

3:45 RESOURCE 01

3:45 readiness review

Prepared People · Ready Structure · Practised Response

Home / unit _____

Review date / review team _____

RATE THE EVIDENCE — NOT YOUR CONFIDENCE

D = demonstrated recently, with an example or test. V = needs verification. N = not in place. Mark N/A only with a reason. Do not calculate a total or interpret this as a safety grade.

Prepared People

What can the home demonstrate?	D / V / N	Evidence or verification needed
A designated, oriented backup can explain the role and current situation.		
Authority, limits, required clinical/public-health escalation and fallback contacts are clear.		
Leadership can arrange support or coverage for competing duties.		
Staff and designated champions know their own recognition/reporting responsibilities.		

Ready Structure

What can the home demonstrate?	D / V / N	Evidence or verification needed
Another shift can find the current contacts, response tools and approved record.		
Assessment, indicated protection and escalation do not wait in a serial queue.		
Actions have an owner, status, barrier escalation and verification step.		
A receiving person accepts pending work and the next review at handover.		

Test the program across shifts

Continue the review, then choose what needs action.

Practised Response

What can the home demonstrate?	D / V / N	Evidence or verification needed
Staff practise with the actual roster, contacts and response tools.		
Backup development and local protocol updates continue after orientation.		
Drills or real events generate actions with owners and realistic deadlines.		
A reassessment verifies that a change works — not just that a document was edited.		

Choose by significance, not the lowest rating

- Identify any immediate risk to assessment, protection, staffing or continuity. Act or escalate now and record an interim safeguard.
- For improvement work, consider likely impact, the frequency of exposure to the gap, evidence available and resources needed.
- Select one meaningful gap for a first improvement. Other serious gaps still require a plan; choosing one does not excuse leaving urgent issues open.

Most important gap to verify or address _____

Immediate action / interim safeguard, if needed _____

Use Tool 08 to track several actions. A lack of recent outbreaks is not evidence that every response process works.

One improvement — owned and verified

Schedule the team review within 30 days. Safety-critical actions may be needed sooner.

Gap and evidence _____

What should happen instead? _____

Action and named owner _____

Support or coverage needed from ED/DOC _____

Deadline and interim safeguard _____

How will a different shift demonstrate that the fix works? _____

Verifier / verification date / result _____

Remaining issue, next review and closure decision _____

BASIS AND USE

Operational teaching material developed for The First 24 Hours. Examples are fictional, not records or dialogue from the source home.

G4. Public Health Ontario: IPAC for Long-Term Care and Retirement Homes. External starting point for current LTC best practices, risk assessment and orientation resources. Accessed October 2, 2026. <https://www.publichealthontario.ca/en/health-topics/infection-prevention-control/long-term-care>

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3:45 RESOURCE 02

Backup readiness and coverage agreement

A name on a roster is not the same as a usable coverage arrangement.

Home / lead / designated backup _____

Coverage period / approving leader _____

Prepare the person

Readiness check	Verified / action needed
Orientation and relevant competence assessed; continuing development arranged.	
Access to current unit concerns, surveillance, contacts and response tools demonstrated.	
Backup can explain role-specific recognition, coordination and follow-through.	
Another shift knows the backup and how to reach the fallback.	

Make authority and limits explicit

Actions within role and approved process _____

Decisions requiring clinician / public health / leadership input _____

Fallback if the lead, backup or first contact is unavailable _____

BOUNDARY

This agreement does not grant authority outside professional scope, law, the home's approved policies or required clinical/public-health direction.

Make the coverage practical

The backup coordinates the response; departments and leadership carry assigned work.

Competing duties and resources

Usual duties that may need cover _____

Who may authorize and arrange that cover? _____

Staff / equipment / communication support available _____

What happens if the support is not available? _____

Show readiness in practice

Brief test with real tools	Result / reviewer / date
Find the current after-hours contact and escalation route.	
Explain what can begin now and what requires further direction.	
Demonstrate a handover with pending items, escalation and accepted ownership.	

Backup acknowledgement / date _____

Approving leader / review date _____

BASIS AND USE

Operational teaching material developed for The First 24 Hours. Examples are fictional, not records or dialogue from the source home.

G5. Public Health Ontario: Orientation for IPAC Leads in Long-Term Care. External professional-development resource; not an endorsement of this presentation or its commercial offerings. Accessed October 2, 2026. <https://www.publichealthontario.ca/en/health-topics/infection-prevention-control/ltc-orientation>

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3:45 RESOURCE 03

First-24-hours operating map

A consistent structure — not identical clinical actions for every concern.

WHEN A MEANINGFUL CONCERN IS RECOGNIZED

Assessment, indicated protective measures and notification/escalation may need to proceed together. Urgent clinical deterioration requires the home's urgent clinical response — not a wait for an IPAC callback. [G1, G3]

Concurrent workstream	Operational questions
ASSESS	What symptoms, timing, baseline changes and clinical urgency are present? Who is assessing within scope?
PROTECT AS INDICATED	Which current risk-based precautions/control measures apply? What support or supply is missing?
NOTIFY / ESCALATE	Who receives the concern now? Use approved clinician, IPAC, public-health and leadership routes; know the fallback.

The loop that keeps the response moving

Communicate	Monitor	Reassess
State what is known, uncertain, implemented and pending. Name owners.	Use the agreed clinical/surveillance plan. Record and escalate changes when identified.	Review risk, measures, barriers and outstanding work; adjust with the right authority.

NOT A ONE-SIZE-FITS-ALL PROTOCOL

GI illness, respiratory illness, invasive group A streptococcal disease, scabies and pest concerns require different controls and support. Bed bugs are an infestation example. This tool is not a diagnosis, automatic isolation rule or outbreak declaration.

Continuity across the actual roster

An alert at 3:45 p.m. occurs during the evening shift in these illustrative patterns.

Typical pattern	Day → evening	Evening → night	Night → day
Pattern A	2:00 p.m.	10:00 p.m.	6:00 a.m.
Pattern B	2:30 p.m.	10:30 p.m.	6:30 a.m.

Illustrative shift patterns supplied by the presenter for teaching. They are not universal schedules or verified case timestamps. Use your home's actual roster.

Before each transfer of responsibility

- **Current picture:** affected people, current symptoms and relevant assessment in the approved record.
- **Actions in place:** what has actually been implemented, not only requested.
- **Pending work:** each item, owner, due time and barrier.
- **Escalation:** agreed triggers and contacts, including a fallback.
- **Accepted ownership:** receiving person, next review and confirmation of understanding.

Our next scheduled handover _____

Leadership / on-call coverage change, if different _____

Next clinical / surveillance review and owner _____

DO NOT WAIT FOR THE CHECKPOINT

Report urgent changes when they occur. Shift times are handover checkpoints, not prescribed monitoring intervals. A 24-hour review does not mean the response or precautions automatically stop.

BASIS AND USE

G1. Public Health Agency of Canada: Routine Practices and Additional Precautions, Part A. External clinical safeguard: indicated Additional Precautions need not wait for a specific diagnosis or microbiological confirmation. Accessed October 2, 2026. <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/routine-practices-precautions-healthcare-associated-infections/part-a.html>

G3. Public Health Ontario: Routine Practices and Additional Precautions. External reference distinguishing Routine Practices from condition/risk-specific Additional Precautions. Accessed October 2, 2026. <https://www.publichealthontario.ca/en/health-topics/infection-prevention-control/routine-practices-additional-precautions>

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3:45 RESOURCE 04

Implementation verification board

Make unfinished work and barriers visible.

Home / response area / date and time _____

Coordinator / next review _____

STATUS MEANS SOMETHING

Assigned: owner identified. **Received:** owner acknowledges receipt. **Implemented:** action is in place. **Checked:** appropriate evidence confirms implementation. **Blocked:** barrier, interim safeguard and escalation owner are recorded. **A sent request is not a completed action.**

Action / required result	Owner	Status / barrier	Evidence / check	Next review

Unresolved barrier / interim safeguard _____

Person receiving responsibility at handover _____

Privacy: use only the minimum operational identifiers needed. Resident-level care and employee health information remain in approved access-controlled records; this board must not become an uncontrolled duplicate chart.

From “sent” to “working”

A fictional access-check example, aligned with the presentation.

1 · OPEN — 10:00 P.M.

The instruction has arrived, but the person taking over cannot open the plan. Receipt is confirmed; access is not. The task remains open.

2 · FOLLOW-UP — ACT NOW

The incoming charge nurse contacts the duty manager immediately and uses the approved backup route for essential information. A follow-up access check is agreed for 10:15 p.m.

3 · VERIFIED — AFTER ACCESS IS RESTORED

The charge nurse uses the authorized account to open the current plan and confirms that the necessary information is available. Record who checked, the actual check time and the result. If access still fails, keep the task open and continue escalation.

Acknowledgement confirms receipt. To confirm implementation, check evidence that the required action is actually in place.

10:00 and 10:15 p.m. are illustrative administrative checkpoints, not clinical-monitoring intervals. Do not wait for the checkpoint to escalate blocked access or urgent concerns. Use approved access controls; do not share passwords.

Apply the same distinction to your home

Action we should verify _____

What would show it is working? _____

This example demonstrates implementation checking, not clinical effectiveness. Review the response and outcomes separately. A new instruction may supersede an old one; record the change and decision-maker.

BASIS AND USE

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3:45 RESOURCE 05

IPAC handover and read-back

The response moves forward when the receiving person knows what they own.

Date / time / outgoing and incoming shift _____

Outgoing person / receiving person _____

RECORD CONFIRMED INFORMATION

Clearly mark results or actions that are pending or not yet verified. If information is unavailable, record it as unknown or pending and identify who will follow it up.

1. Current picture

Affected residents or staff, symptoms, timing, relevant assessment and the location of the approved record.

Current information / secure reference

2. Actions in place

The specific current plan and measures actually implemented. Note changes since the previous update.

Current measures / changes

3. Pending work

Outstanding actions, named owners, due times and barriers. Distinguish confirmed facts from pending results or unverified work.

Outstanding action / owner / due time / barrier

Escalation, ownership and confirmation

Complete the transfer — not just the message.

4. Monitoring and escalation instructions

Agreed plan / secure reference

Changes requiring escalation / person to contact

Fallback when the first contact is unavailable

5. Next review and accepted responsibility

Next review date / time / owner

Receiving person / confirmation date and time

READ-BACK PROMPT

“Here is what I am taking over: the pending items I own, the next review, and the escalation route.” Resolve any difference while both people are available.

See the short illustrative exchange on page 3. The example shows one operational follow-up; it does not replace the resident-specific assessment, care plan or escalation instructions.

Keep completed forms in approved confidential systems. Do not submit them through the conference resource form.

Hear the handover

An illustrative exchange from the presentation's handover demonstration.

Fictional operational segment — not a complete clinical handover, clinical order or dialogue from the source case. “Outgoing lead” and “incoming lead” are teaching roles.

INCOMPLETE MESSAGE

“Two residents are unwell. Precautions started. Continue monitoring.”

A more usable exchange

OUTGOING LEAD

“We're at the ten o'clock handover. We'll review the affected residents, their latest assessments and the specific measures in the secure record together. The outstanding operational task is checking that the incoming team can open the current response plan.”

INCOMING LEAD

“Who's taking that task, and when are we checking back?”

OUTGOING LEAD

“You are. Let's use ten-fifteen for this example. If access is blocked, contact the duty manager straight away and use the approved backup route. You don't wait until ten-fifteen to ask for help. We'll also review the resident-specific monitoring and escalation instructions before we finish.”

INCOMING LEAD — READ-BACK

“I'll confirm that the incoming team can access the current response plan, and record the result by ten-fifteen. If access fails, I'll contact the duty manager immediately and use the approved backup route. Before we finish, let's review the resident-specific instructions and any other pending work so I know what needs monitoring and when to escalate.”

WHAT IS NOW CLEAR?

The task · the receiving owner · the checkpoint · the fallback if blocked · the need to review resident-specific instructions.

10:15 p.m. is an example access-check checkpoint, not a clinical-monitoring interval. Escalate blocked access immediately; do not delay urgent clinical care or indicated precautions. No assessment findings, results or clinical orders are supplied by this example.

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3:45 RESOURCE 06

Whole-home role and champion map

Everyone owns IPAC. Responsibilities are different and connected.

Home / date / approving leadership _____

Role	Operational contribution	Who fills it here?
ED / administrator	Arrange resources, coverage, accountability and escalation for barriers.	
DOC / clinical leader	Provide clinical oversight; support the lead/backup; coordinate staffing and coverage.	
IPAC lead / backup	Coordinate the IPAC response within scope and approved processes; seek further direction when needed.	
Registered staff	Assess within role; document current findings; implement and hand over the care/monitoring plan.	
PSWs and other frontline staff	Recognize and report changes; carry out role-appropriate precautions and directions.	
Department managers	Translate assigned changes into departmental work; confirm receipt, implementation and barriers.	
Designated champions	Reinforce approved practice, help staff find information and escalate concerns — not independent outbreak management.	

Confirm the departmental response

Adapt the examples to the concern, local structure and current directions.

Department / group	Confirm the role-specific change	Owner / evidence
Environmental services	Approved cleaning/disinfection changes, supplies, completion and barriers.	
Dietary	Staff symptom reporting and any directed meal-service or movement changes.	
Life enrichment	Directed activity changes and communication to all relevant shifts.	
Maintenance / operations	Required equipment or environmental support, as relevant to the concern.	
Occupational health / delegate	Staff illness/exposure reporting and work advice through the approved process.	
Resident / family communication lead	Approved, clear information; update route; confidentiality protected.	

CHAMPION CHECK

Ask a champion to show where current information is kept, explain one practice relevant to their department, and demonstrate the escalation route. Ask the same basic recognition/reporting questions of staff who are not champions.

Shift / department not yet represented _____

Action / owner / verification date _____

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3:45 RESOURCE 07

Five-minute readiness huddles

Use actual contacts and tools. Test the process — not the person.

FACILITATOR RULE

All scenarios below are fictional. They test operational readiness, not knowledge of a single universal disease protocol. Use current clinical/public-health guidance for the specific concern. Do not delay real clinical care to complete a practice exercise.

Time	Facilitator action
0:00 – 0:30	Read one scenario. State that this is a practice exercise.
0:30 – 2:00	Ask who takes responsibility, who assesses and what can begin within role.
2:00 – 3:00	Have staff find the actual contact route and current response tools.
3:00 – 4:00	Ask what is communicated, what is pending and who receives ownership.
4:00 – 5:00	Identify one gap. Assign follow-up and a verification point.

Use these three questions every time

- Who is covering, and what is the fallback?
- Show me where the current response information is.
- Who accepts the next action, and how do we know it happened?

Scenario / date / participants _____

Gap observed / next action _____

Owner / deadline / verification _____

Scenarios A–C

The facilitator checks the structure, not a guessed diagnosis.

A. Evening gastrointestinal concern

At 3:45 p.m., during the evening shift, two residents develop new vomiting/diarrhea symptoms. The regular lead is away.

Facilitator check: Look for current clinical assessment, indicated protection and prompt escalation; designated backup/fallback; secure surveillance; department communication; planned night handover.

B. Respiratory concern with deterioration

A resident has new respiratory symptoms and suddenly worsens while the team is trying to reach the IPAC backup.

Facilitator check: The urgent clinical response must not wait for an IPAC callback. Staff also use indicated precautions and the home's communication route. Do not turn the scenario into a fixed PPE rule.

C. The night handover

The incoming nurse receives: “Two residents unwell; precautions started; continue monitoring.”

Facilitator check: Ask what is missing: current findings, specific plan, pending tasks, escalation instructions, next review and accepted responsibility. Use Tool 05.

Scenarios D–F

Different concerns; the same need for ownership, assessment, communication and review.

D. Unexplained itching

Residents and a staff member report new itching. No diagnosis has been confirmed.

Facilitator check: Recognize and report; obtain appropriate assessment/IPAC advice; apply indicated measures. Do not diagnose scabies or give a treatment order from the exercise alone.

E. Suspected bed bug

An employee finds an insect that may be a bed bug on clothing. Identification is not confirmed.

Facilitator check: Use the approved pest-management/environmental pathway and appropriate expert identification. Address dignity and confidentiality. Do not assume a disease outbreak or use the GI isolation script.

F. A required action is blocked

The department confirms receipt of an instruction but reports that the required supply is unavailable.

Facilitator check: Do not mark the task complete. Identify the barrier, escalation owner and interim safeguard; obtain approved direction. Verify that the resolution works.

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G3. Public Health Ontario: Routine Practices and Additional Precautions. External reference distinguishing Routine Practices from condition/risk-specific Additional Precautions. Accessed October 2, 2026. <https://www.publichealthontario.ca/en/health-topics/infection-prevention-control/routine-practices-additional-precautions>

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3:45 RESOURCE 08

Debrief and verified gap closure

Turn an observation into a change that works on another shift.

Event / drill / date / participants _____

Start with the facts

- What was known, when, and from which record or observation?
- What worked well enough to preserve?
- Where did recognition, access, authority, communication or ownership become unclear?
- Which requests were not implemented, and why?
- What is still uncertain? Do not fill missing evidence with assumptions.

One strength to preserve _____

One important gap and its evidence _____

Immediate risk / interim safeguard / escalation owner _____

OUTCOME IS NOT THE WHOLE TEST

No further cases can be a positive result, but it does not prove that every process worked or that an intervention caused the result. Review implementation, barriers and outcome separately.

Assign, follow up, verify

Use one line per action. Keep clinical identifiers out of public copies.

Gap / required change	Owner + support	Deadline / interim action	Verification / result

Before marking an action closed

- Name the evidence that will demonstrate the change — not only the document that will be updated.
- Where relevant, have a different shift or department test the revised process.
- Record verifier, date and result. If the result is not adequate, retain the open status and set the next action.

Approved closure / remaining concerns _____

Next review / accountable leader _____

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