

Pandemic Influenza Business Continuity Plan

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Brain Injury Services of would like to extend its gratitude to the following individuals for their contribution in developing the Pandemic Influenza Business Continuity Plan

**Julia Pemberton, BSc Community Health Sciences
McMaster University**

**Stephanie Trowbridge, RegN CIC
Infection Control Practitioner
St. Joseph's Healthcare**

**Connie Verhaeghe
Emergency Response/Pandemic Influenza Coordinator
Public Health Services Department**

Patricia Fryer & Associates Inc.

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1.0 BACKGROUND

Influenza pandemics arise when a “novel” influenza virus emerges, infects humans, spreads efficiently and sustains among them. Once such an event starts and reaches a certain level of local or regional spread, continued worldwide spread of the virus is considered inevitable. A novel human influenza virus can start as a purely avian influenza virus that adapts, through gradual mutation, to humans or as a hybrid influenza virus that contains a combination of genes derived from both an avian and a human influenza virus. Regardless of its origin, such a virus is termed “novel” because it has not circulated widely among humans in the recent past, leaving most people with no pre-existing immunological protection against the virus.

Influenza A viruses periodically cause worldwide epidemics, or pandemics, with high rates of illness and death. A pandemic can occur at any time with the potential to cause serious illness, death, and extensive social and economic disruption throughout the world. Experts agree that future influenza pandemics are inevitable, but the timing and severity of the next pandemic cannot be predicted. Because there may be little warning, contingency planning is required to minimize the potentially devastating effects of an influenza pandemic.

In nature there are 16 different haemagglutinins and 9 different neuraminidases, which are two important surface glycoproteins of the influenza A virus. Influenza virus subtypes are named according to these “H” and “N” proteins. Although all 16 of the H types can infect birds, to date only H1, H2 and H3 have been associated with widespread human disease and H5, H7 and H9 have demonstrated the ability to cause human disease. It is important to recognize that, as birds are the natural reservoir for these influenza viruses, occasionally people who have close contact with infected birds will become infected with novel viruses. Not all novel viruses, however, will evolve into pandemic viruses; nevertheless, the pandemic potential of any new virus must be considered.

The following conditions are **necessary** for an influenza pandemic to occur:

- A new influenza A virus from a major genetic change, i.e. an antigenic shift;
- A virulent virus with the capacity to cause serious illness and death;
- A susceptible population with little or no immunity; and
- A virus that is transmitted efficiently from person to person.

1.1 GOALS/OBJECTIVES

The goals of influenza pandemic preparedness and response are:

First, to minimize serious illness and overall deaths; and, second, to minimize societal disruption among Brain Injury Services employees/clients/volunteers/students and visitors as a result of an influenza pandemic. The response to an influenza pandemic is based upon Brain Injury Services' ethical values (privacy, respect, dignity towards all).

These goals will be realized only through the coordinated efforts of all levels in planning and preparation.

The objectives of Brain Injury Services are to assist and facilitate appropriate planning and response at all levels by:

1. Developing a plan that is sufficiently flexible to account for the unknown epidemiology of a pandemic and the needs of the parties directly involved with Brain Injury Services;
2. Recommending planning considerations for the appropriate prevention, care and treatment during a pandemic;
3. Recommending planning considerations for appropriate communications, resource management and preventive measures;
4. Providing a plan that is reviewed on an annual basis to ensure the incorporation of new developments and to ensure consistencies with best practices; and
5. Providing an evaluated plan that is sufficiently clear and comprehensive to ensure operational viability.

1.2. STRUCTURE OF THE PLAN

The plan consists of Background, Preparedness/Awareness, Response and Recovery/Debriefing. The Background Section provides the conceptual and historical basis for the plan. The Preparedness/Awareness, Response and Debriefing/Recovery Sections reflect the general principals of response. Under this framework, the types of preparedness and response activities needed for comprehensive pandemic planning can be summarized as follows:

Prevention activities include:

1. Planning actions to ensure that all existing, known or unavoidable risks are contained.
2. Recommendation of immunizations with vaccines (e.g., Influenza Vaccine in the Alert and Interpandemic Period and the Pandemic Influenza Vaccine once it becomes available) in conjunction with infection prevention and control recommendations (e.g. limiting contact if symptomatic, surveillance of employees/clients/visitors for symptoms or diagnosis).
3. Training employees to consistently utilize Personal Protective Equipment, Routine Practices and Additional Precautions.
4. Providing clients and families with information regarding infection prevention and control, hand hygiene and emergency planning.

Preparedness activities include:

1. Education on Pandemic Influenza; preparedness initiatives for Brain Injury Services' employees and clients and personal preparedness.
2. Preparation of the actual plan.
3. Implementation of Infection Prevention and Control Program; including employee training, resource manual, documentation, policies and procedures
4. Training and simulation exercises to pre-test the plan.
5. Communications and other interfaces to inform the public, employees/volunteers and clients.

Mitigation/Response activities include:

1. Containment strategies to prevent and control the transmission of Influenza within Brain Injury Services locations.
2. Implementation of these containment strategies resulting in a series of escalating and potentially varying (but harmonized) responses as the pandemic unfolds across the community.
3. Documentation of activities and outcomes to determine if a more extensive response is required or if adjustments to the planned response are necessary.

Recovery activities include:

1. Organization of post-event activities to ensure restoration of “normal” interpandemic services and service levels.
2. Discontinuation of employee relocation, alternative care sites, phasing out alternate care workers, and introduction of new services that may be required to address the impact.
3. Continuation of activities until the declaration of the end of the pandemic wave by the Ministry of Health, and/or Public Health Services.

Note: the pandemic Influenza may come in waves; therefore, what we learn during the recovery period allows us the opportunity to get ready and respond to the next wave.

1.3 EXTERNAL ROLES AND RESPONSIBILITIES

In general, the roles and responsibilities of the respective jurisdictions are as follows:

- The federal government, through Public Safety and Emergency Preparedness Canada, is responsible for the nationwide coordination of the pandemic influenza response, including surveillance, international liaison and coordination of the vaccine response.
- The federal and provincial Ministers of Health will ensure the distribution of plans to all organizations that may be involved in the pandemic response and liaise with these organizations on an ongoing basis.
- The Government of Ontario is responsible for mobilizing their contingency plans and resources. Health emergency response commences at the local level and moves up the line to the provincial level, and then to the federal level of government.
- Local public health authorities are responsible for planning local responses to an influenza pandemic with direction from both the provincial and federal levels. This involves liaising with local stakeholders (e.g. emergency responders, hospitals, mortuary services) in advance of a pandemic to facilitate a coordinated response if pandemic influenza strikes a community. It is likely that the local public health authorities, through existing or enhanced surveillance, may be the first ones to detect influenza in their communities. It is essential that the lines of communication in communities, and up the line to the provincial and federal levels, are clear and established in advance of a pandemic.

1.4. KEY CONCEPTS

Rapid response. This refers to rapid assessment and response of any kind after possible early pandemic activity has been detected.

Rapid containment. This refers specifically to the attempt to stop further spread of an emerging pandemic virus.

World Health Organization (WHO) Global Phase. Canadian Activity Level

The WHO Phase number reflects the international risk or activity level with respect to the new influenza subtype virus (i.e. Phases 1 to 6) and is determined by the WHO. The Canadian activity level indicator noted after the decimal point would likely be determined by the Pandemic Influenza Committee (PIC) and/or the Public Health Agency of Canada (PHAC) and would summarize the observed new influenza virus subtype activity in Canada. It is proposed that these levels be classified as follows:

- 0 – No activity observed in Canada,
- 1 – Single case(s) observed in Canada (i.e., no clusters), and
- 2 – Localized or widespread activity observed in Canada.

Within the Brain Injury Services community, the levels will correspond to the following:

- GREEN:** 0-No level observed; MILD
- YELLOW:** 1-Single case(s) observed in client community, but no clusters; MODERATE.
- RED:** 2-Localized or widespread activity observed within a closed community, or between client communities; SEVERE.

Pandemic Phases and Examples with Corresponding Brain Injury Services' Levels and Examples (denoted by heading colour)

Note:

The phase terminology used reflects the epidemiological situation and the key objectives of the pandemic response but does not necessarily reflect the level of activation of emergency operations within Brain Injury Services or the province/country.

The agency will implement the levels as applicable to ensure the safe operation of agency business and may use its discretion in the implementation of this plan and the procedures wherein.

A) Interpandemic Period

Phase	Definition	Example(s)
1.0	No new virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals located outside of Canada. If present in animals, the risk of human infection and/or disease is considered to be low.	Highly pathogenic H7N3 detected in poultry outside of Canada. No clients, client's friends/families, employees or volunteers are infected.
1.1	No new virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection is present in animals in Canada but the risk of human infection and/or disease is considered to be low.	Highly pathogenic H7N3 detected in a poultry flock in Canada No clients, client's friends/families, employees or volunteers are infected.
2.0	No new virus subtypes have been detected in humans. However, an animal influenza virus subtype that poses substantial risk to humans is circulating in animals located outside of Canada.	Highly pathogenic H5N1 detected in poultry flocks outside of Canada No clients, client's friends/families, employees or volunteers are infected.
2.1	No new virus subtypes have been detected in humans. However, an animal influenza virus subtype that poses substantial risk to humans is circulating in animals in Canada.	Highly pathogenic H5N1 detected in poultry flocks in Canada No clients, client's friends/families, employees or volunteers are infected.

B) Pandemic Alert Period

Phase	Definition	Example(s)
3.0	Outside Canada human infection(s) with a new subtype are occurring, but no human-to-human spread or, at most, rare instances of spread due to a close contact have been observed. No cases identified in Canada.	<p>Outside Canada sporadic human cases are occurring in connection to an avian outbreak.</p> <p>No clients, client's friends/families, employees or volunteers are infected.</p>
3.1	Single human case(s) with a new subtype detected in Canada. The virus is not known to be spreading from human-to-human or, at most, rare instances of spread to a close contact have been observed.	<p>Case imported into Canada from area outside Canada experiencing an avian outbreak. Case arising in Canada "de novo" or in association with an avian outbreak in Canada.</p> <p>No clients, client's friends/families, employees or volunteers are infected.</p>
4.0	Outside Canada small cluster(s) with limited human-to-human transmission are occurring but spread is highly localized, suggesting that the virus is not well adapted to humans. No cases identified with these cluster(s) have been detected in Canada.	<p>Outside Canada small cluster(s) of human cases with a novel virus are occurring in connection to an avian outbreak.</p> <p>No clients, client's friends/families, employees or volunteers are infected.</p>
4.1	Single human case(s) with the virus that has demonstrated limited human-to-human transmission detected in Canada. No cluster(s) identified in Canada.	<p>Detection of an imported case in Canada that is infected with the novel virus known to be causing small clusters of human cases outside Canada.</p> <p>No clients, client's friends/families, employees or volunteers are infected.</p>

Pandemic Alert Period

<p>***4.2</p>	<p>Small localized clusters with limited human-to-human transmission are occurring in Canada but spread is highly localized, suggesting that the virus is not well adapted to humans.</p>	<p>Detection of a localized cluster of cases in Canada linked to an imported case or from cases arising in Canada.</p> <p>Infection affects a client or friend/family of client, employee or volunteer.</p>
<p>5.0</p>	<p>Outside Canada larger cluster(s) are occurring but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk). No cases identified with these clusters have been detected in Canada.</p>	<p>Outside Canada larger cluster(s) of human cases with a novel virus are occurring.</p> <p>Infection affects a client or friend/family of client, employee or volunteer.</p>
<p>5.1</p>	<p>Single human case(s) with the virus that is better adapted to humans detected in Canada. No cluster(s) identified in Canada.</p>	<p>Detection of an imported case in Canada that is infected with the virus known to be causing larger clusters of human cases outside Canada.</p> <p>Infection affects a BIS client or friend/family of client, employee or volunteer.</p>
<p>5.2</p>	<p>Larger localized cluster(s) with limited human-to-human transmission are occurring in Canada but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk).</p>	<p>Detection of a large but localized cluster of cases in Canada linked to an imported case OR from cases arising in Canada.</p> <p>Infection affects a BIS client or friend/family of client, employee or volunteer.</p>

***** Upon reaching phase 4.2, Brain Injury Services will start the screening process, communication plan and there will be no new admissions. However, some or all of these procedures may, at the discretion of the agency, be enacted within other stages of the pandemic plan if deemed necessary to ensure the safe operation of the agency. The duration of some or all of these procedures will depend upon the direction of officials (e.g. Public Health, WHO) and impact the pandemic has had on the agency.**

C) Pandemic Period

Phase	Definition	Example(s)
6.0	Outside Canada increased and sustained transmission in the general population has been observed. No cases have been detected in Canada.	Countries outside of Canada have reported sustained transmission of the new virus in their populations. Infection affects a client or friend/family of client, employee or volunteer.
6.1	Single human case(s) with the pandemic virus detected in Canada. No cluster(s) identified in Canada.	Detection of an imported case in Canada that is infected with the pandemic virus. Infection directly impacts Brain Injury Services or the extended community.
6.2	Localized or widespread pandemic activity observed in the Canadian population.	Large numbers of clinical cases being rapidly identified in Canada with no history of travel to an affected area. Infection directly impacts Brain Injury Services or the extended community.

D) Pandemic Waves

Defined as the interval between waves or the onset of a second pandemic wave. Regional and local influenza activity will be communicated as sporadic, localized or widespread; these terms are similar to current national surveillance (FluWatch) terminology.

E) Post-Pandemic Period

A recovery period would be expected to occur following Phase 6 (i.e. the Pandemic Period) after which there would be a return to the Interpandemic Period (e.g. Phase 1 or 2). Indicators for the return to the Interpandemic Period will be likely based on epidemiologic indicators (e.g. the return of annual fall–winter cycle of influenza activity, fatality rates) rather than on a “return to normal” of societal or economic indicators.

Brain Injury Services will resume admissions and stop screening at this period or may at its discretion, cease these procedures when deemed appropriate to resume safe agency operation.

2.0 PREPAREDNESS/AWARENESS

The objectives of Brain Injury Services' plan are to:

- Identify issues that will require multi-level collaborative planning during the Interpandemic Period.
- Facilitate awareness of the potential impact of a pandemic on Brain Injury Services.
- Prepare resources and guidelines that may be adapted during a pandemic.

2.1 Infection Prevention and Control and Occupational Health

The incubation period for influenza usually ranges from 1 to 3 days. Person-to-person transmission of the influenza virus occurs through droplets from the respiratory tract that are spread by direct contact, through coughing or sneezing, or by hands (or other surfaces) contaminated with respiratory secretions. The importance of the airborne route in transmission is unknown. Influenza is highly contagious; it can spread quickly in settings where large groups of people (e.g. institutionalized populations) are gathered together.

The period of communicability for influenza is during the 24 hours before the onset of symptoms and during the most symptomatic period, usually 3 to 5 days from clinical onset in adults and up to 7 days in young children. Although viral shedding occurs in the 24 hours prior to symptom onset, transmission of the virus to another person is much more efficient once symptoms are present. In adults, the amount of viral particles shed (e.g. while sneezing or coughing) is related to the severity of illness and temperature elevation.

Survival of the influenza virus outside the body varies with temperature and humidity. It generally survives 24 to 48 hours on hard, non-porous surfaces; 8 to 12 hours on cloth, paper and tissue; and 5 minutes on hands. Survival of the virus is enhanced under conditions of low humidity and in cold temperatures.

2.2 Preparedness and Surveillance Resources

The following are some of the preparedness/awareness resources:

- Local and Provincial Surveillance Roles and Responsibilities
- Brain Injury Services Pandemic Influenza Preparedness Policy
- Brain Injury Services Pandemic Influenza Communication Plan
- Pandemic Influenza Preparedness Plan Client Illness
- Pandemic Influenza Preparedness Plan Employee Illness
- Brain Injury Services Organizational Chart
- Emergency Supply List for Residential Programs
- External Services/Resources
- Screening template
- “Sign In/Out” template
- Signage – for all types of exposure risk, additional precautions
- Outbreak Checklist/Client Confirmed Diagnosis Procedure Checklist
- Area Cleaning/Disinfection Check
- Employee Information Exchange Checklist
- Appointment Summary Report
- Evacuation and Emergency Response Report
- Green memos
- Client Incident Report
- Employee Hazard Incident Accident Reports
- JOHSC minutes and quarterly data
- IPAC Committee minutes and quarterly data

3.0 RESPONSE

It is highly recommended that Brain Injury Services employees be vaccinated once the Pandemic Influenza Vaccine becomes available. The agency will consider the recommendations of the WHO and Public Health in its expectations of community vaccination and, as a result, may stipulate that if an employee refuses to take the vaccine or a medically identified alternative prophylaxis, he or she may be placed on a leave of absence and paid in accordance with the provision of the sick leave policy.

The direction of the local Public Health Services is fundamental to the implementation of the Brain Injury Services Pandemic Influenza Business Continuity Plan; therefore, communications need to be clear and ongoing at all times.

3.1 Procedure for Plan Implementation

1. Management will notify the chief executive officer of any concerns or information relating to a potential pandemic. This will be based on the identifying criteria presented in this manual.
2. Upon medical confirmation of the pandemic influenza virus, the chief executive officer will initiate the Brain Injury Services Pandemic Influenza Business Continuity Plan and notify the Board of Directors. The chief executive officer or delegate will also consult with Public Health Services. This decision will be made within a timely manner of 24 hours from first notification, and will be considered a priority by the board of directors.
3. Employees, clients, families and stakeholders will be immediately notified of the initiation of the pandemic plan. In accordance with the communication plan, the administrative employees of Brain Injury Services will carry this out via telephone, email and/or website. Employees will document in the communication log all contacts made.
4. Visitors considered as contacts (i.e. contact with the index case in the previous three days, or as recommended by the Public Health Services), and have recorded their names in the Sign In/Out Book will be notified of their contact with the index case. These people will be advised by Public Health Services regarding recommendations to prevent and contain influenza.
5. Once the pandemic plan is initiated, group services will close. Group services employees will maintain contact with clients by telephone or email and information posted on website. Ongoing contact with clients will be determined by individual need upon initial contact. The decision will come from the chief executive officer and be implemented by the Brain Injury Services administration employees.

6. Outreach services employees will continue to visit clients in the community using routine practices and additional precautions as required (gowns, gloves, respirators, masks). If a client is suspected to have or confirmed to have the pandemic virus, employees will encourage and recommend that the client receive medical care, and thereafter, site visits will be discontinued and follow-up support offered by telephone or email as needed. When confirmed, this information will be communicated within 12 hours to the first available person of management, who will then contact the chief executive officer. Surveillance of the clients and service team will be implemented.
7. If an employee in outreach services is suspected to have or confirmed to have the pandemic virus, the employee will notify his or her supervisor, refrain from coming to work, and seek medical testing and treatment. Any positive results will be reported to the employee's direct supervisor within 12 hours of confirmation. Once the laboratory receives confirmation of a positive lab result these will automatically be reported to the Public Health Services. Surveillance of the clients and service team will be implemented.
8. Employees in residential services will use routine practices and additional precautions as required (gowns, gloves, respirators, masks). If a residential client is suspected to have or confirmed to have the pandemic virus, the client will be isolated to his/her room and medical care will be arranged by employees. Community outings will be discontinued for all clients and access to visitors and non-essential employees will be assessed. The residence will initiate isolation procedures or procedures as directed by Public Health. Signage will be posted providing instructions for contact. Employees will monitor supplies and reorder as necessary. The supervisor will contact the chief executive officer immediately upon receiving this information. The chief executive officer or delegate will contact public health. Surveillance of the clients and service team will be implemented.
9. If an employee in a residential service is suspected to have or confirmed to have the pandemic virus, the employee will notify his or her supervisor and refrain from coming to work. The residence at which the employee worked may be required to initiate isolation procedures or procedures as directed by Public Health and access to visitors and non-essential employees may be assessed. The supervisor will contact the chief executive officer immediately upon receiving this information. The chief executive officer or delegate will contact public health. Surveillance of the clients and service team will be implemented.
10. Front-line employees are expected to report for their scheduled shifts as expected. Employees will be deployed across the agency to support other services if necessary. Consideration will be given to employees' cultural preferences and beliefs. Employees are expected to report to their duties as scheduled.

11. Management and administrative employees will ensure that the necessary operational practices continue and that the organization meets its obligations to its employees and stakeholders. The succession plan will be utilized to ensure all positions are covered during the absence of any manager/supervisor.
12. Volunteers and/or students will be notified of the pandemic plan and can choose to be used to support clients or the administrative function of the organization as appropriate.
13. Regular ongoing communication with employees, clients, families and stakeholders will ensure that all are aware of the current situation within the organization. Communication will be maintained through phone calls, emails and/or website updates.
14. The chief executive officer, on the advice of Public Health Services, will notify employees, clients, families and stakeholders of the commencement of the post pandemic phase (termination of the pandemic plan).
15. Within one week of the post pandemic phase, employees will be offered the opportunity to debrief with each other, supervisors, director rehabilitative services and chief executive officer. Counseling will be available through the organization's employee assistance program and employees will be encouraged to access all necessary supports. Clients will also be offered debriefing from employees and the agency counselor/psychologist.
16. A post-pandemic committee consisting of the chief executive officer, director rehabilitative services, and at least one employee from each service will be convened to evaluate the organization's performance in implementing the processes required in the pandemic plan. Revisions to the plan will be made as indicated. Emergency supplies will be replenished within three weeks. Communication and debriefing will be completed with all Brian Injury Services employees. A written report based on the pandemic experience will be completed within three months of the committee meeting.

4.0 RECOVERY/DEBRIEFING

In the post-pandemic period, the following checklist should be used to help evaluate the process, the response, and the outcomes as suggested by the Canadian Pandemic Influenza Plan.

- ❑ Convene a post-pandemic planning committee within one month of the termination of the pandemic plan. The committee will be comprised of the chief executive officer, director rehabilitative services and representation from management, and at least one employee from each service.
- ❑ Request client feedback at each site during client meetings and/or with individual debriefing.
- ❑ Evaluate the organization's performance during the pandemic through whatever means are necessary. This may include but is not limited to, employee and/or management interviews, client and families' feedback, documentation reviews, and stakeholder interviews.
- ❑ Submit the findings of the committee as a written report to the board within three months of the termination of the pandemic plan. The report will outline strengths, shortcomings and problems as well as recommended areas for improvement. Review and revise (if necessary) pandemic response guidelines.
- ❑ Replenish all emergency supplies.
- ❑ Update educational materials.
- ❑ Resume routine public health activities and programs.
- ❑ Promote immunization for influenza and other secondary infections observed during the pandemic (if appropriate and applicable).
- ❑ Disseminate all revised guidelines to appropriate stakeholders.
- ❑ Provide recommendations for routine prevention and control including recommendations for any control measures other than vaccines and antivirals.
- ❑ Provide lessons learned for Brain Injury Services and the public and prepare for the next outbreak or exposure. Post the report on the website.

4.1 Employee Debriefing

- ❑ The chief executive officer and director rehabilitative services will ensure that all agency employees have an opportunity to discuss their experience within one week of the termination of the pandemic plan.
- ❑ Employees will be invited to share their experiences that occurred during the pandemic and offer feedback regarding the administration of the plan, the care provided to the clients, and the expectations of and supports available to employees.
- ❑ Group sessions with employee assistance program counselors will be scheduled for interested employees.
- ❑ Program managers/supervisors will be available to provide ongoing debriefing and support to employees.
- ❑ Employees will be invited to participate as members of the post-pandemic planning committee.

5.0 REFERENCES

Pandemic Plans (Ontario, Canada, WHO)
Public Health Agency of Canada
<http://www.phac-aspc.gc.ca/influenza/plans-eng.php>

Centre for Emergency Preparedness and Response
<http://www.phac-aspc.gc.ca/cepr-cmiu/index-eng.php>

Canada Communicable Disease Report (CCDR)
<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/>

Hamilton Public Health Surveillance Unit
<https://www.hamilton.ca/public-health>

Flu Watch-Government of Canada
<http://www.phac-aspc.gc.ca/fluwatch/index.html>

6.0 CONTACTS:

Government Resources

Public Health Agency of Canada 1-844-280-5020

Public Health Ontario 1-877-543-8931

Public Health Units: Hamilton 905-546-2424/ 905-546-2063
Haldimand/Norfolk 519-426-6170
Niagara 905-688-8248 ext. 7330/1-888-505-6074

Ministry of Health and Long-Term Care
1-866-212-2272

Hamilton Surveillance Unit
City of Hamilton, Public Health Services
Surveillance Unit
110 King St. W 4th floor
Hamilton, ON
Phone: 905-546-2424 Ext. 7116
Fax: 905-546-4078
Email: surveillance@hamilton.ca

Ministry of Health and Long-Term Care
Emergency Management Branch
1075 Bay Street, Suite 810
Toronto, Ontario
Canada M5S 2B1
1-866-212-2272
Fax : 416-212-4466
TTY : 1-800-387-5559
E-mail : emergencymanagement.moh@ontario.ca

Telehealth Ontario
1-866-797-0000

Ontario Ministry of Health INFOLine (ServiceOntario)
INFOLine would direct callers to the appropriate information source for health information.
1-866-532-3161 (Toll-free in Ontario only)
in Toronto, call 416-314-5518
TTY 1-800-387-5559

Canadian Centre for Occupational Health and Safety
<http://www.ccohs.ca/pandemic/subject.html>

TABLE 1. SURVEILLANCE ROLES AND RESPONSIBILITIES

Party	Roles and responsibilities
PHAC	Collaborate with provinces and territories to determine core data elements Disseminate Canada-wide ILI activity information Identify circulating virus strains and antiviral resistance through the National Microbiology Laboratory (NML) Through the FluWatch program, collect sentinel health care provider ILI data and share with respective province/ territory, as well as publish in the FluWatch report Issue national Public Health Alerts to share information with public health professionals across the country
MOHLTC ₂ (through the Ministry Emergency Operations Centre (MEOC))	Collaborate with PHO to develop the provincial surveillance strategy Receive surveillance information from PHO Communicate surveillance information to health system partners through situation reports, Important Health Notices (IHNs) and other methods Communicate surveillance information to the public through media briefings, the MOHLTC website and other methods Collaborate with PHO to use surveillance information to determine severity
PHO (through the MEOC)	Collaborate with the MOHLTC to develop the provincial surveillance strategy Lead and communicate the provincial surveillance strategy Perform provincial surveillance data analysis and interpretation Support the MOHLTC to use surveillance information to determine severity Receive and consider analytic and interpretive input from PHUs Engage and collaborate with infectious disease modellers

	<p>Collect, analyze, report and communicate surveillance information through the Ontario Respiratory Virus Bulletin and the Monthly Infectious Diseases Surveillance Report</p> <p>Communicate PHOL testing recommendations and response strategies through Labstracts</p> <p>Identify type, subtype and antiviral resistance of circulating influenza viruses in collaboration with the NML</p> <p>Organize and implement special research studies in consultation with the MOHLTC</p> <p>Monitor for virus mutations</p> <p>Report Integrated Public Health Information System (iPHIS) data to PHAC</p>
PHUs3	<p>Collect local data as per the provincial surveillance strategy</p> <p>Lead and implement local surveillance initiatives</p> <p>Report local data to PHO and contribute any analytic or interpretive insights to the MOHLTC and PHO</p> <p>Analyze, report and communicate local surveillance information to local health system partners</p> <p>Interpret provincial, national and international data for relevance to the local context and communicate this information to local health system partners</p> <p>Facilitate the collection of samples during institutional outbreaks</p>
Long-term care homes and other institutions	<p>Report respiratory infection outbreaks and laboratory-confirmed cases of influenza to the MOH as required by the HPPA</p> <p>Report respiratory infection outbreaks to the Director of the MOHLTC's Performance Improvement and Compliance Branch as required by the Long-Term Care Homes Act</p>
Hospitals	<p>Report respiratory infection outbreaks and laboratory-confirmed cases of influenza to the MOH as required by the HPPA</p> <p>Report data on critical care clients/ patients/ residents (C/P/Rs) through the Critical Care Information System (CCIS)</p>

If participating in an emergency department syndromic surveillance strategy, report data

Primary health care providers

Report laboratory-confirmed cases of influenza to the MOH as required by the HPPA
If a sentinel health care provider, report ILI rates to the national FluWatch program and/or collect respiratory samples from clients/ patients with ILI symptoms as part of the Sentinel Vaccine Effectiveness study

Schools with the support of Boards of Education

Report student absenteeism to the PHU based on local arrangements

2 Throughout the OHPIP, the MOHLTC includes the Minister, the Chief Medical Officer of Health and the rest of the MOHLTC. For information on how decisions are made in the MOHLTC during an emergency, see the [Ministry Emergency Response Plan](#).

3 Throughout the OHPIP, PHU includes boards of health, medical officers of health (MOH) and other PHU health workers (e.g., public health inspectors, epidemiologists, public health nurses, etc.). See the Health Protection and Promotion Act (HPPA) and Ontario Public Health Standards for more information on the roles and responsibilities of various PHU parties.

Emergency Supply List - Residential Programs

Supplies to be checked and purchased as required every year in April and October

Food (enough for approximately 10 days – purchase the following items or some variation of the listed items to meet client needs):

- 8 Pasta sauce (28oz cans)
- 20 Single serving instant soup mixes
- 40 Single serving fruit cups
- 4 Boxes instant potato
- 20 Canned Meat
- 10 Canned Fish
- 10 Canned beans
- 15 Canned prepared pasta/chili
- 10 Applesauce (500ml/19oz jars)
- 2 Liquid honey (500g bottles)
- 2 Arrowroot cookies (1.4kg boxes)
- 40 Packets drink crystals including Gatorade
- 20 Assorted vegetables (398ml/14oz cans)
- 5 Tomato juice (1L cans)
- 2 Boxes powdered milk
- 10 Boxes Kraft Dinner
- 2 Breakfast cereal (1.4kg boxes)
- 1 Box assorted Quaker instant oatmeal (48 packets)
- 20 Soup – prepared no water required (28oz/796ml cans)
- 2 Boxes soda crackers
- 5 Pasta noodles (1 lb bags)
- 4 Cases bottled water (192 bottles)

PPE and Infection Prevention/Control Supplies (4 weeks worth):

- 2 Cases extra large vinyl gloves (10 boxes x 100 gloves per box)
- 2 Cases large vinyl gloves (10 boxes x 100 gloves per box)
- 2 Cases medium vinyl gloves (10 boxes x 100 gloves per box)
- 2 Cases small vinyl gloves (10 boxes x 100 gloves per box)
- 2 Cases surgical masks
- 2 Cases paper disposable gowns
- 4 Cases plastic disposable gowns
- 2 Reusable Yellow Aprons
- 10 Pairs of goggles
- 4 Boxes face shields
- 12 Bottles/dispenser refills of Purell alcohol hand gel
- 4 Cases incontinent briefs - 2 large (160 briefs), 2 medium (180 briefs)
- 2 Cases Disposable Bed Pads
- 2 Cases black garbage bags (2x150)
- 2 Cases black/white small garbage bags (2x250)
- 4 Cases yellow garbage bags (4x250)
- 2 4L jugs disinfectant/cleaner
- 4 Containers disposable wet wipes (100 per container)
- 1 First aid kit (see below for contents)

N95 respirators (number/type of respirators in stock is dependent upon service team compliment & client ratio at service) – enough for approximately three days

Hygiene and Miscellaneous Supplies:

- 1 Bottle of Listerine (original with alcohol)
- 1 Case toilet paper (48 rolls per case)
- 1 1L dish soap
- 2 Flash lights
- 1 Non battery operated flashlight and radio
- 2 Extra sets of batteries – all sizes
- 2 Rolls duct tape
- 2 Hand operated can/bottle opener
- 4 1L liquid body soap
- 2 4L liquid anti-bacterial hand soap
- 1 Box Q-tips
- 2 Cases paper hand towels (16 packs x 250 sheets per pack)
- 2 Boxes Ziploc baggies (XL)
- 1 Box/container laundry detergent

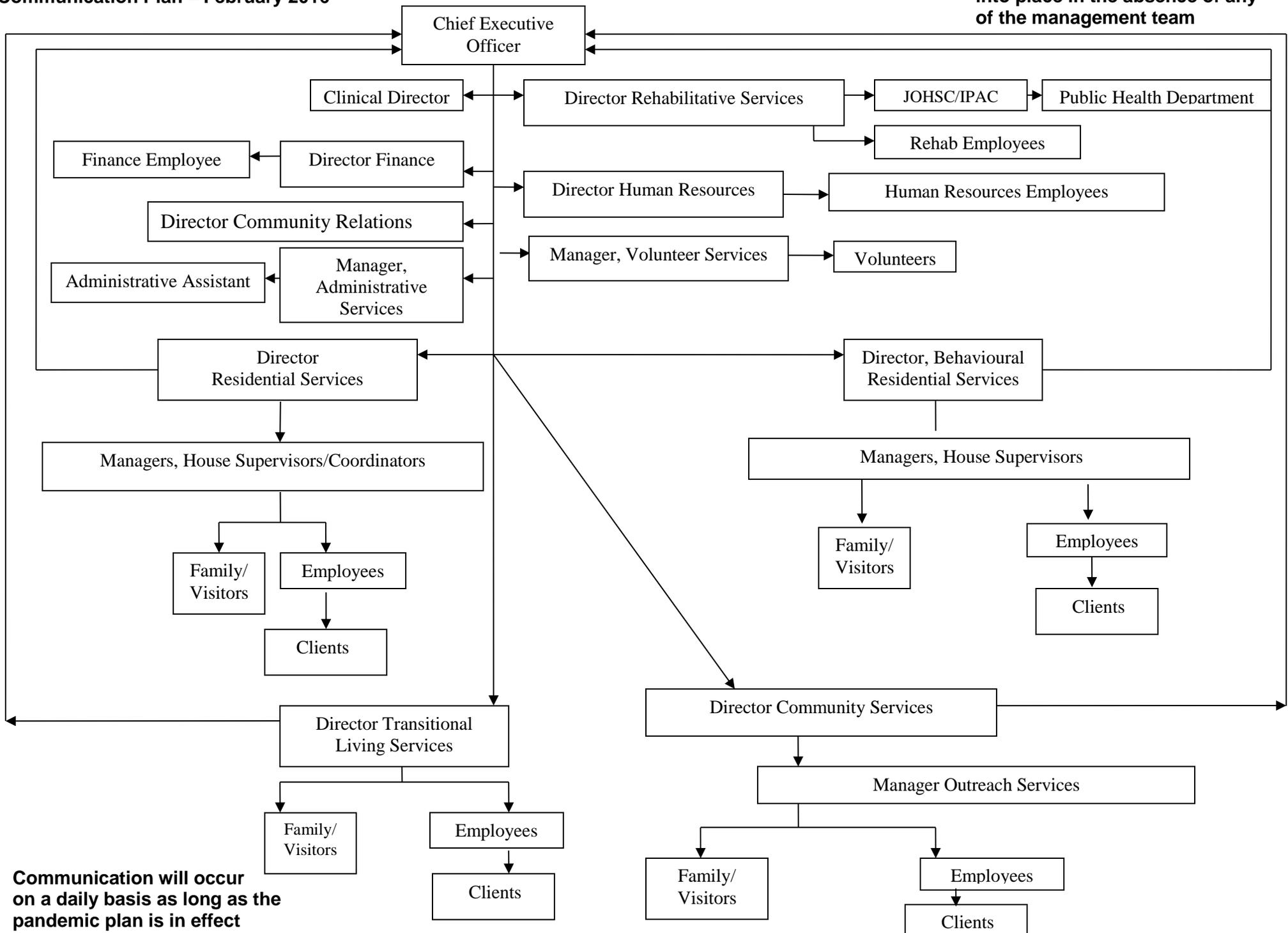
FIRST AID SUPPLIES

*All services must have fully stocked first aid supplies which meet the requirements of WSIB standards for this workplace. This kit must be maintained at required levels at all times.

*Additionally, all services will have first aid kits readily available on all levels of the service. These kits will contain extra immediate need supplies only (e.g. bandages, alcohol wipes, gloves, etc.)

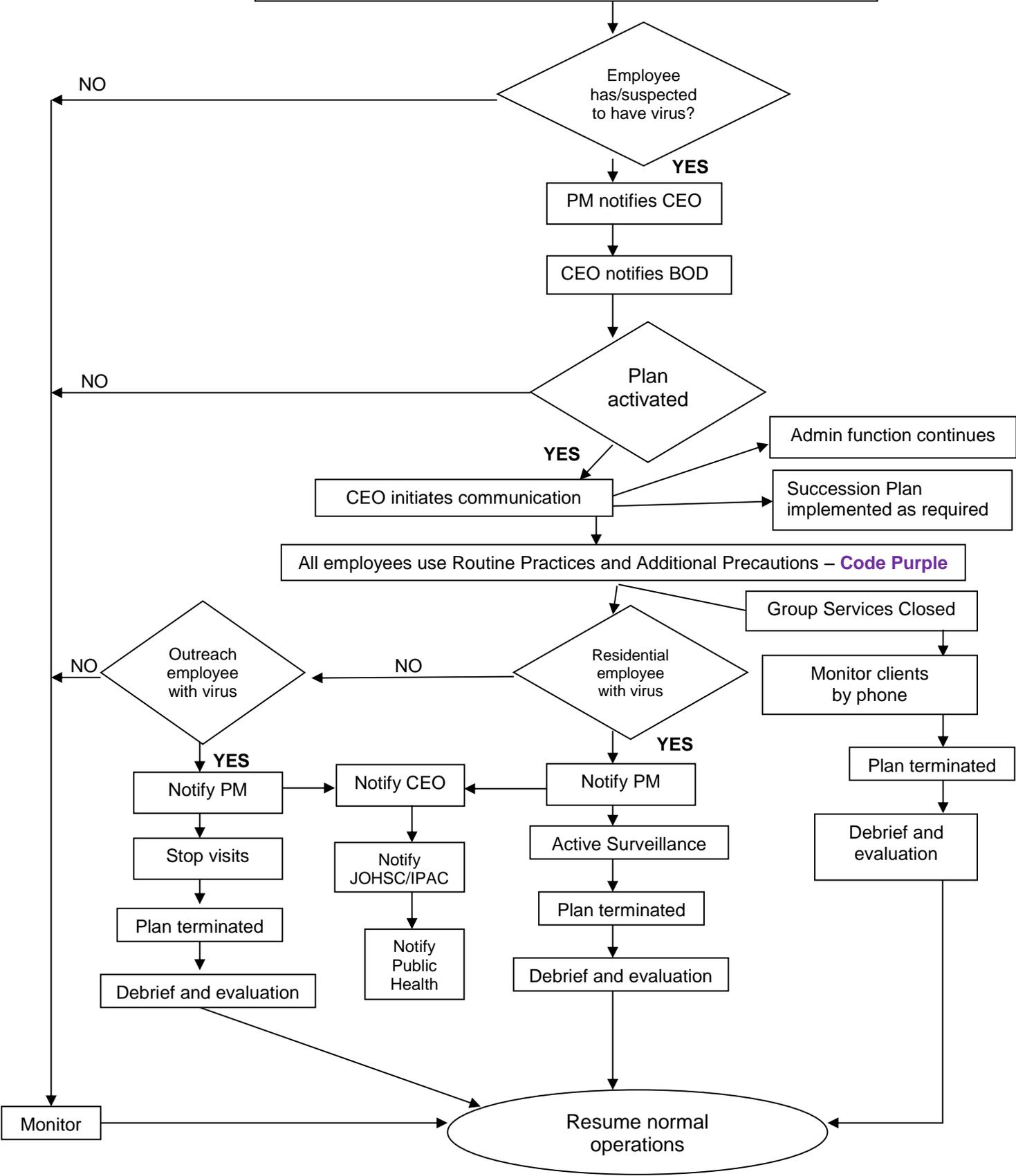
**Pandemic Influenza Business Continuity Plan
Communication Plan – February 2016**

The succession plan will be put into place in the absence of any of the management team



Communication will occur on a daily basis as long as the pandemic plan is in effect

Pandemic Influenza Preparedness Plan *Employee Illness*



Pandemic Influenza Preparedness Plan Client(s) Illness

