code Red, Code Green, Code Green Stat, and Total Evacuation in the event of a chemical spill.

NOTE:

- Spills are defined as releases of pollutants into the natural environment originating from a structure, vehicle, or other container, and that are abnormal in light of all circumstances.

DEFINITIONS:

A **Minor Spill** is one in which **ALL** of the following conditions are met:

- the responsible party is at the scene; and
- the material spilled is known; and
- the material spilled is not highly toxic; and
- the quantity spilled is small; and
- there is no fire hazard present; and
- the spill is completely contained inside the building; and
- the material has little or no potential to reach the environment (e.g., via floor drain); and
- the spill is not in a common area (e.g., a hallway) or other areas accessible to the general public (residents, staff, visitors)
- advanced personnel protective equipment (e.g., more than gloves and a half-face respirator) is not needed to respond to the spill

A **Major Spill** is one in which **ANY** of the following conditions apply:

- the material spilled is highly toxic; or
- a large (or undetermined) quantity was spilled; or
- the material has the potential to reach the environment (e.g., via floor drain); or
- the spill is in a common area (e.g., hallway) or other area accessible to the general public (residents, staff, visitors); or
- advanced personnel protective equipment (more than gloves and a half-face respirator) is required to respond the spill; or
- adverse health effects; or
- safety risk; or

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- loss of enjoyment of normal use of property; or
- interference with the normal conduct of business; or
- a responder is unsure whether the spill should be considered "Minor" or "Major".

PROCEDURE:

Minor Spills:

If the spill is on your Unit:

1. The staff member upon recognizing a minor spill must page Code Brown and the location of spill 3 times.
2. Staff will remove residents from the affected area and block access to the spill area using wet floor signs or any other object necessary to ensure that residents or staff does not enter the spill zone.
3. If at any time staff feel that the residents and their own safety is a risk, they must perform a Code Green or a Code Green STAT.
4. Environmental staff are to report to the spill location paged wearing appropriate PPE and must bring with them the Chemical Spill bag located in the laundry chemical area.
5. Environmental staff must also bring the wet vacuum cleaner to the affected area in order to clear up the spill.
6. Once Environmental staff has cleaned/controlled the area where the spill occurred, they will inform the US to page Code Brown All Clear 3 times and regular duties may be resumed.

If the spill is not on your unit:

7. All staff on units that are not directly affected by the chemical spill must account for residents on their floor and remain alert in order to react to further instructions over the PA system.
8. Two staff members (1 Staff member at night) per unit are expected to report to the affected floor if a Code Green/Green STAT is paged in order to assist with transfer of residents off the unit.

Major Spills:

1. The staff member upon recognizing a major spill must page Code Brown and the location of spill 3 times.
2. Immediately notify the person in charge of the building who will then notify the Environmental Services Manager/Maintenance immediately. After hours maintenance on-call number will be called.

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3. Major spills are to be reported to the Ministry of the Environment, Spills Action Centre: 1-800-268-6060 immediately.
4. Staff will remove residents from the affected area and block access to the spill area using wet floor signs or any other object necessary to ensure that residents or staff does not enter the spill zone.
5. If at any time staff feel that the residents and their own safety is a risk, they must perform a Code Green or a Code Green STAT.
6. Environmental staff are to report to the spill location paged wearing appropriate PPE and must bring with them the Chemical Spill bag located hanging in the laundry chemical area.
7. Environmental staff must also bring the wet vacuum cleaner to the affected area in order to clear up the spill.
8. Once Environmental staff has cleaned/controlled the area where the spill occurred, they will inform the US to page Code Brown All Clear 3 times and regular duties may be resumed.

If the spill is not on your unit:

9. All staff on units that are not directly affected by the chemical spill must account for residents on their floor and remain alert in order to react to further instructions over the PA system.
10. Two staff members (1 staff member at night) per unit are expected to report to the affected floor if a Code Green/Green STAT is paged in order to assist with transfer of residents off the unit.

OUTCOME:

1. Staff respond appropriately if there is a chemical spill.

ADDITIONAL REFERENCES:

1. Ministry of the Environment: www.ene.gov.on.ca

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STANDARD:

1. There is a systematic plan in place to ensure the safety of residents, staff and visitors from immediate danger in the event of an impending emergency/disaster.

2. In most instances, Severe Weather Warning will be initiated by the Atmospheric Environment Service of Environment Canada or Radio/TV Announcements.

3. All employees are responsible for understanding the use of Code Orange - Severe Weather Warning in the event of a disaster/emergency situation.

4. The emergency plan is initiated when the decision to secure residents and staff is made by the Emergency Response person/Charge Nurse.

DEFINITIONS:

Severe Thunderstorm Watch

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

Severe Thunderstorm Warning

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

Tornado Watch

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

Tornado Warning

A tornado warning means that a tornado has been sighted or is imminent. Take immediate precautions.

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The principle effects of a large tornado:

- Disintegration of buildings due to wind pressure
- Injuries and damage by wind-driven objects and by debris falling
- Explosive pressure created by the passage of the center of the tornado's core.

Winter Storm Warning

A warning is issued if hazardous winter conditions are expected or occurring, including a major snowfall of 25 cm (9.8in) or more in a 24-hour period.

Winter Storm Watch

A winter storm watch will be issued in advance of the storm (usually at least 24 hours). It Indicates the risk of a hazardous winter weather event has increased (at least a 50% chance of occurring), but its occurrence, location, and/or timing is still uncertain. It is intended to provide enough lead time so you can make plans to stay safe.

Hot Weather/Heat Wave

A heat wave is a period of abnormally hot weather generally lasting more than two days. Heat Waves can occur with or without high humidity. They have potential coverage of a large area, Exposing a high number of people to hazardous heat.

Follow Policy ID # G-20 Hot Weather-Related Plan in the Resident Care and Services Manual.

Earthquake Early Warning

Earthquake Early Warning is the rapid detection of earthquakes, real-time estimation of the shaking hazard and notification of expected shaking. Earthquake Early Warning provides seconds to tens-of- seconds of notice before strong shaking starts, which can help reduce Injuries, death and property losses.

Hurricanes Watch

A hurricane watch is issued when a tropical cyclone containing winds of at least 74 miles per Hour poses a possible threat, generally within 48 hours.

PROCEDURE:

1. The Administrator/designate will page "Code Orange – Severe Weather Warning" three (3) times.

2. Staff shall move all residents to the corridor and internal central areas, away from windows. Windows on the leeward side (away from the wind) of the building should be opened to

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reduce the explosive effect of suddenly reduced air pressure that occurs during a tornado. Close drapes on the windy side. (Drapes reduce injury from flying glass).

3. Move the beds of residents who are bedridden into the corridor. Put the brakes on the bed. Leave room doors open.

4. Avoid the use of elevators in case of power failure.

5. Keep residents as calm as possible and away from windows and doors.

6. Instruct visitors to remain in the corridors with residents.

7. Leave the radio/TV on to listen for tornado information. Assign a staff member to monitor the radio and provide updates.

8. Assemble the following supplies in a central area:
    - Care Plans
    - Dressing tray with supplies
    - Med Cart & all Med bins
    - Urinals
    - Bedpans
    - Blankets
    - Flashlights
    - Portable phone
    - Fan out List
    - Battery-operated radio
    - Leave of Absence (L.O.A.) Book

9. Announce "Code Orange All Clear" three (3) times when a severe weather warning has ended.

10. The Home follows recovery processes.

11. The reaction to the code will be evaluated and debriefed with the team within 30 days of the incident.

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OUTCOME:

1. All Staff will respond to **"Code Orange – Severe Weather Warning"** as per policy.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # G-15-05, Types of Evacuation policy
2. Emergency Plan Manual, Policy ID # B-10-15, Diagrams and Schematics
3. Atmospheric Environment Services of Environment Canada
4. Resident Care and Services manual, Policy ID# G-20, Hot Weather-Related Plan

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Please refer to the Resident Care and Services Manual, Policy ID # G-20, Hot Weather-Related Plan

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-70
SUBJECT:	LOSS OF COMMUNICATION (LOSS OF RESIDENT-STAFF COMMUNICATION AND RESPONSE SYSTEM	**PAGE:** 1 **OF** 1
		ORIGINAL DATE: December 15, 2017
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. There is a plan and process to effectively manage care and service delivery during a temporary loss of the internal call bell system.

PROCEDURE:

1. In the event of a loss of the internal call bell system; partial or full system loss, contact the supplier and notify them of the disruption in service and request immediate emergency repairs.

2. If the loss of the call bell system is expected to be greater than 6 hours, the Director of Care will inform the Administrator.

3. If the loss of the call bell system is greater than 6 hours, the Director of Care or delegate will ensure that the Ministry of Health and Long Term Care is informed of the loss of the call bell system, followed by a CIS.

4. If out because of Hydro: If loss of hydro occurs during business hours, the Environmental Services Manager will utilize their cellular phone. If loss of hydro occurs after hours, charge nurse or delegate will use their cellular phone.

5. Staff will be requested to inform all residents that the internal call bell system is down and that staff will check on residents every 15 minutes. In addition, staff will be requested to run messages to other floors.

OUTCOME:

1. Staff demonstrate knowledge and follows protocol in the event of loss of resident-staff communication and response system.

ADDITIONAL REFERENCES:

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SUBJECT:	LOSS OF POWER TO SAFETY & EMERGENCY EQUIPMENT	**PAGE:** 1 **OF** 3
		ORIGINAL DATE: December 15, 2017
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STANDARD:

1. There is a plan and process to effectively manage care and service delivery during a temporary loss of power to safety and emergency equipment.

2. The following equipment will need to be managed: Magnetic Door Locks, Therapeutic Surfaces, Fire Panel and the Fire Alarm System.

3. The Loss of Power to Safety and Emergency equipment policy will be immediately implemented when a power outage occurs.

PROCEDURE:

1. If loss of service to the safety and emergency equipment occur during regular business hours, the Administrator will take the lead on activating this policy.

2. If after hours, the Charge Nurse or delegate will take the lead on activating this policy and will notify the Administrator and Environmental Services Manager. The Administrator will provide direction as to the need to contact other Department Managers.

3. If loss of services is anticipated to be of long duration, the Administrator/delegate will contact the Director of Care and inform her of the situation.

Staff Roles and Responsibilities

Administrator:

1. Upon notification of loss of power to safety and emergency equipment, the Administrator, Director of Care or Environmental Services Manager will coordinate the implementation of this plan.

2. The Administrator/Director of Care/Delegate will assume the lead role for the loss of the power to safety and emergency equipment.

3. The Administrator or Delegate will inform the Department Managers of the loss of power to safety and emergency equipment and provide direction as required.

4. The Administrator will assign additional resources as needed.

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Director of Care or Delegate:

1. Inform the Registered Staff that there is loss of service to safety and emergency equipment.

2. If loss of service is to the magnetic lock: direct Registered Staff to assign staff (i.e. Personal Support Workers, Activity Aide, Housekeeper) to monitor each exit door until service resumes.

3. If loss of service is to the therapeutic surface: direct Registered Staff to check on all residents currently on therapeutic surfaces and if required transfer resident onto a therapeutic surface. The Director of Care will notify the Environmental Services Manager that therapeutic surfaces are required. The Environmental Services Manager will obtain the therapeutic surface from the supply room and have it delivered to the resident in need.

4. If the loss of service is to the G-tube Feed: direct Registered Staff to check on all residents with a G-tube feed to ensure battery back-up is operational. The Director of Care will notify the Environmental Services Manager or Delegate the battery back-up is not operational.

5. If the loss of service is to the Fire Panel and or Fire Alarm System, The Director of Care or Delegate will direct nursing staff to implement q15 fire safety checks. If smoke or fire is detected, Code Red will be activated immediately.

6. The Director of Care or delegate will inform the Executive Director if additional resources are required.

7. The Director of Care or delegate will keep the Executive Director informed of any safety risks.

8. The Director of Care or delegate will inform the Ministry of Health and Long Term Care of the loss of elevator service if greater than 6 hours.

Environmental Services Manager:

1. The Environmental Services Manager or delegate will contact service providers as required.

2. Inform department staff that there is a loss of power to safety and emergency equipment.

3. The Environmental Services Manager will support the home in ensuring resident, visitor and staff safety.

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Programs Manager:

1. Inform department staff that there is a loss of power to safety and emergency equipment.

2. Direct department staff as required.

Food Services Manager:

1. Inform department staff that there is a loss of power to safety and emergency equipment.

2. Direct department staff as required.

OUTCOME:

1. Staff demonstrate knowledge and follows protocol in the event of loss of power to safety and emergency equipment.

ADDITIONAL REFERENCES;

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STANDARD:

1. Code Silver is a planned response to ensure the safety of all staff, residents and visitors at the Long-Term Care (LTC) Home when an individual is in possession of a weapon and an enhanced police response is required. Code Silver should be called if there is a threat, attempt, or active use of a weapon to cause harm, regardless of the type of weapon.

2. Code Silver will not result in other LTC Home staff coming to assist, as it is designed to keep people away from harm. Police will be contacted as soon as Code Silver is called.

3. Staff members will immediately call the Receptionist or person in charge after hours and initiate Code Siler when they observe or are told a person who is (or persons who are):

    - Attempting to harm or injure people with any weapon; or
    - Carrying a weapon on or near the LTC Home grounds.

4. When a Code Silver is initiated all staff will make every reasonable effort to protect themselves, residents, visitors and others in their immediate area, following the procedures set out in this document.

PROCEDURE:

A. Staff who are in the immediate area of the assailant:

DO NOT attempt to engage the assailant. This includes verbal and physical attempts to deescalate the situation.

1. **Remain CALM and EVACUATE.**
    - Do not confront a person with a weapon
    - Do not attempt to remove wounded persons from the scene
    - If possible, assist others to leave the area and redirect those trying to enter
    - Evacuate if able and safe to proceed
        - ➢ Only evacuate if you are close to an exit and can get there safely, without attracting attention

- While evacuating keep hands visible at all times (not to be mistaken for the shooter)
- Leave any belongings behind

2. **If unable to evacuate, HIDE.**
   - Use rooms with doors that lock
   - Barricade the door with heavy furniture or equipment
   - Silence mobile devices and turn off any sources of noise (e.g. radios, televisions, etc.)
   - Hide behind large objects (e.g. cabinets, desks, walls, etc.)
   - Remain quiet and low to the ground

3. **SURVIVE.**
   - **Fight only as a last resort and only if your life is in imminent danger**
   - Attempt to disrupt and/or incapacitate the assailant by: Acting as aggressively as possible against him/her, throw items and improvising weapons, yelling, commit to your actions
   - If others are available, work together to distract and attack the assailant as fiercely as possible

4. **CALL the Receptionist or Nurse In-charge after hours as soon as possible.**
   a. Inform the Receptionist/Nurse In-Charge to initiate Code Silver
   b. Give the Receptionist/Nurse In-charge as much information as possible including:
      - Location of the assailant(s) (current, last known, and/or direction headed)
      - Type of weapon(s)
      - Description of the assailant(s)
      - Any comments or demands made by the assailant(s)
      - Information on victims and/or hostages
      - Any other information you feel may be relevant
   c. Remain on the line, and follow the instructions of the Receptionist/Nurse In-Charge (stay as quiet as possible)

When a Code Silver is initiated, all staff will make every reasonable effort to protect themselves, residents, visitors, and others in their immediate area.

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B. All staff in areas near the Code Silver location:

1. If you can leave safely, EVACUATE:

- Remain calm and follow Police direction, if available
- Quickly leave the area, evacuating as many residents and other people as possible
- Redirect any people entering the area to evacuate to a safe location
- Move to a safe, pre-determined meeting point (if possible)

Unit Supervisors/delegate: Once at the meeting point, perform a headcount to determine if your team is accounted for.

2. If you cannot leave safely, HIDE:

- Remain calm
- Protect yourself and individuals in your area by quickly and quietly:
  - Closing doors, locking and barricading yourself and others inside (where possible)
  - Positioning people out of sight and behind large items that offer protection. (e.g. behind desks, cabinets, and away from windows)
  - Silencing personal alarms, mobile phones/tablets and other electronic devices (e.g. TVs, Radios, etc.)
  - Turning off monitors and screens (where possible) to reduce backlighting
  - Instructing others, who are capable of assisting, to do the same with other resident rooms (i.e. visitors may assist with the resident room they are visiting)
- **If able and safe to do so, call the Receptionist/Nurse In-charge or 911 to report where occupants are hiding** (911 has capacity to manage multiple calls as compared to a Receptionist)
- **Do not use the telephone unless directly related to the Code Silver**. Medical Emergency Codes will not be called for victims of the assailant until the incident site is secured by Police
- **Hide in place** until "Code Silver, All Clear" is announced overhead
- **If the assailant enters your work area,** contact the Receptionist/Nurse In-Charge or 911 if it is safe to do so

C. Staff in other Locations within the LTC Home:

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- **Do not attempt to return to your Resident Home Area**
- **Follow the instructions of the Area In-Charge Person/Supervisor in your current location**
- Lock down all external doors and doors between areas, as per the Home's Facility Lock-Down policy, refer to Policy ID # H-10-45.
- Stay where you are, protecting yourself and assisting others in your area, if possible
- Divide into small mixed groups of staff, residents and visitors. Hide in resident rooms, meeting rooms, bathrooms, offices, etc. Wherever is available and safe to do so
- Advise residents, visitors and others to hide; ask them to remain calm, quiet, and to avoid using their phones, any other electronic device, or posting to social media
- Move away from exposed windows, walls, and doors. Cover interior windows if able. Lay on floor, under/behind furniture. If possible, hide against the wall that is on the same side as the door into the room. The room must appear empty
- Minimize movement within the area to essential, safety-related matters
- Silence personal alarms, mobile phones/tablets and other electronic devices
- Do not use the telephone unless directly related to the Code Silver incident

Unit Supervisors/delegate: Once lockdown of the area is complete, and only if safe to do, perform a headcount.

Police must approve all movement throughout the Home until the Code Silver has been cleared. This includes responding to other codes and resident care needs.

D. Upon arrival of Police:

The LTC Home is reminded that law enforcement personnel are the primary responders and will assume control in any Code Silver response.

Do not interfere with the Police Officers by delaying or impeding their movements: The Police are there to stop the threat as soon as possible. Officers will proceed directly to the area the assailant was last seen or heard. The first officers at the scene will not stop to assist injured individuals.

Police Officers will be responding with the <u>intent to use a required level of force to diffuse the situation</u>. Ensure you do not present yourself as a threat to them:

- Drop any items in your hands (e.g. bags, jackets, etc.)
- Immediately raise hands and keep them visible at all times
- Remain calm and follow Officers' instructions; avoid screaming and/or yelling
- Avoid making quick movements toward Officers
- Do not attempt to grab hold of an Officer
- Do not stop to ask Officers for help or direction when evacuating:
- Proceed in the direction from which Officers are entering the area or take direction from internal In-Charge Person

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

Rescue teams comprised of additional Officers and emergency medical personnel may follow the initial Officers when it is safe to do so. 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.

E. Receptionist/In-Charge Person:

If more than one person is available, work to complete all these requirements in tandem.

- **Announce overhead three times *"Code Silver (and specific location, if known)"***
- **Call 911 and notify police.**
  - Advise 911 operator of all available information such as:
    - Location of incident, including current location and any affected locations

  - Description of assailant(s)
  - Type & description of weapon(s)
  - Information on hostages / victims (if any)
  - Any comments or demands made by the assailant
  - Any other information you received from the HCW who reported it
- Remain on the line to provide updates
- Follow instructions of the 911 operator

- **Notify the Administrator/Director of Care in the building or On-Call Nurse immediately after placing the 911 call**
- **Administrator or Director of Care will notify the Owner as soon as possible.**
- Close, lock and, if possible, barricade the area to reception.

F. Admninistrator/Director of Care/Person In-Charge:

When you hear Code Silver overhead, initiate facility lock-down procedures.

- Remain calm
- Notify the Owner of the Code Silver
- Determine if any armed Police or trained law enforcement personnel are already on-site to assist with response
- Use any available remote surveillance tools to monitor and record the assailant
- Determine if Fire Department or EMS personnel are required
- Prepare to meet Police at the pre-determined location
- Prepare floor plan for police review

Upon Police arrival:

- Provide a situation update to Police
- Provide Police with proximity reader access cards (if applicable) and master keys
- Assist Police with all requests
- Confirm attendance of persons from affected area, to determine if anyone is unaccounted for
- Take notes and document all activities
- Secure (as safety allows) specific interior and exterior doors as directed by police
- Ensure all public announcements and/or communications requested by police are made

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- Provide access/egress control as directed.
- Maintain contact with the Police Command Centre, providing regular updates, and information on any situation changes as they occur.

G. Recovery:

Police will advise the Administrator/delegate when it is safe to end the Code Silver.

Once the Police have said it is safe to do so, the Receptionist/delegate will announce *"Code Silver, All Clear"* overhead three times.

All staff should return to their work area for debriefing. Staff from the affected area should go to a designated meeting point.

The Home should consider how to address any operations that may not be immediately available post-incident. This may occur if the affected area is secured for investigation, or if damage to facilities and equipment inhibits their use.

As soon as possible, the Administrator/delegate should conduct a debriefing including participation of any responding law enforcement.

As part of the recovery process, the Home will consider the physical and mental health needs of all staff, residents and visitors. Support will be provided, utilizing existing and additional identified programs (e.g. Employee and Family Assistance Program, individual and group counselling, and workers compensation, as necessary.)

Staff should speak with their immediate supervisor regarding any specific concerns, needs, or considerations.

OUTCOME:

1. In the event of an individual in possession of a weapon (regardless of the type of weapon) is identified in the Home or on the grounds a Code Silver is initiated immediately.

2. When a Code Silver is initiated, all staff will make every reasonable effort to protect themselves, residents, visitors and others in their immediate area, following the procedures set out in this policy.

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3. Upon arrival of the Police, the staff understand that the law enforcement personnel are the primary responders and will assume full control of the Home until they feel it is safe to clear the Code Silver.

4. The Home will hold a practice of the Code Silver procedure at a minimum annually.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual, Policy ID # H-10-40, Priority Code

2. Emergency Plan Manual, Policy ID # H-10-45, Facility Lock-Down

3. Emergency Plan Manual, Policy ID # H-10-15, Building floor plans and schematics

4. Toronto Police Community Relations Liaison Officer

5. Ontario Hospital Association: Sample Code Silver Policy and Procedure, retrieved from web on July 31, 2019: https://www.oha.com/Documents/Code%20Silver%20Policy%20template%20tool.docx

SECTION:	EMERGENCY PROCEDURES	**INDEX I.D.:** EPM H-10-90
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APPROVED BY:		**REVISED DATE:** July 26, 2022

STANDARD:

The primary intent of a boil water advisory is to protect residents, staff and visitors from potential health risks related to drinking water of unacceptable microbiological quality. Emergency boil water advisories should be issued in response to the confirmed detection of Escherichia coli (E. coli) in drinking water. The detection of E. coli in drinking water is a definite indication of human or animal fecal contamination and the possible presence of pathogenic microorganisms. If the presence of E. coli is confirmed in drinking water, an emergency boil water advisory should be issued immediately.

There are several situations which may prompt the issuance of a precautionary boil water advisory. These situations need to be assessed on a case-by-case basis and require the City of Smiths Falls incident response team to conduct an investigation and site-specific risk assessment. They are outlined below:

- Local maintenance or planned repairs in the distribution system which may cause a
- significant pressure drop, a breach in system integrity or potential contamination of
- drinking water;
- Persistent presence of total coliforms in the distribution system, despite remedial
- measures (such as flushing water mains, and increasing chlorine residuals);
- Minor equipment malfunction which may impact treatment efficacy or distribution
- systems;
- Unexpected changes in source water quality that could overwhelm the treatment system;
- Unexpected and significant changes in routine monitoring parameters within the
- distribution system such as pressure, turbidity and disinfectant residuals; and
- A breach in system integrity such as a broken water main (e.g., pressure loss).

PROCEDURE:

ON NOTIFICATION OF A BOIL WATER ADVISORY

1. The Administrator/Delegate to page Code Orange, Boil Water Advisory three (3) times over the P.A. to advise staff, residents, essential caregivers and visitors of the advisory.

2. The Director of Care/Delegate to provide the units with disposable wipes to provide resident care. Residents are to be monitored for symptoms of severe stomach cramps, diarrhea (often bloody), vomiting and fever for 2-5 days after the advisory has been issued and report any symptoms to

Lanark, Leeds and Grenville Public Health.

3. All water used for drinking; preparing food, hot and cold beverages and ice cubes; washing fruits and vegetables; and dental hygiene must be boiled. In the event that boiling is not practical, the local public health or other responsible authority will be able to give directions for the disinfection of water or the use of an alternative supply known to be safe. Refer to Table 1 Specific Guidance During a Boil Water Advisory.

4. The Administrator or designate will contact the Public Health Unit that issues the boil water advisory for more information as needed.

5. The Administrator or designate will ensure that all team members, residents, families, essential care givers and visitors are made aware of a boil water advisory in effect and when it is over.

6. The Administrator or designate will inform the Vice President of Operations or Director of Operations of the boil water advisory.

7. The Administrator or designate will ensure that the Ministry of Long-Term Care is informed of the Boil Water Advisory incident in the Home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5) of the *Fixing Long-Term Care Act, 2021.*

8. The Administrator or designate will ensure alternate water sources are provided to residents, staff, essential care givers and visitors that is safe for drinking.

9. The Infection Prevention & Control Manager or designate will: post signage at the entrance to the Home and at all faucets, including the kitchen area, washrooms, and hand sinks, as a reminder that a boil water advisory is in effect and that the water is not safe to drink.

10. The Infection Prevention and Control Manager or designate will post signage advising team members, residents, essential caregivers and visitors to apply alcohol-based hand sanitizer after normal handwashing procedures with warm tap water and paper towels.

11. The Environmental Services Manager or designate will disconnect all drinking water fountains, beverage dispensers with post-mix service, and ice-making machines from the affected water supply.

12. The Environmental Services Team will provide alcohol-based hand sanitizer, containing at least 70% alcohol, in all public and team member washrooms and at all standalone hand sinks.

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13. The Food Services Manager or designate will discard any ice and beverages that may have been prepared with the affected water supply and sanitize ice cube trays. Direct team to prepare boiled water as needed:

    a. bring water to a rolling boil for at least one minute.
    b. use an electric kettle if possible.
    c. only boil as much water as you can safely lift without spilling.
    d. if boiling water on the stove, place the pot on the back burner.
    e. take all precautions as needed to avoid burns.

14. If providing bottled water, check with Public Health Unit about brands of bottled water or water dispensers considered to be safe that are produced in locations not affected by the boil water advisory.

15. The Food Services Manager/Supervisor will direct staff when preparing food during a boil water advisory to

    a. use boiled water that has been cooled to room temperature or sterile water to wash broken skin and wounds and for other resident care activities (note: commercial bottled water is not sterile).
    b. consider using sterile bottled, boiled, or otherwise disinfected drinking water for severely compromised residents.
    c. discuss with physician/Nurse Practitioner any special precautions that may be needed for residents with weakened immune systems.

    NOTE: Water filtration devices **cannot** be relied on to make tap water safe to drink or cook with. Do not use water unless it has been boiled first.

CLEANING AND SANITIZING PRACTICES DURING A BOIL WATER ADVISORY:

1. Tap water can be used for cleaning and disinfecting contact and non-contact surfaces such as doorknobs, handles, railings, vanities, etc. and non-contact surfaces such as walls, floors, and ceilings can be cleaned and disinfected using normal routine practices.

2. During a boil water advisory, tap water may be used for general laundry procedures. Wet laundry must be dried in a mechanical drying machine on a normal setting or hotter. Consult with Infection Prevention & Control Manager or designate to verify correct procedures for sterile linen processing.

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3. Any instruments or machines that use water to sterilize and disinfect equipment would typically be affected by a boil water advisory. Consult with Infection Prevention & Control Manager or designate before use of any specialized medical equipment directly connected to the water supply.

4. Contact Public Health for specific questions related to water quality.

PREPARING FOOD DURING A BOIL WATER ADVISORY

1. **DO NOT** use the water for drinking, making juices or ice, washing fruits or vegetables, or preparing ready-to-eat foods.

2. Turn off drinking water fountains.

3. Discard ice and beverages that may have been prepared with the affected water supply.

4. Discontinue making ice; use ice from a commercial ice supplier made with safe water.

5. Disconnect ice cream machines, dipper wells, and any other food preparation equipment connected to the water supply.

6. Post signs at all faucets, including kitchen area and washrooms, as a reminder of the boil water advisory and not to drink the water.

7. To make the water safe, bring to a rapid rolling boil for at least one minute. Boil only as much water in the pot as one can comfortably lift without spilling. o Ensure water is cooled appropriately before using or direct handling to prevent scalds.

8. Water that has been boiled for one full minute (water can be boiled the night before, cooled overnight, and stored in a covered disinfected container). Always ensure water is cooled appropriately before use or direct handling to prevent scalds.

9. Commercially bottled water (consult with Infection Prevention & Control Manager or designate to confirm the brand used has not been affected by the Boil Water Advisory)

10. Hauled water from an alternate approved supply not affected by the Boil Water Advisory

11. Beverage machines connected to the cold water supply used to dispense cold drinks (carbonated beverages, iced cappuccino, etc.) **must not** be used during the boil water advisory.

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12. Ensure the coffee maker/hot tea tower produces water at 70° C/160° F. This temperature is sufficient to inactivate disease-causing microorganisms. It is recommended that the coffee pot be held for at least five minutes on the burner prior to consumption. Verify temperature using a probe thermometer.

13. Use boiled, bottled, or an alternate safe water source in the preparation of food products such as powdered drinks, puddings, jellies, sauces, etc.

14. Tap water can be used to prepare foods that will be boiled as long as the water is brought to a rolling boil for one minute.

15. Tap water can be used to wash dishes by hand. Follow the 3-compartment sink dishwashing procedure, and ensure dishes have enough time for complete air drying to take place. The commercial dishwasher can be used to clean and disinfect dishes. Follow normal dishwashing procedures, and ensure dishes have enough time for complete air drying to take place. Domestic style dishwashers can be used in the Home, provided the machine has a hot temperature setting or sanitizer cycle. If the dishwasher does not have a hot temperature setting, stop the dishwasher at the start of the rinse cycle, add 4 teaspoons (20 mL) of liquid household chlorine bleach containing 5.25% sodium hypochlorite, then re-start the dishwasher. Let dishes dry completely, using a heated cycle dry on the dishwasher.

16. Glass washer with cold water rinse **cannot** be used. Glass washers with a cold water rinse **must not** be used during the boil water advisory. Use a hot water sanitizing cycle to wash and sanitize glasses. For further information, discuss with Public Health.

17. Wash kitchen surfaces with soap, then rinse and sanitize with bleach solution. To prepare the bleach solution (sanitizer strength of 200mg/L chlorine solution):

    a. add one teaspoon of liquid household bleach (5.25% sodium hypochlorite) to one litre of room temperature water that has either been previously boiled, is from a safe bottled water source, or has been hauled from a safe public supply.
    b. spray or pour the solution onto food contact surfaces and let sit for a minimum of 2 minutes.
    c. make a new bleach solution every day (bleach breaks down quickly once it is mixed with water).

Note: vinegar is not an acceptable disinfectant.

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WHEN THE BOIL WATER ADVISORY HAS ENDED

1. The Environmental Manager or designate will direct the team to:
    a. Flush all water-using fixtures and faucets by running them for five minutes (if your service connection is long or complex, consider flushing for a longer period of time). In a multi-story building, begin on the top floor, flushing each fixture and faucet for five minutes. Once every fixture and faucet has been flushed for five minutes, proceed to the next floor below; continue the procedure until all fixtures and faucets on all floors are flushed.

    b. Ensure equipment with water line connections, such as refrigerators and ice dispensers, are drained, flushed, cleaned, and disinfected according to the manufacturer's recommendations.

2. The Environmental Services Manager or designate will:
    a. Flush, drain, clean, and disinfect cisterns that contain the affected water source.

    b. Run water softeners through a regeneration cycle according to the manufacturer's recommendations.

    c. Replace the filters on any water filtration devices, and flush the fixture according to the manufacturer's directions.

    d. Drain and refill hot water heaters that have been set below 45o C/110o F.

3. The Administrator or designate will:
    a. Communicate to all team members, residents, and visitors that the Boil Water Advisory has ended.

    b. Conduct a debrief with the leadership team to review procedures and make any adjustments to site-specific practices/Emergency Management Plan as needed.

4. The Infection Prevention & Control Manager or designate will:
    a. Remove signage.

5. The Administrator or designate will debrief and evaluate the reaction to the boil water advisory emergency within 30 days of the incident.

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OUTCOME:

1. In the event a Water Boil Advisory has been announced, staff in the home can continue to provide care and services safely
2. Staff's response is consistent with the policy
3. Home is in compliance with the *Fixing of Long-Term Care Act, 2021* and its Regulations 246/22

ADDITIONAL REFERENCES:

1. Government of Canada, Guidance for Issuing and Rescinding Boil Water Advisories in Canadian Drinking Water Supplies, 2022
2. Public Health
3. *Fixing Long Term Care Act, 2021* and its Regulations 246/22

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Table 1. Specific guidance during a boil water advisory

Use	Instructions (non-outbreak situation)	Instructions (waterborne outbreak situation)
Drinking	Use boiled tap water	
Brushing teeth	Use boiled tap water	
Washing hands	Can continue to be washed using tap water and a proper handwashing technique that includes rubbing all parts of the hands with soap and water for a minimum of 20 seconds	Can continue to be washed using tap water and a proper handwashing technique, followed by the use of an alcohol-based hand gel disinfectant containing more than 60% alcohol, or rub hands with a 65-95 % alcohol solution. Alcohol-based disinfectant should be rubbed into all areas of the hands until hands are dry. Hands should not be towel dried.
Ice cubes	Use boiled tap water	
Preparing food	Use boiled tap water	
Beverages	Use boiled tap water	
Washing fruits/vegetables	Use boiled tap water	

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Table 1. Specific guidance during a boil water advisory

Use	Instructions (non-outbreak situation)	Instructions (waterborne outbreak situation)
Laundry	May be washed in tap water, either by hand or by machine	Wash laundry with detergent in hot water at the maximum cycle length, and then machine (hot air) dry
Showers or baths	Adults may shower, bathe, or wash using tap water, but should avoid swallowing the water. Immunocompromised individuals should be sponge bathed in order to reduce the chance of them swallowing the water.	Sponge bathe only
Washing dishes	May be washed in tap water, either by hand or by machine	If dishes are washed by hand, they should be (1) washed and rinsed in hot tap water, then (2) soaked in a dilute solution of unscented household bleach (20 mL of unscented bleach in 10 L of water) for 1 minute and (3) left to air dry for a minimum of 4 hours Use dishwasher that uses hot water (final rinse temperature of at least 65oC) or has a sanitizing cycle

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STANDARD:

1. Flooding becomes a hazard when it poses a threat to people, property or the environment.

2. Staff must be aware of the local flood messages and be prepared to react.

3. External floods that may affect the building:
    a. **Flood Warning:** flooding is imminent or already occurring
    b. **Flood watch**: there is potential for flooding
    c. **Watershed condition statements**: flood outlook (an early notice of the potential for flooding, based on heavy rain, snow melt, etc.) and water safety information
    d. **Shoreline conditions statements**: flood outlook (an early notice of the potential for flooding in the Great Lakes based on weather and lake conditions) and water safety information

PROCEDURE:

Once the home has been made aware of any local flood messages:

1. In the event of an external flood that may affect the building, the Administrator or designate will:
    a. Call Code Orange 3 times
    b. Tune into local radio/television/internet for information and direction from provincial or community authorities.
    c. Alert team members that an evacuation may be necessary.
    d. If advised by provincial authorities to remain in the building, notify team members, residents, and visitors of the hazard and reasons to "shelter in place".
    e. Monitor radio/television/internet for further updates and remain in shelter until authorities indicate it is safe to come out.

2. The Environmental Services Manager, if there is time and it is safe to do so, will:
    a. Shut down/de-energize utilities not necessary for urgent resident care to reduce ignition sources and damage.
    b. Raise and relocate valuable and easily moveable equipment, furniture, and vital records to a higher elevation/upper floor wherever possible.
    c. Close emergency valves to the sewer drains.
    d. Check sump pumps to ensure they are operable.
    e. Ensure backup power supplies (i.e., lighting, generators) are functional.

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3. The Director of Care will ensure all residents on an air mattress, oxygen, CPAP machines etc., have equipment plugged into outlets that are powered by the generator in case power is lost.

4. The Administrator or designate will Initiate Code Green evacuation procedures as required. If evacuation is required, Code Green will be followed.

5. In the event building is damaged, and evacuation has been initiated, arrange for the building to be inspected before residents and team members are re-admitted.

6. The Administrator or designate will ensure all team members, residents, families, and visitors are made aware of the flood and its impact on the operations of the Home and on residents and staff.

7. The Administrator or designate will inform the Director of Maintenance of the flood issue and its impact on the operations of the Home and on residents and staff.

8. The Administrator or designate will ensure that the Ministry of Long Term Care is informed of the flooding incident in the Home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5) of the *Fixing Long-Term Care Act, 2021.*

9. Social Services Coordinator or designate will provide emotional support to residents, staff, essential caregivers and families.

Recovery Phase:

1. If the home was required to evacuate. The Administrator/Delegate will advise residents, staff, essential caregivers and visitors when it is safe to retune home. A broadcast message is to be sent to all staff/families of the return back to the LTC home.

2. The Administrator or designate will contact the EFAP program if needed to support staff. Social Service Coordinator or designate continue to provide emotional support to residents, staff, essential caregivers and families.

3. The Food Services Manager or designate will inspect food and ensure that the food or water was not contaminated with flood water. If unsure, food must be discarded.

4. The Environmental Services Manager or designate will inspect all heating, utilities and appliance to ensure they are in good operational order and safe to use.

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5. The Environmental Services Manager will take inventory of any damaged items and provide the list to the Executive Director.

6. In the event of any damage to the Home or its contents, the Executive Director or designate will notify the insurance company.

7. The reaction to the flood emergency will be evaluated and debriefed with the team within 30 days of the incident.

OUTCOME:

1. In the event that flood impacts the Home, staff in the Home know how to safely continue to provide care to residents in the Home.

2. Staff are aware of evacuation practices.

ADDITIONAL REFERENCES:

1. *Fixing Long-Term Care Act*, 2021 and its regulation 246/22

2. Canadian Red Cross

3. Government of Ontario: Ontario.ca/protectingpeoplepropertyontariosfloodingstrategy

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APPROVED BY: Parsons	**REVIEWED DATE: July 26, 2022**

STANDARD:

1. A recovery plan will be in place for each emergency to ensure a smooth return to pre-emergency operations within the Home.

2. For a Home level emergency, the Administrator or designate will be responsible for declaring that an emergency has ended.

3. For a widespread emergency, the Director of Maintenance or designate, together with the Home's Management team and in collaboration with other stakeholders will be responsible for officially declaring that the emergency has ended.

PROCEDURE:

1. The Administrator or designate will be responsible for leading the Home through the recovery plan and strategies.

2. The Administrator or designate will note the following on the Emergency Debrief and Evaluation Form:
    - Type of Emergency
    - Date Emergency Initiated
    - Date Emergency Concluded

3. As the Home returns to normal operations, the Administrator or designate will ensure the following is completed:

    - Insurance arrangements completed as necessary
    - Third-Party contracts involved are in place as necessary
    - Pre-emergency staffing levels resumed as appropriate
    - Any paused or altered programs/services or processes are restarted
    - Debrief and evaluation of the emergency is completed within 30 days using the Emergency Debrief and Evaluation form. During the debrief, the following questions will be reviewed:
        - Look at what happened, why it happened, and figure out how to ensure that it will not happen again.

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- Could it have been prevented?
- What procedures worked well?
- What systems did not function well?

➢ Communication with residents via Residents' Council, families via Family Council and/or other means (memo/letter) on the recovery stage/plan, outcomes, and any action items

➢ Collaborate with Joint Health & Safety Committee to execute recovery plan as appropriate

➢ Collaborate with the Finance team and figure out the financial impact

➢ Have nurses assess residents for any physical or psychosocial impact and act on it accordingly

➢ Update staff on recovery plan status and any action items

➢ Coordinate support for residents, families, and staff (i.e. EFAP counselling, support groups, etc.)

➢ Consult with residents, families, staff, and respective external stakeholders to evaluate the emergency plan

➢ Make any necessary changes to the emergency plan; communicate and train those changes accordingly

4. The Administrator or designate will communicate timelines for the recovery stages. Depending on the type of emergency, returning to normal operations may be a slow process.

OUTCOME:

1. The Home smoothly returns to pre-emergency operations.

2. Supports for potential distress post-emergency for residents, families, essential caregivers, and staff are in place.

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ADDITIONAL REFERENCES:

1. *Fixing Long Term Care Act, 2021* and its Regulations 246/22 ss. 268(13)
2. Ministry of Long-Term Care: Long Term Care Emergency Preparedness Manual, May 2022
3. Forms Manual, Emergency Debrief and Evaluation Form

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STANDARD:

1. To ensure there is a process and plan for the receiving of residents outside the organization in the event of a disaster / emergency.

2. All employees are responsible and accountable for understanding and demonstrating ongoing competence in all relevant aspects of reception of residents from outside the organization in the event of a disaster / emergency.

3. The Administrator / delegate will make the decision to accept the evacuees, notifies the Ministry of Health and maintains communication with appropriate agencies.

4. Priority will be given to sister facilities and to those within our catchment area.

5. The criteria used to determine acceptance of evacuees will include some of, but is not limited to the following:
   a) Time / length of relocation required
   b) Numbers of potential evacuees
   c) Availability of resources (staffing from agency, transferring, equipment, etc)
   d) Impact on our services (meals, resident programs, staffing, etc.)
   e) Ability to provide interim care to evacuees based on their care needs and available resources
   f) Restrictions on space and other resource allocations due to legislative requirements

PROCEDURE:

1. The Administrator / delegate meets with the Management Team to:
   a) designate roles and responsibilities to team members
   b) designate the responsibility to communicate with residents, families and staff location receiving evacuees
   c) establish scope, magnitude and impact of receiving evacuees

2. Initiate fan out system based on current knowledge of facts:
   a) Number of expected evacuees
   b) Care requirements
   c) Length of temporary evacuation required
   d) Impact on organizational services / programs / resources

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STANDARD:

1. Code Black is used to alert all employees within the facility that a bomb threat has been received.

2. The Bomb Threat procedure will be initiated immediately to ensure the safety and security of all residents, visitors, employees, and volunteers.

3. The following Emergency Plan is activated when the Home becomes aware of a code black.

PROCEDURE:

1. Remain calm - do not panic.

2. If a telephone or direct verbal bomb threat is received attempt to prolong the conversation and extract as much information as possible from the caller, i.e. location of bomb, time limit and reason for the threat.

3. Pay particular attention to the distinguishing characteristics of the caller's voice, i.e. accent, sex, age or impediment. Listen for background noise such as traffic, music, etc.

4. Record details of the call on the Code Black forms located at the reception desk, in the Nursing Office, on each unit and in each department near phones.

5. If a written bomb threat is received read carefully while handling as little as possible to preserve evidence. Save the evidence for the police.

6. Page CODE BLACK (Include Department / Unit if the specific area is identified by the caller). Repeat CODE BLACK 3 times.

7. Immediately advise the Administrator \ delegate and the Director of Care\delegate

8. The Administrator, Director of Care, Nurse Manager\ delegate will notify the police immediately by calling 911.

9. MAINTENANCE staff, if available, will meet the police and guide them to the affected area(s). Outside normal working hours, this function will be performed by the Nurse Manager\delegate pending the arrival of the Administrator\Director of Care\delegate.

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10. The decision to evacuate will be made by the police or fire Department in consultation with the Executive Director\delegate.

Search Guidelines

STAGE 1 - PRELIMINARY

11 On hearing code black employees in the facility or the specifically targeted department / unit will search the immediate area / vicinity for anything unusual, out of place, or any suspicious object.

11.1 If a suspicious article is found: IMMEDIATELY NOTIFY THE EXECUTIVE DIRECTOR/DELEGATE OF THE LOCATION AND DESCRIPTION OF THE OBJECT. DO NOT TOUCH THE OBJECT. EVACUATE ALL PEOPLE FROM THE IMMEDIATE AREA

11.2 The person in charge of each area will document observations, actions, and names of search participants.

STAGE 2 – POLICE IN ATTENDANCE

11.3 The police will conduct a search of the area / facility utilizing staff in each department who are most familiar with that part of the building. Each area is to be searched in a systematic fashion, moving progressively room by room until each area is complete.

11.4 If a suspicious article is found: IMMEDIATELY NOTIFY THE ADMINISTRATOR/ DELEGATE OF THE LOCATION AND DESCRIPTION OF THE OBJECT. DO NOT TOUCH THE OBJECT. EVACUATE ALL PEOPLE FROM THE IMMEDIATE AREA.

STAGE 3

11.5 If an unusual object is not located, police\fire department\person in charge will determine the need to evacuate the building in which case the CODE GREEN STAT and/or total evacuation procedure will be initiated.

NOTE:

1. While Code Black is in effect employees will reassure residents and visitors and

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where possible stop them from entering the search area / building.

2. Release of any information external to the facility (apart from EMS) shall be made only by the Executive Director / delegate.

OUTCOME:

1. There is evidence that employees demonstrate knowledge of Code Black policy / procedures and their responsibilities in dealing with a bomb threat.

2. There is detailed documentation of bomb threat, actions and outcomes.

3. There is evidence that all aspects of Code Black were followed.

ADDITIONAL REFERENCES:

1. Local Police Department

2. Emergency Plan Manual, Policy # G – 10, Code Green Stat

3. Emergency Plan Manual, Policy # G-15-05, Types of Evacuation

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KEEP CALM: Do not get excited or excite others.

TIME: Call received _____ Terminated: _____

EXACT WORDS OF CALLER: _____

_____

_____

_____

_____(Delay - ask caller to repeat)

QUESTIONS TO BE ASKED:

a) When it is set to explode? _____

b) Where located? Floor _____ Area _____

c) Kind of bomb? _____

d) Description? _____

e) Why kill or injure innocent people? _____

_____

DESCRIPTION OF VOICE:

Male ____ Female ____ Nervous ____ Young ____ Old ____

Middle-aged _____ Rough _____ Refined _____

Accent _____ Speech Impediment _____

(Describe) _____

Unusual phrases _____

Recognize voice? If so, who do you think it was? _____

BACKGROUND NOISE:

Music _____ Running Motor (type?) _____ Traffic _____

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Whistles _____ Bells _____ Horns _____ Aircraft _____

ADDITIONAL INFORMATION:

a) Did caller indicate knowledge of the Home? If so, how?

_____

b) What line did call come in on? _____

FURTHER INSTRUCTIONS:

1. Report threat to: 911 (Indicate names of persons or offices you reported to) _____
2. Be sure to give your name, department and phone number.
3. Do not get excited. Remain calm. Try to get someone else to listen in and record the conversation.
4. Do not talk to others about this incident or in any way excite them.
5. Follow any instructions received from your supervisor.
6. If you are ordered to evacuate, take this checklist with you.

Signature: _____

Department: _____

Date: _____

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-05
SUBJECT:	INTRODUCTION	**PAGE:** 1 OF 1
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The purpose of the Quality Management Section of the Emergency Plan Manual is to provide the Facility team with standards and procedures to assist in monitoring and evaluating compliance with emergency procedures and protocols.

The information in this section supports the facility's overall Quality Management Program and commitment to continuous quality improvement.

The Quality Management section provides information on fire drill procedures, lifts and transfers, and orientation and training of employees. Additionally, it provides various audit tools, report forms, and a pre and post test for fire and universal codes.

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STANDARD:

1. Staff and residents will keep in practice with fire safety procedures and comply with the Long Term Care Facility Act and the Ontario Fire Code Regulation 388/97.

PROCEDURE:

1. A fire drill is conducted monthly on each shift. The Quality Improvement Coordinator schedules the drills and assigns fire drill coordinators.

2. Receptionist, Nurse Manager or delegate calls Alarm Monitoring Company (Advanced Alarms) (613) 283-6238 (I.D. 0773) and Local Fire Department (613) 283-5869 to inform them of the drill 10 minutes prior to drill.

3. Fire Drill Coordinator stages a mock fire on designated floor in accordance with fire drill schedule.

4. After alarm has sounded receptionist or delegate (fire assignment) is to announce location of fire by using microphone located within Emergency Voice Communication Panel (E.V.C.P.). Follow instructions on inside of panel door. Announce the location of the fire using "CODE RED", Zone ____, Room _____ (3 times). The key to E.V.C.P. is located in the keyhole in the small key box (left) at the front reception desk.

5. Fire Drill Coordinator and other assigned personnel to observe staff and residents on each floor while the drill is being held for follow through of proper procedure. Debriefing and reviewed of REACT held following a drill.

6. Reset pull station after drill is completed.

7. Receptionist or delegate resets main panel located at reception as directed by Fire Drill Coordinator or delegate.

8. Receptionist or delegate will announce "ALL CLEAR" 3 times.

9. Receptionist or delegate informs the Toronto Fire Department and the Alarm Monitoring Company the drill is complete and alarm has been reset.

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10. Reset mag lock system. The mag lock reset panel is located on the wall to the left side of the Fire Alarm Panel beside Reception. The key to reset the mag lock system is located in the key box in reception. The key is on the key ring labeled Fire Panel Emergency keys.

11. Department Heads\assigned personnel to forward completed Fire Drill Reports to Staff Development Coordinator by the end of the shift of which the drill has been completed.
12. Staff Development Coordinator checks the reports for problem areas, reports to proper Department Heads to review with their staff.

13. Registered Nurse completes Fire Drill Report and records attendance in fire drill binder, and forwards to the Executive Director for signature and comments.

14. An overall evaluation of each drill will be discussed at Morning Report and forwarded to Occupational Health and Safety Committee as appropriate.

OUTCOME:

1. A fire drill is conducted on each shift every month.

2. The date and time of all fire drills, as well as the names of participating staff, are recorded in a log book.

3. A debriefing meeting is held on each floor following the fire drill.

4. There is evidence that each staff member demonstrates proficiency and competence on code red procedures.

5. There is evidence that annual proficiency testing of all staff on all code red components.

6. There is evidence that each staff member will participate in a fire drill a minimum of once a year.

ADDITIONAL REFERENCES:

1. Fire Safety Planning for Institutional Facilities OFM-TC-02-1999, 7.1 Fire Drills (page 20)

2. Ontario Fire Code Regulations 388/97

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FIRE DRILL OR FIRE INCIDENT REPORT

To be completed by:

Fire Drill: Person in-charge of drill.

Fire Incident: Person in-charge of building.

DATE: _____ **LOCATION:** _____ **TIME:** _____

		YES	NO
1.	WAS THE SF FIRE DEPARTMENT (283-5869) CALLED?	___	___
2.	WAS THE ALARM MONITORING COMPANY CALLED?	___	___
3.	WHO SOUNDED ALARM? _____ (NAME)		
4.	WHICH PULL STATION WAS USED? _____ (SITE)		
5.	WAS EVACUATION PRACTISED?	___	___
6.	DID STAFF REACT PROMPTLY?	___	___
7.	DID ALL FIRE DOORS CLOSED?	___	___
8.	WERE ALL WINDOWS AND DOORS CLOSED?	___	___
9.	DID ALL BEDROOM DOORS LATCH PROPERLY?	___	___
10.	DID ANY RESIDENTS PANIC?	___	___
11.	DID THE STAFF FOLLOW PROPER PROCEDURES?	___	___
12.	WAS THE ALARM MONITORING COMPANY CALLED AFTER?	___	___
13.	WAS FIRE SYSTEM RESET AFTER DRILL OR FIRE?	___	___

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14. DID ALL FIRE ALARM SPEAKERS SOUND PROPERLY? ____ ____

15. WERE ALL RESIDENTS ACCOUNTED FOR? ____ ____

16. WERE THE MAG LOCKS RESET? ____ ____

17. WAS STAFF ATTENDANCE RECORDS PRINTED FROM STAFF SCHEDULED CARE AND ATTACHED TO REPORT? ____ ____

18 . IF THE ANSWER IS "NO" TO ANY QUESTION EXCEPT 10, PLEASE EXPLAIN:

_____

_____

_____

19. IF THE ANSER IS "YES" TO # 10, PLEASE EXPLAIN_____

_____

_____

_____

18. WERE THE FOLLOWING CLOSED?
- Residents room doors: ____ ____
- Fire barrier door ____ ____
- All windows: ____ ____

Were all residents accounted for? ____ ____

19. DID YOU REVIEW THE FOLLOWING WITH YOUR STAFF?
A) R.E.A.C.T ____ ____
B) Location of Fire Extinguishers: ____ ____
C) Location of Fire Alarm Fire Stations: ____ ____
D) Was the alarm and location clearly heard over the P.A. systems? ____ ____

20. WAS THERE ANY OBSTRUCTION IN FRONT OF THE FIRE DOORS AT THE TIME OF THE ALARM? ____ ____
If so, what was the obstruction?

_____

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21. CORRECTIVE ACTION(S) TO BE TAKEN _____

_____

_____

_____

_____

CORRECTIVE ACTION TAKEN BY MAINTENANCE DEPARTMENT IF APPLICABLE:

_____

_____

_____

_____

_____

SIGNATURE OF PERSON COMPLETING REPORT: _____

ENVIRONMENTAL SERVICE MANAGER SIGNATURE: _____

Administrator: _____

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FIRE DRILL OR FIRE INCIDENT REPORT

To be completed by Receptionist or delegate.

Completed form to be returned to person in-charge of Fire Drill or Fire Incident.

Date: _____ Time: _____

	Yes	No
1. Were all fans and other electrical equipment turned off?	___	___
2. Was the emergency evacuation file current and complete?	___	___
3. Did all fire doors close properly?	___	___
4. Located and reviewed for evacuation:	___	___
employee phone numbers	___	___
current resident face sheets binder	___	___
5. R.E.A.C.T. reviewed with the office staff?	___	___

6. If you have answered no to any of the above questions or have any concerns, explain here:

_____

_____

_____

_____

8. Employees on duty:

_____

_____

_____

Signature of Receptionist or Delegate: _____

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FIRE DRILL OR FIRE INCIDENT REPORT

To be completed by Food Service Manager or delegate.

Completed form to be returned to person in-charge of Fire Drill or Fire Incident.

Date: _____ Time: _____

	Yes	No
1. Were all fans and electrical equipment turned off?	___	___
2. Was gas turned off?	___	___
3. Did all fire doors close?	___	___
4. Were all passageways cleared?	___	___
5. Did person in-charge assess dining room before sending staff to fire location?	___	___
6. R.E.A.C.T. reviewed with your staff?	___	___
7. Staff attendance attached to **Fire Drill Report**?	___	___

8. If you have answered no to any of the above questions or have concerns, explain here:

_____

_____

11. Employees on duty:

_____

_____

Signature of Food Services Manager or delegate: _____

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FIRE DRILL OR FIRE INCIDENT REPORT

To be completed by Environmental Services Manager or delegate.

Completed form to be returned to person in-charge of Fire Drill or Fire Incident.

Date: _____ Time: _____

	Yes	No
1. Did Heavy Duty Cleaner and Maintenance staff go to the fire location with an fire extinguisher?	___	___
2. **Laundry:**		
a) Laundry chute door and chute room door closed?	___	___
b) All machines turned off?	___	___
c) All fans turns off?		
3. Have all two washrooms in basement been evacuated and doors closed?	___	___
4. Staff lounge evacuated, equipment off and door closed?	___	___
5. The Responsive Health Management Office evacuated and doors closed?	___	___
6. Two (2) locker rooms (male and female) evacuated and doors closed?	___	___
7. Residents are behind the fire doors in Program Room.	___	___
8. Halls clear and fire doors closed.	___	___
9. R.E.A.C.T. reviewed with you staff?	___	___

10. If you have answered no to any of the above questions or have any concerns, explain here: _____

_____

11. Employees on duty: _____

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Signature of Environmental Services Manager or Delegate: _____

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FIRE DRILL OR FIRE INCIDENT REPORT

To be completed by Program Manager or delegate.

Completed form to be returned to person in-charge of Fire Drill or Fire Incident.

Date:_____ Time:_____

	Yes	No
1. Office:		
a) Fans and equipment turned off?	___	___
b) All doors and passageways clear of clutter?	___	___
2. Moved residents to Main Dining Room on ground floor if safe to do so?	___	___
3. Compiled a list of the names of all residents present in the Program/Main Dining Room?	___	___
4. Residents in Program/Main Dining Room were monitored for safety and comfort unit all clear was paged?	___	___
4. R.E.A.C.T. reviewed with you staff?	___	___

7. If you have answered no to any of the above questions or have any concerns,explain here:

_____

_____

8.Employees on duty :

_____

_____

Signature of Program Manager or Delegate:_____

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UNIT FIRE DRILL REPORT : FL. _____

Date: _____ **Time:** _____

IF DRILL OR FIRE IS ON YOUR UNIT:

1. You are calling CODE RED as you come stat to the fire scene. You are wearing the reflective vest. _____

2. You direct all of your staff to come stat to the fire scene. _____

3. The fire room is: evacuated ____ Door closed ____ Vacant sign up____

3. The fire alarm is pulled. ____

4. Call placed from red emergency phone to beside pull station to person at Fire Alarm Panel identifying the exact location of fire ____

5. The rooms on both side of the fire location are evacuated ____ The room directly across from the fire location is evacuated _____ Doors closed ____ Vacant signs up _____

6. Code Red Room is being called loudly until evacuation is stopped. _____

7. Halls are clear.

IF ALARM IS RINGING:

1. You direct your staff to search the Unit for: any signs of fire _____
   a pulled alarm _____

2. You direct your staff to close all windows and doors. _____

3. You direct the staff to clear the halls. _____

4. You direct the staff to keep paroling the halls for signs on fire until an " all clear" is given. ____

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5. You've evacuated anyone you feel is in danger or a threat to the safety of others. ___

ALL UNITS COMPLETE THIS PAGE.	**YES**	**NO**
1. Did all staff report to the fire location as directed by the Unit Supervisor?	_____	_____
If no, Why not ?		
_____		
_____		
2. Were the following closed? All doors:	_____	_____
All windows :	_____	_____
Fire barrier door:	_____	_____
3. Were all residents accounted for?	_____	_____
4. Did you review the following with your staff?		
R.E.A.C.T.	_____	_____
Location of Extinguishers	_____	_____
Location of Fire Alarm Pull Stations	_____	_____
5. Was the alarm and location clearly heard on the P.A. system?	_____	_____
6. Were there any obstructions in front of fire doors at the time of the alarm?	_____	_____

7. Concerns, problems or suggestions:

_____

_____

8. Names of staff on duty:

_____

_____

Unit Supervisor's signature: _____

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FIRE DRILL ATTENDANCE

DEPARTMENT: _____ **YEAR:** _____

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-10-10
SUBJECT:	ALTERNATE MEASURES	**PAGE:** 1 OF 5
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STANDARD:

1. There is an alternate measures plan in place to provide for the safety of occupants during any shutdown of fire protection equipment and systems or part(s) thereof.

PROCEDURE:

1. The Administrator/delegate will initiate the alternate measures (fire patrol) procedure).

2. The receptionist/delegate will make an announcement to implement the alternate measures procedure.

   NOTE: In the event paging and phone communication systems are also down, staff will be requested to run messages to all floors/departments.

3. The Receptionist/delegate will ensure that the Fire Department, (613) 283-5869, and Advanced Alarms (613) 283-6238 I.D. # 0773, are notified of any fire protection system impairments and planned temporary shutdowns of sprinkler protection systems for repairs or alterations and their restoration of service again. This includes the shutdown of sprinkler control valves or fire protection water supplies for more than a 24 hour period.

4. The Unit Supervisor/delegate will assign one staff per unit to fire safety patrol to check every resident room and washroom and all other rooms on the floor every fifteen (15) minutes until the fire alarm system is operational.

5. One staff member in the Food Services department will be assigned to fire safety patrol to check the kitchen area including all storage rooms, coolers and dining rooms every fifteen (15) minutes until the fire alarm system is operational.

   NOTE: If the Food Services department is closed, the Nurse Manager\person in charge of the building will assign this responsibility.

6. The Maintenance staff will be assigned to fire safety patrol to check all other rooms in the basement and all stairwells every fifteen (15) minutes until the fire alarm system is operational.

   NOTE: If the Maintenance department is closed, the Nurse Manager\person in charge of the building will assign this responsibility.

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7. Staff conducting the fire patrols will record the time and date of each 15 minute tour and will also note any deficiencies and action taken. Records must be forwarded to the Nurse Manager/Nurse In-Charge for filing.

OUTCOME:

1. Staff follow alternate measures to monitor the building if the fire alarm system is not operating due to repairs or malfunction.

2. The fire department is notified of planned temporary shutdowns of the sprinkler protection system for repairs or alterations and their restoration to service including the shutdown of sprinkler control valves or fire protection water supplies for more than a 24-hour period.

3. The fire department is notified of any fire protection system impairments.

4. Each tour of the building by the fire safety patrol is recorded by time and date. Any deficiencies noted and corrective measures are also recorded.

ADDITIONAL REFERENCES:

1. Ontario Fire Code – Article 6.5. 2.1.

2. Fire safety Planning for Institutional Facilities OFM-TG-02-1999, 6.2 Alternate Measures for Temporary Shutdown of Fire Protection Equipment or Systems (pg. 19)

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ALTERNATE MEASURES
CHECKLIST – LAUNDRY/BASEMENT

TO BE COMPLETED BY LAUNDRY STAFF EVERY 15 MINUTES

DATE: _____

SIGNATURE: _____

TIME	LAUNDRY CHUTE	DIRTY LAUNDRY AREA	CLEAN LAUNDRY AREA	PERSONAL CLOTHING ROOM	PROGRAM ROOM	RHM OFFICE	FEMALE/ MALE LOCKER ROOMS	STAFF LOUNGE AND W. ROOMS	RESIDENTS' WASHROOM	BOILER ROOM

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-10-10	
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ALTERNATE MEASURES
CHECKLIST – MAIN FLOOR

TO BE COMPLETED BY MAIN/HOUSEKEEPING STAFF EVERY 15 MINUTES, AFTER HOURS, LAUNDRY STAFF TO COMPLETE EVERY 15 MINUTES.

DATE: _____

SIGNATURE: _____

TIME	OFFICES	LOUNGE	RECEPTION AREA	WASHROOMS	BISTRO	RECEIVING AREA	DISH STORAGE	KITCHEN

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-10-10	
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ALTERNATE MEASURES
CHECKLIST – FLOORS 2 - 6

TO BE COMPLETED BY ASSIGNED NURSING STAFF EVERY 15 MINUTES

DATE: _____

SIGNATURE: _____

TIME	MED ROOM	RESIDENTS' ROOMS	WASHROOMS	SHOWER ROOM	LAUNDRY	UTILITY ROOMS	LINEN CLOSETS	LOUNGE

SECTION: QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-15
SUBJECT: EVENING AUDIT PROCEDURE	**PAGE:** 1 OF 1
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Please refer to the Quality Improvement Program, Section III: Risk and Quality and Quality Indicators and Tools, F Nursing/Resident Care - Building Safety Inspection Audit.

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-20
SUBJECT:	FIRE SAFETY MAINTENANCE AUDITS AND EQUIPMENT INSPECTION SCHEDULE	**PAGE:** 1 OF 3
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STANDARD:

1. There is an organized preventative maintenance and inspection program for all fire safety equipment.

2. To ensure that all components of Fire Alarm System are functional.

3. To prevent premature breakdown of equipment.

PROCEDURE:

1. Internal audits as listed below are completed by Environmental Services Department on a daily, weekly, or monthly basis in Maintenance Care Program and the Fire Log Book.

2. A preventative maintenance and inspection schedule will be maintained and reviewed on an annual basis for completion and effectiveness.

3. A master file will be maintained with all inspection records, follow-up reports and certificates by the Environmental Services Managers

Internal Audits:

Fire alarm and evacuation system daily. In particular check for the following three conditions:

a) **Annunciator:**
Alarm indication.
Trouble indication.
Supervisory indication.
Any unusual condition.

b) **Control Panel:**
Alarm indication.
Trouble indication.
Supervisory indication.
Any unusual condition.

c) **ANY REMOTE TROUBLE LIGHTS FOR TROUBLE INDICATION.**

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-20
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All of the above conditions shall be recorded and verified as "Satisfactory" in the appropriate permanent logbook.

Any condition found to be **"Unsatisfactory"** shall be rectified as quickly as possible. The details of any repairs or replacements together with the date the work was completed satisfactorily and by whom shall also be recorded and verified as **"Satisfactory"** in the permanent logbook.

ADDITIONAL INTERNAL AUDITS INCLUDE:

Commercial cooking equipment weekly

Emergency power systems weekly

HVAC (Heating Ventilation Air Conditioning) weekly

Sprinkler system and water supply equipment weekly

Emergency lighting and exit lights monthly

Emergency power system (Generator) monthly

Fire alarm and voice communication systems monthly

Fire separation doors monthly

Potable fire extinguishers monthly

Sprinkler systems and water supply equipment monthly

Standpipe system hose stations monthly

2. External inspections as listed below are arranged by Environmental Services on a semi annual or annual basis and results are documented:

External Inspections:

Equipment	Frequency of Inspection	Contract Service Provider
Back Flow Prevention System	Annual	MCC

SECTION: QUALITY MANAGEMENT **INDEX I.D.:** EPM J-20

SUBJECT: FIRE SAFETY MAINTENANCE AUDITS AND EQUIPMENT INSPECTION SCHEDULE **PAGE:** 3 OF 3

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Equipment	Frequency of Inspection	Contract Service Provider
Call Bell Inspection	Annual	MCC
Ducts (kitchen and laundry)	Semi-annual	MCC
Fire Alarm Monitoring	On going	MCC
Fire Alarm System	Quarterly	MCC
Fire Extinguishers and Stand Pipe	Annual	MCC
Generator Load Testing	Semi-annual	Generac
HVAC	Quarterly	Millar Mechanical
Kitchen Suppression System	Semi-annual	MCC
Lift Load Testing	Annual	Arjo
Phone System	Contact for service repairs as required	Bell
Sprinkler System	Annual	MCC

4. Document all audits in the Fire Log Book and report any deficiencies immediately.

5. Summarize results of audits and inspections on a monthly basis.

OUTCOME:

1. There is evidence that all fire safety equipment is inspected according to designated schedule.

2. Any condition found to be unsatisfactory is rectified as quickly as possible.

3. The details of any repairs or replacements are recorded in the permanent logbook.

4. There is evidence that a safe environment is provided for residents and staff.

ADDITIONAL REFERENCES:

1. Maintenance Manual

2. Fire Log Binder.

3. Maintenance Care Program.

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4. Annual Inspection Binder (located in the Environmental Services Manager's Office)

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:**	EPM J-25
SUBJECT:	DISTRIBUTION OF EMERGENCY PLAN MANUAL	**PAGE:**	1 OF 1
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STANDARD:

1. To ensure that there is a process and plan for emergency plan manual distribution.

2. To ensure all staff are aware of manual contents.

PROCEDURE:

1. Each department head will ensure that their staff has access to an emergency plan manual and how to access policies and procedures on Policy Medical

2. All new employees will review the Emergency Plan Manual as part of their orientation and will have access to the Emergency Plan Manual electronically in the e-learning program.

3. Emergency plans will be covered in mandatory in-services.

4. Emergency plan will be reviewed at performance reviews.

5. All emergency manuals in the Home will be kept current by a designated staff.

6. The manual is accessible online to all staff.

7. The Administrator and Director of Care will keep a copy of the Emergency Plan Manual and contact procedures lists off site where these are readily accessible.

OUTCOME:

1. There is evidence that employees are aware of the Emergency Plan Manual.

ADDITIONAL REFERENCES:

SECTION: QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-30
SUBJECT: FIRE LOG BOOK	**PAGE:** 1 OF 1
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APPROVED BY: Parsons	**REVIEWED DATE:** July 26, 2022

STANDARD:

The fire logbook is kept in the maintenance department; records are maintained by the Environmental Services Manager\delegate and on request are made available to the Fire Department.

PROCEDURE:

1. Maintenance staff is responsible for regular inspection of fire alarm system and auxiliary equipment.

2. The fire logbook records are maintained by the Environmental Services Manager\delegate.

3. Environmental Services Manager is responsible for developing a schedule for quarterly, semi annual and annual Inspections performed by an outside contractor.

4. The original copy of inspection must be inserted in the Inspection Binder in the Environmental Services Manager's office.

5. In the event of an emergency evacuation of the building, it is the responsibility of the maintenance staff to take the fire log book with them.

OUTCOME:

1. There is evidence of a chronological reference for the fire alarm system maintenance.

ADDITIONAL REFERENCES:

1. Ontario Fire Code

2. Emergency Plan Manual, Policy ID # J-20, Fire Safety Maintenance Audits and Equipment Inspection Schedule

SECTION: QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-35
SUBJECT: FIRE RETARDANT SUPPLIES	**PAGE:** 1 OF 1
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

1. Provide a safe environment for residents and staff.

2. Meet requirements of the Ontario Fire Code.

PROCEDURE:

1. Drapes, curtain and other decorative material, including textiles used in the building, shall meet the requirements for high degree of flame resistance.

2. Purchaser of textile materials shall communicate the requirement of the code with the supplier.

OUTCOME:

1. There is evidence of 100% compliance with the Fire Code regarding fire retardant supplies.

ADDITIONAL REFERENCES:

1. Ontario Fire Code.

SECTION: QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-35-05
SUBJECT: CONTROL OF FIRE HAZARDS	**PAGE:** 1 OF 1
	ORIGINAL DATE: June 1, 2000
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

STANDARD:

Potential fire hazards are controlled.

PROCEDURE:

1. The Environmental Services Manager/delegate conducts a walk through of the entire building at least weekly and checks the following to ensure that potential fire hazards are being controlled:
    - Smoking by staff, visitors and residents is restricted to designated areas, outside of the facility
    - Smoking materials, such as cigarette butts and contents of ashtrays are disposed of with caution and never into combustible containers
    - Ignition sources in areas where oxygen is in use is restricted
    - Flammable liquids or aerosol cans are never disposed of in garbage cans
    - Cooking practices in kitchen area are safe
    - Storage, laundry, furnace and electrical rooms are clear of combustible material
    - Clothing or rags saturated with flammable or combustible materials are not laundered
    - Exit stairwells are free of any materials or equipment
    - All personal electrical appliances used by residents are monitored and meet CSA Standards
    - Fire doors are not wedged open and self-closing devices installed on them are not disengaged

OUTCOME:

1. The Environmental Services Manager/delegate performs a regular (minimum weekly) walk through of the entire facility to identify and control any fire hazards.

ADDITIONAL REFERENCES:

1. Fire Safety Planning for Institutional Facilities OFM-TG-02-1999, 5.0 Control of Hazards (pg.18)

2. Emergency Plan Manual, Policy ID # J-20, Fire Safety Maintenance Audits and Equipment Inspection Schedule.

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-40
SUBJECT:	ORIENTATION & TRAINING OF EMPLOYEES	**PAGE:** 1 OF 4
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. The general orientation program will provide instructions on the Emergency Plan including fire drills and universal codes.

2. There will be a pre-test and post test to ensure that staff have understood the instructions given.

3. Specific in-services will be done throughout the year on the Emergency Plan based on the identified learning needs of staff.

PROCEDURE:

1. During the general orientation program, staff will receive training on the Emergency Plan include the fire drill procedure following the REACT process.

2. Staff will be shown the location of pull stations, phones, and fire extinguishers in each resident home area\department.

3. Staff will be shown the fire alarm panel with an explanation on its use. Paging protocol will be reviewed and practiced by new employees.

4. Pre and post tests will be given and reviewed during the session.

5. Evacuation and emergency lifts and carries will be reviewed but not practiced at this time (see in-service training).

6. All universal codes will be reviewed and each staff member will be given a laminated code card to be kept on their person. This is on the back of their name tag.

7. All staff will review REACT following the monthly fire drill on each shift.

8. Employees will review REACT and the emergency codes during their annual performance review.

9. Quality Improvement Coordinator maintains a record of attendance at fire drills, fire drill reports, and annual fire drill scheduled.

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-40
SUBJECT:	ORIENTATION & TRAINING OF EMPLOYEES	**PAGE:** 2 OF 4
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

10. Quality Improvement Coordinator maintains records of attendance at in-service education sessions.

11. Nurse Managers who are in charge of the building in the absence of the Administrator and Director of Care are trained in the operation of the fire system.

OUTCOME:

1. There is evidence that on hire, all new staff will be familiar with fire drills, evacuation and universal code procedures and be able to respond appropriately to all of them.

2. New staff will also know where to locate policies if they are unsure of procedure.

ADDITIONAL REFERENCES:

1. Emergency Plan Manual.

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-40
SUBJECT:	ORIENTATION & TRAINING OF EMPLOYEES	**PAGE:** 3 OF 4
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

General Orientation

Fire Safety Pre Test

1. Why would you shut all the doors during a fire?
2. Most people who die in a building fire die from?
3. List the actions you would take if the alarm went off in your previous work place?
4. Have you ever used a fire extinguisher?

General Orientation

Fire Post Test

1. Where is the annunciator panel found?
2. How many times is a Code Red announced?
3. What phone is used to call reception?
4. Where are the pull stations located on the resident care floors?
5. How many fire extinguishers are there on each resident care floor? And where are they?
6. Most people, whom die in a building fire, die from what?
7. What does REACT stand for?

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-40
SUBJECT:	ORIENTATION & TRAINING OF EMPLOYEES	**PAGE:** 4 OF 4
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

Post Test for Universal Codes

1. What is Code Black?

2. What is Code Blue?
   a) Who pages a Code Blue?
   b) Where is the "emergency equipment" kept?
   c) Name 2 medical emergencies that a Code Blue may be called for?

3. If you see two residents hitting each other with their canes. One looks injured what code would you call?

4. What is Code Red?

5. Code Green means you evacuate residents _____, to a safe place.

6. Code Green "stat" means you evacuate residents _____, to a safe place.

7. If a resident is not in the building at bedtime, what code would you call?

8. How do you page a code?

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-45-05
SUBJECT:	DOUBLE CRADLE DROP	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To perform the extremity, carry, using proper technique that minimizes risk of injury to both resident and rescuer.

PROCEDURE:

1. Ensure the bed is locked or moved against the wall.
2. Remove all bedding from resident except bottom sheet.
3. Wrap resident in sheet.
4. Both rescuers MUST be in kneeling position, opposite resident's lower chest and knees respectively.
5. First rescuer's arm passes under neck and grasps residents opposite shoulder, other arm below scapular area.
6. Second rescuer's arms go under resident's hip and thigh.
7. Slide the resident to the edge of the bed on count of three.
8. Slide the resident off the bed and smoothly lower to rescuer's thigh and then on to floor on the count of three.
9. Drag resident headfirst to a safe area.

OUTCOME:

1. There is evidence that 100% of the staff will be able to effectively and safely transfer/carry residents in the event of an evacuation.

ADDITIONAL REFERENCES:

1. Fire Safety Training for Employees of Care and Treatment Occupancies.

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-45-10
SUBJECT:	EXTREMITY CARRY NON-AMBULATORY	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

STANDARD:

1. To perform the extremity carry, using proper technique that minimizes risk of injury to both resident and rescuer.

PROCEDURE:

1. Ensure the bed is locked or moved against the wall.

2. One rescuer stands between the resident's legs and grasps the resident's legs either just above the ankles or under the knees.

3. The second rescuer places their arms under the resident's auxilla and clasps the resident's forearms with their hands and crosses the resident's arms across their chest.

4. Both rescuers holding the resident firmly lift the resident simultaneously and move to a safe area.

OUTCOME:

1. There is evidence that 100% of the staff will be able to effectively and safely transfer/carry residents in the event of an evacuation.

ADDITIONAL REFERENCES:

1. Fire Safety Training for Employees of Care and Treatment Occupancies.

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-50
SUBJECT:	QUALITY INDICATORS	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY: Parsons		**REVIEWED DATE:** July 26, 2022

QUALITY INDICATORS

1. 100% adherence to universal codes.
2. 100% proficiency in the application of Universal Codes.
3. All new employees demonstrate knowledge of emergency codes upon completion of orientation program.
4. 100% of staff are actively involved in fire drills every 12 months.
5. In the event of an evacuation / disaster 100% of residents / staff are safely taken out of the building.
6. Emergency contact procedure is initiated within 15 minutes.
7. 100% of families were contacted during the emergency/disaster.
8. 100% of media communication done by executive director\delegate during the emergency/disaster.
9. In an evacuation situation 100% of residents are properly identified for appropriate placement.
10. In an evacuation situation 100% of relocated residents are accurately tracked.
11. In the event triage is required, appropriate assessments are completed 100% of the time.

SECTION:	QUALITY MANAGEMENT	**INDEX I.D.:** EPM J-55
SUBJECT:	EMERGENCY PLAN EVALUATION AUDIT	**PAGE:** 1 OF 1
		ORIGINAL DATE: June 1, 2000
APPROVED BY:		**REVIEWED DATE:** July 26, 2022

Please refer to Quality Improvement Program, Section III, Risk and Quality Indicators and Tools, K: Administration – Annual Evaluation – Emergency Plan.

SECTION: PANDEMIC PLANNING	**INDEX I.D.:** EPM K-05
SUBJECT: PANDEMIC PLANNING	**PAGE:** 1 OF 1
APPROVED BY:	**APPROVED DATE:** July 8, 2022
APPROVED BY:	**REVIEWED DATE:**

Please refer to COVD-19 Home Pandemic Playbook

SECTION: OUTBREAK MANAGEMENT	**INDEX I.D.:** EPM L-05
SUBJECT: OUTBREAK MANAGEMENT	**PAGE:** 1 OF 1
APPROVED BY:	**APPROVED DATE:** July 8, 2022
APPROVED BY:	**REVIEWED DATE:** July 26, 2022

Please refer to the Infection Prevention and Control Manual for the following policies:

G-05. Definition of an Outbreak
G-05-10 Exclusion Policy
G-10. Management Guidelines for Upper Respiratory Outbreak
G-25. Nasopharyngeal Swabbing
G-30. Anti-viral Use: Tamiflu
G-35. Role of Programs Staff
G-40. Role of Dietary
G-45. Role of Housekeeping
G-50. Role of Maintenance
G-55. Role of Laundry
G-60. Role of Nursing
G-65. Outbreak: Communication with Ministry Of LTC and Ministry of Labour
G-70. Submission of Food and Environmental Samples
G-75. Communication
G-80. Organisms Requiring Special Procedures for Staff/Resident Management
G-85. Monitoring Employee's Illnesses
G-90. Role of Public Health Unit