Ministry of Long-Term Care

Approach to Compliance and Enforcement

Overview

As a modern regulator, the Long-Term Care Inspections Branch follows the Regulators' Code of Practice, which commits to honesty, integrity, respect, objectivity, confidentiality, continuous learning and timeliness.

Our inspectors are trained to take the following approach:

- **Be Transparent:** Provide clear information about our compliance approaches and publicly post inspection reports;
- **Be Proportionate:** Enforcement actions should be proportionate to the circumstances with progressive escalation for repeated non-compliance;
- **Be Targeted:** Take a risk-based approach to target our efforts; and
- **Be Professional:** Cooperate with licensees, long-term care home staff and administration.

Enforcement Actions

See the Compliance and Enforcement Fact Sheet for an overview of the compliance and enforcement tools under the *Fixing Long-Term Care Act, 2021* (FLTCA).

If an inspector finds non-compliance with the FLTCA during an inspection, they are required by the Act to take the following factors into account:

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- Severity;
- Scope; and
- Compliance History.

Inspectors receive standardized training on how to decide appropriate enforcement actions so they can:

- Make fair, consistent decisions across the province;
- Determine the most appropriate enforcement action; and
- Document their findings in an inspection report.

Severity

An inspector determines severity based on:

1. The **impact** to the resident(s) as a result of the finding of non-compliance;
2. The **risk** to the resident(s) at the **time of the non-compliance**; and
3. The **risk** to the resident(s) at the **time of the inspection** (when relevant).

Scope

An inspector determines scope based on how many residents were affected by the non-compliance. For example, is the finding of non-compliance an isolated incident or a broader issue in the home.

Compliance History

A licensee is considered to have a history of non-compliance related to a finding if they have a previous finding of non-compliance on the same specific legislative reference (or equivalent in the *Long-Term Care Homes Act, 2007*) in the past 36 months.

Actions

Remedied Non-Compliance

When a non-compliance is identified as having no impact and no or low risk to residents, it may be considered **Remedied Non-Compliance** by the inspector with no further actions issued if:

- The long-term care home demonstrates that they have remedied the non-compliance during an inspection, and
- The inspector is satisfied that the long-term care home is now in compliance.

Written Notification

A Written Notification may be issued when a non-compliance is identified as low impact or risk to a resident.

Compliance Order

A Compliance Order will be issued when a non-compliance is identified as significant impact or risk to a single resident's health, safety or quality of life, or moderate impact or risk to multiple residents.

Administrative Monetary Penalty (AMP) and Re-Inspection Fee

An inspector is required to issue an AMP if a licensee:

- Has not complied with a Compliance Order made under the Act; or
- Has not complied with a requirement under the Act that results in a Compliance Order being issued, and the licensee has received at least one other Compliance Order for non-compliance with the same requirement within a three-year period.

The AMP amount is set out in the FLTCA and Ontario Regulation 246/22 based on the nature of the non-compliance and the compliance history.

A Re-Inspection Fee is issued for the second follow-up inspection for the same Compliance Order. It is a flat rate of $500.

Inspectors have no discretion on whether to issue an AMP / Re-Inspection Fee or the amount of the AMP / Re-Inspection Fee. They must follow the legislation as written.

Provincial Offences

Serious and/or repeat findings of non-compliance, including not complying with a Compliance Order, may result in an investigation, and could lead to a licensee or director or officer of a corporation being charged with a provincial offence.

Director Referrals

Inspectors may issue a Director Referral for:

- Repeated non-compliance;
- Non-compliance with a Compliance Order for the second time;
- Inability to achieve compliance: If an inspector has concerns that the licensee cannot or is unwilling to achieve compliance; and/or
- Action required beyond the inspector's authority that requires the Director's involvement.

The Director's involvement may result in further enforcement action(s) such as:

- Director's Order;
- Administrative Monetary Penalties;
- Order Requiring Management;
- Cease of Admissions; and/or
- Licence suspension or revocation and appointing supervisor.

Compliance Due Date

The Compliance Due Date (CDD) is the deadline for a licensee to comply with a Compliance Order. The CDD may vary depending on the:

- The urgency to remedy the situation
- The severity of the risk to the resident(s) / operations of the home; or
- The scope of the issue.

Ministry of Long-Term Care

Complaints

As of April 11, 2022, the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 have replaced the previous *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 as the governing legislation for long-term care in Ontario.

The FLTCA and its regulation have updated the requirements for licensees with respect to complaints. The updated requirements that are further explained in this document include:

- A licensee must forward all complaints that allege harm or risk of harm to one or more residents, including but not limited to physical harm, immediately to the Director.
- A licensee must provide contact information for the ministry's Long-Term Care Family Support and Action Line and for the Patient Ombudsman to the complainant in response to a complaint.

Licensees must post information in the long-term care home about their complaints procedure for the home, and also provide this information to residents at the time of their admission.

Complaints procedures

The FLTCA requires licensees to have written procedures for a person to make a complaint to the licensee and it must set out how the licensee will deal with complaints.

Homes must post these procedures in a place where they are easy to find and easy to see. They must also post the ministry's telephone number for directly making complaints about homes.

Dealing with complaints

A licensee might receive complaints on a range of topics and in different formats. Any written or verbal complaint made to the licensee or a staff member about resident care or how the home runs requires an investigation and resolution, where possible.

Further, a home must provide a response to the complainant. The timelines for this response depend on the nature of the complaint.

If a complaint alleges harm or risk of harm to one or more residents, including but not limited to physical harm, the licensee must investigate the complaint **immediately**. They must also immediately forward the complaint to the director. If a complaint does not allege harm or risk of harm to one or more residents, including but not limited to physical harm, it is not required to be forwarded to the Director.

Responses

In all cases, the licensee must let the complainant know that they have received the complaint within ten business days. For complaints that cannot be investigated and resolved within 10 business days, a licensee must inform the complainant when they can expect the complaint to be resolved.

A response must be provided to the complainant. The response provided must explain what the licensee has done to resolve the complaint or if the licensee believes there is no cause for complaint, they must explain why.

The response must also include the telephone number of the Long-Term Care Family Support and Action Line for making complaints about LTC homes and the contact information for the Patient Ombudsman.

Where the licensee was required to immediately forward the complaint to the ministry, the response must also let the complainant know that this happened.

Documentation

A licensee must keep a documented record about all complaints it receives about the care of a resident or operation of an LTC home. This includes:

- what the complaint was about
- the date the complaint was received
- the action taken to resolve the complaint, including when it was taken, and when any future actions will occur
- how it was finally resolved, if applicable
- the dates on which any response was provided to the complainant with a description of each response
- and any further responses from the complainant.

The licensee must review and analyze the documented record for trends at least every quarter. The licensee must ensure that the resulting review and analysis inform decisions about improvements required for the home. The licensee must keep a written record of each review and of any subsequent improvements made to the LTC home in response.

Where the licensee has immediately forwarded the complaint to the Director, the documentation related to the complaint must also go to the Director.

When dealing with a verbal complaint that can be resolved within 24 hours of the complaint being received, the requirements in the regulation about documentation, review and analysis as outlined in this section do not apply.

Transition

The FLTCA provides that if someone made a complaint before the FLTCA came into force on April 11, 2022, and it has yet to be dealt with, it should be dealt with according to the new requirements of the FLTCA to the extent possible.

Other methods for complaints

Complainants may not wish to submit their complaint through the home. There are other ways for them to do so. Licensees are encouraged to post this information in the home.

Call the ministry

Call the Long-Term Care Family Support and Action Line: toll-free 1-866-434-0144

Hours of operation: 8:30 a.m. - 7:00 p.m., 7 days a week

The person who answers the call will:

- take down the complainant's information
- ask some questions
- give the information to an inspector for follow-up

The complainant will hear back within two business days.

Write to the ministry

Send a written letter, by mail, to:

Director
Long-Term Care Inspections Branch
Long-Term Care Operations Division
119 King St. W, 11th Floor
Hamilton ON L8P 4Y7

The complainant will receive a reply letting them know that the ministry has received the complaint. The complaint will be forwarded to an inspector who will look into the matter.

Contact the Patient Ombudsman

If the complainant has already contacted the home directly and the Long-Term Care Family Support and Action Line (toll-free at 1-866-434-0144) and was not able to reach a satisfactory resolution, they can contact the Patient Ombudsman:

- online
- by calling 1-888-321-0339 (toll free) or 416-597-0339 (in Toronto)
- TTY: 416-597-5371

Ministry of Long-Term Care

Continuous Quality Improvement Initiative

As of April 11, 2022, the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 have replaced the previous *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 as the governing legislation for long-term care in Ontario. As part of the government's plan to fix long-term care, the FLTCA and its regulation place greater emphasis on resident quality of care, quality of life, and continuous quality improvement.

General Overview

The continuous quality improvement initiative

The FLTCA requires that a licensee implement a continuous quality improvement initiative for a long-term care home. As part of the continuous quality improvement initiative, the FLTCA and its regulation require every licensee to:

- establish an interdisciplinary quality improvement committee, within six months after the coming into force of the applicable section of the regulation under the FLTCA;
- ensure the home's continuous quality improvement initiative is co-ordinated by a designated lead;
- prepare an interim report on the continuous quality improvement initiative for the home for the 2022-23 fiscal year, within three months after the coming into force of the applicable section of the regulation under the FLTCA, and publish the report on its website, subject to the regulatory requirements for websites;

- prepare a report on the continuous quality improvement initiative for the home each fiscal year and publish the report on its website, subject to the regulatory requirements for websites; and,
- maintain a record setting out the names of the people who participated in evaluations of improvements in the continuous quality improvement report.

Some of these requirements expand the previous legislative requirements. Others replicate regulatory requirements under the previous LTCHA within a continuous quality improvement initiative report, which is intended to streamline reporting and enhance transparency.

The continuous quality improvement requirements are intended to drive continuous quality improvement across and within long-term care homes. They establish a foundation for quality improvement to help long-term care homes meet the diverse needs of its residents, their families and caregivers, and staff.

Licensees are encouraged to leverage existing processes and structures as part of their quality improvement initiative and to develop the policies, procedures, and processes necessary to comply with the FLTCA and its regulation and support further implementation over time.

The continuous quality improvement initiative committee

An interdisciplinary continuous quality improvement committee is intended to support an ongoing culture shift in long-term care that encourages continuous quality improvement through collaboration between the long-term care home's staff and leadership as well as representatives from the Residents' Council and Family Council, if any. The committee is intended to create a safe and collaborative space for its members to fulfil their responsibilities, as set out in the regulation.

The ministry recognizes that it may take time to comply with the requirements of the continuous quality improvement committee as set out in the regulation. Long-term care homes must establish a continuous quality improvement committee within six months after the coming into force of the applicable section under the regulation.

Required members for the continuous quality improvement committee

The regulation sets out the required minimum membership of a long-term care home's continuous quality improvement committee. Some of the required members include certain representatives from a long-term care home's staff and leadership as well as a representative from each of the Residents' Council and Family Council, if any.

The continuous quality improvement committee, must include at least the following members:

1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52 of the regulation.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

Requirements for the continuous quality improvement committee and its composition address the diversity of long-term care homes across Ontario

The new requirements are intended to drive continuous quality improvement across and within long-term care homes. They establish a foundation for quality improvement to help long-term care homes meet the diverse needs of its residents, their families and caregivers, and staff.

Licensees are encouraged to leverage existing processes and structures as part of their quality improvement initiative and to develop the policies, procedures, and processes necessary to comply with the FLTCA and its regulation and support

further implementation over time. This may include, but is not limited to, considering ways to address issues such as frequency and mode of meetings, sub-committees, conflicts of interest and privacy requirements, additional members, and additional responsibilities of the committee.

The continuous quality improvement report and the Quality Improvement Plan (QIP) required under the Service Accountability Agreement between each licensee and Ontario Health

A licensee must comply with the FLTCA and its regulation. The FLTCA and its regulation do not prevent a licensee from integrating their QIP into their continuous quality improvement report to streamline public reporting requirements.

Over the upcoming year, the ministry will continue to work with Ontario Health and the sector to look for opportunities to further strengthen and align quality improvement efforts.

The interim report and the continuous quality improvement report

Licensees are required to prepare an interim report for the 2022-23 fiscal year within three months of the coming into force of the applicable section under the regulation. Among other things, it must name the designated lead for the continuous quality improvement initiative and describe the home's priority areas for quality improvement. A copy of the interim report must be provided to the Residents' Council and Family Council, if any, and published on the home's website, subject to the regulatory requirements for websites.

The continuous quality improvement initiative report must be prepared by a licensee for each fiscal year no later than three months after the end of the fiscal year. The first report is for the fiscal year ending March 31, 2023. The continuous quality improvement initiative report must contain, for example, the actions taken to improve quality improvement in the home for the fiscal year and the home's priority areas for the next fiscal year. A copy of each continuous quality improvement initiative report is to be provided to the Residents' Council and Family Council, if any, and published on the home's website. The report does not need to be submitted to the ministry.

Ministry of Long-Term Care

Whistle-blowing protections

As of April 11, 2022, the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 have replaced the previous *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 as the governing legislation for long-term care in Ontario.

The FLTCA continues the strong protections for whistle-blowers that were included in the (former) LTCHA, and expand these to apply to any disclosure by anyone to any personnel of the ministry and to a long-term care home's Residents' Council and Family Council, if any.

The whistle-blowing protections are intended to give anyone the confidence to bring forward anything about an LTC home, including the care of a resident, without fear of retaliation.

The FLTCA continues to require licensees to post in the LTC home an explanation of the whistle-blowing protections afforded under the legislation. They must also provide this information specifically to residents, staff and volunteers.

Prohibitions

The FLTCA prohibits anyone from retaliating or threatening to retaliate against someone else because of a disclosure to:

- an inspector or the Director
- **any other personnel of the ministry [NEW]**
- **a residents' council [NEW]**
- **a family council, if any [NEW]**

This prohibition also applies where evidence has been or may be given in a proceeding.

A long-term care home cannot do anything that discourages someone from making a disclosure, nor can a home encourage someone to fail to make a disclosure.[1]

Retaliation

The prohibited retaliation against another person includes acts or by omissions. It can include (without limiting its meaning):

- Dismissing, disciplining or suspending a staff member
- Imposing a penalty on any person
- Intimidating, coercing or harassing any person

The FLTCA gives protection to residents and family members from worrying that raising concerns or issues would affect the care or services that a resident receives.

If a resident or their family member makes a disclosure, the FLTCA prohibits:

- the discharge of the resident from the LTC home, including threat of discharge.
- in any way subjecting the resident to discriminatory treatment (such as change or discontinuation of any service or care to the resident),
- threats of doing or the possibility of doing any the former to the resident.

[1] This prohibition applies specifically to: a licensee or third party manager of an LTC home; officers and directors of licensees and third party managers if they are a corporation; staff of an LTC home; and members of a committee of management or board of management for a specific LTC home.

Disclosures

A disclosure can be about anything. Anyone can come forward at any time to an inspector or the Director. This includes when someone makes a mandatory report to the Director about certain serious matters under the FLTCA.

The FLTCA clarifies that a disclosure may be made by any method, such as by making a complaint to the ministry or by calling the ministry's action line.

For more information about a licensee's responsibilities for managing and dealing with complaints, see the LTC complaints fact sheet.

Ontario

Ministry of Long-Term Care

Infection Prevention and Control Standard

Why is the Ministry issuing this Standard? What is the purpose of this Standard?

The *Infection Prevention and Control (IPAC) Standard* (the "Standard"), once effective, will mandate certain requirements that licensees must follow in respect to IPAC programs in Ontario's Long-Term Care homes, including requirements related to IPAC program evaluation, hand hygiene, symptom surveillance, and infectious disease screening. These requirements are in addition to other IPAC requirements that licensees are required to comply with, including those in *the Fixing Long-Term Care Act, 2021* (FLTCA), O. Reg. 246/22 (the "Regulation"), and the Minister's COVID-19: Long-term care home surveillance testing and access to homes Directive.

The Regulation provides that a licensee is required to implement any standard or protocol issued by the Director with respect to infection prevention and control. Once FLTCA comes into force, licensees will be required to comply with the Standard, which is grounded in current evidence and best practice.

Each section of the Standard contains requirements for evidence-based IPAC programming, which licensees must follow.

Questions?
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What is the Standard based on?

The Standard is based on guidance from several agencies including IPAC Canada, and Public Health Ontario. As well, it was also developed based on current advice from expert IPAC practitioners with direct experience in long-term care and other healthcare settings, and will be updated regularly when related evidence or best practice changes.

What new requirements related to IPAC are included in FLTCA and the Regulation?

FLTCA and the Regulation build on requirements in *the Long-Term Care Homes Act, 2007* related to IPAC, and also add new requirements, including:

- Additional required training and education for designated IPAC leads;
- Certification for designated IPAC leads three years after the regulation comes into force;
- Minimum required hours of work per week on site for designated IPAC leads;
- A new requirement for a quality management program for IPAC;
- Additional personnel and resource assignments as may be required for the IPAC program;
- A requirement that the IPAC program is implemented in a manner consistent with the precautionary principle as set out in the standards and protocols issued by the Director under subsection 102 (2) of the Regulation and the most current medical evidence, and
- The requirement that the licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control, which would include the Standard.

Questions?
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What are the main sections of the Standard?

The main sections of the Standard include:

- IPAC Program
- IPAC Resources
- Surveillance
- Outbreak Preparedness and Management
- IPAC Policies and Procedures
- Personal Protective Equipment (PPE)
- Training and Education
- Regular Evaluation and Quality Improvement
- Routine Practices and Additional Precautions
- Hand Hygiene Program
- Immunization and Screening

How often will this Standard be updated?

This Standard will be updated and amended regularly as new evidence or best practices emerge.

What is the timeline for implementation of the Standard?

The Standard will be in effect and enforceable under FLTCA once FLTCA comes into force. At that time licensees will be required to comply with the Standard.

Will the Ministry of Long-Term Care be developing informational or other supports that licensees may use in implementing the Standard?

Yes. The Ministry of Long-Term Care will be developing informational and other resources for licenses relating to the implementation of the Standard.

Questions?
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Additional resources will address specific new requirements in the Standard such as the requirement for an ethical framework for the IPAC Program.

As well, further educational webinars and other events will be scheduled in the coming months.

Questions?
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Ministry of Long-Term Care

Palliative Care

As of April 11, 2022, the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 expand palliative care requirements from the previous *Long-Term Care Homes Act, 2007* (LTCHA). The palliative care requirements under the FLTCA and its regulation reflect a shift in practice towards a broader, more holistic approach to palliative care.

Ontario Provincial Framework for Palliative Care

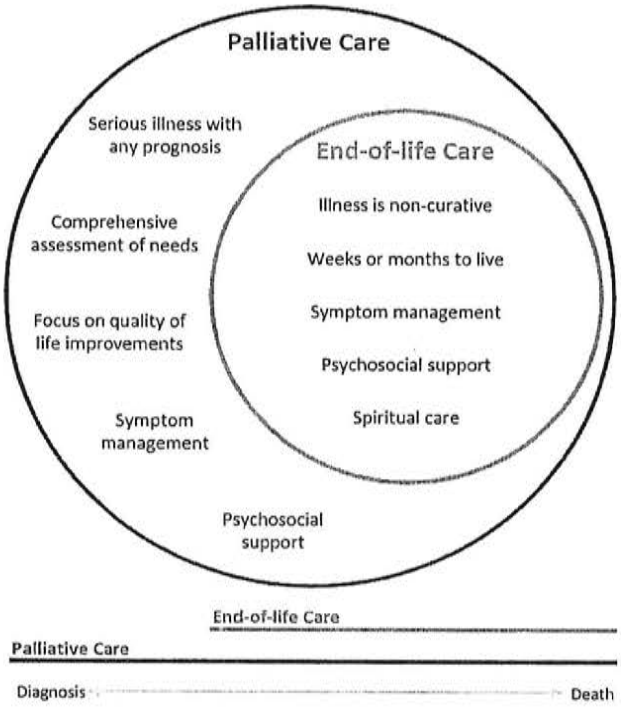
The palliative care requirements under the FLTCA and its regulation align with the *Ontario Provincial Framework for Palliative Care*, which sets out a vision for palliative care in Ontario where people can "...receive the holistic, proactive, timely and continuous care and support they need...to live as they choose and optimize their quality of life, comfort, dignity, and security."

The *Ontario Provincial Framework for Palliative Care* was tabled in the Ontario Legislature in December 2021. Consistent with definitions developed by the World Health Organization and the Canadian Hospice Palliative Care Association, it defines palliative care as "...an approach to care that aims to relieve suffering and improve the quality of living and dying for every person with a serious illness. [Palliative care] strives to help the individual and their family/caregiver(s) to:

- address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears;
- prepare for and manage end-of-life choices and the dying process;
- cope with loss and grief;

- treat all active issues and prevent new issues from occurring; and
- promote opportunities for meaningful and valuable experiences, and personal and spiritual growth."

The framework acknowledges that while end-of-life care, described as focusing "... on preparing for an anticipated death of the individual (child or adult) and managing the end stage of a serious illness", is one component of palliative care, it is only one of many components.



Instead of focusing solely on end-of-life care, the definition of palliative care in the framework reflects the shift in practice towards a broader, more holistic approach that includes, but is not limited to, early palliative care and end-of-life care. Using a holistic and comprehensive assessment to determine the care and services a person needs, this approach considers a person's physical, psychological, social, linguistic, cultural, ethical, and spiritual needs. It recognizes that, while the palliative care and services a person needs may, or may not, include end-of-life care, it also considers a person's need for quality of life improvements, symptom management and psychosocial support.

Questions?
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FLTCA and O. Reg 246/22: Palliative Care

The palliative care requirements under the FLTCA and O. Reg 246/22

The FLTCA and its regulation expand palliative care requirements from the previous LTCHA.

The FLTCA adds a new right to the Residents' Bill of Rights that states that it is the right of every resident to be provided with care and services based on a palliative care philosophy.

The FLTCA also requires that every licensee ensure that a resident's plan of care covers all aspects of care, including palliative care and that a resident is provided with care or services that integrate a palliative care philosophy. Its regulation requires a licensee to ensure that an interdisciplinary assessment of the resident's palliative care needs for their plan of care considers a resident's physical, emotional, psychological, social, cultural, and spiritual needs. Based on the assessment, a licensee must ensure that an explanation of the palliative care options that are available to the resident is provided to the resident, the resident's substitute decision-maker, if any, and any other person or persons designated by the resident or their substitute decision-maker. These options must include, at a minimum, quality of life improvements, symptom management, psychosocial support, and end-of-life care, if appropriate.

Before taking any action to assess a resident's needs, or provide care or provide services to a resident, a licensee shall ensure the resident's consent is received.

A licensee must comply with the requirements for programs respecting palliative care and the palliative care philosophy within six months after the coming into force of the applicable section of the regulation under the FLTCA.

In addition to the above, the regulation under the FLTCA updates palliative care training and removes the training exemption that was applicable under the LTCHA for persons such as medical directors and physician.

Questions?
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Understanding palliative care is more than just end-of-life care

The new palliative care requirements under the FLTCA and its regulation reflect a shift in practice towards a broader, more holistic approach to palliative care. They are consistent with the *Ontario Provincial Framework for Palliative Care*, which was developed based on consultation with community partners and stakeholders, including advisors from hospitals, primary care, long-term care homes, hospices, home and community care providers, health care associations and organizations as well as individuals and their families and caregivers from across Ontario.

Under the regulation the palliative care options made available to a resident may include, but must not be limited to, end-of-life care. Based on the assessment of a resident's palliative care needs for their plan of care, the regulation under the FLTCA requires a licensee to ensure that an explanation of the palliative care options that are available to the resident is provided to the resident, the resident's substitute decision-maker, if any, and any other person or persons designated by the resident or their substitute decision-maker. These options must include, at a minimum, quality of life improvements, symptom management, psychosocial support, and end-of-life care, if appropriate.

The ministry is committed to working with the broader health sector to identify and help long-term care homes access existing tools and resources for residents, families, caregivers as well as long-term care home staff and leadership to improve awareness about the shift in practice towards a broader, more holistic approach to palliative care.

Responding to the diverse needs of long-term care residents

The palliative care requirements under the FLTCA and its regulation respond to the diverse and often complex needs of long-term care residents across Ontario, including residents who may not require palliative care to address their needs. They align with the *Ontario Provincial Framework for Palliative Care*, which reflects the shift in practice towards a broader, more holistic approach to palliative care.

At the outset, it is important to note, that a licensee must ensure that the rights of residents in the Residents' Bill of Rights are fully respected and promoted. In addition, the Residents' Bill of Rights and the fundamental principle of the FLTCA is to be applied when interpreting the FLTCA and anything required or permitted under it, such as the palliative care requirements.

The FLTCA requires that every licensee ensure that a resident's plan of care covers all aspects of care, including palliative care based on an interdisciplinary assessment of the resident's palliative care needs. The licensee must ensure that the interdisciplinary assessment considers a resident's physical, emotional, psychological, social, cultural, and spiritual needs. Based on the assessment, a licensee must ensure that an explanation of the palliative care options that are available to the resident is provided to the resident, the resident's substitute decision-maker, if any, and any other person or persons designated by the resident or their substitute decision-maker. These options must include, at a minimum, quality of life improvements, symptom management, psychosocial support, and end-of-life care, if appropriate.

Before taking any action to assess a resident's needs, or provide care or provide services to a resident, a licensee shall ensure the resident's consent is received.

Impact on existing plans of care in place before April 11, 2022

The FLTCA and its regulation state that, where immediately before the coming into force of the applicable section of the regulation, a plan of care under the previous LTCHA is in place for a resident, it is continued as a plan of care under the FLTCA. For the purposes of determining when the plan of care must be reviewed and revised, the plan of care is deemed to have been developed or revised under the FLTCA on the same day it was developed or revised under the previous LTCHA.

For example, if a resident's plan of care was developed and in place on March 4, 2022, under the previous LTCHA it would be considered to have been developed on March 4, 2022, under the FLTCA. The resident's plan of care would then need to be reviewed or revised according to the requirements in the FLTCA and O. Reg 246/22.

Supports for caregivers*

The Ontario Caregiver Organization supports caregivers across Ontario with programs and resources including the 24/7 Ontario Caregiver Helpline 1-833-416-2273 (CARE), counselling and peer support groups, webinars, and checklists.

Your local Home and Community Care Support Services organization can also provide more information or local caregiver supports.

Regional palliative care networks*

The Regional Palliative Care Network (RPCN) directors and clinical co-leads can help to support local connections by identifying providers with palliative care expertise. Please reach out to Info@ontariopalliativecarenetwork.ca for contact information for your local RPCN leadership team.

The Ontario Centres for Learning, Research and Innovation also shares regional palliative care resources.

Other information and resources

Information and resources about palliative care are available on the Ministry of Health and Ministry of Long-Term Care website.

Additional information and training resources may be available through:

- Ontario Health (Ontario Palliative Care Network)*
- Home and Community Care Support Services*
- Ontario Centres for Learning, Research and Innovation*
- Ontario Long-Term Care Association*
- AdvantAge Ontario*
- Ontario Long-Term Care Clinicians*
- Hospice Palliative Care Ontario*
- Ontario Caregiver Organization*

*Please note that the Ministry of Long-Term Care does not guarantee the accuracy of the content on external sites, nor does it endorse the opinions and positions expressed, either in related materials or on external sites.

Ministry of Long-Term Care

Enhanced Screening Measures in LTC Homes

As of April 11, 2022, the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 have replaced the previous *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 as the governing legislation for long-term care in Ontario.

The new Regulation under the FLTCA introduces enhanced screening requirements for staff, volunteers, and members of the licensee's board of directors, its board of management or committee of management or other governing structure.

These include restrictions on hiring staff, accepting volunteers, and establishing and maintaining relationships with members of a licensee's board of directors, its board of management or committee of management or other governing structure based on offences against vulnerable individuals, and acts of professional misconduct by a regulated professional.

This document provides an overview of the screening requirements with which each licensee must comply.

Introduction

The FLTCA includes requirements that licensees must comply with for screening measures that enhance requirements for police record checks under the previous LTCHA as well as

- **Prohibiting the hiring of staff if they have been convicted of offences** prescribed in the regulations,
- or **found guilty of an act of professional misconduct** prescribed in the regulations.
- The legislation also states that a licensee shall not permit persons convicted of such prescribed offences or found guilty such acts of professional misconduct **to be a member of the licensee's board of directors, its board of management or committee of management or other governing structure.**
- The prohibition is time limited.

The Regulation under the FLTCA includes the following enhanced screening requirements:

- Provisions setting out **screening processes for members of a licensee's board of directors, its board of management or committee of management or other governing structure.**

Types of Offences that Prohibit the Hiring an Individual

The Regulation prohibits the hiring staff, accepting volunteers, and on members of a licensee's board of directors, its board of management or committee of management or other governing structure if they have been convicted of prescribed offences or found guilty of an act of professional misconduct as prescribed in the regulation.

Prescribed offences that indicate a risk of harm to long-term care residents restrict hiring a person, including those involving **abuse or neglect, improper or incompetent treatment or care, or misuse or misappropriation of an individual's money.**

Additional restrictions set out in the Regulation are based on findings of guilt for **offences under precursor legislation**, a specified section under the ***Criminal Code***

(Canada) which include **offences for which there can be no conditional sentence**, and offences under the ***Cannabis Act (Canada)***, the ***Controlled Drugs and Substances Act (Canada)*** or the ***Food and Drugs Act (Canada)***.

The prohibition is time limited and is in place until five years after the end of the persons sentence, if any, and until five years after the consequences, if any for the professional misconduct expired.

Professional Misconduct that Prohibits the Hiring an Individual

The regulation under the *Fixing Long-Term Care Act, 2021* sets out the prescribed acts of act of professional misconduct. Some of these acts include an act of misconduct as a member of a health profession or as a member of a regulated profession as prescribed. The prohibition would be time limited and would be in place until five years after the consequences, if any, for the professional misconduct expired.

*Regulations also set out requirements for retaining records to facilitate compliance with enhanced screening measures.

Screening for Members of a Licensee's Board of Directors, its Board of Management or Committee of Management or Other Governing Structure

To ensure that persons convicted of prescribed offences or found guilty of professional misconduct defined in the Regulation do not serve as members of a licensee's board of directors, its board of management or committee of

management or other governing structure, **generally, a police record check is to be conducted within six months before the person becomes a member of the licensee's governing structure.**

Where a person will become a member of the governing structure as a result of their election under the *Municipal Elections Act, 1996*, that person must provide a police record check as required that was conducted no earlier than six months prior to the date their term of office beings. However, this requirement does not apply if their term of office ends on November 14, 2022.

When a person becomes a member of the licensee's board of directors, its board of management or committee of management or other governing structure during a pandemic, there are exceptions that may apply. For example, a police records check conducted within six months before the person becomes a member of the licensee's board of directors, its board of management or committee of management or other governing structure would not be required.

There are exceptions for members of a licensee's board of directors, its board of management or committee of management or other governing structure. The licensee will have six months from the date the regulation came into force to comply with the police record check and signed declarations.

Please refer to the regulation for additional details.

Limited Exceptions to Screening Requirements

Licensees are required to ensure that individuals are screened in accordance with the legislative and regulatory requirements, The police records check and declarations do not apply in limited circumstances such as:

If person who is, or who is being hired to be, a staff member who will be performing work at the home:

a) is working in the home pursuant to a contract or agreement with the licensee, or pursuant to a contract or agreement between the licensee and an employment agency, or other third party;
b) will only provide occasional maintenance or repair services to the home;
c) will not provide direct care to residents; and
d) will be monitored and supervised, in accordance with the licensee's policies and procedures to monitor and supervise such persons while they provide services to the home.

A vulnerable screening check may not be required upon hiring for certain professions where it may be required upon registration or for the regulatory colleges. However, licensees must ensure that **these persons provide signed declarations** as required.

Individuals hired **during a pandemic** must be **screened in accordance with the requirements for police record checks within three months of being hired or accepted as a volunteer**. For individuals who were hired or accepted before the Regulation under the FLTCA came into force, licensees have three months from the in-force date to ensure these individuals are screened in accordance with these requirements.

Ontario

Ministry of Long-Term Care

Updates to Emergency Planning Preparedness

As of April 11, 2022, the *Fixing Long-Term Care Act, 2021* (FLTCA) and Ontario Regulation 246/22 have replaced the previous *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 as the governing legislation for long-term care in Ontario.

Long-term care homes are required to have emergency plans in place that comply with regulatory requirements, including measures for preparing and managing emergencies such as pandemics, as well as procedures for evacuation and relocation of residents and staff in the event of an emergency.

In response to the COVID-19 pandemic and recommendations received from the Auditor General, LTC COVID-19 Commission, and other sector partners, the FLTCA and its regulation set out requirements to strengthen the respective emergency and evacuation plans of long-term care homes.

Where emergency plan requirements currently comply with the previous LTCHA, that plan continues and is deemed to have met the emergency plan requirements under FLCTA until three months after the coming into force of the new emergency plan requirements. After such time, emergency plans are required to meet all requirements under FLCTA to be in compliance.

Questions?

mltc.correspondence@ontario.ca

What's New

Below is an overview of relevant **new additional** requirements set out in regulation under the FLTCA regarding emergency planning. Please refer to the FLTCA for a full list of all new regulation requirements. Education, information and detailed communication will be shared with licensees in the coming weeks to support licensees to operationalize these changes.

Emergency Plans

Every licensee must record emergency plans in writing, make plans available on its website and make physical copies available upon request.

In developing and updating their plan, the licensee must consult with entities that may be involved in or provide emergency services in the area where the home is located (e.g., agencies, health service providers, etc.) as well as Residents' Councils, and Family Councils (if any).

The types of emergencies that the licensee shall ensure that the emergency plan provides for has been expanded to include but is not limited to, outbreaks of communicable diseases, gas leaks, natural disasters and extreme weather events, boil water advisories, and floods.

There are additional requirements that every licensee shall ensure that an emergency plan related to outbreaks of communicable diseases, outbreaks of a disease of public health significance, epidemics and pandemics includes, such as:

- Identifying an area of the home to be used for isolating residents as required
- A process to divide staff and residents into cohorts as required
- Staffing contingency plans during an emergency for all programs required under the FLTCA and its regulation
- Policies to manage staff who may be exposed to an infectious disease
- A process to manage symptomatic residents and staff
- A process for an Outbreak Management Team and identifying members of the Team and their roles and responsibilities.

The licensee shall also ensure that the local Medical Officer of Health or their designate is invited to participate in developing, updating, testing, evaluating, and reviewing emergency plans related to matters of public health significance.

The licensee shall also ensure that the infection prevention and control lead is involved in developing, updating, evaluating, testing and reviewing the emergency plan related to the various types of outbreaks as set out in the Regulation.

The requirements of what emergency plans must provide for have been expanded under the FLTCA, for example:

- Additional requirements specific to resourcing and supplies, personal protective equipment (PPE) and equipment for the emergency response, as well as a process to ensure that required items have not expired.
- Identification of emergency service providers roles and responsibilities.
- A plan for food, fluid and drug provision in an emergency.

In addition to the components of the emergency plans which existed previously under the LTCHA, there are new requirements that every licensee shall ensure, including:

- That the emergency plans address recovery from an emergency, such as:
    - Requiring residents and their substitute decision-maker (if any), staff, volunteers, and students be debriefed after the emergency,
    - Establishing how to resume normal operations in the home, and
    - Establishing how to support those experiencing distress during the emergency.
- That the plan activation section must clearly state how the plan is activated and deactivated.
- That the home's communications plan has a process to ensure frequent and ongoing communication, initiated at the beginning of the emergency, when there is a significant status changes, and when the emergency is over.

Emergency plans are to be evaluated and updated within 30 days of the emergency being declared over. Every licensee shall ensure that entities that have been involved in the emergency response are provided an opportunity to offer feedback.

Emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies, and violent outbursts, gas leaks, natural disasters, extreme weather events, boil water advisories, infectious diseases, including outbreaks, epidemics and pandemics, and floods must be tested annually. All other emergency plans must be tested once every three years. Licensees must keep a written record of the tests and include any resulting changes.

Evacuation Plans

In addition to the regulation requirements for evacuation of the home which existed under the previous LTCHA, the regulation under the FLTCA sets out at a minimum what a home's evacuation plan must include, for example:

- Identification of a safe evacuation location which the licensee has obtained agreement on in advance for residents, staff, students, volunteers, and others,
- A transportation plan to move residents, staff, students, volunteers, and others to the evacuation location, and
- A plan to transport critical medication, supplies, and equipment during an evacuation to the evacuation location to ensure resident safety.

Licensees must conduct a planned evacuation at least once every three years and keep a record of this test and any changes made to improve the plan.

Staff and Volunteer Training

Every licensee must ensure that staff, volunteers, and students are trained on the emergency plans before performing their responsibilities, and at least annually thereafter.

Attestation

Licensees are required to prepare an attestation attesting to their compliance with section 90 of the FLTCA and maintain a record of every attestation. The attestation must be completed by the home administrator and the licensee shall ensure that it is submitted annually to the Director.

Website

Each licensee in a location in the province with consistent and reliable internet service shall ensure they have a website that is open to the public and includes at minimum certain information, for example:

- The physical address of the home
- The approximate number of licensed beds at the home
- Direct contact information including telephone and a regularly monitored email address for the:
    - Licensee, senior officer of the licensee, or in the case of a municipal home or a First Nations home, a person who is on the committee of management,
    - The home administrator,
    - The Director of Nursing and Personal Care, and
    - All infection prevention and control leads
- The Ministry toll-free number for making complaints about the home
- The current annual report
- The current version of the emergency plans
- The current version of the visitor policy

Ontario

Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes

April 2022

Introduction:

Comprehensive evidence-based Infection Prevention and Control (IPAC) practices are critical to the safety of residents, staff, caregivers and others in Ontario's long-term care homes. This document has been developed based on current evidence-based requirements for IPAC in long-term care and reflects robust practices that are appropriate to the long-term care setting.

Requirements under *the Fixing Long-Term Care Act, 2021*

This Infection Prevention and Control (IPAC) Standard (the "Standard") for Long-Term Care Homes is issued by the Director pursuant to section 102(2)(b) of the Regulation under the *Fixing Long-Term Care Act, 2021* (the "Act").

The licensee is required to implement any standard or protocol issued by the Director with respect to infection prevention and control. The Act and O. Reg. 246/22, contain requirements related to IPAC and also require the licensee to implement any standard or protocol issued by the Director with respect to IPAC.

This document sets out requirements for IPAC programs in Long-Term Care (LTC) homes during periods of regular operations and during infectious disease outbreaks. Licensees must comply with these requirements in a way that respects and promotes residents' rights as set out in the Residents' Bill of Rights under section 3 of the Act.

Homes are to review the Act and the Regulation in their entirety. In the event of a conflict between this Standard and another requirement under the Act, the Regulation or any other applicable law, the requirement in the Act, the Regulation, or other applicable law prevails.

Effective Date:

This IPAC Standard for Long-Term Care Homes is effective as of the date when O Reg. 246/22 under the Act comes into force and remains in force until it is amended or revoked.

1. Infection Prevention and Control (IPAC) Program

Act/Regulation: The Act requires every licensee of a long-term care home to ensure that there is an IPAC program for the home (s. 23(1) of Act). The licensee shall also implement any standard or protocol issued by the Director with respect to IPAC (s. 102(2)(b) of the Regulation).

The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead (s. 102(8) of the Regulation).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

1.1 The licensee shall ensure that staff roles, responsibilities, and accountabilities related to the implementation and ongoing delivery of the IPAC program are clearly defined and communicated regularly to all staff.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

1.2 The licensee shall keep written records of the process described in requirement 1.1 (definition and communication of staff roles and responsibilities) and shall ensure that the record is kept in a readable and useable format that allows a complete copy of the record to be readily produced.

What is an IPAC Program?

An IPAC program is generally defined as: an organized set of activities, processes and services for infection prevention and control which is administered by people with IPAC training and expertise in the organization.

***Goals of IPAC Programs:**

To optimize safety in the LTC home to mitigate risk of resident infections and to reduce morbidity and mortality; and

To prevent the spread of infections among those inside the home (including residents, staff and others) and transmission from the community into the home.

(*Adapted from IPAC Canada, 2016)

Components of the IPAC program

Based on the Act, O. Reg. 246/22 and this Standard, each licensee shall ensure that the IPAC program includes, but is not limited to, the required components noted in the table below.

Program component	
a)	IPAC Lead and interdisciplinary team
b)	Evidence-based policies and procedures
c)	Training and education
d)	**ADDITIONAL REQUIREMENT UNDER THE STANDARD:** Routine Practices and Additional Precautions
e)	Infectious Disease Surveillance
f)	Outbreak Management (OM) system
g)	Hand Hygiene program
h)	**ADDITIONAL REQUIREMENT UNDER THE STANDARD:** Personal Protective Equipment (PPE)
i)	Quality program and evaluation
j)	**ADDITIONAL REQUIREMENT UNDER THE STANDARD:** Ethical framework
k)	Application of the precautionary principle

2. IPAC Resources

Requirement for IPAC Lead

Act/Regulation: The licensee of a long-term care home shall ensure that the home has an IPAC Lead whose primary responsibility is the home's infection prevention and control program (s. 23(4) of the Act). The responsibilities of the IPAC Lead are detailed in s.102(7) of the Regulation.

As required by the Regulation, the licensee shall ensure that the IPAC Lead works regularly in that position on site at the home for at least the following **minimum hours:**

- For homes with a licensed bed capacity of 69 beds or fewer (smaller homes), **at least** 17.5 hours per week.
- For homes with a licensed bed capacity of more than 69 beds but less than 200 beds, **at least** 26.25 hours per week.
- For homes with a licensed bed capacity of 200 beds or more, **at least** 35 hours per week. (s.102(15) of the Regulation).

Explanatory Note:
IPAC programming and required resources, including resources available on a specific shift, must be sufficient to address home and resident factors such as: age of the home; layout; and resident complexity and/or vulnerability, as these may directly impact IPAC practices.

As well, the role should be prioritized and resourced in a manner that ensures that the required roles and responsibilities can be performed; including daily surveillance.

Education of the IPAC Lead

Act/Regulation: The IPAC Lead shall have, at a minimum, education and experience in IPAC practices, including:

a) Infectious diseases;
b) Cleaning and disinfection;
c) Data collection and trend analysis;
d) Reporting protocols;
e) Outbreak management;
f) Asepsis;
g) Microbiology;
h) Adult education;
i) Epidemiology;
j) Program management; and
k) Within three years of s.102(6) of the Regulation coming into force, the IPAC Lead shall have current certification in infection control from the Certification Board of Infection Control and Epidemiology (ss.102(5) and 102(6) of the Regulation).

Responsibilities of the IPAC Lead

Act/Regulation: As detailed in section 102(7) of the Regulation, every licensee shall ensure that the IPAC Lead carries out the following responsibilities as well as those also required under this Standard, as described below:

1. Working with the interdisciplinary IPAC team to implement the IPAC program;
2. Managing and overseeing the IPAC program;
3. Overseeing the delivery of IPAC education to all staff, caregivers, volunteers, visitors, and residents;
4. Auditing of IPAC practices in the home (please note that auditing of IPAC practices can also include overseeing audit activities performed by other staff in the home in collaboration with, or under the direction of, the IPAC lead);

> **ADDITIONAL REQUIREMENT UNDER THE STANDARD:**
>
> **2.1** The licensee shall ensure that the IPAC Lead conducts at a minimum, quarterly real-time audits of specific activities performed by staff in the home, including but not limited to, hand hygiene, selection and donning and doffing of PPE.

5. Conducting regular infectious disease surveillance;

> **ADDITIONAL REQUIREMENT UNDER THE STANDARD:**
>
> **2.2** The licensee shall ensure that the IPAC Lead reviews infectious disease surveillance results regularly to ensure that all staff are conducting infectious disease surveillance appropriately and to ensure that appropriate action is being taken to respond to surveillance findings.

6. Convening the Outbreak Management Team (OMT) at the outset of an outbreak and regularly throughout an outbreak;
7. Convening the interdisciplinary IPAC team at least quarterly, and at a more frequent interval during an infectious disease outbreak in the home (this may also include convening the team during other disease outbreaks (i.e, non-infectious);
8. Reviewing the symptom screening gathered pursuant to subsection 102(9) of the Regulation;
9. Reviewing daily and monthly screening results collected by the licensee to determine whether any action is required;
10. Implementing required improvements to the IPAC program as required by audits or by the licensee; and

> **ADDITIONAL REQUIREMENT UNDER THE STANDARD:**
>
> **2.3** The licensee shall ensure that the IPAC Lead, in collaboration with the interdisciplinary IPAC team, implements required improvements to address any evaluation and/or audit findings as well as recommendations arising from the quality program for IPAC.

11. Ensuring that there is in place a hand hygiene program in accordance with this standard which includes, at a minimum, access to hand hygiene agents at point-of-care (s.102(7) of the Regulation).

Contact information for the IPAC Lead:

Act/Regulation: The licensee shall ensure that the direct contact information, including a telephone number and an email address that are monitored regularly, of all IPAC Leads for the home are provided:

a) To the local medical officer of health appointed under the *Health Protection and Promotion Act* or their designate; and

b) Where there exists a person or entity that is designated as the relevant IPAC hub for the home under a funding agreement with the Ministry of Health, to that IPAC hub (s.102(19) of the Regulation).

Additional IPAC Staff:

Act/Regulation: The licensee of a long-term care home shall consider the complexity and vulnerability of their resident population in the home and shall determine if the infection prevention and control lead is required to work more than the minimum number of hours in the home required by subsection 102 (15) of the Regulation, or whether to designate additional IPAC Leads as required. (s.102(16) Regulation).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.4 The licensee shall ensure that the IPAC program is appropriately resourced, including that additional staff with education in IPAC are available to provide support to the IPAC Lead, as needed, on every shift.

Note: The designation of an additional IPAC Lead, or other supporting staff, does not relieve the licensee from the obligation to ensure that the designated lead works the minimum number of hours required by the Regulation.

Consultation with the Medical Director and other Healthcare Professionals

Act/Regulation: The licensee shall ensure that an interdisciplinary infection prevention and control team that includes the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator co-ordinates and implements the program (s.102(4)(b) of the Regulation).

The licensee shall ensure that all staff participate in the implementation of the IPAC program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead (s.102(8) of the Regulation).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.5 The licensee shall ensure that the IPAC Lead consults with the Medical Director and other healthcare professionals in the home which shall include at a minimum, consulting with the Medical Director on policies and procedures for the IPAC program that impact medical care.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.6 The licensee shall ensure that the IPAC Lead seeks advice from the interdisciplinary IPAC team and other health care professionals in the home (e.g. dietician, occupational therapist) on specific policies and procedures of the IPAC program, in particular those that directly impact resident care.

Interdisciplinary IPAC Team

Act/Regulation: The licensee shall ensure,

a) That there is an interdisciplinary team approach in the co-ordination and implementation of the IPAC program;
b) That an interdisciplinary infection prevention and control team that includes the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator co-ordinates and implements the program;
c) That the interdisciplinary infection prevention and control team meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home; and
d) That the local medical officer of health appointed under the *Health Protection and Promotion Act* or their designate is invited to the meetings (s.102(4)(a)-(d) of the Regulation).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.7 The licensee shall ensure that the interdisciplinary team approach in the co-ordination and implementation of the IPAC program includes engagement with:

a) The home's Occupational Health and Safety (OHS) lead, or other individual with OHS responsibility for the home, where an OHS lead is not in place, and the Joint Health and Safety Committee (JHSC) or health and safety representative;
b) The Residents' Council and Family Council, if any, on a regular basis (at least quarterly) to seek advice on IPAC measures and their impacts on residents and families/caregivers; and
c) The Residents' Council and Family Council, if any, on the IPAC program evaluation and quality activities. This shall include the Council(s) providing advice on program improvements.

Ethical Framework

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.8 The licensee shall ensure that the implementation and ongoing delivery of the IPAC program includes an ethical framework to inform decision-making.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.9 The licensee shall ensure that a clearly documented ethical framework is included as part of the IPAC program. The ethical framework must include key principles which have been discussed and developed in collaboration with the interdisciplinary IPAC team, the home's leadership team (where not already represented on the interdisciplinary IPAC team), the continuous quality improvement committee (once established), and the Residents' Council or Family Council, if any.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.10 The licensee shall ensure that the ethical framework for the IPAC program includes the following key principles:

- Fairness;
- Equity;
- Transparency;
- Consideration of available evidence;
- Consideration of impacts of decisions on residents and staff;
- Resident quality of life as a primary driver;
- Risk relative to reward of key decisions; and
- Safety.

Precautionary Principle

Act/Regulation: The licensee shall ensure that the IPAC program is implemented in a manner consistent with the precautionary principle as set out in the standards and protocols issued by the Director and the most current medical evidence (s.102(4)(g) of the Regulation).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.11 The licensee shall ensure that the application of the precautionary principle is guided by the key principles in the ethical framework.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.12 The licensee shall ensure that when determining whether to apply the Precautionary Principle, they consider recommendations including those of a provincial scientific table, and the Chief Medical Officer of Health appointed under the *Health Protection and Promotion Act*, where available.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

2.13 The licensee shall ensure that processes are established for the de-escalation of practices where the precautionary principle has been applied.

The licensee shall ensure that as part of this process, the OHS lead, Joint Health and Safety Committee (JHSC), or health and safety representative, and the interdisciplinary IPAC team are engaged.

What is meant by escalation and de-escalation of practices?

The decision to apply the precautionary principle can include making a risk-based decision to transition from routine practices to additional precautions (escalation). Requirement 2.13 refers to the need for a plan for the de-escalation of practices where this has been done related to the application of the precautionary principle.

Please see the following document that discusses de-escalation of COVID-19 control measures, for example.

De-escalation of COVID-19 Outbreak Control Measures in Long-term Care and Retirement Homes (publichealthontario.ca)

3. Surveillance

Act/Regulation: The licensee shall implement any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance (s.102(2)(a) of the Regulation).

The licensee shall ensure that on every shift,

a) Symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director; and
b) The symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required (s.102(9) of the Regulation).

The licensee shall ensure that the symptom screening information gathered under subsection 102(9) of the Regulation is analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends, for the purpose of reducing the incidence of infection and outbreaks (s.102(10) of the Regulation).

The infection prevention and control program must also include daily monitoring to detect the presence of infection in residents (s. 23 (2) (c)) of the Regulation).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

3.1 The licensee shall ensure that the following surveillance actions are taken:

a) Training staff on how to monitor for the presence of infection in residents;
b) Ensuring that surveillance is performed on every shift to identify cases of healthcare acquired infections (HAIs), device-associated infections and Antibiotic Resistant Organisms (AROs);
c) Ensuring that established case definitions for specific diseases are understood and used by staff;
d) Using common forms and tools, and making them available to staff at locations where they are needed, for surveillance reporting in the home;
e) Developing and using a surveillance database and reporting tool for use in the home (e.g., Microsoft Excel spreadsheet or other tool) to collect and collate data;
f) Ensuring that surveillance information is tracked and entered into the surveillance database and/or reporting tools;
g) Ensuring that staff are aware of requirements for infectious disease reporting within the home;
h) Ensuring that the interdisciplinary IPAC team is regularly updated on surveillance findings; and
i) Employing syndromic surveillance regularly to monitor for symptoms, including but not limited to, fever new coughs, nausea, vomiting, and diarrhea, and taking appropriate action.

4. Outbreak Preparedness and Management

Act/Regulation: The licensee shall ensure that there are in place, an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the *Health Protection and Promotion Act*, communication plans, and protocols for receiving and responding to health alerts; and a written plan for responding to infectious disease outbreaks (s. 102(11) of the Regulation).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

4.1 The licensee shall ensure that the outbreak management system includes:

a) Organizational risk assessments;
b) Outbreak management policies, procedures and protocols;
c) Assigned outbreak management team (OMT) and staff roles and responsibilities;
d) Approaches to engage residents, staff, and caregivers;
e) Approaches to engage with the local *board of health;
f) Reporting protocols based on the home's critical incident system;
g) Protocols for testing, screening for infection and cohorting, as required;
h) Processes for accessing additional supports if required (e.g. through the IPAC hubs, public health units, other);
i) Strategies to address various modes of disease transmission in outbreaks;
j) Processes to ensure that staff have the knowledge and ability to transfer outbreak information from shift to shift for continuity and continuous monitoring of disease and outbreak status; and
k) Processes to consider the unique features of the home in the outbreak management plan such as:
    - The size and physical layout of the home including rooms available for separating and/or cohorting residents;
    - Staffing supply, mix, and models;
    - Resident population and unique needs and/or features;
    - Impacts of outbreaks on residents including impacts of social isolation;
    - Cultural safety; and
    - Community impacts.

*Please note that public health unit is a colloquial name used for boards of health which are defined under the *Protection and Promotion Act, 1990.*

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

4.2 The licensee shall ensure that the IPAC Lead is involved in outbreak management activities in collaboration with the interdisciplinary IPAC team and the OMT in the manner described below.

The IPAC Lead's role shall include, but not be limited to:

a) Advising on IPAC practices to manage the outbreak and minimize risk(s) to residents and staff;
b) Assisting with securing IPAC-related resources needed to support the outbreak management response. This may also include working in collaboration with the licensee and the OMT to secure needed PPE and other supplies as required;
c) Ensuring that accurate disease-related information is tracked and documented;
d) Engaging with the local board of health on the outbreak response (when relevant) including when an outbreak has been declared;
e) Implementing changes to IPAC practices as needed to support the outbreak response; and
f) Providing IPAC-related education and training to staff and others to support the outbreak response.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

4.3 The licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

5. IPAC Policies and Procedures

Act/Regulation: The IPAC program must include evidence-based policies and procedures (s.23(2)(a) of the Act).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

5.1 The licensee shall ensure that the IPAC Lead works with the interdisciplinary IPAC team as well as affected departments in the home, including but not limited to: housekeeping; environmental health, occupational health and safety; and clinical leadership (where not already represented on the interdisciplinary IPAC team), to develop a comprehensive inventory of evidence-based policies and procedures for the IPAC program.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

5.2 The licensee shall ensure that the IPAC policies and procedures are reviewed at least annually for completeness, accuracy, and alignment with evidence and with best practice, and are updated based on that review.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

5.3 The licensee shall ensure that the policies and procedures for the IPAC program include policies and procedures for the implementation of Routine Practices and Additional Precautions including but not limited to:

a) Point of Care Risk Assessments;
b) Respiratory Etiquette;
c) Contact transmission and precautions;
d) Droplet transmission and precautions;
e) Airborne transmission and precautions;
f) Combinations of Additional Precautions;
g) Management of antibiotic-resistant organisms (AROs); and
h) Cleaning and disinfection.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

5.4 The licensee shall ensure that the policies and procedures for the IPAC program also address:

a) Safe administration and handling of medications, including safe handling of needles and other sharps (related to IPAC practices specifically);
b) Reprocessing of medical equipment both offsite and onsite. This shall include the requirement for offsite processing to be performed by a licensed provider;
c) Surveillance and screening activities including data collection and reporting;
d) Personal protective equipment (PPE), including training and education related to appropriate selection, and use as well as a plan for appropriate stewardship;
e) Policies and procedures for the hand hygiene program as a component of the overall IPAC program;
f) Policies and procedures for disease-specific management;
g) IPAC related practices for aerosol generating medical procedures (AGMPs);
h) Staff training and education requirements;
i) Culturally safe and appropriate IPAC practices;
j) Assessment, review, and evaluation of environmental cleaning products;
k) IPAC policies for housekeeping, laundry, cleaning, and disinfecting;
l) Waste management;
m) Facility maintenance standards for heating, ventilation, and air conditioning (related to IPAC specifically);
n) IPAC policies and procedures for food services including:
    i. Food storage;
    ii. Food preparation; and
    iii. Food handling
o) Program audit activities; and
p) Program evaluation and quality improvement.

*Policies and procedures may be combined/grouped as appropriate.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

5.5 The licensee shall identify how IPAC policies and procedures will be implemented in the home.

6. Personal Protective Equipment (PPE)

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

6.1 The licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions. The licensee shall ensure that the PPE supply and stewardship plan is consistent with any relevant Directives and/or Guidance, regarding appropriate PPE use, from the Chief Medical Officer of Health or the Minister of Long-Term Care, which may be in place.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

6.2 The licensee shall ensure that training is provided to staff on the appropriate selection, application, removal, and disposal of PPE.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

6.3 The licensee shall ensure that training and assistance, appropriate to their needs and level of understanding, is provided to residents, related to use of PPE.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

6.4 The licensee shall ensure that individuals have access to fit-testing where fit-testing is required for specific equipment.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

6.5 The licensee shall ensure that the IPAC Lead is involved in the review, selection and purchasing of PPE, as required.

What is PPE Stewardship?

PPE stewardship includes all aspects of managing PPE in the home. This includes; ensuring adequate supply; making choices about distribution, and ensuring that PPE is selected, used and disposed of properly. It should also include ensuring that PPE is selected and used in an evidence-based manner.

Optimizing the Supply of Personal Protective Equipment During the COVID-19 Pandemic (ontariohealth.ca)

7. Training and Education

Act/Regulation: The IPAC program is required to include an educational component in respect of infection prevention and control for staff, residents, volunteers and caregivers (Act ss. 23(2)(b)). Licensees should also refer to other requirements in sections 257-263 of the Regulation).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

7.1 The licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program for residents, caregivers, staff and visitors which includes at a minimum the following:

a) Caregivers shall receive orientation and training on IPAC policies and procedures appropriate to their role;
b) Residents shall also receive training, education, and/or information appropriate to their needs and level of understanding that helps them to understand the IPAC program and specific IPAC practices that may affect them;
c) The licensee shall communicate relevant IPAC information and requirements and provide education to residents, caregivers and other visitors (including family members), which includes but is not limited to: visitor policies, physical distancing, respiratory etiquette, hand hygiene, applicable IPAC practices, and proper use of PPE;
d) The licensee shall provide IPAC retraining and education on an annual basis or more frequently, to respond to emerging public health issues and/or new evidence;
e) Training shall be accessible, tailored to learner needs and reduce potential barriers to comprehension including language and literacy; and
f) The licensee shall also ensure that visitors receive information about required IPAC practices that is appropriate to the level of risk that visitors present to themselves and to others in the home.

What is respiratory etiquette?

Respiratory etiquette refers to personal practices that help prevent the spread of bacteria and viruses that cause acute respiratory infections (e.g., covering the mouth when coughing, care when disposing of tissues).

Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for prevention, surveillance and infection control management of novel respiratory infections in all health care settings. 1 st revision. Toronto, ON: Queen's Printer for Ontario; 2020.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

7.2 The licensee shall ensure that the IPAC Lead develops and oversees the implementation of an IPAC training and education program for staff and volunteers required by the Act and Regulation which has the following minimum requirements:

a) The required orientation and training on IPAC under the Act and Regulation shall be appropriate to the staff and volunteer role;
b) The training shall be accessible, tailored to learner needs and reduce potential barriers to comprehension including language and literacy;
c) IPAC education shall be tailored to the job of the staff member receiving the education. For example, environmental cleaning, allied health staff, food service workers, laundry services; and
d) The JHSC or health and safety representative shall be engaged in the development of training and education relevant to worker safety.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

7.3 The licensee shall ensure that the IPAC Lead plans, implements, and tracks the completion of all IPAC training and:

a) Assessments/audits and feedback processes are used to determine if staff have met training requirements as required by the Act and Regulation, or when individual staff need remedial or refresher training; and
b) Ensures that audits are performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role.

8. Regular Evaluation and Quality Improvement

Act/Regulation: The licensee shall oversee the development and implementation of a quality management program to assess and improve IPAC in the home, as set out in a standard or protocol issued by the Director under subsection 102(2) of the Regulation (s. 102(18) of the Regulation).

The licensee shall ensure that the IPAC program is evaluated and updated at least annually in accordance with the standards and protocols issued by the Director under subsection 102(2) and (s. 102(4)(e)) of the Regulation. The licensee shall also ensure that a written record is maintained for each evaluation including evaluation dates and time period, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

8.1 In evaluating and updating the IPAC program, at a minimum on an annual basis, the licensee shall:

a) In addition to the requirement to ensure that the IPAC program is evaluated and updated at least annually, ensure that the IPAC program, including the IPAC policies and procedures, are reviewed and updated, more frequently in accordance with emerging evidence and best practices;
b) Ensure that the evaluation of the IPAC program also includes specific actions to evaluate outbreak preparedness and response activities;
c) Ensure that evaluation approaches also include, at a minimum:
    i. A system to monitor the compliance of staff with IPAC program policies and procedures, as well as processes for correcting and improving identified gaps;
    ii. An audit plan, including audit processes for on-site review of IPAC practices by staff with education and corrective actions; and
    iii. Engagement with the Quality Committee to appropriately link program evaluation with Quality initiatives.
d) Ensure that quality reviews shall also be conducted annually in collaboration with home leadership, the Quality Committee, the IPAC Lead, and the interdisciplinary IPAC team.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

8.2 The licensee shall ensure at minimum, that the following activities are carried out in the quality management program:

a) Establishment of goals and key quality indicators (both process and outcome-related) for the IPAC program in the home;
b) Training and education for staff related to quality indicators and needed improvements for IPAC in the home;
c) Reporting on quality indicators and metrics for IPAC in the home; and
d) Engagement with the Quality Committee, the interdisciplinary IPAC team and family and resident councils related to IPAC in the home.

9. Routine Practices and Additional Precautions

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program.

At minimum Routine Practices shall include:

a) The use of infectious disease risk assessments including point of care risk assessments;
b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact);
c) Respiratory etiquette;
d) Proper use of PPE, including appropriate selection, application, removal, and disposal; and
e) Use of controls, including:
    i. Environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available;
    ii. Engineering controls, including but not limited to, use of safety-engineered needles point-of-care sharps containers, disposable equipment, barriers; and
    iii. Administrative controls, including but not limited to, comprehensive IPAC policies and procedures.

At minimum, Additional Precautions shall include:

a) Evidence-based practices related to potential contact transmission and required precautions;
b) Evidence-based practices related to potential droplet transmission and required precautions;
c) Evidence-based practices related to airborne transmission and required precautions;
d) Evidence-based practices for combined precautions;
e) Point-of-care signage indicating that enhanced IPAC control measures are in place;
f) Additional PPE requirements including appropriate selection application, removal and disposal;
g) Modified or enhanced environmental cleaning procedures; and
h) Communication regarding Additional Precautions with transport of residents to other facilities (e.g. hospital).

For more detailed information on Routine Practices and Additional Precautions, please refer to Public Health Ontario's Routine Practices and Additional Precautions (PIDAC, 2012).

And/or - Public Health Agency of Canada

Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings - Canada.ca

10. Hand Hygiene Program

Act/Regulation: The licensee is required to implement a hand hygiene program (s. 23(2)(e) of the Act). The licensee is required to ensure that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under s. 102(2) of the Regulation, which includes, at a minimum, access to hand hygiene agents at point-of-care (para 11 of s. 102(7) of the Regulation).

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

10.1 The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

10.2 The hand hygiene program shall be multifaceted and multidisciplinary. The licensee shall ensure that the program includes, at minimum, training and education, hand hygiene audits, a hand care program, and hand hygiene and hand care support for residents.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

10.3 Hand washing facilities provisioned with appropriate supplies must also be accessible in common areas and work areas where hand washing may be required.

ADDITIONAL REQUIREMENT UNDER THE STANDARD:

10.4 The Licensee shall ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as:

a) Hand hygiene signage;
b) Training and education related to hand hygiene practices at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact);
c) Identification and engagement of hand hygiene champions in the home to promote best practice; audits to monitor hand hygiene compliance including feedback and correction of practices when indicated;
d) These activities shall be linked to the overall audit, evaluation, and quality approach for the full IPAC program:

i. This shall also include monthly audits of adherence to the four moments of hand hygiene by staff;

e) A hand care program to assess and maintain the skin integrity of staff who perform frequent hand hygiene;

f) Hand hygiene training and awareness as part of orientation and ongoing training of all staff, volunteers and visitors (including caregivers and family members);

g) Involvement of the IPAC Lead and OHS staff in product selection for hand hygiene and skin maintenance, to ensure that PPE durability is not compromised (e.g., interaction of hand care products and the break-down of latex gloves);

h) Support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting; and

i) Support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

Please also refer to Just Clean Your Hands

Just Clean Your Hands – Long-term Care | Public Health Ontario

11. Immunization and Screening

Act/Regulation The licensee shall ensure that the following immunization and screening measures are in place:

a) Each resident admitted to the home must be screened for tuberculosis within 14 days of:
   i. Admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee;
b) Residents must be offered immunization against influenza at the appropriate time each year;
c) Residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the website of the Ministry of Health;
d) Staff is screened for tuberculosis and other infectious diseases in accordance with any standard or protocol issued by the Director;
e) There must be a staff immunization program in accordance with any standard or protocol issued by the Director;
f) A licensee is exempt from screening for TB with respect to a resident:
   i. Who is being relocated to another long-term care home operated by the same licensee and section 240 of the Regulation applies; or
   ii. Who is transferring to a related temporary long-term care home, a re-opened long-term care home or a replacement long-term care home operated by the same licensee;
g) The licensee shall ensure that any pets living in the home or visiting the home have up-to-date immunizations. (Regulation ss 102(12)-(14)).

ADDITIONAL REQUIREMENTS UNDER THE STANDARD:

11.1 The licensee shall work collaboratively with the local board of health regarding immunization of residents and staff, which may include offering immunizations onsite. This may also include offering additional immunizations as recommended by the local board of health.

As well, the licensee shall implement a staff immunization program that includes informational resources regarding the benefits of immunization to resident and staff safety. This shall also include communicating expectations regarding immunization at hiring (for example, regarding recommended immunizations such as Measles/Mumps/Rubella (MMR) and yearly influenza immunization).

11.2 The licensee shall ensure that staff is screened for tuberculosis and other infectious diseases. This shall include ensuring accordance with evidence-based practices and where there are none, accordance with prevailing practices. This may also include consultation with the local board of health to ensure that screening is undertaken to address specific risks in the community.

Licensees may wish to refer to the Canadian TB Standards for guidance related to TB Screening

Canadian Tuberculosis Standards 7th Edition: 2014 - Canada.ca

Appendix 1: FLTCA 2021:

Item
23 (1) Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home. (2) The infection prevention and control program must include, (a) evidence-based policies and procedures; (b) an educational component in respect of infection prevention and control for staff, residents, volunteers, and caregivers; (c) daily monitoring to detect the presence of infection in residents of the long-term care home; (d) measures to prevent the transmission of infections; (e) a hand hygiene program; and (f) any additional matters provided for in the regulations. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes and accountability measures, provided for in the regulations. (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program. (5) Every licensee of a long-term care home shall ensure that the infection prevention and control lead possesses the qualifications provided for in the regulations.

Appendix 2: Ontario Reguation 246/22 inder the *FLTCA*: s. 102 Infection prevention and control program

(1) Every licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 23 (1) of the Act complies with the requirements of this section.

(2) The licensee shall implement,

(a) any surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance; and

(b) any standard or protocol issued by the Director with respect to infection prevention and control.

(3) The Director shall update the standards and protocols mentioned in subsection (2) regularly to reflect relevant evidence and best practice.

(4) The licensee shall ensure,

(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that an interdisciplinary infection prevention and control team that includes the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator co-ordinates and implements the program;
(c) that the interdisciplinary infection prevention and control team meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home;
(d) that the local medical officer of health appointed under the *Health Protection and Promotion Act* or their designate is invited to the meetings;
(e) that the program is evaluated and updated at least annually in accordance with the standards and protocols issued by the Director under subsection (2);
(f) that a written record is kept relating to each evaluation under clause (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented; and
(g) that the program is implemented in a manner consistent with the precautionary principle as set out in the standards and protocols issued by the Director under subsection (2) and the most current medical evidence.

(5) The licensee shall designate a staff member as the infection prevention and control lead who has education and experience in infection prevention and control practices, including,

(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols;
(e) outbreak management;

(f) asepsis;
(g) microbiology;
(h) adult education;
(i) epidemiology;
(j) program management; and
(k) current certification in infection control from the Certification Board of Infection Control and Epidemiology.

(6) A licensee is not required to comply with the qualification requirements for the infection prevention and control lead under clause (5) (k) until three years after this section comes into force.

(7) The licensee shall ensure that the infection prevention and control lead designated under subsection carries out the following responsibilities in the home:

a. Working with the interdisciplinary team to implement the infection prevention and control program.
b. Managing and overseeing the infection prevention and control program.
c. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.
d. Auditing of infection prevention and control practices in the home.
e. Conducting regular infectious disease surveillance.
f. Convening the Outbreak Management Team at the outset of an outbreak and regularly throughout an outbreak.
g. Convening the interdisciplinary infection prevention and control team referred to in subsection (4) at least quarterly, and at a more frequent interval during an infectious disease outbreak in the home.
h. Reviewing the information gathered pursuant to subsection (9).
i. Reviewing any daily and monthly screening results collected by the licensee to determine whether any action is required.
j. Implementing required improvements to the infection prevention and control program as required by audits under paragraph 4 or by the licensee.
k. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care.

(8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

(9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

(10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

(11) The licensee shall ensure that there are in place,

(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the *Health Protection and Promotion Act*, communication plans, and protocols for receiving and responding to health alerts; and

(b) a written plan for responding to infectious disease outbreaks.

(12) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

2. Residents must be offered immunization against influenza at the appropriate time each year.

3. Residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the website of the Ministry of Health.

4. Staff is screened for tuberculosis and other infectious diseases in accordance with any standard or protocol issued by the Director under subsection (2).

5. There must be a staff immunization program in accordance with any standard or protocol issued by the Director under subsection (2).

(13) A licensee is exempt from paragraph 1 of subsection (12) with respect to a resident,

(a) who is being relocated to another long-term care home operated by the same licensee and section 240 applies; or

(b) who is transferring to a related temporary long-term care home, a re-opened long-term care home or a replacement long-term care home operated by the same licensee.

(14) The licensee shall ensure that any pets living in the home or visiting the home have up-to-date immunizations.

(15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

3. In a home with a licensed bed capacity of 200 beds or more, at least 35 hours per week.

(16) Every licensee of a long-term care home shall consider the complexity and vulnerability of their resident population in the home and shall determine if the infection prevention and control lead is required to work more than the minimum number of hours required by subsection (15) or whether to designate additional infection prevention and control leads as required.

(17) The designation of an additional infection prevention and control lead under subsection (16) does not relieve the licensee with respect to its obligation to ensure the minimum hours worked in subsection (15) by the infection prevention and control lead.

(18) The licensee shall oversee the development and implementation of a quality management program to assess and improve infection prevention and control in the home, as set out in a standard or protocol issued by the Director under subsection (2).

(19) Every licensee of a long-term care home shall ensure that the direct contact information, including a telephone number and email address that are monitored regularly, of all infection prevention and control leads for the home are provided,

(a) to the local medical officer of health appointed under *the Health Protection and Promotion Act* or their designate; and

(b) where there exists a person or entity that is designated as the relevant IPAC hub for the home under a funding agreement with the Ministry of Health, to that IPAC hub.

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Abbreviations

ABHR Alcohol-Based Hand Rub

AGMPs Aerosol Generating Medical Procedures

AP Additional Precautions

ARI Acute Respiratory Infection

ARO Antibiotic-Resistant Organism

ASP Antimicrobial Stewardship Program

CIC® Certification in Infection Control

C.diff Clostridioides difficile

CPE Carbapenemase-Producing Enterobacterales

EMC Emergency Management Committee

ESBL Extended Spectrum Beta-lactamases producing Enterobacterales

FTE Full-time Equivalent

HAI Health care-Associated Infection

HCW Health Care Worker

ICP Infection Prevention and Control Professional

IPAC Infection Prevention and Control

MRSA Methicillin-Resistant Staphylococcus aureus

OHS Occupational Health and Safety

OMT Outbreak Management Team

PHAC Public Health Agency of Canada

PIDAC Provincial Infectious Diseases Advisory Committee (Ontario)

PPE Personal Protective Equipment

RP Routine Practices

VRE Vancomycin-Resistant Enterococci