OKANAGAN INDIAN BAND

COMMUNICABLE DISEASE EMERGENCIES

Preparedness Plan

RECORD OF AMENDMENTS

Date	Subject	Page	Amended By
MARCH 17, 2020	Plan Created and partially completed	All	Valerie Genaille
March 17, 2020	Updated	All	Valerie Genaille
March 20, 2020	Updated	23	Peter Vlahos
March 23, 2020	Updated	All	Craig Moore
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Contents

COMMUNICABLE DISEASE EMERGENCIES PREPAREDNESS

Introduction

Planning the response for a communicable disease emergency (CDE), such as a pandemic, holds many challenges. This document is a collaborative effort of many individuals in Community including the Emergency Management Department, Senior Administration, and other organizational partners. It is a useful tool to support our community to develop, strengthen and update the CDE plan.

Many types of CDE events can occur, the response structure, the roles and responsibilities of different partners and stakeholders, and response activities may need to be adjusted. Therefore, it is important for CDE plans to be flexible in order to scale up or scale down the response activities, depending on the circumstances of the CDE event.

At the start of a CDE event, access the CDE plans and use them to guide response activities during the event. As more information becomes known, the plan(s) may need to be revised.

Purpose

This document has been developed to provide guidance for Okanagan Indian Band to prepare for and respond to CDEs.

Background

A CDE may present as an outbreak, epidemic or a pandemic. An outbreak is an unusual occurrence of an illness and is declared by the Medical Health Officer; an epidemic is an outbreak of an illness, within a defined geographical location; a pandemic is an outbreak of the same illness in a number of countries at the same time, and can only be declared by the World Health Organization (WHO).

There have been a number of documented pandemics, with the most recent occurring in 2009 and being influenza. Outbreaks, such as pertussis, influenza or measles, occur more frequently. At some point in the future BC will face another epidemic or pandemic, although it is difficult to predict exactly when this will happen. It is also difficult to predict if it will be caused by influenza or some other pathogen, although experts believe that the most pandemic prone organism is the influenza virus.

In a CDE, the Provincial Health Officer or MHO will make a declaration of an outbreak or pandemic, in response Health Authorities and Local Governments will activate their CDE plans. Local governments or jurisdictions may declare a state of emergency at that time to facilitate response and movement of resources.

FNHAs role in a CDE is to provide support to Communities in all aspects, clinical and practical, of their response. The FNHA CDPPH team will be directly involved, providing a direct information link between Federal, Provincial and Local partners, education and resources for health care staff and facilitation of resource flow/ relationships between Communities and partners. FNHAs Crisis Response team is involved in supporting Communities in their disaster response activities including psycho-social and cultural supports as well as practical issues of transportation etc.

Objectives of This Plan

The objectives of CDE planning are:

- Create a document that is rooted in culture, taking into account community strengths, resilience and incorporating historical lessons in disaster response
- To minimize suffering, serious illness and overall deaths
- To facilitate communication between CDE response partners
- To increase community readiness and community member awareness
- To develop a plan that is a living document, changing to meet future needs

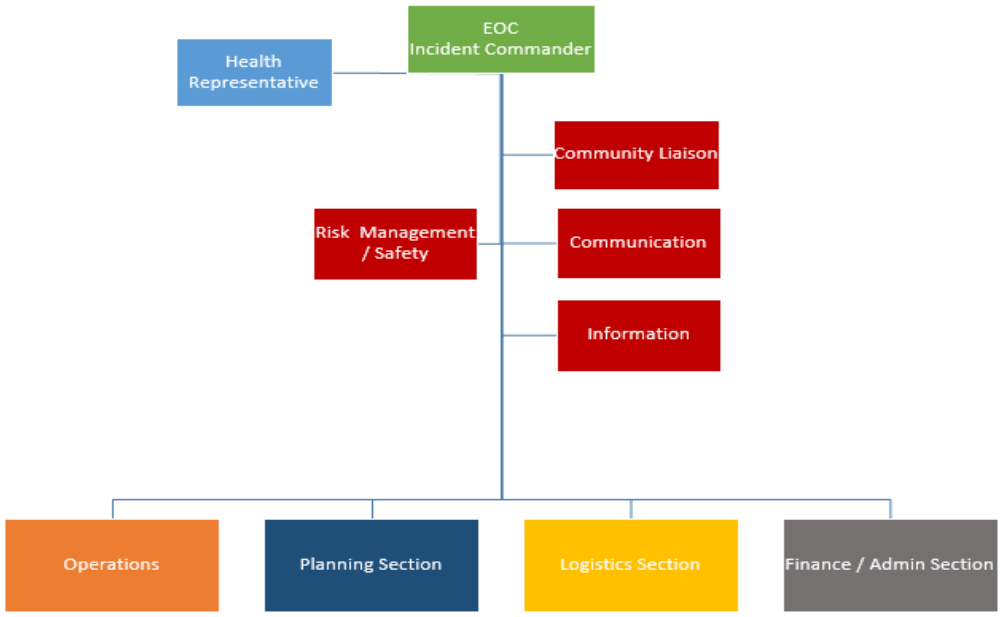
Considerations for Communicable Disease Emergency Response (CDER) planning

- Review the regional/community governance structure.
- Integrate the CDE plan with other local/regional plans (ie. Insert Community Emergency Response Plan, integrate Community CDE plan into Regional Health Authority plan, other local and regional jurisdictions), and ensure its preparedness and response activities are complementary.
- Review emergency plans for neighbouring towns: https://www.rdks.bc.ca/content/emergency-preparedness
- Establish linkages with emergency preparedness and response partners such as FNHA, Indigenous and Northern Affairs Canada (INAC) and provincial/regional/local Emergency Preparedness Plan (EPP) personnel.

Emergency Operations Centre (EOC) with Incident Command System (ICS):

- ❖ Unique aspects of the CDE EOC are the inclusion of a Health Representative with direct communication to Incident commander. **In the case of CDEs, decisional input from Health Representation is vital as CDEs are unique and have significant differences from environmental hazards.**
- ➢ Specify clear roles and responsibilities for both the planning and response phases for all partners.

Sample CDE EOC Structure



Roles

- ➢ Incident Commander (or EOC Director)
  - Sets objectives and priorities
  - Has overall responsibility at the site

- ➢ Health Representative
  - Provides direct input to Incident Commander on unique aspects of Communicable Disease Emergencies which differ from All-hazards response.

- ➢ Operations
  - Likely role for Health Director
  - Directs resources
  - Carries out the response activities described in the plan
  - Directs operations and ensures safety of staff

- Planning
    - Collects and evaluates information
    - Develops incident action plans
    - Maintains resource status (personnel, equipment)
    - Maintains incident documentation

- Logistics

    - Provides support to meet the incident needs
    - Provides resources
    - Provides other services to support the incident

- Finance/Administration
    - Monitors costs related to the incident
    - Provides accounting, procurement, time recording and cost analysis

(See Appendix 1- Fillable EOC structure and contacts)

Planning information regarding CDE Communications

The goal of CDE communications is to build trust through the delivery of timely, clear, transparent and consistent messaging to the community during a CDE event. To ensure plan effectiveness, it should specify communication processes with Community members, health care partners and other stakeholders (e.g. – neighbouring communities, other organizations) as well as align with the provincial communication plan.

- Develop a plan to determine how CDE-related information will be communicated to community staff and members. (See appendix 3 - Communication plan template)
- Develop a plan to determine how CDE-related information will be received and/or disseminated to external partners, including province, FNHA Regional offices, ISC, while respecting confidentiality and privacy laws.
- See appendices for sample messaging for communities on how to reduce spread of respiratory and other pathogens. Regional Health Authorities or FNHA may provide direction or sample messaging for communities.

MEASURES TO REDUCE THE SPREAD OF COMMUNICABLE DISEASE

One of the strongest factors to successfully address a CDE is the existence of a responsive, trusted, well-developed community health programs with policies and procedures which can be built on in a CDE.

- Providing care to community members with chronic health concerns to strengthen their resilience
- Existing trusted public health immunization program, including annual influenza and pneumococcal programming
- Maintaining CHN knowledge and skills in Infection Prevention and Control Best Practices, Communicable Disease surveillance, follow-up and response.
- Strong public health messaging integrated throughout programs (community gatherings, head start, schools etc.), such as:
    - Handwashing, hand sanitizer
    - Covering cough
    - Voluntarily staying home when ill
    - Cleaning hard surfaces with anti-microbial solutions in public spaces (i.e. Bleach).
- Developing relationship with Regional Health Authority Communicable Disease teams, MHOs, and other health teams to facilitate information flow and mutual understanding in CDE events.
- Developing and using Community and Health Care Centre Infection Prevention and Control policies to reduce the risk of spread of pathogens.

See Appendix **2** **RHA MHO/CD Team Contact List**

Additional information regarding infection control and environmental cleaning, please refer to the *Housekeeping Manual for First Nations Community Health Facilities*:

Housekeeping Manual - https://www.fnha.ca/WellnessSite/WellnessDocuments/HP_Housekeeping-Manual.pdf#search=housekeeping

Chapter 1, Section 1, page 69-*Procedure for mixing Surface Cleaner/Disinfectant*

Chapter 1, Section 2-*Preventing Infection in Special Situations*

Chapter 2, Section 7-*Housekeeping Supplies and Chemicals*

Community-based disease control strategies:

Public health infection control measures are measures that seek to disrupt the ability of a pathogen to travel between people. These alone will probably not be effective at controlling spread of a pandemic in the community. Control will likely also require availability and use of an effective vaccine or other treatments, if available, however, the following are recommendations for community-based strategies which can be part of slowing disease spread;

- All CDE:
    - Voluntary self-isolation, when ill is strongly recommended; advise community members to stay home when ill

- EOC team to review the need to cancel public gatherings (schools, church, feasts, sport events), due to illness, or possibility staffing levels.
    - Risk of pathogen transmission at community events is higher when events are crowded, held indoors or without access to sufficient hand hygiene (washing and alcohol-based sanitizer stations);
    - Risk should be balanced against need for community and cultural connection to strengthen resilience, FNHA CDPPH team, FNHA OCMO and Regional MHO are resources available to communities looking to find a reasonable balance.
- Alcohol-based hand sanitizing stations are recommended in public buildings (band office, community recreation center, nursing station, day care and school)

Severe CDE

- In severe CDE the Regional MHO has the authority to require and compel cases and contacts to self-isolate, or accept treatment. There may be potential in some remote areas to delay the pandemic strain until after the antivirals or vaccines become available by introducing:

- Strict public health measures
- Monitoring and if necessary restricting access to communities during a pandemic.

*Please see **Appendix 3** and **Appendix 4** for Public Health messaging resources

Vaccines or Medications to reduce the spread of disease:

In response to a CDE, vaccines, antivirals or other treatments may possibly become available to protect individuals and reduce disease spread. Vaccine and other medication procurement, management, (including obtaining supplies and ensuring appropriate storage and handling), and administration is part of day-to-day operations at the community level, which can be utilized in a CDE.

- Assess current vaccine and medication delivery processes, and determine if modifications need to be made to allow for quick delivery of these during a CDE event (i.e. – mass immunization plan, identification of high risk individuals and provision or home or community treatment, linking with neighbouring communities for support, etc.).

DURING A COMMUNICABLE DISEASE EMERGENCY

Community Responsibilities

The community's Emergency Operations Centre (EOC) will activate and meet as soon as possible to action this plan with direction and consultation from Healthcare Services, as well as any local control measures. Each local control measure (such as individual isolation or cancelling events) will need to be discussed and decided upon separately before being implemented.

*See **Appendix 1** for updated information.

Health team members will need to coordinate responses with their own RHAs, BCCDC and FNHA when applicable.

Establish communication links with RHA and FNHA

*See contact information in **Appendix 1**

Open communication with other communities in our area as it is likely that what affects them can/will affect our community as well. This will also be important in the event that our or their community is severely affected by the CDE and either community needs help.

Plan for mass triage/treatment centres

Plan: In the event that the number of suspect and confirmed cases requiring treatment or prophylaxis is beyond the capacity of existing Healthcare facilities, the EOC will designate a site/facility to establish a mass triage/treatment centre. The Planning and Logistic team will ensure the facility is open with sufficient supplies and equipment to support the health team.

*Please see **Appendix 3** and **Appendix 4** for Public Health Flu, Hand Hygiene, and Cough Etiquette Resources

The Nursing Station/Health Centre will have lists of specific population groups within the community that may be especially vulnerable to communicable disease and/or may need to be prioritized for medical treatment/prophylaxis (ie. Elders, prenatal/postnatal clients, children under one year, chronic disease). These lists should be available annually.

*Please see **Appendix 5- (Community's) Priority Lists** for more information

Band members list of those living on reserve is updated annually. If for some reason a community member cannot attend the clinic, either the CHN will attend that person's home or a member of the logistics team will arrange to pick up that community member.

As appropriate, Health Teams may be asked to communicate with their RHA regarding vaccine utilization in their communities. If access to vaccine from the Regional Health Authority becomes difficult, contact immunize@fnha.ca for assistance with coordination of supplies.

Please note: Health Teams must maintain their immunization competency

Health Services Delivery

○ Implement infection prevention and control (IPC) measures.

Link to BCP plan if available, develop Health Care IPC policy, and ensure access to PPE for Staff.

Outbreaks and Pandemics may be caused by any known or unknown diseases and therefore, it is important that infection prevention and control measures and processes be in place to prevent its spread in all Health Care centres.

Plan: Healthcare workers identified as being at risk for exposure to communicable diseases, will wear the appropriate personal protective equipment (PPE) identified by their point of care risk assessment (PCRA; See Appendix 8 and 9). PPE equipment selected will vary depending on how the organism is spread (transmission). It is recommended higher level precautions if how the organism spreads is unknown.

Note: it will be the responsibility of the Health Team to consult with either Regional Health Authorities, and/or FNHA to ensure that these precautions are appropriate as well as to ensure adequate supplies of personal protective equipment for all modes of transmission (how an organism spreads): airborne (through the air), droplet (through respiratory secretions), contact (on surfaces). It will also be the responsibility of the Health Team to ensure best practices for their infection prevention and control measures and processes. For IPC program questions and support, please contact **cdmgmt@fnha.ca.**

For environmental cleaning, consult with the Housekeeping Manual (Appendix 8) to determine the appropriate cleaning methods and materials to be used.

○ Provide health care services on a priority basis.

Plan: Once notified by a community member of an illness, a member of the Health Team will either attend their residence if indicated, or have them attend a location to triage their level of illness e.g. Nursing Station. As other members of the community become ill, the Health Team may establish a priority list indicating who requires what level of care (e.g.- at home, alternative care site or hospitalization).

When community members are triaged, they may be classified in one of the following ways:

1. Have symptoms and can care for themselves (advise them to self-isolate and report any changes), check back with them to re-triage as appropriate.

2. Have symptoms and have family or others who can care for them (advise them to self-isolate and report any changes) check back with them to re-triage as appropriate.
3. Have symptoms and cannot care for themselves and have no family or others who can care for them, arrange for a health team member or other designated community member to care for them or set up an alternative care site in collaboration with EOC.
4. They are having severe symptoms and need advanced medical care, a first responder will transfer the client to the Health Centre/facility. Depending on the status of the client and available community resources, the client may be transferred to the nearest available health facility.

Isolation

There are 3 levels of isolation (individual, household, community) which may be used to help prevent the spread to our community members. In the case of individuals or households who are isolated, someone will need to be identified to check on those people to ensure they are not getting sicker, or require supplies such as food or medication.

Community - If community isolation is being considered, a meeting/communication must take place explaining fully as to the reasons for the isolation and any restrictions that are in place because of it, as well as expected timelines of the isolation.

○ Establishing Alternate Sites for Providing Medical Care

Plan: In the event that community members become too ill to care for themselves (or a loved one cannot care for them), or there are too many community members sick and unable to care for themselves, an alternative care site will be established.

When possible and depending on what is known about the disease and how it spreads, these sites could possess the following: an area large enough for more than 5 people to be cared for, running water, washroom facilities, a place to cook, large sinks, heat, and enough room to isolate patients from each other as well as for patient care. Other considerations include: beds, bedding, buckets, lights, patient care and medical equipment, personal protective equipment (PPE), washcloths, sponges, paper towels, scissors, water, soap, oxygen, patient record keeping material.

Arrange for Transportation of Ill Cases

Plan: If a member of our community has been identified as being too ill to be cared for within the community, the Health Team will arrange for transportation to the closest hospital.

Note: it is the responsibility of the Health Team to ensure communication to transport teams regarding the condition of the clients, updates to the possible mode of disease transmission, and the IPC measures implemented for the client.

Recognize the Need for Deceased Management

Plan: The most current information regarding dealing with persons who have died as a result of a communicable disease and implement the appropriate IPC measures (i.e. airborne, droplet, and/or contact precautions, or just hand washing). This will be monitored closely by FNHA and if information changes regarding handling of the deceased during the outbreak or pandemic then infection control measures may need to be altered.

In the case where the number of deaths as a result of the pandemic is so overwhelming that the Hospital, coroner's office, or funeral homes cannot receive a deceased person immediately, they may be required to stay in the community. This period of time may be for hours, days or in extreme cases, our community may be advised to keep the corpse on site and to make direct funeral arrangements.

See Appendix 9 - Location for Deceased during a CDE

Bury the deceased as soon practical and appropriate for the community.

As long as the death was as a direct result from the flu, there may not be a need for the Coroners' Office or the Family Physician to view the deceased, which will be determined by the coroner's office. If the deceased is remaining in the community then the NIC/CHN needs to complete a 'Registration of Death' (form number HLTH 406 REV 92/12) Province of British Columbia – Ministry of Health, et al.

Discuss Funeral Arrangement Issues

Plan: If a community member dies as a result of the illness, then attempt to send the deceased to the Hospital, Coroner's office, or Funeral Home as you would normally do when a community member passes away.

There may not be any need for those persons who are sitting with deceased (no contact) to wear any protective equipment. This will be monitored by the Medical Health Officer (MHO) and FNHA Chief Medical Officer (CMO) office and if information changes, communities will be notified to make applicable changes.

If the deceased remains in the community from death to funeral, appropriate PPE may be required for all persons attending the funeral in case someone attending is ill. We will also make every effort to provide supporting arrangements for the deceased as soon as appropriate and possible. It is recommended that only direct family members attend the funeral as a way to limit the number of persons at the funeral (minimize large gatherings)

Note 1: A Death Certificate must be issued before the deceased can be buried.

Surveillance

Establishing local surveillance (monitoring ill people)

Plan: It will be recommended that all community members report their illness to the Health Team during a CDE. The Health Team, will inform community members of their responsibility to inform the Health Team when they are ill.

For example, with influenza illness, ensure timely reporting of influenza activity to the communities' RHA and FNHA.

Plan: When a community member (or caregiver) suspects having Influenza-like-illness (ILI) or symptoms of an illness communicated to community from public health, they will notify a member of the health team and be triaged as per the triage section above.

The British Columbia Centre for Disease Control (BCCDC) website has health professional information on Influenza surveillance updates, antiviral guidelines and ILI outbreak forms.

http://www.bccdc.ca/health-info/diseases-conditions/influenza

Communication

As soon as our community leadership has been made aware of a health emergency, our community communication plan will be implemented to provide information to community members. Encourage community members who do not live in the community full time to attend.

Plan: The following information will be provided via the most efficient media such as VHF, community Facebook page, telephone calls and written community notices:

- What an outbreak or pandemic is
- The current state/status update of transmission in Okanagan Indian Band.
- Getting vaccinated if vaccines is an option (this is very important to community members who do not live in the community full time, especially if we decide to limit travel into our community).
- Detailed protective measures for those who have declined or unable to receive the vaccine or if disease has no vaccine option
- Antiviral information if applicable
- Self-monitoring (if a community member becomes ill, they must inform the Health Team of their illness to get quick and proper treatment).
- Personal hygiene (importance of hand washing, cough etiquette)
- Travel restrictions (ill people returning to the community)
- Infection control measures (i.e. the use of personal protective equipment, cleaning recommendations, etc).

Often experts from our RHA, FNHA or Consultants are available to assist with communications.

Have a clearly identified central spokesperson.

Plan: The media liaison (see Appendix 1), acting as the community spokesperson, will conduct any media interviews, or communications required on behalf of the community. If he or she is not available, then someone will be delegated on behalf of the community.

AFTER A COMMUNICABLE DISEASE EMERGENCY

Community Responsibilities

An outbreak or pandemic is over when the local, provincial, and federal public health authorities declare it being over. For example, pandemic influenza may come in waves and therefore, our community should not assume a pandemic is over until it has been announced as formally being over.

Our community incident command team shall meet and:

- Deactivate the plan,
- Hold a critical incident debriefing session for all team members; provide or arrange grief counselling to community and staff members as needed.
- In a timely manner, the Incident Command team will assess the effectiveness of this plan, and revise the plan as necessary
- Inform community members of the pandemic being over, and discuss how it affected the community. It would be best to do this in a community gathering, as this would be a good time to support each other as well. As there will be very few persons not affected by the pandemic or outbreak, many community members may feel the need for support and counselling. Crisis counselling services will be accessed and provided as necessary.
- Arrange for the return of any community members who may have been out of the community in hospital or at other care sites.
- Help to arrange grief counselling to the community and members as needed. Document lessons learned by the community. There are only a few times in history where we have the opportunity to possibly save our community from future pandemics. It is important to write down and pass along how our community did during the outbreak, what worked and what could have worked better.
- If the community was financially impacted by the health emergency, then seek financial redress.
- Our Health Team will complete the surveillance report with the information required by our RHA and FNHA.
- Resume regular surveillance activities.

Note: There will be a continued need for regular surveillance for illness in the community for some time. Although the pandemic has passed, we need to ensure that if community members become ill, that it is reported to the Health Team. The effects of a pandemic can and will be felt for a long time in the community once the pandemic is over.

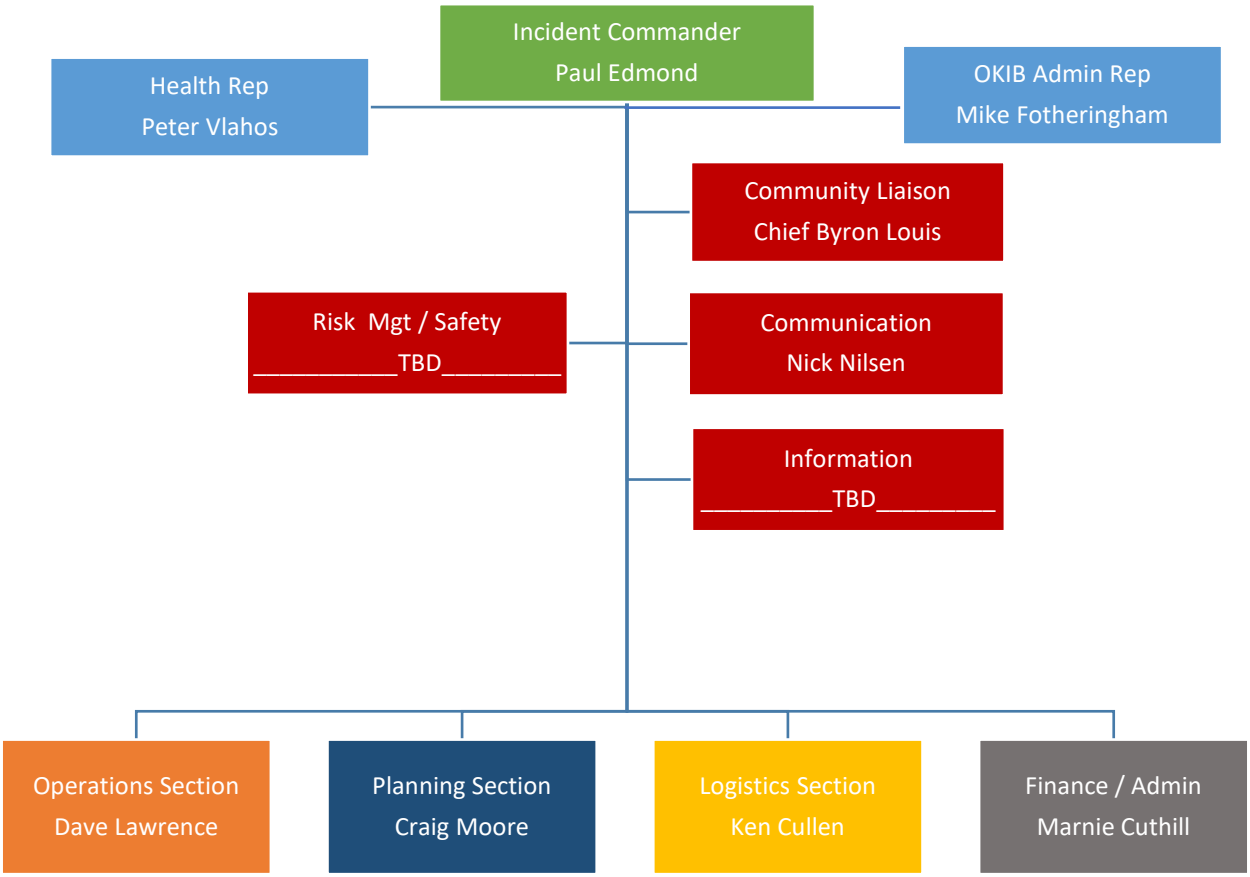
Encourage planning for future pandemics.

APPENDIX 1: CONTACT INFORMATION OF Emergency Operation Centre

TO BE REVIEWED/UPDATED TWICE PER YEAR

Date last updated: _____MARCH 23, 2020_____

Fillable EOC (ICS Structure)



INCIDENT COMMAND SYSTEM (ICS) STRUCTURE in EOC:

ICS ROLES	
Role	**Position in Community**
Incident Commander	Paul Edmond – Red Dragon Consulting
Health Representative	Peter Vlahos

OKIB Admin Representative	Michael Fotheringham
Community Spokesperson	Chief Byron Louis
Operations	Ken Cullen – Fire Department
Planning	Craig Moore – Rider Ventures Ltd.
Logistics	Dave Lawrence – Fire Department
Finance/Admin	Marnie Cuthill – Rider Ventures Ltd.
Worker Counsellor/Support	Gisele Duquette

APPENDIX 2: **RHA MHO/CD Team Contact List for Surveillance Reporting**

Check off most applicable RHA contacts for your community

Check Off Applicable Contacts	Agency	Position	Contact
☐	Fraser Health Authority	Central Communicable Disease Intake Line – Health Protection	1-866-990-9941
☐	Fraser Health Authority	Medical Health Officer (MHO) on call after hours	604-527-4806
☒	Interior Health Authority	Communicable Disease Unit	1-866-778-7736
☒	Interior Health Authority	MHO on call after hours	1-866-457-5648
☐	Island Health Authority	South Island Communicable Disease Hub	1-866-665-6626
☐	Island Health Authority	Central Island Communicable Disease Hub	1-866-770-7798
☐	Island Health Authority	North Island Communicable Disease Hub	1-877-887-8835
☐	Island Health Authority	MHO on call after hours	1-800-204-6166
☐	Northern Health Authority	Central Communicable Disease Hub	1-855-565-2990
☐	Northern Health Authority	MHO on call after hours	250-565-2000
☐	Vancouver Coastal Health	Communicable Disease Control	604-675-3900
☐	Vancouver Coastal Health	MHO on call after hours	604-527-4893

For updated information please refer to www.FNHA.ca/CDE

APPENDIX 3: CDE PUBLIC MESSAGING

Key message components:

1. Expression of empathy
2. Clarification of facts and/or call to action
    a. Who
    b. What
    c. When
    d. Where
    e. Why
    f. How
3. What we do not know
4. How leadership is going about getting answers
5. Statement of commitment
6. Referrals for more information or supports
7. Next scheduled communication

Check messaging for the following:

Positive action steps, honest/open tone, message clarity and congruence with other messaging from partner organizations, simplicity, avoidance of jargon or judgmental phrases, humor or extreme speculation.

Refer to CDE Communication at www.FNHA.ca/CDE for FNHA public communication.

APPENDIX 4: PUBLIC HAND HYGIENE/COUGH ETIQUETTE MESSAGING

Infection Prevention and Control Canada (IPAC)

http://www.ipac-canada.org/links_handhygiene.php Health

Link BC

http://www.healthlinkbc.ca/healthfiles/hfile85.stm

Provincial Infection Prevention and Control Network of British Columbia

https://www.picnet.ca/resources/posters/infection-control-posters/

BC Centre for Disease Control

http://www.bccdc.ca/health-info/prevention-public-health/hand-hygiene

APPENDIX 5: INFECTION PREVENTION AND CONTROL MEASURES

Point of Care Risk Assessment, Routine Precautions, Additional Precautions
https://www.picnet.ca/wp-content/uploads/PHAC_Routine_Practices_and_Additional_Precautions_2013.pdf

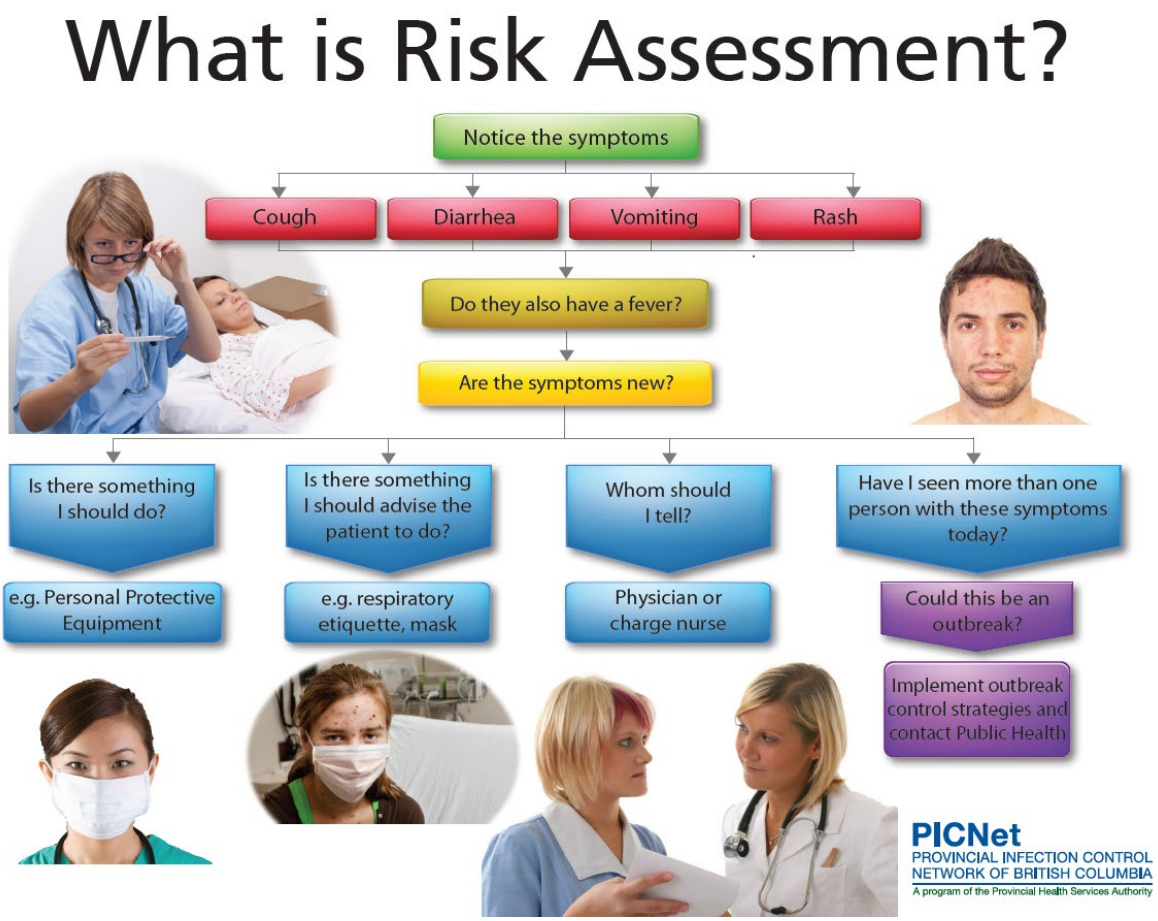
Environmental Cleaning Best Practice Guidelines
https://www.fnha.ca/WellnessSite/WellnessDocuments/HP_Housekeeping-Manual.pdf#search=housekeeping

BEFORE A COMMUNICABLE DISEASE EMERGENCY (CDE)

Community Responsibilities

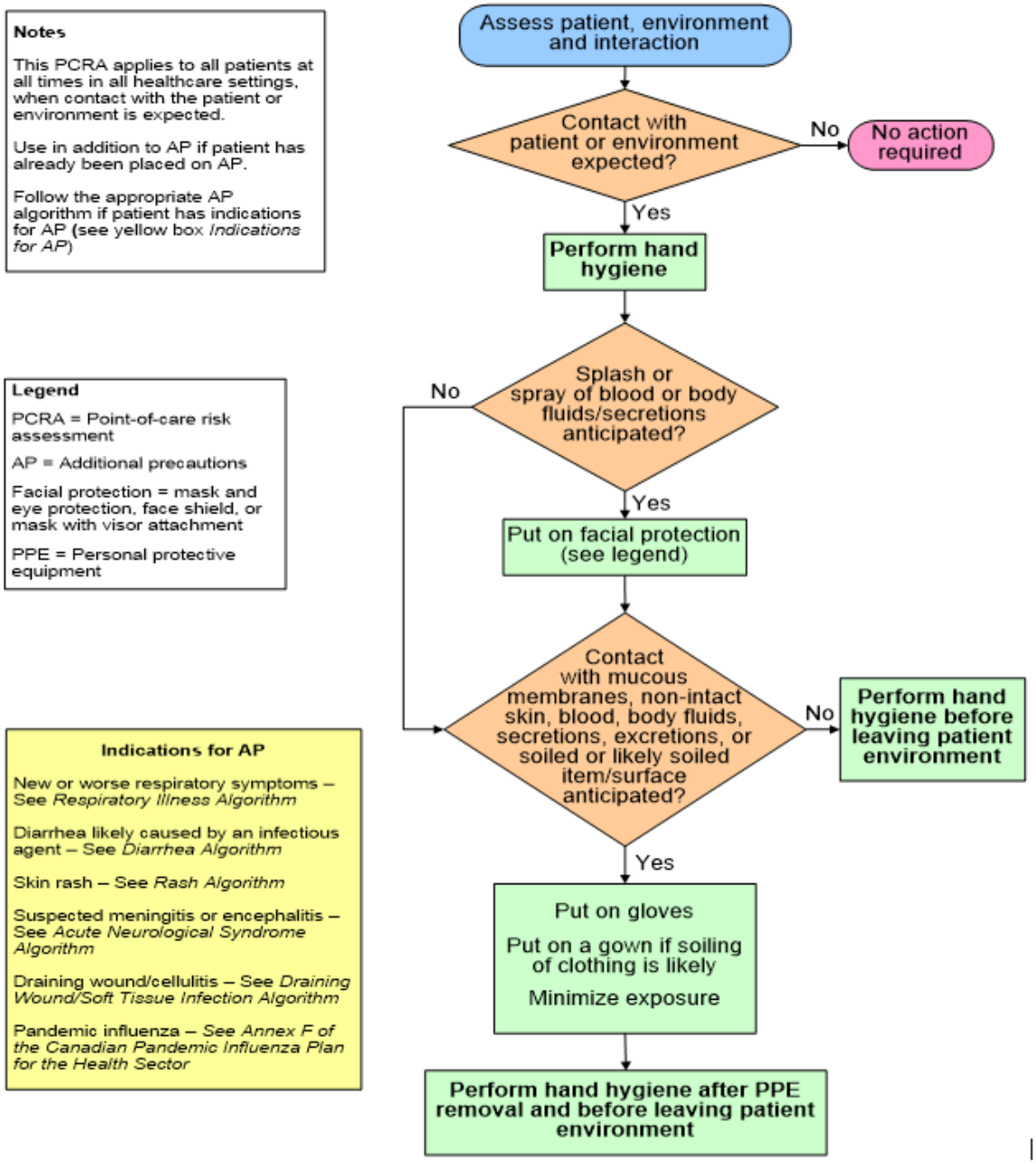
- Community leadership and health team members will be responsible for supporting the preparation of a communicable disease emergency response plan as an appendix to their emergency preparedness plan. They should also coordinate with their RHA to ensure it is integrated with the RHA's pandemic CDE plan (Contact the Infection Prevention and Control Program of your local Regional Health Authority).
- Community leadership is responsible to support the work required to review, revise and exercise this CDER plan annually, or as needed.
- Community leadership will ensure that all community members are made aware of this CDER plan by providing copies to each household located in the community and to band members living within close proximity to the community.
- Community health team members are responsible to ensure that community leaders, senior administration and community members are kept apprised of any updates or information as it relates to health emergencies, such as localized outbreaks, epidemics or pandemics.
- Communicable Disease Emergency Response planning team will ensure that everyone whose name has been included in this plan with any responsibilities will be provided a copy of the plan and have their responsibilities explained to them.
- Ensure that we have established communication links with organizations listed in **Appendix 1**.
- Designate a central spokesperson (to the community and media). The community spokesperson will conduct any media interviews, or communications required on behalf of the community.

Example 1


What is Risk Assessment?
Notice the symptoms
Cough
Diarrhea
Vomiting
Rash
Do they also have a fever?
Are the symptoms new?
Is there something I should do?
Is there something I should advise the patient to do?
Whom should I tell?
Have I seen more than one person with these symptoms today?
e.g. Personal Protective Equipment
e.g. respiratory etiquette, mask
Physician or charge nurse
Could this be an outbreak?
Implement outbreak control strategies and contact Public Health
PICNet
PROVINCIAL INFECTION CONTROL NETWORK OF BRITISH COLUMBIA
A program of the Provincial Health Services Authority

Example 2

1.3 PCRA Algorithm for the appropriate use of PPE



Source: Public Health Agency of Canada. (2012). Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings. Retrieved from http://publications.gc.ca/collections/collection_2013/aspc-phac/HP40-65-2012-eng.pdf

APPENDIX 7: EVACUATION PRIORITY LISTS

***UPDATED QUARTERLY**

*Please see Community Health Nurse for updated lists

NOTE: Please do not directly attach evacuation lists directly onto CDE plan. Names on this list are considered confidential information.

CHN note: To maintain patient confidentiality, priority/evacuation lists that are to be shared with the Emergency Operation Centre and should only contain minimal client information that is needed for transport.

APPENDIX 8: VOLUNTEER SUPPORT CONTACT LIST

(MEALS, RUNNERS, MESSAGING)

In-Community Volunteer Support	
Volunteer Role (eg. Meal prep for emergency/health staff)	**Contact Information**
Health Department / Emergency contact	**Name:** Peter Vlahos **Work:** 236-600-2075 **Mobile:** (250) 241-6704 **Email:** hsddirector@okanagan.org
Emergency Coordination / Spokesperson	**Name:** Chief Byron Louis **Mobile:** 250-306-8883 **Email:** Byron.Louis@okanagan.org
Messaging	**Name**: Nick Nilsen **Work**: 250-549-5053 **Email:** communications@okanagan.org
Meal Preparation coordinator	**Name**: Bev Simpson **Work**: 250.308.8479 **Email:** beverly.simpson@okanagan.org

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Name of local emergency lead:

FNHA HEM lead: Emily Dicken, email: Emily.Dicken@FNHA.ca

Local EPP personnel:

- Be aware of the community's all-hazard EPR and business continuity plan (BCP), and be familiar with their content.

  Location of all-hazards plan: o DRIVE

  Location of BCP:

  Lead for all-hazards plan:

  Lead for BCP:

- Prioritize community programs/services, including health services, in case of lack of staff availability (minor to major) depending on emergency event.

  Priority list of which programs we would keep running (health centre, medical transfer services, etc):

  1. Emergency Operations Centre

2. Health Centre, with restrictions
3. Home & Community Care
4. Patient Transfer and Transportation
5. Food Security

- Discuss the possibility of mutual aid and sharing of resources with neighbouring communities.

  Who could you contact in a neighbouring community to discuss sharing resources in case of a Communicable Disease Emergency (name and number):

  1.

  2.

  3.

APPENDIX 9: **Location for Deceased during a CDE**

The Head of the Lake Hall has been identified as the location for the deceased during a pandemic until burial (the area must be kept cool and dry). If the Head of the Lake Hall is unavailable or unfit to be used as a location for the deceased during a CDE until burial during the Pandemic, the CHN will notify the Medical Health Officer.

APPENDIX 10: PLANNING ASSUMPTIONS WITH INFLUENZA FOCUS

British Columbia has developed a Provincial Pandemic Plan (2012) using certain assumptions to help guide planning activities.

British Columbia "Planning Assumptions" (BCPIRP, section 1.3, 2012):

- Pandemic of moderate to high intensity, high peak first wave. Rates of impact of population health measures applied to entire population, rather than age segments.
- The 2nd wave is expected to begin in September to model a worst-case scenario as a result of children returning to school.
- For the 1st wave, public health measures and antivirals result in a reduction in transmissibility and hospitalization.
- Time from declaration of pandemic by WHO to 1st wave in BC is one day.
- 12-week duration of the 1st wave.
- 12-week period between waves.
- 12-week duration of the 2nd wave.
- A 1:1 symptomatic to asymptomatic ration for infected individuals was chosen.
- The Clinical Attack Rate will be 20%.
- Vaccine will be delivered to Health Authorities and other vaccine providers starting in the first week of the 2nd wave and delivered to 75% of population (an estimate of all those who will want to receive the vaccine).
- There will be a campaign to immunize all those who wish to be immunized in a 6-week period (in line with an anticipated receipt of one-sixth of our pandemic vaccine supply per week from the onset of the second wave with random population vaccination rather than by specific high risk groups since the vaccine will arrive so quickly.)
- Vaccine efficacy of 90%.
- Antivirals are given to all those seeing a physician.
- Antivirals have an efficacy of 80% and reduce hospitalizations by 38%.
- Antiviral distribution was based on the experience during H1N1 in BC.
- Public Health infection transmission reduction strategies, such as cough etiquette, handwashing, social distancing and staying home while ill, will reduce transmissibility by 20%.

- The numbers greater than or close to, or above 1000, are rounded to the nearest 1000. Numbers below that are rounded to the nearest 5.

Antivirals for Influenza

Consult our nurse, nurse practitioner, or doctor early if you develop flu-like symptoms and you have a condition that puts you at higher risk of complications. Consider asking medical professionals to pre-prescribe for those at highest risk of influenza.

Antiviral medication is most effective if given within 48 hours once symptoms start, and the sooner the better. You should also call your health professional if your symptoms get worse, such as shortness of breath or difficulty breathing, chest pain or signs of dehydration (dizziness when standing, low urine output). Reference: http://www.healthlinkbc.ca/healthfiles/hfile12b.stm