Miawpukek First Nations (MFN)

Conne River Health & Social Services Centre

Ebola Virus Disease Tabletop Exercise

February 26, 2015

The Tabletop Exercise

Why choose a Tabletop Exercise?

- The focus of a tabletop exercise is normally on familiarization with key roles, procedures and responsibilities.
- They are based on facilitated discussion and provide an opportunity for players to analyze emergency plans, policies and coordination issues.
- A well-structured tabletop exercise will enable managers to review or confirm mechanisms for dealing with critical issues.

Characteristics of a Tabletop Exercise

- Discussion-based.
- Facilitated group analysis of a situation.
- Conducted in an informal, low-stress environment.
- Normally designed for the examination of plans or policies, combined with in-depth problem solving.
- Usually deal with "what if" scenarios.
- Delivered within a structured framework.

Exercise Purpose

- The exercise purpose should be captured in a broad statement which clearly identifies the aim.
- It should communicate the intent of the exercise.
- It does not contain detail on how the aim will be achieved.

Exercise Objectives

- An objective is a description of the performance expected from participants.
- Objectives provide a framework for the scenario.

Possible objectives:

- To introduce or validate a plan or policy.
- To analyze or validate a decision-making process.
- To prepare for a functional or field exercise.
- To train or practice staff in emergency procedures.

Exercise Scope

- The scope identifies exactly what the exercise is to cover.
- It defines the composition and number of exercise participants.
- It limits the exercise by time, hazard type, plans to be exercised, etc.
- It must be kept manageable –neither too broad nor too complex.

Exercise Scenario

- The scenario is the "story line" on which an exercise is based. It must be:
  - realistic (believable)
  - threat-based; and
  - directly related to the exercise purpose.
- The scenario must be carefully designed to engage participants in a way that approximates real-world responses.
- It should be demanding but not overwhelming.

Exercise Participants

- There are three principal categories of exercise participants:
  - controllers (usually called "facilitators" in a tabletop exercise);
  - players; and
  - observers.
- It is important to maintain the distinction between "players" and "observers"(the terms are self-explanatory).

Post Exercise Requirements

- "Hot Wash-up" should be held at the conclusion of the exercise to capture immediate feedback from participants.
- An After Action Report (Debriefing Report) should be published approximately 4 weeks after the exercise, to identify:
  - what went well;
  - areas for improvement;
  - recommendations; and
  - action plan

TABLETOP EXERCISE

"Ebola Virus Disease "

PURPOSE

To better enable the Conne River Health and Social Services Centre (CRHSSC) to prepare for and manage (in cooperation with the Provincial Medical Officer of Health (MOH), Containment & Transport Team-Eastern Health, Central Health, and Health Canada) an Ebola virus disease suspect or confirmed case.

OBJECTIVES

To identify and prioritize emergency response activities (e.g., medical transport, triage, communication, infectious processes: PPE, waste management, housekeeping services, ethical issues, contact tracing- health care workers and community, psychosocial requirements).

To identify/confirm roles and responsibilities related to emergency response.

To identify available resources.

To identify/confirm notification protocols (internal/external).

To determine the ability to activate the personnel required for the prevention and control of the suspect or confirm case (emergency response).

NEEDS

To understand the emergency response procedures, roles and responsibilities at the CRHSC in collaboration with the MOH, Medical Transport Team- Eastern Health, Central Health, Health Canada and Aboriginal Affairs and Northern Development Canada for a suspect or confirmed Ebola case .

SCOPE

How to deal with a suspect or confirmed Ebola virus disease case that not only impacts the following services at CRHSSC: triage/care for patient, infection prevention and control, communicable disease control, housekeeping, psychosocial supports, waste management services, but also the community as a whole including communication, ethical decision making.

Tabletop Exercise Participants & Observers

Theresa O'Keefe- Director, CRHSSC
Staff- CRHSSC
Les Keays - White- Health Canada
Cheryl Morris – Health Canada
Tammy Drew- General Manager, MFN Government
Clinton Jeddore – MFN Government
Tracy Howse- MFN Government
Glen Benoit - MFN Government
Rocky John - MFN Government
Siobhan Jeddore- MFN Government
Alma Benoit –MFN Government
Morgan Henstridge- Central Health
Bob Allen – Central Health
Hayley Cooze – Central Health
Betty Moulton- Facilitator

SCENARIO

Part 1

At **0900 hrs on March 12, 2015** a 50 year old female arrives at the CRHSSC. She advises the receptionist that she has been experiencing ILS since last night including fever, chills, headache, aches & pains and is just starting to feel nauseated. She requested to see the doctor/nurse practitioner.

Discussion Points

1. What actions would need to be taken immediately?

2. Who undertakes those actions?

3. Who is responsible for ensuring these actions take place?

Part 2

At **0920 hrs** the patient sees the physician and after some discussion she reveals the following information.

- Returned from Sierra Leone 12 days ago
- Worked as a volunteer in a church operated orphanage
- Lives in Conne River with spouse, who is 53 years old and father in law who is 75 years old. No children currently living at home.

Discussion Points

1. What would the response procedures of the attending physician involve?

2. What would the response procedures of the NP/RN and LPNs at the Centre involve?

3. Who else within the health care system (regional/provincial/federal level) needs to be informed of the situation at this point?

4. Would additional staff be called back at this point? What is the process to call additional staff back?

5. What process, if any, would be set up within the CRHSSC and MFN Government to manage and provide updates to staff, MOH, Health Canada, Central Health and the General Manager, MFN Government?

6. What, if any, additional precautions have been taken to address the patient's deteriorating condition? Who is responsible to carry out these actions?

7. What are the concerns regarding infection control (internal and external)?

8. How are these concerns being addressed?

9. Does the staff and managers, CRHSSC as well as physicians from St. Alban's Clinic, and receive information and education on infection control and isolation precautions, personal protective equipment (PPE), etc?

10. Does the CRHSSC have a procedure to provide PPE, including surgical masks, N-95 respirators, gowns, face shields, foot and leg coverings, head covering and gloves to designated work locations?

11. What, if any, updates would be provided to the media/ at this point? What might be some triggers for general public notification? Who takes the led in public notification: MOH, Director-CRHSSC, Band Chief?

12. What are some potential ethical issues that could be raised at this point? What process, if any, is developed to address same?

Part 3

At **1000 hrs** a decision is made, in consultation with the Provincial MOH, that the patient will have to be transported to Eastern Health for treatment.

Discussion Points

1. Who would coordinate the patient transfer to the Health Science Centre, St John's? What would the processes involved in transporting the patient to the Health Sciences Centre include?

2. Who would be responsible to ensure that the patient transfer is communicated to the Central Health, Health Canada, General Manager, MFN Government etc?

3. If there is a delay in transporting patient (in climate weather, mechanical issues with designated ambulance) to the Health Science Centre does the CRHSSC have an ability to manage the care of the patient until the following morning?

4. What other health care workers would be involved at this point? What would be their responsibilities?

5. What staff issues or concerns may arise at this time? Is there a requirement for psychosocial support? Who would provide this service, if required?

6. What involvement, if any, would take place at this point with the patient's family?

Part 4

At **1600 hrs** the Containment and Transport Team arrive from Eastern Health.

Discussion Points

1. What are the key recovery processes that the CRHSSC would be engaged in once patient is transported to the Health Sciences Centre? (Services including: psychosocial support, waste management, house keeping, etc)

2. Does the CRHSSC have a formal evaluation process established to capture lessons learned from exercises and real-life emergency disaster events?

Evaluation

Exercises are pointless without the inclusion of an evaluation. During this exercise, the focus is on the evaluation of the processes in place, not the people. Staff who are unfamiliar with processes must take responsibility to increase awareness through available resources.
It is the role of those involved with the planning of their exercise to ensure that identified processes and systems achieve their intended purposes.

Throughout the exercise it is important that all participants note what went well, areas for improvement and other observations as this will be the key areas discussed in the post exercise debriefing.

Post Exercise Debriefing/Action Report

The Post Exercise Debriefing will commence immediately following the exercise. An Action Report will be completed and forwarded to the Director, CRHSSC for distribution.

Appendix A

Miawpukek First Nations (MFN)

Conne River Health and Social Services Centre's Community Care Plan for Highly Fatal Infectious Diseases

December 10, 2014

Miawpukek First Nation (MFN)

Miawpukek is the traditional Mi'kmaw name for our community. "Miawpukek" is used as the name of the community in most documents produced by Miawpukek First Nation (MFN) Government. Documents produced elsewhere most often uses "Conne River". The name means "Middle River".

Miawpukek became a permanent community sometime around 1822. Before 1822 it was one of many semi-permanent camping sites used by our people who were at the time still nomadic and traveling throughout the Mi'kmaq Domain of Newfoundland, Labrador, Quebec, New Brunswick, Nova Scotia, Prince Edward Island and Maine.

Miawpukek Reserve was established according to traditional oral history in 1870. It was officially designated as Samiajij Miawpukek Indian Reserve under the Indian Act in 1987. Most of the members, as of June 1985, are registered Indians. The ancestries of our community members include Mi'kmaq, Innu, Abenaki and European lines.

The membership of the Miawpukek community of Conne River is 787 on-Reserve and 1779 off-Reserve. Our total population on-Reserve as of August, 2006 is 867. (787 Native and approximately 80 non-Native).

Since being established as a reserve in 1987, Miawpukek has gone from a poor, isolated community with almost 90% unemployment to a strong vibrant community with nearly 100% full time/part-time employment. Miawpukek is one of two of the fastest growing communities in the province of Newfoundland and Labrador. We are often pointed to by Aboriginal Affairs as a model community for other First Nations.

The MFN's community of Conne River is located on the south coast of the island part of the province of Newfoundland and Labrador. By land the community is 224 km from the nearest service center, the international airport town of Gander. The community is accessible by land, air and water.

Conne River Emergency Health and Social Services Mandate

The Conne River All-Hazard Community Emergency Plan requires the Conne River Health and Social Services (CRHSSC) to develop, implement and test an Emergency Health and Social Services plan. This document describes the CRHSSC's plan in preparing for, mitigating against, responding to and recovering from a Highly Fatal Infectious Diseases such as the Ebola virus disease and as such should be read in conjunction with the overarching CRHSSC Emergency Plan.

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SECTION 1

1.1 Introduction

The CRHSSC acknowledges its role and responsibility in the event of a public health emergency that may impact the MFN's community of Conne River or the CRHSSC itself. In order to implement an integrated, comprehensive, and coordinated plan specific to managing Highly Fatal Infectious Diseases the CRHSSC will work closely with Central Health as well as Health Canada officials.

The purpose of this document is to guide the preparedness, response, mitigation, and recovery efforts of the CRHSSC to a public health emergency involving the need for isolation and/or quarantine to contain the spread of a highly fatal infectious disease. An adequate response will involve coordination of efforts of various associated agencies and community organizations. The goal of this preparedness and response is first to minimize serious illness and overall deaths and second to minimize societal disruption among residents of the community. Objectives to meet this goal include making recommendations for prevention and care as well as ensuring adequate surveillance capacity and appropriate communications are in place. This plan will be formally reviewed on an annual basis to ensure the incorporation of
all new developments and to ensure consistency with best practices.

1.2 Estimated Impact of a Highly Fatal Infectious Disease on the First Nations Community of Conne River and Central NL

The impact of such a highly fatal infectious disease is difficult to predict, and is dependent on how virulent the virus is, how rapidly it spreads from population to population, and the effectiveness of prevention and response efforts. Despite the uncertainty about the magnitude of such disease spread, estimates of the health and economic impact remain important to aid public health policy decisions and guide planning for health and emergency sectors. Therefore, it is essential that CRHSSC take a leadership role in supporting initiatives to mitigate against the risk of such a disease and to respond effectively and efficiently should a suspect or confirmed case present.

1.3 Roles and Responsibilities

The CRHSSC will work in conjunction with Central Health and the on-call Medical Officer of Health (MOH) contact number **1-877-709-0505** in all aspects of managing a suspect or confirmed highly fatal infectious disease and relying heavily on the lead direction from the MOH regarding clinical issues such as disease surveillance and overseeing the distribution of vaccines and antivirals, if applicable. The Director of the CRHSSC is responsible for mobilizing the contingency plans and resources and developing a cost estimate and options for decision making. Additionally, the Director

will also ensure staff become educated and promote measures to prevent disease transmission such as hand hygiene. Resources to facilitate these initiatives will be obtained through Central Health and Health Canada.

1.4 Assumptions and Considerations

The following assumptions provide a foundation for the action described in the CRHSSC Community Care Plan for Highly Fatal Infectious Diseases. The assumptions are based on historical experience, scientific knowledge, and expert consensus. They are also reflective of Central Health's planning assumptions.

- Index cases will be transported to a designated treatment site in St. John's.
- An Emergency Operations Centre (EOC) and approved governance structure (Incident Command System (ICS) will be immediately set up in the community where the index case is identified (suspect or confirmed).
- The CRHSSC where the index case is identified takes the lead in the coordination and implementation of the Public Health Measures and Community Care Plan.
- The CRHSSC will receive support from Central Health, provincial and federal agencies with public health expertise and responsibility.
- The provincial support team will be comprised of the MOH, the ADM of Population Health and/or the Director of Communicable Diseases, a provincial epidemiologist, an infection control specialist, a communicable disease control nurse specialist, and a communications advisor.
- The Public health Agency of Canada (PHAC) Response Team will consist of a physician expert in infectious diseases and outbreak management and an epidemiologist.
- At the time of the public health emergency, decisions and actions of international, federal, and provincial levels of government will influence the implementation of this plan.
- A provincial operational and logistics group will support the command center with on site IT, telecommunications and other logistical support.
- MFN, where the index case is identified, and where contact tracing and possible isolation of persons is occurring, will be engaged in the response.
- Supplies will be stockpiled at Central Health and will be dispensed to the CRHSSC, as required.
- In additional to the MFN Government's EOC, Central Health would also set up their Regional EOC to coordinate an appropriate regional response.
- Essential community services may be disrupted.

1.5 Planning Environment

To guide planning, the CRHSSC will focus on the periods of time before, during, and after a public health emergency. These periods will be referred to as Emergency Preparedness, Emergency Response/Mitigation and Emergency Recovery periods. To maintain consistency, CRHSSC's plan will focus on the key components of an all-hazards approach to emergency planning.

1. ***Preparedness*** refers to the period before an emergency is declared. It includes all the actions involved in anticipating the onset and in limiting the potential impact or repercussions – basically everything involved in getting ready to deal with an emergency.

2. ***Response*** activities refer to the actions that each division will engage in based on the pre-determined roles and responsibilities in a public health emergency. Response actions will start when there is a specific mandate to protect the health of the population, to provide clear, relevant, and mobilizing information, and to ensure people's psychosocial well-being is supported.

3. ***Mitigation*** refers to measures that the health centre can take in advance of a public health emergency in order to prevent, lessen or alleviate the impacts and overall outcomes of the event. These measures are longer term strategies that provide a strong foundation for successful emergency management.

4. ***Recovery*** consists of activities that assist the health centre's programs in the to return to normal modes of operation after an emergency.

1.6 Planning/Preparedness

The components for Planning/Preparedness of this plan include:

1.6.1 Public Health Measures

- Surveillance
- Contact Tracing and follow-up
- Community Emergency Planning and Response
- Vaccine Administration (if applicable)
- Antivirals (if applicable)
- Infection Control Measures
- Community Care
    - Needs for Daily Living
    - Communication

i. Surveillance

The objectives of the surveillance system are:

- To provide data on the current status of the infectious disease.
- To detect in a timely fashion the emergence of new cases and to monitor the spread and impact on the community of Conne River.
- To rapidly prioritize and maximize efficiency of surveillance activities.
- To communicate surveillance data in a timely manner to stakeholders within the region, province and country.

Surveillance responsibilities will be assigned to the community Public Health Nurse who will report all surveillance data to the Communicable Disease Control Nurse, Central Health.

ii. Contact Tracing and Follow-up

Active monitoring of community contacts of a viral disease occurs when a public health authority takes responsibility for establishing regular communication with potentially exposed individuals including such measures as checking daily to assess the presence of symptoms rather than relying solely on individuals to self-report symptoms if they develop. Persons involved in community contact tracing and follow-up should be trained so they are familiar with basic information on the viral disease, contact tracing, monitoring and follow-up procedure, and tools for contact tracing and required safety precautions.

Contact Tracing and Follow-up responsibilities will be assigned to the community Public Health Nurse who will maintain contact and obtain clinical support from Communicable Disease Control Nurse, Central Health.

iii. Community Emergency Planning and Response

The objectives of emergency planning and response are:

- Establish communications with local stakeholders.
- Enlist assistance of volunteer groups.
- Encourage collaboration between emergency response personnel and Central Health to ensure coordination of efforts.
- Ensure an Emergency Command System is developed.
- Facilitate ongoing training and education specific to emergency preparedness and response.
- Test and revise emergency response plans.

iv. Vaccine Administration (if applicable)

The objectives of a vaccine program are:

- To provide a safe and effective vaccine program, in corporation with Central Health, to the residents of Conne River as soon as possible.
- To allocate, distribute and administer vaccine as rapidly as possible to the appropriate groups of people.
- To monitor the safety and effectiveness of vaccination programs.

Vaccine Administration responsibilities will be assigned to the community Public Health Nurse (and other nurse, as required)who will deliver the vaccine program and obtain clinical support from Communicable Disease Control Nurse, Central Health.

v. Antivirals (if applicacble)

The objectives of intervention with antivirals are:

- To implement the recommended strategy for use of antivirals.
- To ensure the security and distribution of available anti-viral drugs to appropriate groups of people.
- To monitor and report adverse events and drug resistance.

AntiViral responsibilities will be assigned to the community Public Health Nurse (and other nurse, as required) who will deliver the antiviral program and obtain clinical support from Communicable Disease Control Nurse, Central Health.

vi. Infection Control Measures

Infection Control Measures is key to successfully managing a highly fatal infective disease and as such Personal Protective Equipment (PPE) and respective training are essential. PPE kits and training will be provided to the CRHSSC by Central Health. Coordination of the delivery of these services will be carried out by the Director of the CRHSSC and Regional Manager of Para-medicine Services and the Regional Infection Control Prevention Coordinator, Central Health.

vii. Community Care

Needs for Daily Living

During a public health emergency the needs of a community may vary. In the case of an emergency involving a highly fatal infectious disease it is anticipated that isolation and quarantine will be a factor Isolation separates sick people with a communicable disease

from well people. Quarantine involves the separation of a person who has been exposed to a communicable disease who is not yet ill until the longest incubation period has passed. Based on these definitions from the PHAC it is expected that quarantine may occur in private homes, in which case **alternate accommodations** may be needed for other family members and the person in quarantine will need food, medication, and other supplies delivered to them. **Psychological support, security** and **management of infected waste** may also be issues needing attention.

With regard to securing alternate accommodations for family members who require accommodations from a suspect or confirmed highly fatal infectious disease case the CRHSSC has access to the **Women's Shelter (Main floor -three bedroom house) and if required the basement (one bedroom apartment)** can also be available.

Psychosocial support will be available to all staff and members of the community, as required. Both alternate accommodations and psychosocial support (including Psychological First Aid, food and medication deliveries, if required) will be coordinated through the Case Management Social Worker.

Security services will be provided, as required by the RCMP. This will be coordinated through the Director of the CRHSSC.

Management of infected waste products will be coordinated by the Director of CRHSSC in consultation the Environmental Health and Safety Coordinator, Central Health.

Communication

The objectives of communication planning are:

- To identify specific activities to promote consistent, coordinated and effective public communications designed to retain public confidence, minimizing disruptions and anxiety.
- To clarify communications processes during a public health emergency.
- To coordinate communications activities during each phase of the public health emergency.
- To articulate CRHSSC's role during a public health emergency.
- To inform and educate the public regarding relevant information related to health and community services during each phase of the public health emergency.

The MFN Government's EOC is responsible for coordinating all communication during an emergency response. All internal and external information will be directed through the EOC. The Director of the CRHSSC will work with the General Manager (Incident Commander in activated EOC) and Communications Director (Chief's Assistant) for the

MFN Government and develop /implement a communications strategy to address the event.

SECTION 2

2.1 Preparation and Maintenance of CRHSSC Community Care Plan

The development and maintenance of the CRHSSC's Community Care Plan for Highly Fatal Infectious Diseases is the responsibility of the Centre's Director. This plan will be done in consultation with staff and officials from Central Health and Health Canada.

This plan will be formally reviewed on an annual basis to ensure the incorporation of all new developments and to ensure consistencies with informed practices. Evaluation and exercising components of the plan will be routinely carried out. Efforts are ongoing to establish a process for exercise development, implementation and evaluation.

2.2 Implementation of the CRHSSC Community Care Plan

The Director for the CRHSSC or designate may activate appropriate components of the Community Care Plan for Highly Fatal Infectious Diseases **(** e.g., Surveillance, Communications, etc.) based on a change in the situation. In the event that component/s or the entire Community Care Plan for Highly Fatal Infectious Diseases requires activation, the Director will assume the lead role in notifying key officials at Central Health and Health Canada as well as the General Manager for the MFN Government of the change in the situation and the implications related to same. The Director, in consultation with officials, will determine the requirement to convene the community EOC to manage and coordinate the event.

2.3 Activation of the MFN Government's Community Care Plan's Emergency Operations Centre

The MFN Government's EOC will be established to manage a coordinated response and recovery effort to a suspected or confirmed highly fatal infectious disease. The CRHSSC will be represented in an activated EOC (by the Director) and the implementation and evaluation of this plan will be coordinated through that representation.

Concept of Operations:

1. When the Community Care Plan is activated by the General Manager – Incident Commander (in consultation with the Director of the CRHSSC) the Emergency Operations Center may already be in place.

2. The Director of the CRHSSC will notify the Centre staff as well as the Regional HEM Coordinator, Central Health and Health Canada of the activation of the MFN Government's EOC and the implementation of the Community Care Plan.

3. The Director of the CRHSSC will oversee all aspects of the plans implementation and will work closely with the General Manager (Incident Commander) in the activated MFN Government's EOC.

5. The EOC shall employ the ICS structure to manage the MFN Government's response to a public health emergency.

6. Information sharing can flow between all members of the EOC and the stakeholders; however, all formal requests for assistance, resources, information or policy discussion must flow through the operations section of the EOC. Official reports must also flow through the operations section of the EOC.

7. At various points in the emergency, the EOC Team shall gather for debriefing and preparation of a post event debriefing report. This report will aid refinement of CRHSSC's future emergency management capability.

2.4 Emergency Operations Center Location/s

The primary location for the EOC is the **Great Hall of the Administration Building. St. Ann's School and the Mikmaq Discovery Centre being the alternate sites.** This location has required computer and telephone connections as well as a breakout room.

2.5 Termination of the Community Care Plan /Deactivation of the Emergency Operations Centre

The General Manager (Incident Commander), in consultation with the Director of the CRHSSC will advise termination Community Care Plan or components of the plan when:

i. The public health emergency is declared over by Provincial Medical Officer of Health, and

ii. Local impact has diminished to a level where normal services may be resumed.

If a local emergency was declared, the MOH will recommend to the Director of the CRHSSC that the response phase of the Community Care Plan be terminated. The Director will advise the General Manager (Incident Commander) of this decision and will

notify the staff at the CRHSSC and assist with the notification of community residents of the plans' termination and future actions, as required.

The General Manager (Incident Commander) will direct the communication to response agencies and stakeholders of the termination of the response plan. Once the determination is made by the General Manager (in consultation with the Director of the CRHSSC) that the response and recovery efforts no longer requires an activated EOC, the General Manager (Incident Commander) will deactivate the EOC.

PROTOCOL WHEN SUSPECTED EBOLA PATIENT PRESENTS AT THE CRHSSC

START:
Patient presents at CRHSSC

Triage Patient:
Patient is symptomatic and has travelled to affected country (Liberia, Serria, Leone, Guniea)

Isolate Patient
(Nurse Practitioner's Exam Room)

Attending Physician/NP notifies Medical Officer of Health (MOH) On-Call 1-866-270-7437

Attending Physician /NP notifies Director of CRHSSC. Director notifies the General Manager will activate EOC to manage event.

MOH Completes Risk Assessment

END:
Not Suspect Case

Suspect Case

MOH On-Call Notifies Chief MOH & ADM-Population Health

Activated EOC
Information Officer to contact Chief & Council, Dir of CRHSSC to contact Central Health

MOH On-Call Notifies Medical Communications Centre 1-877-709-0505

MOH On-Call asks for Air Dispatcher and request activation of the Containment & Transport Team

Containment & Transport Team

Site Attending Physician/NP and Receiving Physician-HSC (Members of the Containment & Transport Team) Coordinate Patient Transfer with Central Health (ambulance services) identifying transfer plan.

Director of CRHSSC will ensure that Psychosocial Support Services are in place throughout the response and recovery phases.

Containment & Transport Team

On-Call MOH, Site Attending Physician, Receiving Physician (HSC), Emergency Medical Services (EMS), On-line Medical Control Physician, Eastern Health (CH) Clinical Chiefs or designate-IC and ICU, Manager of OHS (EH) and Director of Infection, Protection &Control (EH)

Location of PPE: Nurse Practitioner's Office (next to doctor's office)

Immediate Staffing Response: NP transports patient to designated treatment room and begins notification process. Calls back alternate NP and/or PHN and other staff as needed to cover and help deal with the situation as per protocols. Director of CRHSSC or alternate is notified of suspect case.

Appendix C

Central Health's Public Health Measures and Community Care Plan for Highly Fatal Infectious Diseases

Under Development

Appendix D EBOLA FACT SHEET

What is EBOLA?

Ebola Virus disease (EVD) formally known as Ebola hemorrhagic fever, is a severe, often fatal illness in humans. It is transmitted by direct contact with the infected person or their blood, body fluids / secretions and by medical equipment contaminated with EVD or direct contact with infected animals. Handling of deceased bodies has also been linked to transmission. Airborne transmission has not been documented in previous outbreaks.

Signs and Symptoms

EVD is a severe acute viral illness often characterized by sudden onset of fever, intense weakness, muscle pain, headache and sore throat. This is followed by vomiting, diarrhea, rash decreased kidney and liver functioning and in some cases internal and external bleeding.

Are Certain People at Risk for EBOLA?

People at risk for EBOLA would have clinical illness (see signs and symptoms above) AND one of the flowing:

- Travel to an affected country
- Contact with a suspect or probable case
- Direct contact with blood, body fluid secretions of an suspect or confirmed infected person or animal
- Work in a lab or animal facility that handles hemorrhagic fever viruses

How can we stop the spread in hospital?

- Symptomatic patients must be given a surgical mask to wear and be placed in an isolation room
- In addition to Routine Practices add **Contact** and **Droplet Precautions**
- If an **Aerosol generating procedure** must take place use **Airborne Precautions**
- Keep door closed and a log of all who enter (essential staff only), have someone monitor use of PPE (Protective Personal Equipment)
- **Visitors only in exceptional circumstances –** Must be instructed in PPE and provided info on EVD
- Medical equipment to be dedicated to patient
- When handling linen or cleaning room wear recommended PPE -- Note gown must be impermeable and disposable. Used approved hospital grade disinfectants to clean equipment.

- **Blood samples taken from patients are an extreme biohazard risk. Staff must immediately notify The Medical Officer of Health and Infection Control Prevention and Control.**