

Pandemic Influenza Plan Annexes Part 2



September 2016

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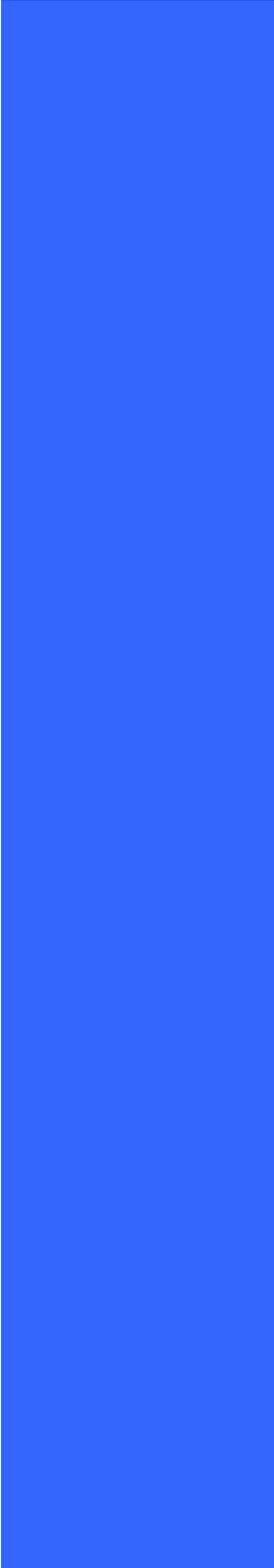
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Pharmacy Plan for Community

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Community Pharmacy
Pandemic Plan

Hawkes Bay Community Pharmacy

Pandemic Plan

AUTHORITIES INVOLVED

Hawke's Bay Community Pharmacies

RELATED DOCUMENTS

1. Individual pharmacy's Emergency and Business Continuity Plan.
2. Pharmaceutical Society of New Zealand. Emergency Response and Business Continuity Plan. Pharmaceutical Society of New Zealand, Wellington, 29 May 2014.
https://www.psnz.org.nz/Folder?Action=Download&Folder_id=86&Folder_File=Pharmacyemergencyresponseplantemplate.doc
3. Pharmaceutical Society of New Zealand. Step by Step Workbook. To Prepare your Pharmacy for a Disaster or Other Emergency. Pharmaceutical Society of New Zealand, Wellington, 29 May 2014.
https://www.psnz.org.nz/Folder?Action=View%20File&Folder_id=86&File=Pharmacyemergencyresponseplanworkbook.pdf

INTRODUCTION

Aims and general purpose

The aim is to maintain the community based dispensing of pharmaceuticals and other services provided by community pharmacies during a pandemic.

These include services to, but not limited to:

- The Public
- Residential care facilities (Rest Homes, IHC homes etc)
- Addiction services (Methadone clients)
- Mental health clients (Clozapine)
- General Practices and other medical facilities
- Hawke's Bay Regional Prison

Assumptions

- 1 An influenza pandemic is inevitable.
- 2 There will be little warning. Experts believe there will be between one and six months between the time the novel influenza strain is identified and the time that outbreaks begin in New Zealand.
- 3 Outbreaks are expected to occur simultaneously throughout much of New Zealand.
- 4 The effects on the community will be relatively prolonged compared to most other natural disasters.
- 5 The impact of the next pandemic could have a devastating effect on the health and well being of the public and pharmacy work force. This may affect a pharmacy's ability to provide pharmaceutical services.
- 6 The regular supply of pharmaceuticals to Hawkes Bay may be affected due to world wide production difficulties and transportation problems.
- 7 Pharmacists and staff will be at increased risk due to their frequent contact with the public.

- 8 Illegal attempts by the public to obtain antiviral and antibiotic medications could affect the safety of pharmacy staff. This could result in more aggressive behaviour by some individuals and an increase in pharmacy burglaries.

The Community Pharmacy Pandemic Plan will be implemented at the time the pandemic is identified in New Zealand and Hawke's Bay.

Related Legislation

Emergency legislation modifying the requirements of the Medicines and Misuse of Drugs Acts and their Regulations may be required. While it is not expected that the Pharmaceutical Schedule business rules will be changed an open mind needs to be maintained.

Employment law will be an important consideration and pharmacists should review contracts with their staff and work with them to have an understanding of how they will deal with issues like the temporary closure of a pharmacy.

Operational Structure Relevant to this Plan

The pharmacies of Hawke's Bay are primarily individually owned but are able to work together in a collegial manner in some circumstances.

Each pharmacy has contractual obligations to the HB District Health Board in regards to the provision of pharmaceutical services.

Sector Services reimburse the cost of most medicines and contracted pharmaceutical services, under direction from PHARMAC, from the HBDHB combined community pharmaceutical budget.

Communication Plan

Five communication systems have been organised:

1. HBDHB email / fax system (HealthScape)

Email and fax messages can be sent to all pharmacies in the HB region through the HealthScape database

Entry point: Chief Pharmacist



878 1314 ☎ 878 8109 ext 2565

✉ william.allan@hbdhb.govt.nz

or

Portfolio Manager, Pharmacy



878 1374 ☎ 878 8109 ext 4625

✉ Gopy.Sundararajah@hbdhb.govt.nz

Alternatively:

2. Fax System

Fax messages can be sent to all pharmacies in the HB region through an auto-fax system.

Entry point: Tamatea Pharmacy Ltd



843 9729

Or:

3. E-mail System

E-mail messages can also be sent to all pharmacies in the HB region.

Entry point: Flaxmere Pharmacy



879 8361 📠 879 9880



timflaxmerepharmacy@xtra.co.nz

Any messages relevant to a pandemic can be disseminated quickly using either system or both systems simultaneously.

4. Communication within and between cluster groups.

In the event that the two above systems are not able to operate the cluster groups will be used (see Appendix). The link pharmacies in the clusters will also liaise with the hospital pharmacy where appropriate.

Preparedness

Each pharmacy should have a pandemic planning document. Pharmacies pandemic plans should consider areas such as the following:

- Strategic aims of New Zealand's Pandemic Plan
- Powers of the Medical Officer of Health in a pandemic emergency
- Human resource obligations
- Deciding whether a work place should stay open
- Risks to employees and others must be reasonable
- Health and Safety in Employment Act
- Other human resource legislation
- Preparing for the possibility of a workplace or business closing
- Keeping communication open and frequent
- Short, medium and long term planning for the pharmacy
- Influenza manager
- Activation of Pandemic Continuity Plan
- Communication with staff
- Maintaining essential business activities
- Identification of core people and core skills
- Business planning for absence
- Knowledge management
- Communications
- How might shortage of supplies affect business operations
- How we can protect staff and customers from getting sick
- Restrict work place entry of people with influenza symptoms
- Personal hygiene
- Work place cleaning
- Air conditioning
- Increased social distancing
- Managing staff who become ill at work
- Contact management
- Personal protective equipment
- Information sources

The Pharmacy Guild of NZ has also prepared a document *Managing Infection Control in Your Pharmacy during a Pandemic*. This is an advisory note to help pharmacists planning during an influenza pandemic. This document will be updated as new information comes to hand.

METHADONE SERVICE

Pharmacies providing methadone services will continue to do so. If a pharmacy is unable to make their supplies of methadone to clients, the after hours arrangements already in place will be used. The Methadone Clinic has advised that in such an emergency the alternative pharmacy providing the supply will be able to contact the clinic to obtain a prescription (before making the supply).

CLOZAPINE SERVICE

Pharmacies providing clozapine to clients should liaise with the Mental Health In-patient Unit to ensure information, prescriptions and test results are available.

OPERATIONAL PROCEDURES

Hawke's Bay pharmacies have been placed into cluster groups (see Appendix). These groups will work together to ensure a continuity of pharmaceutical services to the community and to mitigate the problems of reduced staffing levels. The groups will also liaise with each other.

The pharmacies nearest the Community Assessment Centres, set up to see suspected pandemic cases, will be seen as a priority for the maintenance of pharmacy services. This is to ensure a pharmacy service to pandemic victims.

Community Assessment Centre	Servicing Community Pharmacy
Wairoa Health Centre	Wairoa Pharmacy
The Doctors Napier	Unichem Napier Pharmacy
City Medical	Napier Pharmacy
Tamatea Medical Centre	Tamatea Pharmacy
Taradale Medical Centre	Taradale Medical Pharmacy
Hastings Health Centre	The Pharmacy @ HHC
The Doctors Hastings	Unichem Russell Street
Te Mata Peak Practice	Denton's Peak Pharmacy
Totara Health Flaxmere	Flaxmere Pharmacy
CHB Health Centre	Unichem Waipukurau Pharmacy

FINANCE

Proprietors of pharmacies should make arrangements with their bank that in the event of Sector Operations not being able to make payments on time (due to staff shortages) the pharmacy is able to carry on business in a regular manner.

WORK FORCE ISSUES

The cluster groups will work together to mitigate the problems of reduced staff levels. The pharmacist in charge needs to ensure staffing levels are adequate to provide appropriate pharmaceutical services.

CDC Pharmaceuticals Ltd (☎ 06 831 0620; 🖨 06 831 0057) maintain a register of locum pharmacists.

DELIVERY OF PRESCRIPTIONS

During a pandemic there will be an increased demand for the delivery of prescriptions. This will be due to un-well people requiring deliveries, and suspected pandemic cases will be asked to reduce social contact by staying at home. Pharmacists should make plans to meet this increased demand.

IN THE EVENT OF A PHARMACY NOT BEING ABLE TO OPEN

When a pharmacy closes the Pharmacist in Charge will ensure that:

1. A sign is placed in the window explaining where pharmaceutical services will be available from. A contact phone number will also be displayed.
2. The local doctors will be informed.
3. A backup media (CD, hard-drive or USB) is taken to the pharmacy providing services so appropriate records are maintained and claims for payment can be made.
4. The hospital pharmacy will be informed so patient discharge records can be directed appropriately.

STOCK CONTROL

- Pharmacies will continue to maintain stock levels as well as they can using their computer stock control systems and anticipated stock use.
- The main pharmaceutical wholesaler in Hawke's Bay (CDC) will maintain their stock as best they can. Disruption to deliveries from suppliers is possible.
- Neither CDC nor pharmacies are able to stockpile medication unless specific arrangements, along with funding, are put in place beforehand.
- The Ministry of Health has a plan to stockpile medication and is contracting with suppliers in an effort to ensure supply.

PRESCRIPTION DISPENSING RULES

The Ministry of Health and PHARMAC control the rules for dispensing prescriptions. It is anticipated the rules will be reviewed in the event of a pandemic to help maintain supplies of pharmaceuticals.

Pharmacists are subject to audit and are required to dispense according to current rules. These allow for a repeat supply to be obtained once the previous supply is 'substantially used up'. For a one month supply this is considered to be no sooner than 20 days. An amendment has allowed the overruling of this limitation specifically for a 'Pandemic Emergency Supply'. However in the interests of stability and storage requirements any message to patients should be to advise them to ensure they do not make a habit of running out of their medicines before obtaining a new supply i.e. develop the habit of always having two weeks supply on hand rather than stockpiling an extra lot that may deteriorate in storage.

Robert Duncan
17 May 2006
Updated June 2013
Updated May 2016 (Billy Allan, Chief Pharmacist)

PANDEMIC PLANNING

Hawke's Bay Pharmacy Cluster Groups

Wairoa
Wairoa Pharmacy - link with Gisborne pharmacies

Napier A
Wairoa Pharmacy - link between Napier and Wairoa groups
Ahuriri Pharmacy - link between the two Napier groups
Unichem UFS Pharmacy (HB)
Life Pharmacy Napier (Gahagans)
Unichem Pharmacy Napier
Napier Balmoral Pharmacy
Napier Pharmacy
Charleston Pharmacy
Gilmours Pharmacy - link between Havelock North and Napier groups

Napier B
Ahuriri Pharmacy - link between the two Napier groups
Marewa Pharmacy
Maraenui Pharmacy
Andrew Spence Pharmacy
Tamatea Pharmacy - link between Napier and Taradale groups
Westshore Pharmacy
Bay View Village Pharmacy

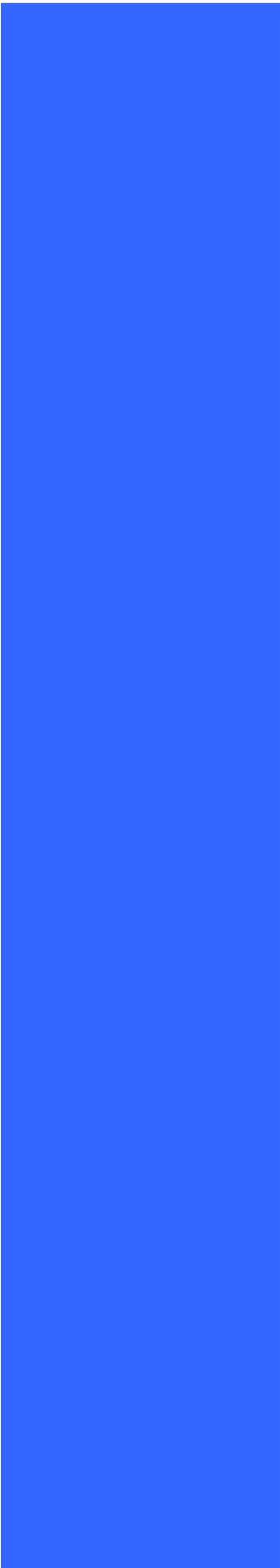
Taradale
Tamatea Pharmacy - link between Napier and Taradale groups
Greenmeadows Pharmacy
Unichem Greenmeadows Pharmacy
Greendale Pharmacy
Glenns Pharmacy
Unichem Taradale Pharmacy
Taradale Medical Pharmacy
Gees Pharmacy
Flaxmere Pharmacy - link between CHB and Taradale groups

Central Hawke's Bay
Flaxmere Pharmacy - link between Taradale and CHB groups
Unichem Waipukurau Pharmacy
Waipawa Pharmacy - link between CHB and Hastings groups

Hastings A
Waipawa Pharmacy - link between CHB and Hastings groups
Life Pharmacy Hastings
Unichem Hastings Pharmacy (@ Pak 'n Save)
Raureka Pharmacy
Unichem Stortford Lodge
Hawke's Bay Hospital Pharmacy
Care Pharmacy Hastings
Mahora Pharmacy - link between Hastings two groups

Hastings B
Mahora Pharmacy -link between Hastings two groups
The Pharmacy @ Hastings Health Centre
Bay Plaza Pharmacy
Unichem Russell Street
Hastings UFS Pharmacy
Parkvale Pharmacy -link between Havelock North and Hastings groups

Havelock North
Parkvale Pharmacy - link between Hastings and Havelock North groups
Denton's Peak Pharmacy
Whittaker Pharmacy
Clive Pharmacy
Weleda
Gilmours Pharmacy - link between Napier and Havelock North groups



Port and Airport Procedures

Port and airport procedures for pandemic influenza

Introduction:

This plan was developed as part of a number of workstreams to enhance Hawke's Bay pandemic preparedness. It has been developed to guide a response in the unlikely event that a case of pandemic influenza enters Hawke's Bay via the airport or port early in a New Zealand epidemic when it is still considered feasible to control initial clusters of disease.

Definitions

Case: someone who is thought by a doctor to meet the case definition for pandemic influenza. The case definition is on the Ministry of Health website: http://www.moh.govt.nz/moh.nsf/wpg_index/About-Influenza+-+avian+influenza+-+case+definition

Contact: Anyone who has had:

- Contact with the respiratory secretions of a case in an enclosed space.
- Contact with the faeces of a case.

Household, work and institutional contacts during the infectious period of the case will almost always be defined as contacts.

Isolation means restricting the activities of cases until they are no longer infectious.

Quarantine means restricting the activities of contacts (people who have been exposed to a case but are still not sick) until the incubation period has expired.

Quarantinable diseases are currently defined as plague, cholera, yellow fever and Avian influenza capable of being transmitted between human beings. The Epidemic Preparedness Act 2006 enables the Prime Minister, on the advice of the Director General of Health, to extend quarantine powers to cover pandemic influenza for aircraft and ships. Although the Health (Quarantine) Regulations 1983 are specifically targeted to "quarantinable diseases" symptoms of other infectious conditions warranting quarantine measures to be taken should not be ignored.

Abbreviations

CIMS – coordinated incident management system
HECC – Health Emergency Coordinating Committee
HBDHB – Hawke's Bay District Health Board
HPO – Health Protection Officer
MOH – Medical Officer of Health
PHS – Public Health Service
Port – airport or seaport
PPE – personal protective equipment

Related legislation

Health Act s70, 71 (requires public health or civil defence emergency to be declared); s79 (MOH power to detain people) does not.

Other sections which may be relevant include: 72,75,76,80,84,86,96,97,99,105,106,111,112.

Civil Defence Emergency Management Act 2002.

Powers of Medical Officers of Health under the Health Act at the border in an emergency.

Health (Quarantine) Regulations 1983.

Epidemic Preparedness Act 2006. This Act enables the Prime Minister on the advice of the Director-General of Health to introduce a wide range of emergency powers including:

- extension of quarantine powers to cover aircraft as well as ships and to cover pandemic influenza. (Currently the Health (Quarantine) Regulations 1983 do not apply to influenza).
- redirect aircraft to another place
- powers for police to assist the Medical Officer of Health. Police may consider (as a last resort) using the following statutory provisions to detain anyone who does not comply with MOH requests: Summary Offences Act (obstruction); Crimes Act (criminal nuisance). However the powers under the Epidemic Preparedness Act 2006 should be sufficient.
- information to assist contact management
- management of infected people
- disposal of infected things or craft

Related HBDHB pandemic plans

HBDHB pandemic plans for

- Quarantine and isolation
- Communication
- Interagency plan for management of first cases
- Management of Communicable Disease at the Port or Airport Procedure - PH/PPM/8146

Aims and general purpose

To minimise the spread of pandemic influenza by identifying and managing cases and contacts arriving at the airport or sea port in Napier.

Assumptions

1. Early identification of a case of influenza and exposed passengers and crew will enable the PHS to collect information about their travel plans and to give them information and treatment. Retrospective contact tracing once they have left the port or airport is difficult if not impossible.
2. If a suspected case arrives at a port early in a New Zealand epidemic, a CIMS response will be activated. The incident controller will be the MOH.
3. Intensive “stamp-it-out” actions at the border will no longer be useful once there is an influenza epidemic in Hawke’s Bay. Therefore a CIMS response will not be activated at a port after a MOH has declared that there is an established epidemic in Hawke’s Bay.
4. If the MOH requires isolation of cases and quarantine of contacts, this will be managed according to the *Quarantine and isolation plan for pandemic influenza. Hawke’s Bay District Health Board.*
5. Cases and contacts arriving at the sea port will be isolated on the ship if at all possible. Those arriving at the airport will be triaged at the airport and then moved to hospital, their homes, their hotel or to alternative accommodation arranged by HBDHB.

Conditions under which this procedure comes into force

This procedure should be followed for all suspected and confirmed cases of pandemic influenza arriving at Napier Airport or the Port of Napier. It is intended to “stamp out” an outbreak if there are no or few clusters of influenza in Hawke’s Bay. The plan will not be operationalised if the MOH has declared that there is an established epidemic in Hawke’s Bay.

Operational Structure:

The HBDHB is the lead agency during a pandemic. All other agencies are support agencies. The MOH and the staff of the PHS will coordinate CIMS response if a suspected case of pandemic influenza arrives at a port.

Primary health care providers and police will be asked to assist as needed.

Relationships with other levels of government

Use of MOH powers under s70 and 71 of the Health Act require a public health emergency to be declared by the Director-General of Health or a civil defence emergency to be declared.

Emergency powers of the MOH under the Epidemic Preparedness Act 2006 will only be available when unlocked by the Prime Minister.

This procedure may be affected by recommendations from:

- A national interdepartmental group managed by Customs which is planning border preparedness.
- The Ministry of Health’s Pandemic Influenza Technical Advisory Group.

Communication Plan/Issues:

Types of messages, how they will be distributed, obligations on receipt

PHS pratique procedures – the Health Protection Officer would not grant pratique.

Preparedness:

Relationships required

PHS	↔	Air Napier
PHS	↔	Hawke’s Bay Airport
PHS	↔	NZ Customs
PHS	↔	Police (for enforcement)
PHS	↔	St John Ambulance (in case evacuation of cases to hospital is required)

Risk assessment

Failure of sea or aircraft to follow pratique requirements.

If there are no MOH emergency powers early in the epidemic it will mean that the MOH has limited capability to organise an effective response in the face of non-compliance by any party e.g. failure of passengers or crew to comply with public health requirements on arrival.

Hawke's Bay Airport and Air New Zealand have the following concerns planning for arrival of a case on a domestic flight because:

- They perceive it is unlikely that a passenger would be diagnosed as a probable influenza case during a domestic flight in sufficient time to introduce controls on passenger/crew movements.
- They perceive that crew and passengers would be unlikely to comply with requests to await information and triage, unless compulsory legal powers were in force for the MOH to use.
- Concern about interruption to commercial activities. They would want the plane emptied as soon as possible but are have no suitable Hawke's Bay airport premises for triage and communication with passengers and crew.

PHS may be unable to access sufficient support deployed from other parts of the HBDHB and unable to cope with the intensive workload required.

Operational Procedures:

Roles, relationships and tasks

Agency responsible	Role and task	Relationships
PHS via normal pratique communications	Advise incoming international flights and vessels when an epidemic has started in Hawke's Bay.	Captains Air Napier Ltd Port of Napier
Medical practitioners from <i>City Medical (The Doctors, Napier as backup)</i>	On call response 24/7 at MOH request to attend suspected cases at the port or airport. Both organisations have agreed to carry out this role. The Doctors at Hastings may be asked to provide an on-call roster in Hastings to carry out the same role for casual suspect cases (e.g. tourists on a bus or in a motel).	MOH St John Ambulance
MOH	Incident controller for a CIMS response	Port and airport management Customs St John Ambulance Air and sea captains
PHS, MOH	Manage cases and contacts at the port (triage movement of people, arrange lab testing, recommend and enforce isolation, give advice and support including PPE, provide treatment)	Attending medical practitioner Port and airport management
Police	Respond to MOH request for assistance enforcing isolation or quarantine	MOH
HBDHB	Coordinate volunteer and social support for people in isolation and quarantine	MOH, PHS

Situation Assessment

The HPO should obtain preliminary information such as:

- Number and names of cases
- Likely diagnosis, if known
- Symptoms and onset date
- Travel history / medical history

- The type of exposures that other passengers and crew have had to the case(s)

Then the HPO and MOH jointly undertake a risk assessment and action plan. Things to consider:

- Medical support required (a visiting urgent medical service, hospital, ambulance). The agent may be involved, work with them. If a doctor is to be consulted, obtain their name so further diagnostic information can be obtained.
- How to collect contact details for exposed passengers and crew.
- An assessment and triage area may need to be established.
- Infection prevention and control advice that may be required for airline or port / airport staff.
- Need for personal protective equipment.
- What other agencies need liaison and briefing – port/airport management, airlines, agents, Ministry of Health (e.g. National Focal Point), Customs, Ministry for Primary Industries (MPI), Immigration and Police.
- Additional Public Health staff / resources that may be required.
- A decision needs to be made as to whether the passengers should remain on board or disembark into separate areas. This will depend on the number of cases and type of illness.
- A location for the ship / aircraft to berth/park so that controls can be imposed on people entering and leaving. If it is decided that passengers / crew are to remain on the vessel / aircraft, separate areas will need to be established on board.
- The route to be taken by disembarking passengers and crew.
- The areas where sick and well people are to be separated on disembarkation.
- The HPO should ensure that on disembarkation, the sick and well people are separated into their different areas immediately. Close liaison will need to occur with customs.
- Equipment should be sourced such as tape and cones to help create the designated areas. Both the port and airport have some equipment.

Interviewing

The HPO should:

- Wear personal protective equipment (PPE).
- Follow the HBDHB infection prevention and control policies (e.g. Hand Hygiene and General Glove Use ICM/010 and Standard Precautions Guidelines ICM/021) at all times.
- Consult the MOH. Screening questions will depend on the type of illness.

Passenger Locator Form

If it is decided to collect contact information for any exposed passengers or crew, use the Passenger Locator Form. (Passengers should be advised that they could update their information by reporting the amendments to any public health service in New Zealand).

Forms from people travelling on to places covered by another public health service should be forwarded to the MOH at that public health service accordingly.

Medical Assessment

The MOH will decide whether any urgent medical assistance is required. Cases may be asked to contact their own GP or a 24 hour medical clinic for a diagnosis.

If medical assessment at the airport is necessary, the MOH should contact the following 24 hour services for a clinical assessment to be undertaken at the port or airport:

- City Medical, phone 835 4999.
- The Doctors in Napier (as backup), phone 835 4696

The doctor will liaise directly with the MOH.

Cruise Ships

The Port of Napier is often visited by cruise ships'. Either the ship's agent or the previous port Public Health Service can advise that there is an outbreak on board the cruise ship. The general philosophy is that any measures applied to vessels are no different from those applied for similar community-based outbreaks for any notifiable diseases (other than quarantinable diseases).

Communication between public health staff and the vessel's medical staff is required to determine the aetiological agent (either suspected or confirmed), clinical description of illness and incubation, duration and severity and any need for medical assistance on shore. The Public health Service should provide advice and support as required.

Resources e.g. designated sites, equipment required

Suitable facilities are required at the port and airport for interview and medical examination.

- For sick people – private, easily cleaned, fewer people so less space needed, room to lie down, ventilated, separate toilet and bathroom facilities, room for official visitors e.g. doctor.
- For well contacts (passengers and crew) – room for up to 14 people, toilets, phone access, chairs, magazines and kitchen facilities.

Short-term isolation and quarantine facilities

These are short-term facilities (several hours, not days) for people needing to be isolated until they have been assessed and a plan made.

Hawke's Bay Airport

Air Napier Ltd

Skyline Aviation Ltd

Airport conference room and adjacent rooms

Port of Napier

Crew and passengers should remain on the vessel. Sick and well passengers and crew should be separated if possible.

The port administration building may also be useful.

Longer Term Isolation and Quarantine Facilities

A plan is in place with Kennedy Park, Napier. Refer to Quarantine and Isolation Plan.

Workforce issues

Urgent redeployment of PHS staff onto the incident.

Urgent secondment of staff (e.g. nursing or clerical) to assist the PHS from other parts of the DHB would be helpful.

Admitting People to Hospital

If admitting a case of infectious disease to hospital, the doctor or MOH must advise the HBDHB Emergency Response Advisor. Infection control will need to be discussed with HBDHB Infection Prevention and Control Advisors and St John Ambulance.

Cleaning

- Cleaning surfaces in isolation rooms. Refer to HBDHB Isolation Policy Precautions and Procedure Guidelines ICM/006 and the infection Control Standard and Transmission Precautions Handbook 2015.
- Ensure cleaning staff are aware of correct disposal methods and have access to correct disposal equipment (e.g. biohazard bags, sharps containers). Refer to HBDHB Waste Management Policy OPM/008).

Equipment

Ministry of Health Identification card – public health staff should carry their card with them at all times

High viz jacket – should be worn, labelled with Public Health, to enable clear identification for passengers and other agencies.

Personal Protective Equipment – packs containing hat, eye protection, facemasks, gowns and gloves are available in the on-call vehicle. Extra stock is in the emergency cupboards.

Throat swabs/naso-pharyngeal swabs and viral transport medium. Medical staff/nursing staff will normally take these swabs. The swabs will need to be transported asap (by taxi or PH vehicle) to the Hawke's Bay Hospital Laboratory, who will forward on the relevant national laboratory.

Reporting

Daily count of number of cases in isolation and the number of contacts in quarantine. This would form part of the daily PHS report to the Communications team (or the Planning and Intelligence Unit under a CIMS structure).

Names, addresses and contact numbers

Refer to the HBDHB list of pandemic contact details.

Organisation	Name	Phone	Email
Port of Napier	Marine Service Manager	Ph: 833-4495 027-495-7917	bruce1@napierport.co.nz

	Bruce Lockhart Duty Pilot	Fax: 833-4408 Ph: 833-4471	
MPI	Chris Martin 24 hr quarantine	Ph: 835-4229 Ph: 0800-222-009	chris.martin@mpi.govt.nz
NZFSA vets (at the port)	Colin Johnstone	Ph: 870-6794	colin.johnstone@nzfsa.govt.nz
Customs	Port Manager Daniel Mcguire On-call officer	Ph: 974-1350 Fax: 974-1361 0800-428-786 24 hr: 0800-4customs 029-295-9671	napier.planners@customs.govt.nz
Air Napier	Manager Gary Peacock	Ph: 835-6182 027-445-1499 Fax: 835-6192	admin@airport.co.nz
Hawke's Bay Airport	General Manager Nick Storey Olivia Pierre	Ph: 834-0742 027-580-9515 A/H: 877-6852 Fax: 836-6192 021-025-81926	hbairport@xtra.co.nz olivia@hawkesbay-airport.co.nz
Air New Zealand	Manager Greg Smith	Ph: 835-4790 021-990-209	greg.smith@airnz.co.nz
Napier Aero Club	Len Searle Elizabeth Searle Graham Duley	Ph: 027-440-0888 Ph: 027-440-0884 Ph: 844-4470 021-499-208	

For further information refer Management of Communicable Disease at the Port or Airport PH/PPM/8146.

Appendix

Port of Napier pandemic plan documentation.

Table 2. Ports of Napier Pandemic Management Strategy and Associated Actions

STAGE	NZ STRATEGY	MoH / DHB ALERT CODE	OBJECTIVE AND ACTION
1	Plan for it (Planning)	WHITE (Information gathering and preparation)	<ul style="list-style-type: none"> • Devise a plan to reduce the health, social and economic impact of a pandemic on the Port of Napier or Hawke's Bay Airport • Monitor pandemic to keep up with the potential arrival of it in New Zealand • Identify and have operational and administrative procedures ready for implementation of following activity levels • Purchase personal protective equipment
		YELLOW (Standby)	<ul style="list-style-type: none"> • Communicate pandemic procedures to staff • Communicate general virus information to staff • Set up regular communication lines with customers
2	Keep it out (Border management for staff in contact with ships crew)	RED (Activation)	<ul style="list-style-type: none"> • Issue virus PPE to Marine and Cargo staff in contact with ships crew • Instigate procedure for checking on ship or planes condition prior to arrival • Prevent ships from berthing until cleared by health authorities • Keep ship or planes crew on board ships at all times • Regular communication with staff and customers • Cancel all overseas travel
3	Stamp it out (Preventing it from entering the Port from inside New Zealand)		<ul style="list-style-type: none"> • Maintain border management • Set up Influenza Manager and systems • Instigate working from home for applicable staff • Cancel all internal travel • Issue all staff with virus specific PPE • Provide cleaning equipment and instructions to all staff • Daily communication with staff and customers
4	Manage it (Pandemic Management – reducing the impact on Port staff and operations)		<ul style="list-style-type: none"> • Instigate all pandemic procedures • Close Port or Airport to everyone except essential personnel • All cleaning undertaken by staff • Continuous phone or computer communication only • Social distancing measures in place • Management of sick personnel

5	Recover from it (Recovery)	GREEN (Stand down)	<ul style="list-style-type: none">• Return to work only with medical clearance• Removal of pandemic procedures• Return to normal operations
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Primary Care Plan

Pandemic Plan Template for General Practice



September 2016

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INTRODUCTION

Influenza pandemics are typically characterised by the rapid spread of a novel type of influenza virus to all areas of the world, resulting in unusually high morbidity and deaths for approximately two to three years. Factors that need to be present for a pandemic to occur include: the emergence of a new viral subtype; the capacity for the virus to spread efficiently from person to person; and being virulent enough to cause disease.

The primary purpose of this plan is to provide the framework and methodology to efficiently respond to an influenza pandemic in general practice. This purpose must consider as the situation develops primary care response will necessarily evolve with additional forms of care delivery being activated.

Assumptions

1. An influenza pandemic is inevitable.
2. There will be very little warning. Most experts believe that we will have between one and six months between the time that a novel influenza strain is identified and the time that outbreaks begin to occur in New Zealand.
3. Outbreaks are expected to occur simultaneously throughout much of New Zealand, preventing shifts in human and material resources that normally occur with other natural disasters.
4. The effect of influenza on individual communities will be relatively prolonged -- weeks to months -- when compared to minutes-to-hours observed in most other natural disasters.
5. The impact of the next pandemic could have a devastating effect on the health and well being of the New Zealand public. Based on CDC projections it is **estimated that in Hawke's Bay alone, over a course of 2 to 3 months:**
 - Up to 53 thousand people will become clinically ill
 - Up to 25 thousand people will require primary health care
 - Up to 600 people will be hospitalized
 - Up to 1325 people will die (this is a conservative estimate of the impact)Essentially this means that 97% of care delivery will occur in the primary care setting.
6. Effective preventive and therapeutic measures -- including vaccines and antiviral agents -- will likely be in short supply, as well as antibiotics to treat secondary infections.
7. Health-care workers and other first responders will likely be at even higher risk of exposure and illness than the general population, further impeding the care of victims.
8. Widespread illness in the community will also increase the likelihood of sudden and potentially significant shortages of personnel in other sectors who provide critical community services: police, firemen, utility workers, and transportation workers, just to name a few.

PANDEMIC PHASES – DEFINITIONS

For purposes of consistency, comparability and co-ordination of the national, regional and local response, identification and declaration of the following phases will be done at the national level.

WHO Pandemic Phase	Definition
Inter-Pandemic Period (WHO Phase 1)	No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.
Novel Virus Alert (WHO Phase 2)	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.
Pandemic Alert (WHO Phase 3)	Human infection(s) with a new virus sub-type, but no human-to-human spread, or at most rare instances of spread to a close contact.
(WHO Phase 4)	Small cluster(s) with limited human-to-human transmission but spread is highly localised, suggesting that the virus is not well adapted to humans.
(WHO Phase 5)	Larger cluster(s) but human-to-human spread still localised, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).
Pandemic Period (WHO Phase 6)	Pandemic: increased and sustained transmission in general population.

WHO PERIOD*	WHO PHASE*	NZ STRATEGY	MoH/DHB ALERT CODE
Interpandemic Period	Phase 1	Planning	N/A
	Phase 2		WHITE (Information / Advisory)
Pandemic Alert Period	Phase 3		Border Management
	Phase 4	RED (Activation)	
	Phase 5	Cluster Control	RED (Activation)
	Pandemic Period	Phase 6	
Post Pandemic Period	Post Pandemic Period	Recovery	GREEN (Stand Down)

MINISTRY OF HEALTH CASE DEFINITION

Suspected case of Pandemic Influenza

Person with an influenza like illness of abrupt onset, characterised by:

- History of fever, chills and sweating; or
- Clinically documented temperature $\geq 38^{\circ}\text{C}$; and
- Cough or sore throat

Probable case of Pandemic Influenza

Person with an influenza like illness who has a strong epidemiological link to a confirmed case or defined cluster.

Confirmed case

An individual for whom laboratory testing demonstrates one or more of the following:

- a. positive viral culture for Pandemic Influenza; or
- b. positive RT-PCR for Pandemic Influenza; or
- c. four-fold rise in novel influenza virus specific neutralising antibodies.

PRIMARY CARE MANAGEMENT

During inter-pandemic period:

- Encourage annual influenza immunisation.

During pandemic alert:

- Determine daily activities that can be deferred during the pandemic event.
- Contact at-risk patients to determine coping strategies/action plans, this may include pneumococcal vaccination to reduce incidence and severity of secondary infection.
- Ensure access to updated clinical information on the emerging infectious disease including case definition and management and treatment guidelines.
- Make decisions regarding practice collaboration or referral of influenza-related illness to a larger practice.
- Assess staff availability.
- Purchase sufficient supply of personal protective equipment to cover 7-10 days.
- Promote the public education strategy led by the HBDHB.
- Initiate staff training plan.

During pandemic imminent stage:

- Fully activate the practice response plan.
- Obtain contact details for advice about, and referral of, suspect patients.
- Obtain the influenza hospital admission criteria and treatment guidelines produced by HBDHB.
- Increase cleaning services in all areas.
- Place appropriate visible signage advising patients and others of any restrictions or required actions.
- Educate all patients who think they have influenza to seek advice by phone before presenting at the practice.
- Ensure provision for additional supplies of oxygen (BOC contracted by the DHB), pulse oximetry and radiology services along with increasing supplies of oxygen masks and tubing in consultation with the DHB.

During the pandemic:

- Notify the Medical Officer of Health of all probable cases of influenza and related deaths in the community.
- Administer antiviral agents and vaccine to patients and staff according to national recommendations.
- **Utilize telephone service for general practitioners at Hawke's Bay Hospital on 0800-442-312**, this service allows direct discussion with a consultant physician for advice and support.

Admission criteria and treatment guidelines will be written by the Infectious Diseases Physicians nationally on confirmation of the virus involved. These will be disseminated to all general practices on completion.

Utilise triage checklist (Appendix 1) to screen suspected cases.

The patient care clinical pathway (Appendix 2) should be followed for all identified suspected cases.

Practice Responsibilities

Every practice must identify a liaison person whose role will be to:

1. Take lead responsibility for all infection prevention and control issues affecting the practice.
2. Ensure that general practitioners, practice nurses and reception staff are kept up to date with current information from the DHB and the Ministry of Health.
3. Ensure that all staff are adequately trained in infection control practice.

OPTIONS FOR SERVICE DELIVERY

Options to consider:

1. Practices with a limited number of staff may elect to take a collaborative approach with another practice.
2. Community Assessment Centres for the provision of primary care surge capacity arising from a sudden increase in demand (triggered by Code Red).

Functions:

- Provision of clinical assessment and advice
- Dispensing of antivirals and antibiotics
- Provision of triage and referral to other primary or secondary care
- Infection prevention and control

These centres would be based around those existing practices with the physical and management structures to support this form of care delivery.

3. Mobile general practitioner and practice nurse teams to manage home visits. Assessment of the patient and their household contacts should be by phone prior to the visit, if possible.

RECOGNITION AND MANAGEMENT

Utilise triage checklist to screen suspected cases. Patient's who telephone and are advised to attend the practice should be asked to bring their current medications with them.

The patient care clinical pathway should be followed for all identified suspected cases. Antiviral medicines will be supplied to patients meeting the criteria, some antibiotics and paracetamol may also be supplied.

Admission and treatment guidelines will be supplied by HBDHB.

Antiviral medicines will be used in the stamp it out phase for:

- The treatment of early cases
- Post-exposure prophylaxis of contacts
- Possibly pre-exposure prophylaxis of health-care workers

Antiviral medicines will be used in the manage it phase for:

- Patients with severe clinical influenza-like illness.
- Patients with influenza-like illness who are at high risk of influenza-related complications (immunocompromised or suppressed patients, pregnant women, severe or poorly controlled congestive heart failure, severe chronic respiratory disease, severe asthma, patients on renal replacement therapy).
- Patients with influenza-like illness who live or work in high risk institutions (residents of aged residential care facilities [ARRC] or other chronic care

facility, people who provide services in relatively closed settings to persons at high-risk).

- Cluster and/or infection control where appropriate on discussion with the Medical Officer of Health.

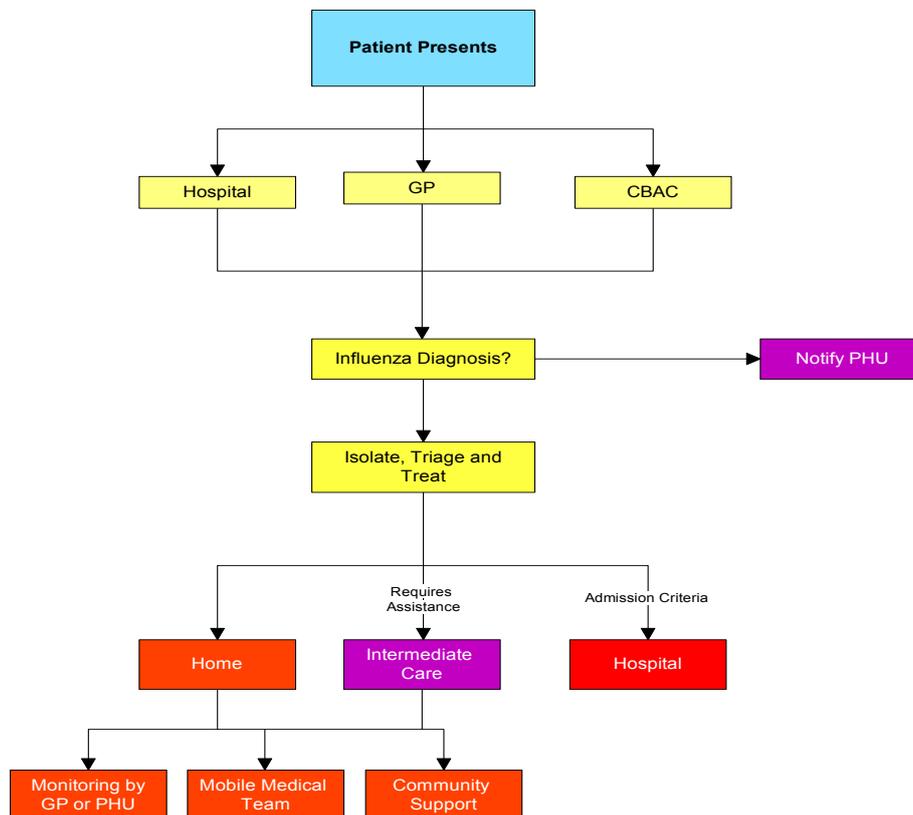
The MOH will be responsible for application to the MoH for release of the national supply to HB hospital pharmacy.

Effective vaccine is unlikely to be available for at least 12-16 weeks at which point the Public Health Unit will coordinate a mass immunisation campaign.

COMMUNITY OUTREACH SERVICE

Patients who are home bound may need to be visited and assessed by a registered nurse following infection prevention and control procedures. See Outreach Service Plan.

Patient Management Pathway



COMMUNICATION PLAN

Name	Title	Contact	After hours	Availability
DHB				
Ken Foote	Company Secretary	878-8109	N/A	8-5 Mon-Fri
	Emergency Response Advisor	878-8109		On-call
Margaret Drury	IPC	878-8109		On-call
Public Health Unit				
Dr Caroline McElroy	Medical Officer of Health	878-8109	As contact	On-call
Dr Rachel Eyre	Medical Officer of Health	878-8109	As contact	On-call
Dr Nick Jones	Medical Officer of Health	878-8109	As contact	On-call

Useful Websites:

Ministry of Health <http://www.moh.govt.nz/pandemicinfluenza>

WHO <http://www.who.int>

CDC <http://www.cdc.gov>

Daily reports to Emergency Operations Centre at Hawke's Bay Hospital during Phases 5 and 6.

REPORTING CASES

1. Early in the epidemic

Immediate notification of the first suspected cases is crucial. Phone 834-1815 (seven days). Ask to speak to a Medical Officer of Health (MOH). Do not leave a message. Make sure you speak directly to a MOH. Detailed information will be required about each case and the MOH will work closely with the practice to formulate an immediate plan of action, including investigation and management of the case and contacts.

2. When the MOH advises that a Hawke's Bay epidemic is established

At this point the MOH will advise all centres that the reporting requirements are to be reduced to a minimum, Pandemic Minimum Data Set (PMDS), e.g. report date, name, age, gender, ethnicity and suburb or street address. PMDS Forms to be faxed to the DHB's Emergency Operations Centre.

SURVEILLANCE

Surveillance means collecting and reporting data about cases to describe the evolving epidemic to help guide a response. Surveillance will be carried out by the Public Health Service (PHS).

Surveillance updates will be available for practitioners on the **Hawke's Bay** District Health Board website: <http://hawkesbaydhb.govt.nz/> click "Public Health Alerts".

ISOLATION OF SUSPECTED CASES

The separation of routine patients from those suspected of having influenza must be planned. This can be achieved by the following strategies: minimising time spent in waiting rooms, separating suspected patients as quickly as possible, providing separate entrance/waiting rooms for these patients, placing suspected patients directly into a single, dedicated room. Designated staff should manage the patients in this area.

Prompt triage will assist in patient placement. Providing a surgical mask will minimise contamination of others and the environment.

INFECTION PREVENTION AND CONTROL PRECAUTIONS

Initial precautions

Such a major health event can only be handled by the whole general practice or Accident and Medical (A&M) team and the team should be involved in any planning and preparation. Do not forget the cleaner. Your first suspicion of influenza in your community may come through a phone call. Consider how you will deal with this.

It is recommended that all staff be vaccinated each year against seasonal influenza. While this may not protect against pandemic influenza, it will maintain the general wellness of your team. Create an expectation that sick staff should stay at home.

Initial precautions for people dealing with someone suspected of having pandemic influenza include:

- **Keep your distance**
One metre is accepted as safe and significantly reduces your exposure
- **Wear a surgical mask and gloves**
Also offer a mask to any patient and support people
- **Rigorous, frequent hand hygiene**
Use an antimicrobial hand gel or wash in warm water with soap, Dry hands with paper towels.
- **Where possible try to separate patients with respiratory symptoms from other patients**
- **Ventilation**
Keep windows open if possible, if air conditioning is used, ensure that designated areas can be isolated from the rest of the facility

Each general practice or A&M should promote hand washing, the use of tissues when coughing or sneezing, or sneezing/coughing into the elbow.

Include in your plan:

- How to handle patient care equipment and soiled linen (backtraps should be fitted to all bag-mask devices to enable ease of cleaning)
- Environmental cleaning and spills management
- Appropriate waste disposal processes (biohazard bags supplied by the DHB, HB Medical Waste contracted by the DHB to collect waste daily)
- Support for staff to regularly monitor their own health
- Provision for individuals responsible for monitoring staff use of PPE and infection prevention and control practice

Patients should:

- Be isolated if possible, if single rooms are not available, suspected cases may be grouped in one area
- Be encouraged to wear a disposable surgical mask
- Be asked to cough/sneeze into a tissue and to dispose of the tissue afterwards, then wash hands in warm water with soap or use an antiseptic hand gel, hands must be thoroughly dry

Essential supplies

- Gloves
- Surgical masks
- Disposable thermometers
- Tissues – for both waiting and consulting rooms
- Waste disposal bins and medical waste disposal bags – with lids for infection prevention and control
- Antimicrobial hand gel or soap and water and paper towels for drying

DAILY ENVIRONMENTAL CLEANING

Horizontal surfaces should be wiped down with environmental wipes after each suspect patient. Patient care areas must be cleaned at least daily on completion of other routine cleaning.

Protective clothing (mask, gown and gloves) must be worn. Use sodium hypochlorite 100mL in 1L of water (1:10). Clean all horizontal surfaces and all surfaces that are touched by patients and staff. Floors are to wet mopped with clean water and detergent with the mop rinsed thoroughly on completion and inverted to dry. Cleaning cloths should be disposed of in a biohazard bag. All patient equipment unable to be disposed of should be cleaned with environmental wipes followed by sodium hypochlorite 100mL in 1L of water (1:10) and left to dry.

A linen skip and a biohazard bag must be kept in the designated area. Minimal linen should be used and changed after each patient taking care not to shake it. All waste (except sharps) must go into the biohazard bag. Linen and waste must be emptied daily or when containers are two thirds full.

INFORMATION

Messages to the public will be distributed centrally by HBDHB following MoH advice, this will assist in managing expectations. HBDHB will also provide public information on local arrangements.

Information pamphlets are available on the MOH website. (www.moh.govt.nz/pandemic). Regular bulletins will be coordinated through the DHB. A hotline number may be made available through the DHB for updated information on 0800 777 790.

LABORATORY AND RADIOLOGY FACILITIES

Laboratory specimens will only be collected in the early stages of the pandemic. See Appendix 5 for specimen collection procedures.

Patients with suspected pandemic influenza should not be sent to a community laboratory for collection of throat or nasopharyngeal swabs.

Specimens should be double-**bagged and couriered to the Laboratory at Hawke's Bay Hospital.**

Radiology service arrangements will continue as normal practice arrangements **dictate. They will be supported by Hawke's Bay Radiology for non influenza patients** with transport to services the responsibility of the DHB.

SUPPLIES

Supplies of PPE should be held by each practice to manage initial cases with resupply through the national reserve held by HBDHB on release by the MoH.

Essential supplies recommended by the MOH for primary healthcare include: gloves, surgical masks, at least two higher level PPE kits, disposable thermometers, tissues, waste disposal bins with lids, and antimicrobial hand gel or soap and paper towels for drying.

Equipment for collection of multiple specimens (as describe above) for viral culture and PCR.

Include in your plan:

- A system for management of stock levels and reordering
- Security for critical supplies

TEMPORARY ACCOMMODATION

Arrangements for temporary accommodation for staff who are willing to work but do not wish to go home should be made.

Coordination of temporary accommodation, if required, for patients who live alone will be carried out by HBDHB.

TRAINING

A training plan has been prepared by HBDHB to ensure consistent messages for all staff.

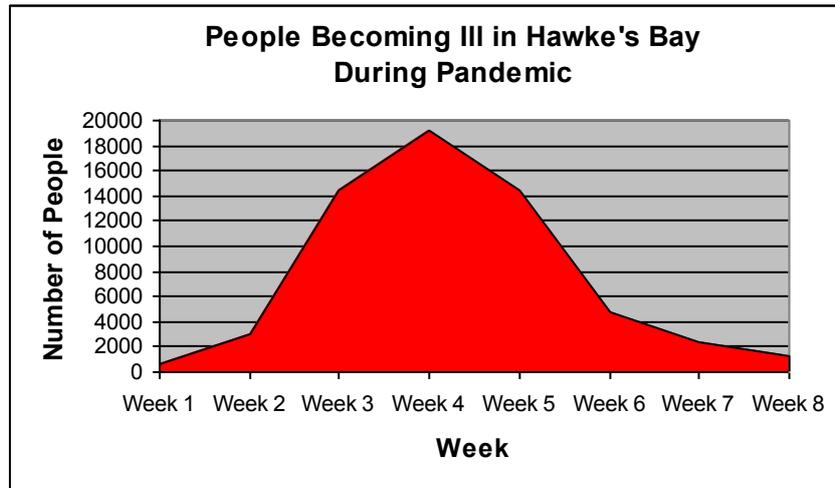
WORKFORCE MANAGEMENT

Workforce management requires sensible rostering, cover for sickness and absenteeism and attention to staff welfare. Volunteers and ex staff may be utilised although considerable thought is required as to the tasks that may be allocated to these groups. Rostering should consider short rotations in influenza care provision and adequate break time.

Discussion with staff in the planning phase is essential to determine who will be most likely to be available, and skills that might be adapted to provide cover.

In the event of practices amalgamating to provide cover, advice should be given to patients using a standardised approach.

Workforce planning should consider the need for increased staffing during the peak of the pandemic.



Note: This is one scenario for a pandemic wave based on a Ministry of Health modelling tool which draws on data from the 1918 pandemic using a "standard planning model" of 40% attack rate and 2% case fatality rate. This would result in 59,702 cases and 1194 deaths in Hawke's Bay.

For further information regarding workforce planning refer to the Ministry of Economic Development planning guide:

http://www.med.govt.nz/templates/MultipageDocumentTOC_14455.aspx

APPENDIX 1

CHECKLIST – INFLUENZA PANDEMIC STRAIN

Complete the following checklist at first contact with patient, i.e. in triage room or over the telephone.

30 September 2016

Yes

1. History of fever, chills, sweating or clinically documented temperature $\geq 38^{\circ}\text{C}$

Plus

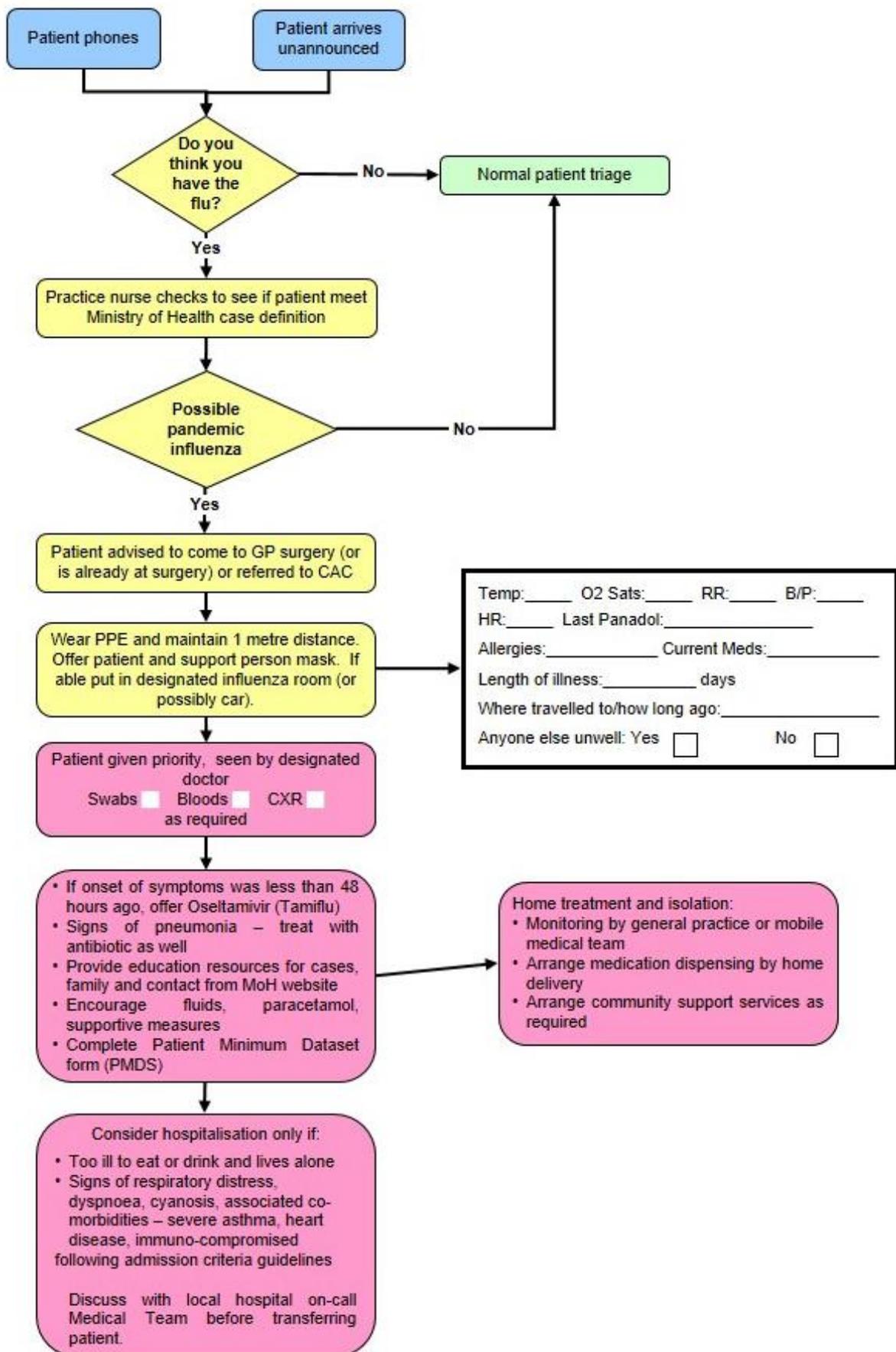
2. Cough **or** sore throat

Patients with **both 1 and 2** meet the definition of influenza-like illness.

If you have a suspect case, direct patient to nearest community assessment centre, if activated, or general practice caring for influenza related illness if triage over the phone. If patient has presented at general practice, put a mask on the patient and put on protective clothing immediately, direct the patient to the designated influenza area.

APPENDIX 2

**Primary Health Pandemic Influenza Presentation
Patient Care Clinical Pathway**



APPENDIX 3



**Pandemic Minimum
Data Set**

Name of Practice:	Date:
Clinical Assessor:	Signature:

Name:	Given	Middle	Family
Address:			
House Number:			
Street:			
Suburb:			
Town:			

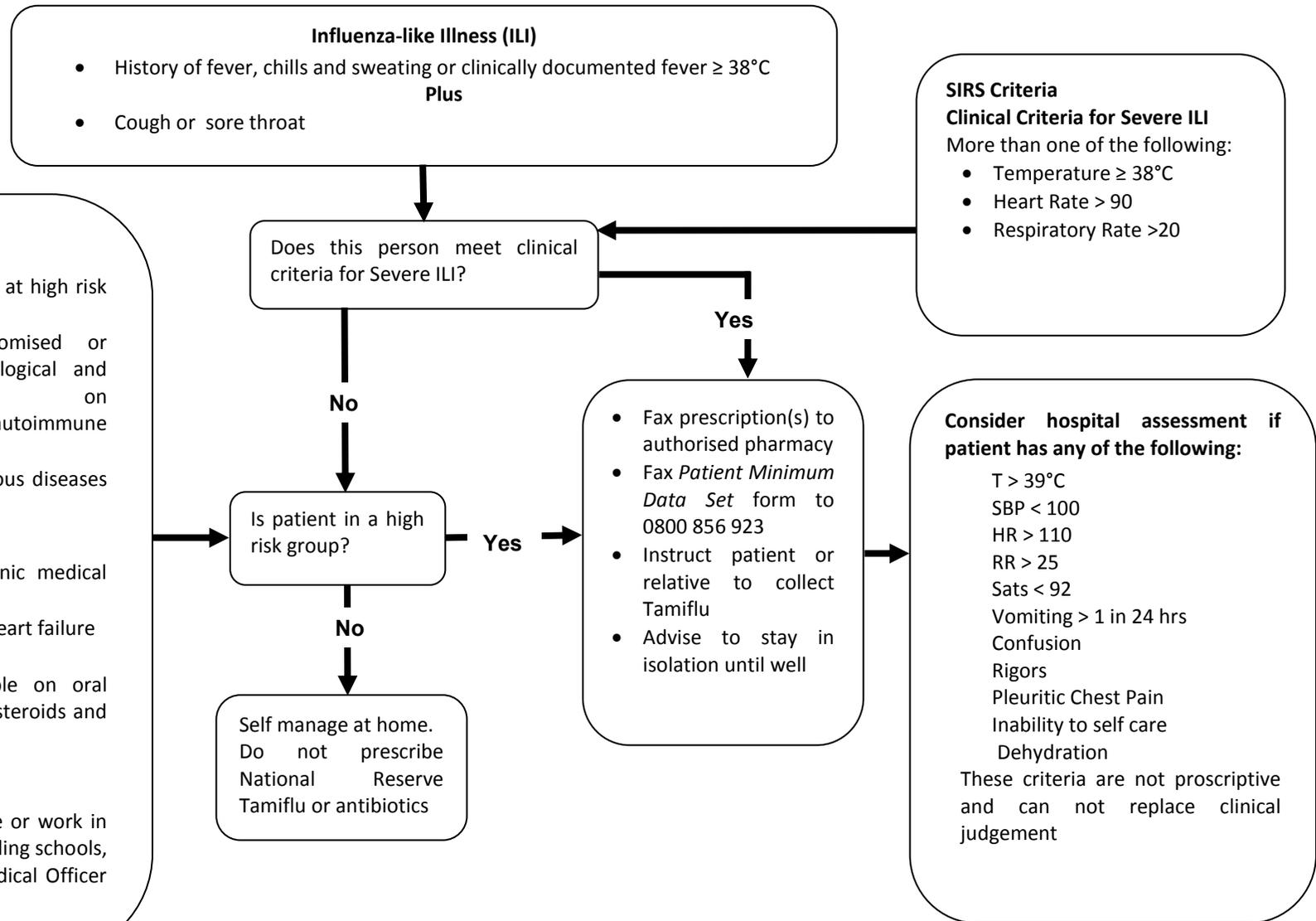
Gender: M / F	DOB:	NHI:		
Ethnicity:	European	Maori	Pacific	Other

Please Circle Appropriate Codes

Category Codes		Antiviral Status Codes	
GEN	General Public	TRT-T	Treatment provided – Tamiflu
HCN	Health Care Nurse	TRT-R	Treatment provided – Relenza
HCD	Health Care Doctor	OWN-T	Antiviral treatment from own supply - Tamiflu
HPA	Health Care Ambulance	OWN-R	Antiviral treatment from own supply - Relenza
HCO	Health Care Other Direct Contact	POP-T	Post exposure prophylaxis with Tamiflu
BOR	Border Worker	POP-R	Post exposure prophylaxis with Relenza
POL	Police	Antibiotic Codes	
DEF	NZDF Member	NIL	No antibiotics provided
COR	Corrections Worker	TRT	Antibiotic treatment provided – evidence of existing respiratory bacterial infection
FIR	Fire Service Worker	PRO	Prophylactic/precautionary antibiotics provided because of unusual vulnerability to bacterial infection (e.g. person with COPD, CHF, asthma or other condition)
SOC	Civilian Social Support Worker	Antibiotic Prescribed	
Treatment Rationale Codes		AUG	Augmentin
ILI	Severe influenza-like illness	COT	Co-Trimoxazole
HRG	High risk group	DOX	Doxycycline
HRI	High risk institution – MUST be discussed with the Medical Officer of Health	FLU	Flucloxacillin

Please fax completed form and copy of prescription to: 0800 856 923

Management of Patient with Influenza-Like Illness



APPENDIX 5

	DHB _____	Location _____	Date _____	Local code/number _____
PATIENT IDENTIFICATION		Compulsory Information		
Date of Birth* ____/____/____	Age* _____	NEXT OF KIN Name _____		
Family Name* _____	Sex* M <input type="checkbox"/> F <input type="checkbox"/>	Address _____		
Given Name* _____	Middle Name* _____	Phone _____		
Address: No.* _____ Street* _____		Relationship to you _____		
Suburb* _____	City/Town* _____	DO YOU HAVE: Yes No Details		
Phone no.* _____	Other phone _____	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
GP* _____	NHI (if known) _____	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
OTHER INFORMATION How many days have you been unwell? _____ days		Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
What are your symptoms?	Yes No	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Uncontrollable shivering	<input type="checkbox"/> <input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Drowsiness or confusion	<input type="checkbox"/> <input type="checkbox"/>	Other illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
Severe pain	<input type="checkbox"/> <input type="checkbox"/>	ARE YOU: Yes No Details		
Headache	<input type="checkbox"/> <input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/> <input type="checkbox"/>	Disabled	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/> <input type="checkbox"/>	Living alone	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/> <input type="checkbox"/>	if living alone have you someone nearby to look after you <input type="checkbox"/> <input type="checkbox"/>		
Red/watery eyes	<input type="checkbox"/> <input type="checkbox"/>	Allergic?	<input type="checkbox"/>	<input type="checkbox"/> What to?
Ear ache	<input type="checkbox"/> <input type="checkbox"/>	MEDICATIONS: Please list _____		
Aching muscles	<input type="checkbox"/> <input type="checkbox"/>	_____		
Sore throat	<input type="checkbox"/> <input type="checkbox"/>	_____		
Diarrhoea	<input type="checkbox"/> <input type="checkbox"/>	_____		
Yellow/bloody/brown sputum	<input type="checkbox"/> <input type="checkbox"/>	_____		
Sharp chest pain on breathing	<input type="checkbox"/> <input type="checkbox"/>	OCCUPATION: General public <input type="checkbox"/> Dr <input type="checkbox"/> Nurse <input type="checkbox"/> Other health care <input type="checkbox"/> Police <input type="checkbox"/> Border worker <input type="checkbox"/> Corrections worker <input type="checkbox"/> Fire Service <input type="checkbox"/> Defence forces <input type="checkbox"/> Civilian social support worker <input type="checkbox"/>		
Other symptoms?	<input type="checkbox"/> <input type="checkbox"/>	_____		
ETHNICITY: European <input type="checkbox"/> Maori <input type="checkbox"/> Pacific <input type="checkbox"/> Asian <input type="checkbox"/> Middle Eastern/Latin American/African <input type="checkbox"/> Other _____				
		TRIAGE NOTES		
Time				
≥200		≥130		
190		120		
180		110		
170		100		
160		90		
150		80		
140		70		
130		60		
120		50		
110		≥40		
100		≥30		
90		25		
80		20		
≤70		15		
≥39		10		
38.5		5		
38		A		
37.5		V		
37.0		P		
36.5		B		
36.0		≥90		
35.5		88-90		
≤35		≥60		
BSL		Pain/10		
MEWS key	1	2	3	
		CBAC Area Initials		
		Move to CBAC area according to MEWS score.		
		CLINICAL NOTES AND TREATMENT		
		ANTIVIRALS: YES Treatment given		
		<input type="checkbox"/> Post-exposure <input type="checkbox"/> Own supply <input type="checkbox"/>		
		Dose _____		
		No Offered & declined <input type="checkbox"/> 48 Hr+ <input type="checkbox"/>		
		Failed case definition <input type="checkbox"/>		
		ANTIBIOTICS: Underlying condition? Yes <input type="checkbox"/> No <input type="checkbox"/>		
		Given for infection <input type="checkbox"/> or prophylaxis <input type="checkbox"/>		
		Antibiotic _____		
		Dose _____		
		EXIT/PLACEMENT Home (No assistance) <input type="checkbox"/> Home (with assistance) <input type="checkbox"/>		
		CBAC area 1 or 2 <input type="checkbox"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/> Delsite _____		
		Referred to _____		
		CLINICAL ASSESSOR (Area 3) Print name _____		
		Signature _____ Discharged time _____		
		Qualification: RN <input type="checkbox"/> DR <input type="checkbox"/> Other (Please state) _____		

CBAC AREA 1 & 2 INITIAL ASSESSMENT					<small>Local code/number space</small>
Australasian Triage Score (circle) 1 2 3					Record obs. on front sheet Initials
TREATMENTS All prescriptions must be signed for by Nurse (if standing order) or Prescribing Dr.					
Drug/Fluids/Oxygen	Dose	Route	Signature or Standing order	Given by	Time
OTHER INSTRUCTIONS					Initials
EXAMINATION FINDINGS					Initials
POST-TREATMENT FINDINGS					Initials
DIAGNOSIS AND OTHER INFORMATION					Initials
DISCHARGE ADVICE/TREATMENT					Initials
PRESCRIPTIONS					
ANTIBIOTICS*		ANTIVIRALS*		OTHER MEDICATION PRESCRIBED	
Underlying condition? Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes Treatment given <input type="checkbox"/> Post-exposure <input type="checkbox"/>		Initials	
Given for infection <input type="checkbox"/> or prophylaxis <input type="checkbox"/>		Own supply <input type="checkbox"/> Dose _____			
Antibiotic _____		No Offered & declined <input type="checkbox"/> 48 Hrs+ <input type="checkbox"/> Failed			
Dose _____		Case definition <input type="checkbox"/>			
NEEDS REFERRAL TO OTHER SERVICE: Referred time _____ to _____					
Referral accepted? _____					
Requires transport to other service? Yes <input type="checkbox"/> No <input type="checkbox"/> Time transport ordered _____					
Time transferred to other service _____ By _____					Initials
CLINICAL ASSESSOR (Area 1 or 2) Print name _____ Signed _____					
Qualification: RN <input type="checkbox"/> Dr <input type="checkbox"/> Other (Please state) _____ Discharge time _____ Place _____					

CRAC AREA 1 & 2 INITIAL ASSESSMENT					Local identifier space (as on front sheet)
Australasian Triage Score (circle) 1 2 3 Record Obs. on front sheet					Initials
TREATMENT					
Drug/Fluids/Oxygen	Dose	Route	Signature or Standing order	Given by	Time
OTHER INSTRUCTIONS					Initials
EXAMINATION FINDINGS					
					Initials
POST-TREATMENT FINDINGS					
DIAGNOSIS AND OTHER INFORMATION					
					Initials
DISCHARGE ADVICE/TREATMENT					
PRESCRIPTIONS					
ANTIBIOTICS		ANTIVIRALS		OTHER MEDICATION PRESCRIBED	
Underlying condition? Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes Treatment given <input type="checkbox"/> Post-exposure <input type="checkbox"/> Ova supply <input type="checkbox"/> Dose _____		Initials	
Given for infection <input type="checkbox"/> Prophylaxis <input type="checkbox"/>		Offered & declined <input type="checkbox"/> 48-Hrs+ <input type="checkbox"/> Failed course			
Antibiotic _____		Definition <input type="checkbox"/>			
Dose _____					
NEEDS REFERRAL TO OTHER SERVICE Referred time _____ to _____					
Referral accepted? _____					
Requires transport to other centre? Yes <input type="checkbox"/> No <input type="checkbox"/> Time transport ordered at _____					
Time transferred to other centre _____ By _____					Initials
Person accompanying _____ Relationship to child _____					
CLINICAL ASSESSOR (Area 1 or 2) Print name _____ Signed _____					
Qualification: RN <input type="checkbox"/> Cr <input type="checkbox"/> Other (Please state) _____ Discharge time _____					

APPENDIX 7

PERSONAL PROTECTIVE EQUIPMENT

Recommendations for PPE use

Personal protection equipment (PPE) includes masks, eye/face shields, gloves, gowns and aprons. Varying levels and types of PPE are required, depending on the level of exposure and the risk of transmission.

Whatever the level of PPE to be used, education and training is necessary to ensure **the equipment is used and disposed of correctly, to maintain the equipment's effectiveness.**

Estimate for PPE for GP Practice

One patient requires one GP and one Nurse:

PPE required for 1 patient = 2 masks, 2 pair gloves, 2 gowns

GP sees 4 patients per hour = 8 pair gloves per hour
= 96 patients per 24 hours
= 192 pairs per 24 hours
= 672 patients per week
= 1344 pairs gloves per week

Gloves supplied per box = 100 therefore 26-27 boxes of gloves per week

PFR95 masks ≤ 4 hours = 12 per day per one GP and one Nurse (6 each)
= 84 per week

PFR95 masks supplied per box = 35 therefore 2.4 boxes per week

Surgical masks for patients = 672 patients per week
Surgical masks supplied per box = 50 therefore 13-14 boxes per week

If the gown is to last 4 hours = 12 per day (as for masks)
= 84 per week

Gowns supplied per carton = 50 therefore 2 cartons per week

Gowns - you will need to decide how long your gown should last. In the hospital situation a gown is single use. In the primary care setting you may decide to use one gown for 4-8 hours. This will depend on the contact with patients and the care and contamination of the gown.

Gloves may not be required for all patient contacts. Hand hygiene (antimicrobial hand gel or soap and water wash) will be sufficient in most cases.

NOTE: These numbers are only estimates and may vary during the phases of a pandemic. There are many variables to be considered i.e. practice size, patients seen, acuity, potential for contamination of PPE.

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Summary of PPE requirements:

	Entering Room but no close contact (> 1 metre from patient)	Close patient contact (<1 metre from patient)	Aerosol generating procedure being performed (including nose/throat swabs)
PFR95 mask	No	No	Yes
Surgical mask	Yes	Yes	No
Gown, non sterile, long sleeved	No	Yes	Yes
Gloves, non-sterile	No	Yes	Yes
Eyewear, protective	No	No	Yes

Using disposable surgical masks, gloves and gowns/aprons

Disposable surgical masks are recommended for first responders and health care/support workers in a health care setting who are at risk from droplet transmission.

Disposable gloves are recommended as a means of reducing the likelihood of influenza transmission when handling objects contaminated with respiratory secretions. Apart from health care settings, the use of gloves is less important than careful hand hygiene. The use of gloves does not replace the need for hand hygiene.

Disposable gowns or splash resistant aprons may also reduce opportunities for transmitting influenza. However, it may not always be practical to use gowns/aprons outside the health care setting.

Using particulate respirator masks (PFR95), eye protection, gloves and gowns/aprons (full PPE)

Health care workers should wear particulate respirator masks, eye protection, gloves and gowns/aprons (i.e. full PPE) when there is a high risk of direct contact with respiratory secretions, particularly via aerosols. This will apply mostly in inpatient settings during some invasive procedures.

In most other settings a disposable surgical mask (with or without eye protection and disposable gloves) will provide sufficient protection from droplet transmission for health care workers in close contact and/or providing direct personal care to patients with pandemic influenza.

Checklist for Staff before Entering Designated Areas

The following points must be checked before entering a designated area:

- Cellphones or pagers left outside the area along with pens, stethoscopes and tourniquets
- Shoulder length hair must to clipped or tied back
- Shoes should cover and protect feet from splashes and dropped equipment and should have wipeable surfaces
- A mask must be worn and fit securely
- A gown must be worn and be tied firmly
- Gloves must be worn and cover the wrists

APPENDIX 7

USING PERSONAL PROTECTIVE EQUIPMENT

Order for putting on:

- Change into work clothing, shoes should be either designated work shoes or be suitable for disinfection
- Put on gown or apron
- Fit mask ensuring a good seal (can be worn for 4 hours before being replaced unless wet)
- Put on gloves ensuring they are a good fit

Removal:

- Remove gown/apron and gloves (if worn) taking care to minimise contamination of self and clothes
- Using two hands, untie mask strings and lift off forwards taking care not to touch the pouch of the mask

Perform hand hygiene

Notes:

If any of the following occurs the mask must be changed:

- if you touch it
- if it is grossly contaminated
- if it becomes wet for any other reason
- if it becomes hard to breathe through

Masks should be placed in a biohazard bag after removal.

If at any time gloves become contaminated, they must be removed, hand hygiene performed and clean gloves put on.

Gloves are not a replacement for hand washing.

SPECIMEN COLLECTION

All samples should be sent by the usual Southern Community Laboratories specimen collection service to **Hawke's Bay Hospital Laboratory**.

Who should be swabbed?

- Swabbing should be reserved for only those patients with influenza-like illness who are in high risk groups or situations.

People on antiviral medication

- Antiviral medication reduces the yield from viral swabs.
- If an adult case has commenced a *twice-daily treatment* course of antiviral medication, do not take swabs. Children excrete a higher viral load. If a child case has been on a *twice-daily treatment* course of antiviral medication for ≥ 48 hours do not take swabs.
- For contacts on *once-daily prophylaxis* with antiviral medication who develop symptoms, a swab is indicated if within 48 hours of commencing antiviral medication.

People not on antiviral medication

- Virus shedding declines with time in untreated patients.
- Do not take swabs from an adult case who has had symptoms for five days or longer.

APPENDIX 7

- Children (especially young children) shed for longer, so untreated children can be swabbed even if they have had symptoms for longer than five days.

Samples required

- Nasopharyngeal swab in viral transport medium

Sample collection

Respiratory specimens should be collected as early as possible in the course of the illness. The likelihood of recovering most viruses and many bacteria diminishes markedly >72 hours after symptom onset. Some respiratory pathogens may be isolated after longer periods.

Equipment:

One pernasal swab with non-wooden shaft and synthetic fibre tip

One green top virology swab with viral transport medium

One pair of scissors

PPE i.e. gloves, gown, PFR95, faceshield, hat

Antimicrobial hand product

(i) Collection of nasopharyngeal swab

Use a pernasal swab with non-wooden shaft and synthetic fibre tip:

Insert swab into one nostril, parallel to the palate, rotate gently and advance until resistance is felt. (One eye often waters when swab is in the correct position.)

Press swab tip on the mucosal surface of the mid-inferior portion of the inferior turbinate and leave in place for a few seconds, then slowly withdraw using a rotating motion.

Place swab into **green pre-labelled viral transport medium tube.**

Cut off the cap with scissors and discard the cap.

Lay the medium tube to one side.

(ii) If the viral transport medium is liquid

Cut the swab sticks off just below the level of the bottle - so that there is no swab pressure for the viral media lid to pop off.

Ensure lid is firmly closed on viral specimen and taped to prevent leakage of viral media.

Packaging and Transport:

- The laboratory form should clearly indicate that this is a **request for "PCR testing for novel influenza infection"**. Write **"copy result to the Medical Officer of Health"**. Notifying the MOH is not required before sending the swab.
- Ensure the laboratory request form is fully completed with details including the NHI number and that the specimen container contains the patient name and NHI number.
- Specimens should always be double bagged and ensure that the snap lock is sealed on both bags. Place the request form in the pocket of the outside bag.
- Specimens should be transported by Southern Community Laboratories to the **Hawke's Bay** Hospital Laboratory.

APPENDIX 8

USE OF ANTIVIRALS

Influenza viruses develop significant resistance quickly for M2 channel blockers and zanamivir is not available in New Zealand. Therefore only oseltamivir (Tamiflu) will be described in detail.

First line health care workers will be using antivirals **from the Government's stockpile**, because the antiviral medication will be in short supply when the pandemic strikes. The MoH (directly or through Medical Officers of Health) will be communicating guidelines, protocols, and priorities for its use.

Tamiflu might be used prophylactically for exposed travellers, containment of sporadic clusters, essential services staff and therapeutically for all patients (initially), high-risk patients, essential services staff.

Tamiflu is licensed for the treatment of **influenza in adults and children ≥ 1 year of age**.

Tamiflu is indicated for the prophylaxis of influenza in adults and adolescents ≥ 13 years of age.

Presentation

Tamiflu capsules 75mg blister pack of 10 capsules

Tamiflu powder for oral suspension 12mg/mL bottle pack with 30g of powder

Dosage and Method of Administration

Tamiflu may be taken with or without food. However, Tamiflu taken with food may enhance tolerability in some patients.

Standard Dosage

Treatment of influenza

Treatment should begin within the first or second day of onset of symptoms of influenza.

Adults and adolescents

The recommended oral dose of Tamiflu capsules in adults and **adolescents ≥ 13 years** is a **75mg capsule twice daily, for 5 days**. **Adults and adolescents ≥ 13 years of age** that are unable to swallow capsules may receive a dose of 75mg Tamiflu suspension bid for 5 days.

Children

Children > 40 kg or ≥ 8 years who are able to swallow capsules may also receive treatment with a 75mg capsule twice daily as an alternative to the recommended dose of Tamiflu suspension (see below).

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The recommended oral dose of Tamiflu suspension for children ≥ 1 year of age is:

Body weight	Recommended dose for 5 days
≤ 15 kg	30mg twice daily
> 15 to 23 kg	45mg twice daily
> 23 kg to 40kg	60mg twice daily
> 40 kg	75mg twice daily

No dose adjustment is necessary for patients with creatinine clearance above 30mL/minute. In patients with creatinine clearance between 10 and 30mL/minute receiving Tamiflu it is recommended that the dose be reduced to 75mg of Tamiflu every other day or 30mg suspension every day. No dosing recommendation is available for patients undergoing routine haemodialysis and continuous peritoneal dialysis with end stage renal disease and for patients with creatinine clearance ≤ 10 mL/minute.

No dose adjustment is required for patients with hepatic dysfunction and no dose adjustment is required for elderly patients.

The safety and efficacy of Tamiflu in children under 1 year has not been established. Tamiflu should not be used in children under 1 year of age.

A bottle of 30g Tamiflu powder for oral suspension contains 25.713g of sorbitol. One dose of 45mg oseltamivir administered twice daily delivers 2.6g of sorbitol. For subjects with hereditary fructose intolerance this is above the recommended daily maximum limit of sorbitol.

Prophylaxis of influenza

The recommended oral dose of Tamiflu for prophylaxis of influenza is 75mg once daily for at least 10 days. Therapy should begin within two days of exposure.

Contraindications

Hypersensitivity to oseltamivir phosphate or any component of the product.

Information derived from pharmacology and pharmacokinetic studies of oseltamivir suggest that clinically significant interactions with other medicines are unlikely.

At present, insufficient data are available in pregnant women taking Tamiflu to enable an evaluation of the potential for oseltamivir cause foetal malformations or foetal toxicity. Tamiflu should therefore be used during pregnancy only if the potential benefit justifies the potential risk to the foetus.

APPENDIX 8

Undesirable Effects

Table 1: Most frequent adverse events in studies in naturally acquired influenza

Adverse Event	Treatment		Prophylaxis	
	Placebo N=1050	Oseltamivir 75mg bd N=1057	Placebo N=1434	Oseltamivir 75mg od N=1480
Nausea (without vomiting)	71 (6.8%)	113 (10.7%)	56 (3.9%)	104 (7.0%)
Vomiting	32 (3.0%)	85 (8.0%)	15 (1.0%)	31 (2.1%)
Diarrhoea	84 (8.0%)	58 (5.5%)	38 (2.6%)	48 (3.2%)
Bronchitis	52 (5.0%)	39 (3.7%)	17 (1.2%)	11 (0.7%)
Abdominal pain	21 (2.0%)	23 (2.2%)	23 (1.6%)	30 (2.0%)
Dizziness	31 (3.0%)	20 (1.9%)	21 (1.5%)	24 (1.6%)
Headache	16 (1.5%)	17 (1.6%)	251 (17.5%)	298 (20.1%)
Insomnia	10 (1.0%)	11 (1.0%)	14 (1.0%)	18 (1.2%)

Single doses of up to 1000mg of Tamiflu have been well tolerated apart from nausea and/or vomiting

HBDHB holds a small number of courses for management of a first case and close contacts. **The Ministry of Health reserve will be released to DHB's following this and distributed according to a national priority list.**

APPENDIX 9

VACCINE

Vaccine Management should be based on the following assumptions:

1. There will be a minimum of 6 months between a novel virus alert and the availability of vaccine.
2. The entire population will be susceptible and may require two doses of vaccine, one month apart, for adequate protection.
3. The proportion of influenza vaccine to be distributed and administered through the public versus the private sector is unknown. Even so, the amount, if not the proportion, of vaccine that will be distributed through the public sector during a pandemic will be greater than the amount distributed by the public sector in non-pandemic years.
4. There will be a national contract for purchase of vaccine.

Vaccine Administration

Vaccinators are authorised by the Medical Officer of Health pursuant to regulation 44a of the Medicines Regulations. Hawkes Bay has authorised vaccinators available with a database being maintained to record all vaccinations. A list of currently authorised vaccinators is held by the PHS. There are other registered nurses who could be rapidly trained and authorised to vaccinate.

Priority Groups List for Receipt of Vaccine

Because vaccine shortage during an influenza pandemic is likely, the MoH, in conjunction with various advisory committees, is in the process of formulating recommendations for a rank-order list of high priority groups for vaccination. The order of these groups will be based on a number of factors, including the need to maintain the infrastructure necessary to carrying out the pandemic response plan; to limit mortality among high-risk groups; to reduce morbidity to the general population; and to minimize social disruption and economic losses.

While any Priority Groups List will be subject to change, the list will most likely include the following groups:

- Health-care workers and public health personnel involved in the distribution of vaccine and antiviral agents
- Persons responsible for community safety and security, e.g. police, fire-fighters, military personnel, corrections officers, "first responders" not included in first priority group (e.g. ambulance officers)
- Other highly skilled persons who provide essential community services whose absence would either pose a significant hazard to public safety (e.g. air traffic controllers) or severely disrupt the pandemic response effort (e.g. persons who operate telecommunications or electric utility grids, care givers at residential facilities). [NOTE: Members of this target group are likely to vary widely from region to region, depending on local circumstances.]
- Persons traditionally considered to be at increased risk of severe influenza illness and mortality:
 - Persons of any age with high-risk medical conditions
 - Pregnant women
 - Persons in aged residential care facilities and other long-term care facilities
 - Persons > 50 years of age without high-risk medical conditions
 - Infants age 6-12 months (if supported by epidemiologic and clinical data)
 - Household contacts of persons with high-risk medical conditions

APPENDIX 9

- Others who, in the judgement of national and district health officials, provide critical community services (e.g. utility workers, funeral services personnel, personnel involved in the transport of essential goods such as food)
- Healthy persons age 18-49 years
- Pre-school-age (especially day-care-centre attendees) and school-age children (the population least likely to have severe illness)

Vaccination will be coordinated by the Public Health Service at HBDHB.

Information on Quarantine (Home Isolation) for Influenza

You have been asked to stay in isolation because:

1. You have suspected influenza and are infectious to others. Isolation in your home should continue for 72 hours after starting Tamiflu or 4 days if you are not taking Tamiflu.
2. You may have been exposed to influenza. Isolation in your home should continue for 72 hours after starting Tamiflu or 4 days if you are not taking Tamiflu.

The period of isolation may be lengthened if somebody else in your household becomes sick with suspected influenza.

We want you to restrict your activities to protect the safety of your family, friends and the community. This information sheet is to tell you what isolation means.

Staying at home.

You must not go to school, work, child care or out in public until cleared by the Public Health Nurse. This means you must not attend shopping centers, movies, parties or any social gatherings at all.

Visitors

You should have no visitors until you come out of isolation. Talk by phone and have things delivered to the door. Sometimes a visitor is essential (for example someone has to come into the house to give you essential home support). The visit should be brief. You and the visitor must both wear a mask. Talk with the visitor outside in the open air if possible and keep at least two metres away from them.

Preventing the spread of infection

Stay in a part of the house where you have minimal contact with other people. Try to keep well people and sick people apart.

Give people who have a fever and/or diarrhoea plenty to drink.

Give Paracetamol for fever. *Do not give Aspirin to children under 12 if they have a fever.*

Open doors and windows and ventilate the house as much as possible.

Cover your mouth and nose with a tissue or toilet paper when you are coughing or sneezing. Put the used tissue straight into a rubbish container. Wash and dry your hands afterwards.

Wash and dry your hands after you use the bathroom or toilet. Wash and dry your hands before you prepare food and eat, and when you are looking after sick people.

If you have more than one toilet, then one should be reserved for use by sick people.

Twice a day clean the following: with 1 part household bleach to 10 parts water:

- toilet handle and door handles of toilet, bathroom and rooms of isolated people
- bathroom sink and taps

Use 1 part household bleach to 10 parts water.

Nobody else should use anything that could be contaminated with your throat or nose secretions or coughing or faeces – e.g. towels, handkerchiefs, eating utensils, food, bed linen, cigarettes, marijuana joints, P pipes, kava bowls.

Sharing bedding, clothing and utensils may spread infection, but you do not need to wash a **sick person's bedding**, clothing and utensils separately from the rest of the family's.

If you wash and dry all these things in the usual way they will then be safe for others to use.

Using face masks.

The Public Health Nurse will show you how to wear a mask.

- Sick people should wear a surgical mask if anyone is in their room and if they have to leave their room.
- People who are in quarantine but not sick should wear a particulate respirator (PFR95) mask if they are in the same room as a sick person.
- Essential visitors to the house should wear a particulate respirator (PFR95) mask through their visit.

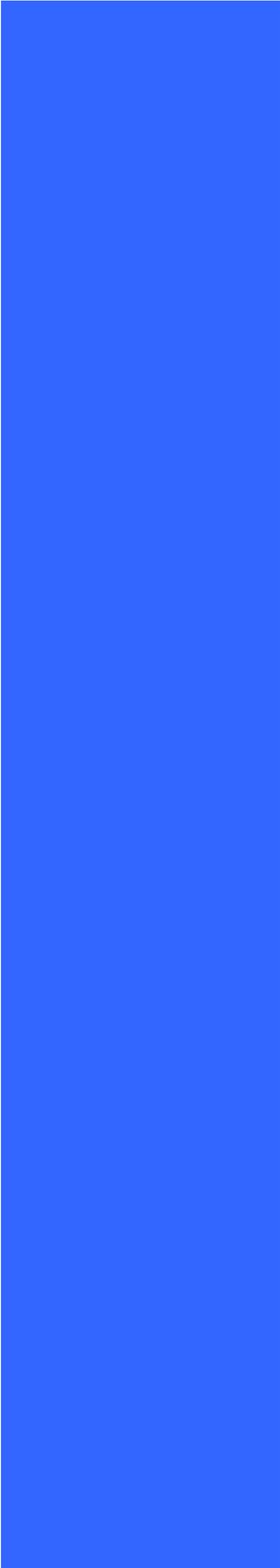
Used masks should be put in the normal household rubbish.

Coming out of isolation

The Public Health Nurse or your doctor will tell you when you are cleared to come out of isolation. At that time you will be non-infectious to others. It will then be safe for you to resume your normal life.

Questions

Your Public Health Nurse will be happy to answer any questions.



Public Gathering SOP

Closure and re-opening of public places, events and gatherings

Plan for pandemic influenza

Introduction:

This plan is developed as part of a number of workstreams to enhance Hawke's Bay pandemic preparedness.

Definitions

Public place or event – any congregation of people at any premises or place, whether indoors or outdoors, public or private. This may include workplaces. There are a few exceptions - see Related legislation.

Order – a published order by a MOH which closes premises or forbids congregation of people.

Abbreviations

CIMS – coordinated incident management system
HECC – Health Emergency Coordinating Committee
HBDHB – Hawke's Bay District Health Board
MOH – Medical Officer of Health
PHS – Public Health Service
PPE – personal protective equipment

Related legislation

Health Act s70, 71 (requires public health or civil defence emergency to be declared), s79.
Other sections may be relevant: 72,75,76,80,84,86,96,97,99,105,106,111,112.

Epidemic Preparedness Act 2006 repeals and replaces some sections of the Health Act. This Act enables the Prime Minister on the advice of the Director-General of Health to introduce a wide range of emergency powers including:

- The MOH would have powers to require premises to close and to forbid people to congregate. These premises and congregations of people may be public or private. "Premises" does not include private dwellings, parliament, courts or prisons. The MOH must publicise an order.
- Powers for police to assist the Medical Officer of Health. Police may consider (as a last resort) using the following statutory provisions to detain anyone who does not comply with MOH requests: Summary Offences Act (obstruction); Crimes Act (criminal nuisance). However the powers under the Epidemic Preparedness Act 2006 should be sufficient.

Civil Defence Emergency Management Act 2002.

Related HBDHB pandemic plans

- Communication
- Security
- Command and Control
- Trigger Points

- Deceased Persons Procedures
- Pandemic Section in CDEM plan

Related plans of other agencies

New Zealand Influenza Pandemic Plan.

Ministry of Education: Pandemic Planning Kit for Schools and Early Childhood Education (ECE) Services.

<http://www.minedu.govt.nz/index.cfm?layout=document&documentid=10981&indexid=10898&indexparentid=6088>

Aims and general purpose

To describe the purpose and processes for closure and re-opening of public places and events during a pandemic.

Assumptions

Closure of public places and events will achieve social distancing and this will reduce the opportunities for virus transmission.

Some degree of voluntary social distancing will occur spontaneously by the public during a pandemic. Most people will be happy to follow recommendations from the MOH.

Some people and groups will be reluctant or extremely opposed to social distancing which interferes with their planned activities. They will ignore public health recommendations for closure of public places or events. Some people will give cultural and lifestyle considerations priority over the need for social distancing.

Indoor events will be more likely to transmit infection than outdoor ones.

Closure of places and events involving children will have relatively more effectiveness than those involving adults only. Children shed more virus, for longer, and are less likely to be able to observe infection control recommendations.

Closure of places and events involving children will have significant flow-on effects on health and all economic activity because parents will have to cease work to care for children.

Closure of workplaces would lead to significant economic hardship for many people.

Conditions under which the plan comes into force

From the earliest stage in the epidemic, during the “Stamp-it-out” phase focused closure of public places and events should be considered as part of the public health management for every case.

Widespread closure of public places and events should be considered during the epidemic as clusters of cases appear and when cases become widespread.

Operational Structure:

The decision to close public events and places will be made by the Medical Officer of Health who has the necessary legal powers. This decision should be made with the Response Coordinator.

Relationships with other levels of government

Use of MOH powers under s70 and s71 of the Health Act require a public health emergency to be declared by the Director-General of Health or a civil defence emergency to be declared.

Emergency powers of the MOH under the Epidemic Preparedness Act 2006 will only be available when a notice is placed in the Gazette by the Prime Minister.

Communication Plan/Issues:

Types of messages, how they will be distributed, obligations on receipt

Under the Epidemic Preparedness Act 2006, orders by the MOH *must* be communicated via newspaper *and* a TV channel or radio station that most people in the district can receive.

Orders by the MOH will also be communicated to people in the following ways:

General channels

- HBDHB 0800 number and website
- News media – local radio, TV and newspapers
- Local authority community development officers
- Primary healthcare providers, including Māori and Pacific Island NGO providers
- Through Iwi / taiwhenua to marae representatives

Specific to particular groups affected by the closures

- Letters, including to marae committees
- Email bulletins
- Telephone trees
- Text messages
- Websites
- Fax
- Notices at venues e.g. marae, churches, clubrooms etc

Preparedness:

Relationships required

Iwi

Police

Educational institutions

Organisations involved in social, business, tourism and leisure activities

Media

Risk assessment

The public may be unprepared for the possibility of closures because insufficient public communication has been carried out.

People may ignore the closures and police enforcement may be necessary.

Closures may be perceived as unpopular and ineffective because the virus will spread despite closures.

The media may communicate the messages in a way which raises rather than lessens public alarm.

Groups and organisations may have no contingency plans for closures, with resulting confusion and poor implementation.

Public health and police personnel may have insufficient resources to enforce orders. Therefore orders should be realistic and carefully considered.

Some Māori will wish to use their marae as places to take their sick. They will expect treatment services to be there and to be able to leave or remain with their sick according to their preference. Not all Māori will take this course – some will stay away from the marae for fear of infection.

Operational Procedures:

Roles, relationships and tasks

Agency	Role and task	Relationships
MOH	Identify closures needed and make the orders. Communicate the details of the orders rapidly. Revoke the closure orders.	Response Coordinator The police The public The media
Police	Support the MOH as requested to enforce orders.	MOH
Response coordinator	Communicate with Incident Management Team about the orders.	MOH

Action required at different alert phases

Closures will be made throughout the epidemic from the first cases or clusters until the epidemic has waned.

Revocation of closures should only be made after consultation with the Incident Management Team. Consideration should be given to the possibility that further epidemic waves might make the revocation premature.

Resources e.g. designated sites, equipment required

Police for enforcement.

Contingency plans needed for all organisations and groups.

Workforce issues

The closures will impact on workforce in industries, including health. If there is widespread civil disobedience of closures they will impact seriously on police and security workload.

Reporting

Daily report on closures in place to Response Coordinator, Police, CACs, Outreach Services and the MoH.

This would form part of the daily PHS report to the Planning and Intelligence Manager.

Names, addresses and contact numbers

Lists held by the HBDHB will be used to communicate closures.

Implications

The workforce group should examine the issue of whether compensation will be paid for loss of business earnings if premises are closed.

Lists of email contacts are needed for access to organisations involved in social, business, tourism and leisure activities.

Communication about the possibility of closures should begin before a Hawke's Bay epidemic begins so that closure orders do not come as a surprise. Such communication should include the likelihood that closures will only reduce the rate of transmission, not

prevent it entirely. This communication plan should include discussions with Hawke's Bay media so that accurate information can be conveyed which minimises unnecessary alarm.

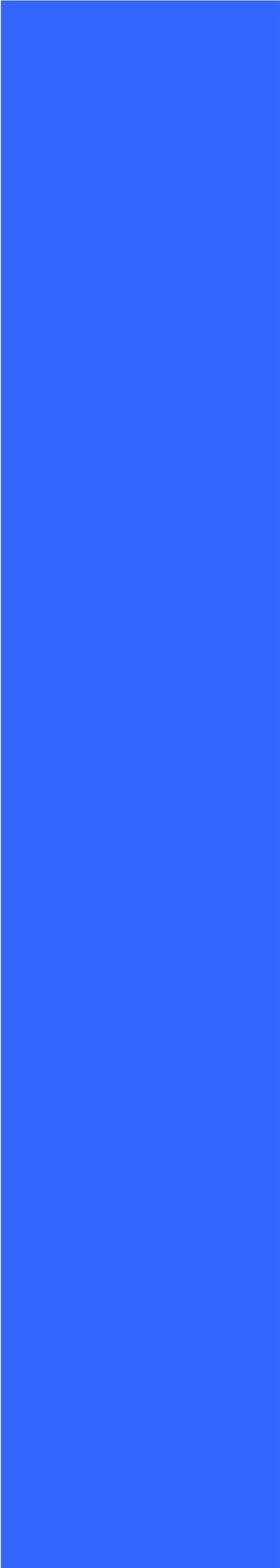
All groups and organisations need to be advised to develop contingency plans for closures.

Police should consider options for increased workload which may be involved in enforcing closures.

The HECC should be aware that Māori may be expecting treatment services at their marae.

If Māori intend to go to their marae when there is a closure order on public premises or gatherings, the MOH and response coordinator will need to decide:

- How the risk of increased transmission on marae can be clearly communicated to Māori
- How HBDHB can best work with marae to make the marae gatherings as safe as possible



Quarantine and Isolation Plan

Quarantine and isolation plan for pandemic influenza

Introduction:

This plan is developed as part of a number of workstreams to enhance Hawke's Bay pandemic preparedness.

Definitions

Case: someone who is thought by a doctor to meet the case definition for pandemic influenza. The case definition is on the Ministry of Health website: http://www.moh.govt.nz/moh.nsf/wpg_index/About-Influenza+-+avian+influenza+-+case+definition

Contact: Anyone who has had:

- Contact with the respiratory secretions of a case in an enclosed space.
- Contact with the faeces of a case.

Household, work and institutional contacts during the infectious period of the case will almost always be defined as contacts.

Isolation means restricting the activities of cases until they are no longer infectious.

Quarantine means restricting the activities of contacts (people who have been exposed to a case but are still not sick) until the incubation period has expired.

Abbreviations

HECC – Health Emergency Coordinating Committee

MOH – Medical Officer of Health

PHS – Public Health Service

PPE – personal protective equipment

Related legislation

Health Act s70, 71 (requires public health or civil defence emergency to be declared), s79.

Other sections may be relevant: 72,75,76,80,84,86,96,97,99,105,106,111,112.

The Epidemic Preparedness Act 2006 enables the Prime Minister on the advice of the Director-General of Health to introduce a wide range of emergency powers including:

- extension of quarantine powers to cover aircraft as well as ships and to cover pandemic influenza. (Currently the Health (Quarantine) Regulations 1983 do not apply to influenza).
- Medical Officer of Health powers to close public events and requisition resources.
- powers for police to assist the Medical Officer of Health. Police may consider (as a last resort) using the following statutory provisions to detain anyone who does not comply with MOH requests: Summary Offences Act (obstruction); Crimes Act (criminal nuisance). However the powers under the Epidemic Preparedness Act 2006 should be sufficient.
- information to assist contact management
- management of infected people
- disposal of infected things or craft

Civil Defence Emergency Management Act 2002.

Powers of Medical Officers of Health under the Health Act at the border in an emergency.

Related HBDHB pandemic plans

HBDHB pandemic plans for

- Interagency Plan for Management of First Cases
- Port and Airport
- Communication
- Public Health Service - Quarantine Policy for Port of Napier and Hawke's Bay Airport - PHU PPM/81
- Antivirals
- Security
- Primary Care
- Non-seasonal Influenza Policy, Public Health Service, Hawke's Bay District Health Board

Aims and general purpose

To minimise the spread of pandemic influenza by isolating cases and quarantining contacts.

Assumptions

1. During an epidemic most cases will not be able to be hospitalised (or not be sick enough to be hospitalised).
2. Quarantine will reduce transmission from those contacts who become cases.
3. Isolation and quarantine are important early in an epidemic and may help to slow the spread of the disease. Isolation and quarantine will be enforced early in an epidemic.
4. Isolation of cases as early as possible may help to control the rate of growth of the epidemic in its early stages. Isolation and quarantine are likely to be less effective when an epidemic is established. Enforcement of isolation and quarantine (as opposed to education and persuasion) are not useful when the epidemic is established.
5. Duration of isolation and quarantine will be determined when more is known about the virus. At present it is thought that isolation might last: 8 days for adults, 14 days for children, 21 days for infants. Quarantine for contacts will last seven days.

Conditions under which the plan comes into force

This plan should be followed for all suspected cases of pandemic influenza.

Operational Structure:

The HBDHB is the lead agency during a pandemic. All other agencies are support agencies. The MOH and the staff of the PHS will coordinate all isolation and quarantine events during a pandemic.

At the beginning of an epidemic the PHS will coordinate management of the cases and contacts. Primary health care providers and police will be asked to assist as needed.

When an epidemic is established the PHS will not be able to be involved in individual cases, but will provide guidance for the health care sector and the public about recommendations for isolation and quarantine.

Relationships with other levels of government

Use of MOH powers under s70 and 71 of the Health Act require a public health emergency to be declared by the Director-General of Health or a civil defence emergency to be declared.

Emergency powers of the MOH under the Epidemic Preparedness Act 2006 will only be available when unlocked by the Prime Minister.

The duration of isolation/quarantine and national expectations will be defined by the Ministry of Health.

There is a Ministry of Health “clinical pathways” group will provide “guidance around the pathways for care for people with suspected or confirmed cases of pandemic influenza. The guidance will cover the continuum of care from self-care, to the use of community-based assessment centres (CACs), secondary care and intensive care in the event of an influenza pandemic”.

This plan may be affected by recommendations from the Ministry of Health’s “Pandemic Influenza Surveillance Working Group” or the “Pandemic Influenza Technical Advisory Group”.

Communication Plan/Issues:

Types of messages, how they will be distributed, obligations on receipt

Cases will be notified to the PHS by health care personnel or the public. It is expected that practitioners will notify by phone early in the epidemic and fax or electronically notify once the epidemic is established.

The PHS will advise the primary care sector when the epidemic has become established. At this point PHS follow-up of cases will cease and hospital and community clinicians will be expected to give advice to cases and contacts.

Cases and contacts need to receive the information in the Appendix 1. This information is to be supplied by:

- the PHU (in the early stages of an epidemic)
- the doctor or practice nurse (when the epidemic is established)

Preparedness:

Relationships required

Doctors (hospital or community)	↔	PHS (for joint management of early cases)
PHS	↔	Police (for enforcement)
PHS	↔	All sectors (to communicate the phases of the epidemic)
PHS	↔	The group organising accommodation (for isolation and quarantine of cases and contacts who have no Hawke’s Bay home).

Responsibilities of different agencies

See Roles, relationships and tasks

Risk assessment

The biggest risk is that the patient will present late, or the diagnosis will be delayed or the diagnosing doctor will not notify or liaise with public health early enough for isolation and quarantine to be implemented.

Non-compliance with instructions for isolation may stretch police or security resources.

PHS unable to access sufficient support deployed from other parts of the HBDHB and is unable to cope with the intensive workload required.

Operational Procedures:

Roles, relationships and tasks

1. Early in the pandemic i.e. when the first cases are diagnosed and “stamping out” outbreaks is feasible.

Agency	Role and task	Relationships
Medical practitioners	Diagnose and notify cases	MOH
Hospitals	Manage cases meeting hospital admission criteria (arrange lab testing, recommend and enforce isolation, give advice and support including PPE, provide treatment)	MOH (pre-discharge)
PHS, MOH	Manage cases in the community (arrange lab testing, recommend and enforce isolation, give advice and support including PPE, provide treatment)	Medical practitioners
PHS, MOH	Identify and manage contacts (recommend and enforce quarantine, give advice and support, provide prophylaxis)	Medical practitioners
Police	Respond to MOH request for assistance enforcing isolation or quarantine	MOH
HBDHB	Coordinate volunteer and social support for people in isolation and quarantine	MOH, PHS

2. Once the epidemic is established i.e. when there are an escalating numbers of clusters and the MOH has declared that the epidemic is established.

Hospitals	Diagnose and notify hospitalised cases Manage cases meeting hospital admission criteria (recommend and enforce isolation, give advice and support including PPE, provide treatment)	MOH and GP (pre-discharge)
Medical practitioners	Diagnose and notify community cases Manage cases in the community (recommend self-isolation, give advice and support including PPE, provide treatment) Identify and manage contacts (recommend quarantine, give advice and support, provide prophylaxis) Laboratory testing will not be required	PHS

Action required at different alert phases**Resources e.g. designated sites, equipment required**

Primary care practitioners and the PHU will require copies of the information for cases and contacts.

A memorandum of understanding has been signed between HBDHB and Kennedy Park Top 10 Holiday Resort to use the facility to accommodate those who cannot remain in their own homes.

Workforce issues

Urgent secondment of staff (e.g. nursing or clerical) to assist the PHS from other parts of the DHB and from local authorities would be helpful. This would only be feasible in the early stages of the epidemic ("stamp-it-out" phase) and would only be useful at that stage. Once the epidemic is established individual case follow-up by the PHS will no longer be useful and staff elsewhere in the DHB will be too overloaded to assist the PHS.

Reporting

Daily count of number of cases in isolation and the number of contacts in quarantine. This would form part of the daily PHS report to the Planning and Intelligence Manager.

Locations, equipment, operation, staffing

Cases who are seriously ill will be admitted to hospital. Once the epidemic is established they will have to meet clinical admission criteria.

Cases and contacts who are not seriously ill will be isolated/quarantined in their own home. Early in the epidemic they will be subject to daily monitoring (arranged between the doctor and the PHU). Once the epidemic is established they will be given information only.

Cases and contacts who are not seriously ill and do not have a home in Hawke's Bay will be accommodated at a quarantine centre.

Names, addresses and contact numbers

Refer to the HBDHB list of pandemic contact details.

For further information refer to the Public Health Service Non-seasonal Influenza Virus Policy.

Appendix 1

Information on quarantine (home isolation) for influenza

You have been asked to stay in isolation because:

1. You have suspected influenza and are infectious to others. Isolation in your home should continue for 72 hours after starting Tamiflu or 4 days if you are not taking Tamiflu.
2. You may have been exposed to influenza. Isolation in your home should continue for 72 hours after starting Tamiflu or 4 days if you are not taking Tamiflu.

The period of isolation may be lengthened if somebody else in your household becomes sick with suspected influenza.

We want you to restrict your activities to protect the safety of your family, friends and the community. This information sheet is to tell you what isolation means.

Staying at home.

You must not go to school, work, child care or out in public until cleared by the Public Health Nurse. This means you must not attend shopping centers, movies, parties or any social gatherings at all.

Visitors

You should have no visitors until you come out of isolation. Talk by phone and have things delivered to the door. Sometimes a visitor is essential (for example someone has to come into the house to give you essential home support). The visit should be brief. You and the visitor must both wear a mask. Talk with the visitor outside in the open air if possible and keep at least two metres away from them.

Preventing the spread of infection

Stay in a part of the house where you have minimal contact with other people. Try to keep well people and sick people apart.

Give people who have a fever and/or diarrhoea plenty to drink.

Give Paracetamol for fever. *Do not give Aspirin to children under 12 if they have a fever.*

Open doors and windows and ventilate the house as much as possible.

Cover your mouth and nose with a tissue or toilet paper when you are coughing or sneezing. Put the used tissue straight into a rubbish container. Wash and dry your hands afterwards.

Wash and dry your hands after you use the bathroom or toilet. Wash and dry your hands before you prepare food and eat, and when you are looking after sick people.

If you have more than one toilet, then one should be reserved for use by sick people.

Twice a day clean the following: with 1 part household bleach to 10 parts water:

- toilet handle and door handles of toilet, bathroom and rooms of isolated people
- bathroom sink and taps

Use 1 part household bleach to 10 parts water.

Nobody else should use anything that could be contaminated with your throat or nose secretions or coughing or faeces – e.g. towels, handkerchiefs, eating utensils, food, bed linen, cigarettes, marijuana joints, P pipes, kava bowls.

Sharing bedding, clothing and utensils may spread infection, but you do not need to wash a sick person's bedding, clothing and utensils separately from the rest of the family's. If you wash and dry all these things in the usual way they will then be safe for others to use.

Using face masks

The Public Health Nurse will show you how to wear a mask.

- Sick people should wear a surgical mask if anyone is in their room and if they have to leave their room.
- People who are in quarantine but not sick should wear a particulate respirator (PFR95) mask if they are in the same room as a sick person.
- Essential visitors to the house should wear a particulate respirator (PFR95) mask through their visit.

Used masks should be put in the normal household rubbish.

Coming out of isolation

The Public Health Nurse or your doctor will tell you when you are cleared to come out of isolation. At that time you will be non-infectious to others. It will then be safe for you to resume your normal life.

Questions

Your Public Health Nurse will be happy to answer any questions.



Residential Home Plan

Pandemic Influenza Plan Template for Healthcare Providers (Hawke's Bay) Residential Homes



September 2016

PURPOSE

This plan serves to ensure that **(NAME)** Residential Home and Hospital can cope with a Pandemic – responding in a way that keeps people safe and protects them from harm.

Firstly, this plan outlines the actions required of personnel coming directly under the control of **(NAME)**, in the event of a Pandemic. Note: This Plan does not include home-based self-care services or outlining independent villages (either on-site or under the named Organisation) due to contractual and health and safety risks.

Secondly, this plan is designed to meet the requirements of the Hawke’s Bay District Health Board Pandemic Influenza Plan.

DECLARATION

In the event of a Pandemic Influenza Residential Providers will find it difficult to cope.

Essential Services will need to be maintained by doing the best within the resources available in a given time

The contents of this plan are to be followed as closely as possible to avoid confusion, but appropriate discretion must also be employed where no specific direction is laid down.

Signed _____
Chief Executive Officer

Dated this _____ day of _____ 20

LIABILITY/RISK

- The specific agency accepts responsibility for reporting the issues/risks
- The Hawke’s Bay District Health Board acknowledges and accepts the clinical and contractual risk to specific agencies by asking the specific agencies to operate above and beyond their Contractual obligations

Signed _____
Hawke’s Bay District Health Board Chief Executive Officer

Dated this _____ day of _____ 20

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2. **R**esponse to Pandemic Influenza – Refer to Part two
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PART ONE

GENERAL INTRODUCTION

General Overview

How influenza differs from the common cold

Transmission

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Impact on Society

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Employment Law Advice

GENERAL OVERVIEW

An influenza pandemic occurs when a new strain of influenza virus emerges, spreading around the world and infecting many people at once.

An influenza virus capable of causing a pandemic is one that people have no natural immunity to, can easily spread from person to person, and is capable of causing severe disease.

There were three influenza pandemics last century: in 1918, in 1957/58 and in 1968/69. The 50s and 60s pandemics were caused by viruses containing a combination of genes from a human influenza virus and an avian influenza virus.

HOW INFLUENZA DIFFERS FROM THE COMMON COLD

Influenza is characterised by rapid onset of respiratory and generalised signs and symptoms, including fever, chills, sore throat, headache, dry cough, fatigue and aching.

Influenza is easily spread through droplets from an infected person (suspended in the air through coughing or sneezing) being inhaled by another person, or through contact with contaminated objects.

The incubation period can range from one to seven days, but is commonly one to three days. Adults are contagious for one to two days before most symptoms start until about day five of the illness. Children generally remain infectious for up to seven days.

TRANSMISSION

- Highly infectious
- Aerosol/droplet
- Also hand to hand and via inanimate objects
- Infectivity starts before symptoms and lasts for 3-7 days

POTENTIAL SCALE OF A PANDEMIC - NATIONALLY

The Ministry of Health (the Ministry) has taken a 'maximum credible event' approach to pandemic planning. Using the November 1918 pandemic influenza wave in New Zealand as a basis, the Ministry has developed a standard planning model to provide planners with an indicative pandemic wave scope, scale and duration.

The New Zealand standard planning model assumes a pandemic wave in which 40% of the NZ population become ill over an 8-week period. The model indicates that over 1.6M people could become ill over this time. The peak incidence is over weeks 3 – 5, when about 1.3M people, around a third of New Zealand's population, would be ill, convalescent, or only just recovered.

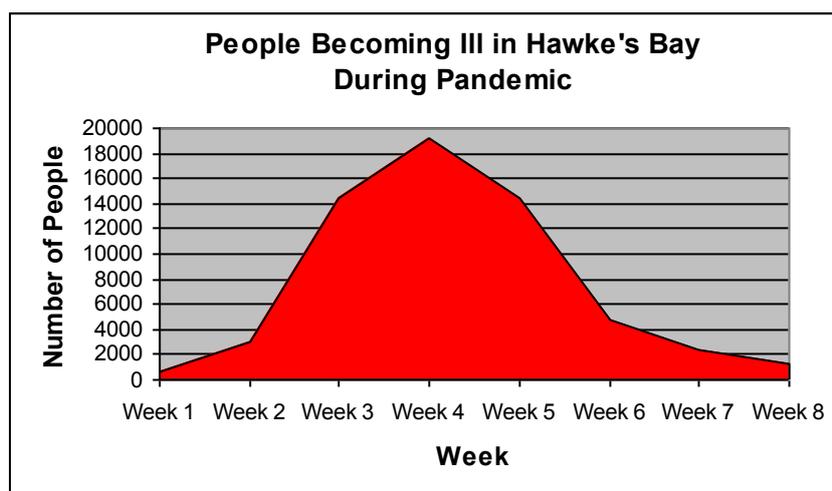
The model assumes a total case fatality rate of 2%, which would see about 33,000 deaths over the 8 week period, peaking at about 10,000 in week 4.

It is important to note that this is not a prediction or a forecast of what will happen should a pandemic occur – it is not possible to make any such forecast before a

pandemic develops. A 21st century pandemic may not reflect the course, incidence, or fatality rates of the 1918 pandemic.

The model's purpose is to provide a structure around which Health, Government and New Zealand as a whole can plan for a very large event with severe impacts on all aspects of society. As the 1918 pandemic in New Zealand is relatively well understood and documented it has been selected to provide the basis for the standard planning model, and clearly it is necessary that plans be based on the extreme circumstances that 1918 may represent.

POTENTIAL SCALE OF A PANDEMIC - LOCALLY



IMPACT ON SOCIETY

A pandemic will likely be characterised by a high level of absenteeism in the workforce as people fall ill or stay at home to care for sick relatives.

Essential services such as police, fire, transportation, communications and emergency management services need to be maintained during a pandemic.

Other services and supplies – including food, water, gas, electricity supplies, educational facilities, postal services and sanitation – are also likely to be affected.

It is right to assume that normal business activities, regardless of their nature, will suffer during a pandemic.

CARE IN THE COMMUNITY

Due to the high rates of infection possible during pandemic influenza, all except the seriously ill may need to be cared for at home.

Public and private hospitals will need to prioritise admissions, rationalise services and review staff rosters.

DHBs will need to consider additional supplies of medication and equipment (e.g. ventilators, oxygen supplies and syringes). It may be necessary to utilise other facilities (e.g. community centres or hotels) if extra space is required, particularly for outpatients or patients post discharge. In general, emphasis should be given to out-

of-hospital care and saving hospital beds for only the most severe cases. DHBs will need to liaise with local councils, their civil defence emergency management groups and voluntary groups so that they can assist in providing community care.

Health professionals, such as nurses, general practitioners, paramedics, locums, health clinic staff and social service personnel, will require DHB support and co-ordination. Pharmacists will experience a rise in workload, with increased demand for medication, dispensing prescriptions and over-the-counter products. They will be closely involved in the provision of frontline advice to members of the community and in the management of adverse reactions to the usual prescribed medications.

CARE OF DEPENDANTS

During a pandemic, there are likely to be substantial numbers of people whose normal care givers are unable to provide assistance. This could include children when parents are sick, elderly, people with chronic illness or disability, and people living on their own.

Two situations may occur:

- children orphaned due to the death of their caregiver(s)
- children left without their prime caregiver(s) due to that person or persons being hospitalised

Both cases will result in children requiring care being present at a hospital or primary health centre. It would not require very many of these children to reduce the capacity of the institution to function to its full capacity.

In the first instance, modelling (using the 35 percent infection rate) indicates that approximately 200 children nationwide would be left without their caregiver(s), or with temporary care from an alternative relative. These numbers are unlikely to stretch the capacity of the local social services, particularly when regional distribution is taken into account. Of greater short-term concern during a pandemic is the second instance, which may involve over 800 children in 400+ family groupings.

CARE OF THE DECEASED

The standard planning model assumes about 33,000 deaths over an 8-week pandemic wave, with a peak of around 10,000 in the peak week. For context, New Zealand averages about 550 deaths per week in normal times. Clearly normal services will be unable to manage the numbers involved, and special arrangements will be necessary for the storage, management and eventual disposal of the deceased.

MINISTRY OF HEALTH CASE DEFINITION

Suspected case of Pandemic Influenza

Person with an influenza like illness of abrupt onset, characterised by:

- History of fever, chills and sweating; or
- Clinically documented temperature $\geq 38^{\circ}\text{C}$; and
- Cough or sore throat

Probable case of Pandemic Influenza

Person with an influenza like illness who has a strong epidemiological link to a confirmed case or defined cluster.

Confirmed case

An individual for whom laboratory testing demonstrates one or more of the following:

- a. positive viral culture for Pandemic Influenza; or
- b. positive RT-PCR for Pandemic Influenza; or
- C.** four-fold rise in novel influenza virus specific neutralising antibodies.

PANDEMIC PHASES – DEFINITIONS

For purposes of consistency, comparability and co-ordination of the national, regional and local response, identification and declaration of the following phases will be done at the national level.

WHO Pandemic Phase	Definition
Inter-Pandemic Period (WHO Phase 1)	No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.
Novel Virus Alert (WHO Phase 2)	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.
Pandemic Alert (WHO Phase 3)	Human infection(s) with a new virus sub-type, but no human-to-human spread, or at most rare instances of spread to a close contact.
(WHO Phase 4)	Small cluster(s) with limited human-to-human transmission but spread is highly localised, suggesting that the virus is not well adapted to humans.
(WHO Phase 5)	Larger cluster(s) but human-to-human spread still localised, suggesting that the virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).
Pandemic Period (WHO Phase 6)	Pandemic: increased and sustained transmission in general population.

WHO PERIOD*	WHO PHASE*	NZ STRATEGY	MoH/DHB ALERT CODE
Interpandemic Period	Phase 1	Planning	N/A
	Phase 2		WHITE (Information / Advisory)
Pandemic Alert Period	Phase 3		
	Phase 4	RED (Activation)	
	Phase 5		Cluster Control
Pandemic Period	Phase 6	Pandemic Management	RED (Activation)
Post Pandemic Period	Post Pandemic Period	Recovery	

ACTIVATION OF PANDEMIC CONTINUITY PLAN

MoH will widely publicise any changes to the "alert codes" which are designed to alert government agencies to action, and may signify the need to activate business continuity plans.

This table has been reviewed and changes made relevant to the Residential Sector

Suggested Summary Actions for Infrastructure Providers for Each Alert Code

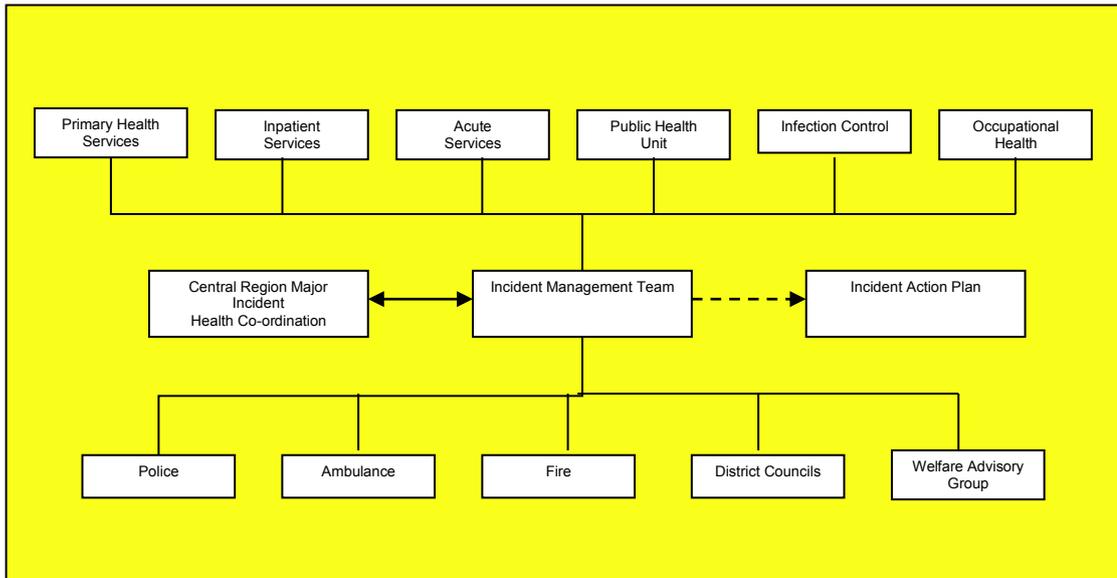
Stage	New Zealand Strategy	MoH/DHB Alert Code	Suggested Infrastructure Provider Actions
1	Plan for it (Planning)	<p>White (Information/advisory)</p>	<p>Review business continuity plans:</p> <ul style="list-style-type: none"> Identify essential services Plan for up to 50% staff absences for periods of 2-3 weeks at the height of the pandemic, and lower levels of staff absences for a few weeks on either side of the pandemic Assess staff requirement needs, and ensure essential positions are backed-up by an alternative staff member Identify ways to increase "social distancing", containment in the event of in the workplace Consider organisational policies to encourage the sick to stay at home
		<p>Yellow (Standby)</p>	<ul style="list-style-type: none"> Identify ways to minimise illness amongst staff and residents and consider how essential messages (e.g. basic hygiene) can be communicated Identify needs for PPE and cleaning equipment Purchase additional contingency supplies.
2	Keep it out (Border Management)	<p>Red¹⁴ (Activation)</p>	<ul style="list-style-type: none"> Alert staff to change in pandemic status Activate staff overseas travel restrictions

Suggested Summary Actions for Infrastructure Providers for Each Alert Code

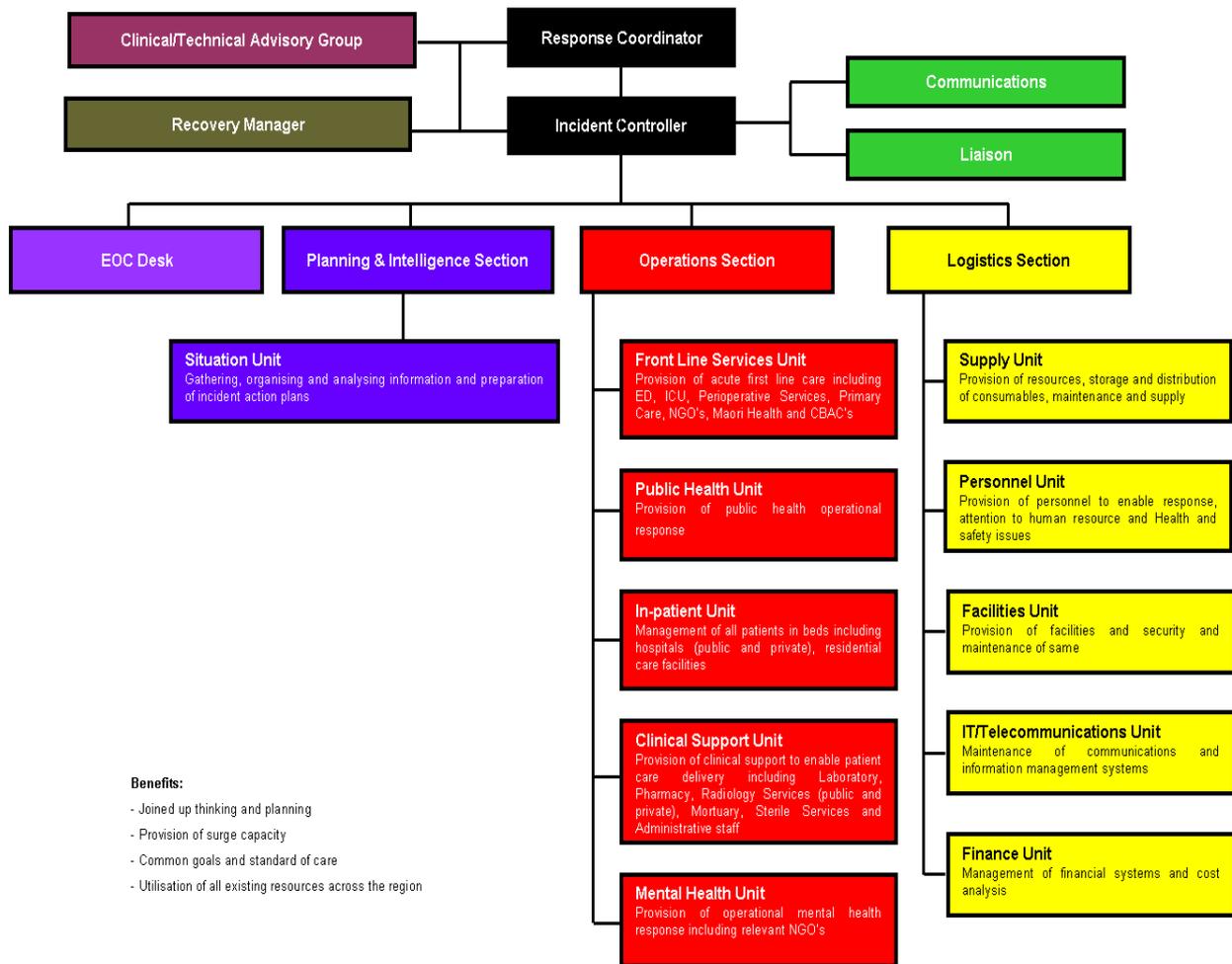
Stage	New Zealand Strategy	MoH/DHB Alert Code	Suggested Infrastructure Provider Actions
3	Stamp it out (Cluster Control)		Alert staff to change in pandemic status
4	Manage it (Pandemic Management)		<p>Activate essential business continuity measures</p> <p>Activate measures to minimise introduction and/or spread of influenza in work place (post notices; social distancing, managing ill staff members, workplace cleaning, etc)</p> <p>Communicate with staff to promote confidence in the workplace</p> <p>Activate contact tracing where staff become ill at work during Cluster Control phase</p> <p>Activate process for recovered/well staff members to return to work</p>
5	Recover from it (Recovery)	Green (Stand down)	Manage return to business as normal

THE ROLE OF THE DISTRICT HEALTH BOARD

- Hawke's Bay District Health Board becomes the lead agency
 - Primary and secondary care
 - Public health advice
- Ministry of Health – national leadership, surveillance
- CDEM (Civil Defence Emergency Management Group) – manage civil defence declaration



HEALTH CIMS STRUCTURE



Benefits:

- Joined up thinking and planning
- Provision of surge capacity
- Common goals and standard of care
- Utilisation of all existing resources across the region

EMPLOYMENT LAW ADVICE

Referenced from Healthcare Providers New Zealand

(PLEASE NOTE: Permission granted to include this information in this Plan by the CEO of Healthcare providers New Zealand)

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A pandemic will not be like a physical disaster. A pandemic has unique characteristics compared with a more "typical" disaster. For example:

- **Widespread impact:** the pandemic is likely to be widespread, and not localised to a single area. There may be little outside assistance;
- **Not a physical disaster:** a pandemic is not a physical disaster. It has some unique characteristics that require implementation of activity to limit contact such as restriction of movement, quarantine and closure of public gatherings;
- **Duration:** a pandemic would not be a short, sharp event leading immediately to commencement of a recovery phase. Overall a pandemic wave may last about 8 weeks. Further, the pandemic may come in waves of varying severity over time;
- **Notice:** it is quite likely that there will be some advance warning from the development of the pandemic overseas. However, it is also possible that any warning period may be short. Should the pandemic spread within New Zealand it will probably be some weeks before the full impact on the workforce will be felt, although there may be some more immediate impacts resulting from closing of schools and similar containment measures;
- **Primary effect is on staffing levels:** unlike natural disasters, it is anticipated that disruptions to business will be mainly human resource orientated. The Ministry of Health advises that businesses should plan for up to 50% staff absences for periods of about two weeks at the height of a pandemic wave, and lower levels of staff absence for a few weeks either side of the peak.

STAFF ABSENCES

Staff absences can be expected for many reasons:

- Illness/incapacity (suspected/actual/post-infectious);
- Some employees may need to stay at home to care for the ill;
- People may feel safer at home (e.g. to keep out of crowded places such as public transport);
- Some people may be fulfilling other voluntary roles in the community; and
- Others may need to stay at home to look after school-aged children (as schools are likely to be closed).

HUMAN RESOURCE ISSUES

All businesses will benefit significantly from some degree of preparedness. Planning will reduce the human cost and improve business viability during and after a pandemic.

DECIDING TO STAY OPEN OR TO CLOSE

A workplace may close through lack of staff or customers, or because it presents an unacceptable level of risk to employees or others.

Different industries will have varying degrees of risk in a pandemic, and there will be varying scope for staying in operation. For example, farmers should be able to manage the hazard with relatively few restrictions. On the other hand, the challenges for shops and restaurants to stay open will be far greater.

All employers have responsibility for the health and safety of employees and others in their workplace. They must also ensure that their employees actions (or inactions) do not cause harm to others.

The most relevant sections of the Health and Safety at Work Act 2015 are:

Where a significant hazard, including the likelihood of pandemic influenza, is identified, the steps an employer must take include:

1. *Where practicable*, the significant hazard must be **eliminated**;
This may involve removing the hazard or hazardous work practice from the workplace.
2. *If elimination is not practicable*, the significant hazard must be **isolated**;
This may involve isolating or separating the hazard or hazardous work practice from people not involved in the work or the general work areas. It could mean reducing the potential for contamination through changing work practices to achieve a greater degree of social distancing, or installing screens or barriers.
3. *If it is impracticable to eliminate or isolate the hazard completely, then the employer must minimise the likelihood that the hazard will harm employees. In addition, the employer must, where appropriate:*
 - Provide, make available to, and ensure the use of suitable clothing and equipment to protect the employees from any harm arising from the hazard;
 - Monitor employees exposure to the hazard;
 - Seek the consent of employees to monitor their health; and
 - With their informed consent, monitor employees health.

Section 45: Employees must take steps to ensure health

Requires employees to take all reasonable steps to ensure their own health and safety at work, and that they do not cause harm to others.

REFUSAL TO PERFORM WORK

Employers should be aware that under the *Health and Safety at Work Act 2015* employees have the right to refuse to perform work if they believe it is likely to lead to their suffering serious harm. This belief must be based on reasonable grounds, and they must have attempted to resolve the matter with their employer before they can continue to refuse to work.

The right to refuse unsafe work does not apply unless the understood risks of the work have materially increased. That means that the right of a nurse to refuse is different to that of an accounts clerk.

CLOSEDOWN

It may be possible to use the "closedown" provisions of the *Holidays Act*. This Act gives employers the ability to "closedown" the work place for a fixed period after giving staff 14 days notice. During this time, employees would be required to take their annual leave (whether or not they had any to take). The *Holidays Act* defines a close down period as a period in which a employer **customarily**:

- Closes the employers operations or discontinues the work of one or more employees; and
- Requires employees to take all or some of their annual holidays.

To fall within that definition the employer would need to argue that they would **customarily** close their business down when confronted by a significant hazard such as a pandemic influenza.

Employers can have different close down periods for different areas of their business. This means that if the risk of infection is greater in one part of the business, potentially the employer would be able to just close down that area. If the employer has work places around the country, the close downs could be used at different times depending on how the pandemic spreads.

STRIKES AND LOCKOUTS

Under the *Employment Relations Act* employees can strike and an employer can lockout if there are reasonable grounds for believing that it is justified on the grounds of health or safety. While the cases for establishing that such action is justified are notable for their lack of success, the circumstances of a pandemic may reach the point that is likely to provide that justification. Employers are not required to pay wages during a lockout.

Strikes and lockouts can severely damage employment relationships. They should only be contemplated if it is apparent that no reasonable agreement is able to be reached between the business and employees.

THE HEALTH ACT

The Ministry of Health currently defines pandemic influenza contacts as people who have had close physical (less than 1 metre) or confined air space contact with an infected person, within 4 days of that person developing symptoms. These are likely to include family members and work mates (if in close contact situations or confined air space environments).

Under the *Health Act* contacts will be expected to stay at home and avoid contact with others for a recommended period. This period will be determined by health officials, and is not at the discretion of the employer.

The role of contact tracing may vary according to the phase of the pandemic. At an early phase when efforts are directed at keeping the pandemic out, or in managing small clusters, contact tracing and the associated quarantine of cases and contacts will be vigorous. However, if the pandemic begins to affect large numbers of people across the country, it will not be an effective strategy and may be dropped.

PAYMENT

There is no simple answer to whether employees should be paid during a pandemic if they do not work. It will also depend on how the pandemic spreads and effects the employer's business and the economy.

Generally, an employer is obliged to pay an employee where that employee is told to stay home (such as in suspension cases). However, in exceptional circumstances there may be a point where an employer is allowed to draw the line.

The situation would be different where the employee is sick and has decided to stay home (as opposed to being directed to stay home by the employer). Employees may use their sick leave where they are sick (or a dependant is sick). In these circumstances an employee is entitled to be paid their contractual sick leave entitlement, and can also opt to take annual leave as sick leave where sick leave is exhausted.

In the event that both sick leave and annual leave have been exhausted, and the employee considers that they are still too sick to come to work, the employer does not have an obligation to continue to pay that employee.

Employers may also face the situation where employees opt to stay away from work in an attempt to protect themselves from being infected. As indicated earlier, employees have the right to refuse to perform work likely to cause serious harm. In the event of an employee exercising this right, employers will be faced with the question of whether or not they are required to pay these employees. This is something that would need to be determined in light of the circumstances, taking into account the risk of infection and what a reasonable employer would have done.

The same issue arises under the *Health Act*. A Medical Officer of Health has special authority to try and contain the spread of infectious diseases. This includes requiring people who are infected to be quarantined and to close buildings which are thought to be contaminated.

In the event of an employee being prevented from turning up to work because of a direction given under the *Health Act* the same sick leave and annual leave payment options apply if the employee is sick. If the employee is not sick but has been directed to stay at home this again is something that would need to be determined in light of the circumstances, taking into account the risk of infection and what a reasonable employer would have done.

On a practical level, whatever an employers legal obligations are, it is entirely possible that employers will simply be unable to comply with their obligations. This may be because the employer simply cannot afford to sustain paying employees. If this is the case, the employer would need to either:

- Make the employees redundant (ensuring that the proper procedure was followed); or
- Obtain the employees agreement that they will not be paid while there is no work.

WHAT THIS MEANS

What this means is that employers must be prepared. If a business is going to try and continue to operate through a pandemic then to comply with its health and safety obligations it must have a plan to either **eliminate**, **isolate** or **minimise** the hazard where practicable, or where it is not practicable to ensure that the employees have suitable protective clothing and equipment, and to monitor the employees exposure.

Statutory and contractual requirements relating to employment relationships will not be suspended during a pandemic. Employers should be aware of their duties and ensure that their plans comply. If they are unlikely to comply, then employers should discuss the possible impact on the business with their staff and agree if possible on solutions. Whatever agreement and clarification can be achieved before a pandemic is likely to be a valuable investment should the pandemic arrive.

PART TWO IN THE EVENT OF

Assumptions

Person responsible for Co-ordination

Risk/Impacts

Management

Planning for the Pandemic

During the Pandemic

During the Pandemic – Communication Plan

Appendix 1: Fact sheet - Handout for staff

Appendix 2: Personal Protection

Appendix 3: Estimated PPE Supplies

Appendix 2: Signage Templates

Appendix 3: Diagnosis/Management Template

Appendix 4: Communication Fax Template

ASSUMPTIONS

1. An influenza pandemic is inevitable.
2. There will be very little warning. Most experts believe that we will have between one and six months between the time that a novel influenza strain is identified and the time that outbreaks begin to occur in New Zealand.
3. Outbreaks are expected to occur simultaneously throughout much of New Zealand, preventing shifts in human and material resources that normally occur with other natural disasters.
4. The effect of influenza on individual communities will be relatively prolonged -- weeks to months -- when compared to minutes-to-hours observed in most other natural disasters.
5. The impact of the next pandemic could have a devastating effect on the health and well being of the New Zealand public. CDC estimates that in Hawke's Bay alone, over a course of 2 to 3 months:
 - Up to 53 thousand people will become clinically ill
 - Up to 25 thousand people will require primary health care
 - Up to 600 people will be hospitalized
 - Up to 1194 people will die (this is a conservative estimate of the impact)
6. Effective preventive and therapeutic measures -- including vaccines and antiviral agents -- will likely be in short supply, as well as antibiotics to treat secondary infections.
7. Health-care workers and other first responders will likely be at even higher risk of exposure and illness than the general population, further impeding the care of victims.
8. Widespread illness in the community will also increase the likelihood of sudden and potentially significant shortages of personnel in other sectors who provide critical community services: police, firemen, utility workers, and transportation workers, just to name a few.

PERSON RESPONSIBLE FOR THE CO-ORDINATION

Owner/Chief Executive Officer/Manager or Nurse Manager/Senior Nurse on duty/Designated Infection Control Officer designated as "Outbreak Manager".

Responsibilities

1. Take lead responsibility for all infection prevention and control issues
2. Ensure staff/residents/families are kept up to date with current information from the DHB and the Ministry of Health.
3. Ensure that all staff are adequately trained in infection prevention and control practice.

RISKS/IMPACT

- Overwhelming number of sick residents
- Looking after acutely unwell residents who cannot be admitted to Hospital
- Staff absenteeism
- Stock reduction – food, products etc
- Relatives
- Robbery for our supplies
- Disposing of wastes
- Disposing of bodies

MANAGEMENT

Overall goal

In the event of a Pandemic Influenza Residential Providers will find it difficult to cope.

Essential Services will need to be maintained by:

- Doing the best within the resources available in a given time
- Containment of an outbreak
- Minimisation of the risk of cross infection

Expected outcome

Effectiveness of the precautions instituted will be demonstrated by reduced transmission of disease

PLANNING FOR THE PANDEMIC

In the event of an emerging infectious disease-related emergency all residential facilities need to have the following minimum capabilities

PREPARATION

A Plan in Place

Resident details

- Demographic data – up-to-date – including next of kin details
- Anticipatory directive order forms and funeral arrangements – up-to-date

Staff details

- It is recommended that all staff be vaccinated each year against seasonal influenza. While this may not protect against pandemic influenza, it will maintain the general wellness of your environment.
- Create an expectation that sick staff should stay at home
- Note: MoH advises that businesses should plan for up to 50% staff absences for periods of about two weeks at the height of a pandemic wave and lower levels of staff absence for a few weeks either side of the peak)
- Staff profile and contact phone numbers
- A designated area for staff – wanting to stay over etc

Environment

- A designated area for the disposal of biohazard, rubbish disposal
- Laminated signage for entrances (re informing unwanted visitors etc)
- Laminated signage for infected residents (suggested wording Resident Isolation – use all precautions – visitors must inquire at reception before entering – *refer to Appendix 2*)

Stock includes (It has been recommended to have at least two weeks stock supply for the number of residents and staff in your facility – refer to Appendix 3 for stock formula)

- Medical (pharmaceutical/day-day medications)
- Nutritional (fresh/dry/storage etc)
- Meals – staff and families staying over
- Linen (contracted supplies may not occur – able to provide washing facilities on-site etc)
- Incontinent products (contracted supplies may not occur)
- Personal Protection Equipment (this stock kept separate from other stock – but checked frequently for expiry)
 - Gloves (differing sizes)
 - PFR95 masks
 - Surgical masks
 - Disposable gowns
 - Plastic aprons
 - Face shields
 - Hand soap/antimicrobial hand gel
 - Paper towels
 - Single use clinical thermometers
 - Biohazard bags
 - Tissues
 - Toilet paper
 - Sodium hypochlorite

Training

- Infection prevention and control training (includes caring for self, hand hygiene, appropriate wearing, removing and disposal of PPE and contact/isolation precautions)
- Residential Facilities to attend Hawke's Bay District Health Board training programmes

During pandemic alert

Continue business as usual

Communication/update to all staff/residents/visitors

Check stock supplies (medical/cleaning/nutritional. Note: Stock supply should be adequate for a two week period as per number of residents in facility and staff).

Ensure there is **detailed information about all residents**

This will include:

- Full name (including any AKA's - pseudonyms or pet names)
- Name and contact details of two nominated relatives/friends

- Special needs - any medical conditions, medications, allergies
- Age/date of birth
- Physical description - height, eye colour, hair colour, skin tone, identifying marks, scars, tattoos etc
- Ethnicity
- Funeral arrangements
- A recent coloured photograph should also be attached to the form
- All personal identification will be kept

Plan the workforce

- Check staff emergency call back list is current
- Discuss/confirm with staff in the event of – will they be coming to work

Communication to the Emergency Operation Centre

- Report bed numbers and occupancy (this information will aid in bed management/bed overview for the community)

Obtain the influenza hospital admission criteria/treatment guidelines produced by the HBDHB.

DURING PANDEMIC IMMINENT STAGE

Fully **activate the pandemic plan**

Communication to all staff/residents/visitors

Prevent any sick/unknown person from entering the facility (signs at entrance), no “respiratory unwell” residents to enter facility

Minimise contacts

- Avoid meeting people face –face – use telephone/email
- Avoid unnecessary travel or group education
- Do not congregate in tearooms or other areas where staff socialise
- Avoid shaking hands or hugging
- “Practice “ghost” shifts changes wherever possible, with the shift going off duty leaving the workplace before the new shift enters
- Ventilate the workplace
- Staggered meal breaks so staff are not in the lunch areas together

Increase cleaning services in all areas

Activities to be deferred

- Diversional/leisure activities
- Communal activities
- Day-care/respite
- Volunteers

DURING THE PANDEMIC – Outbreak

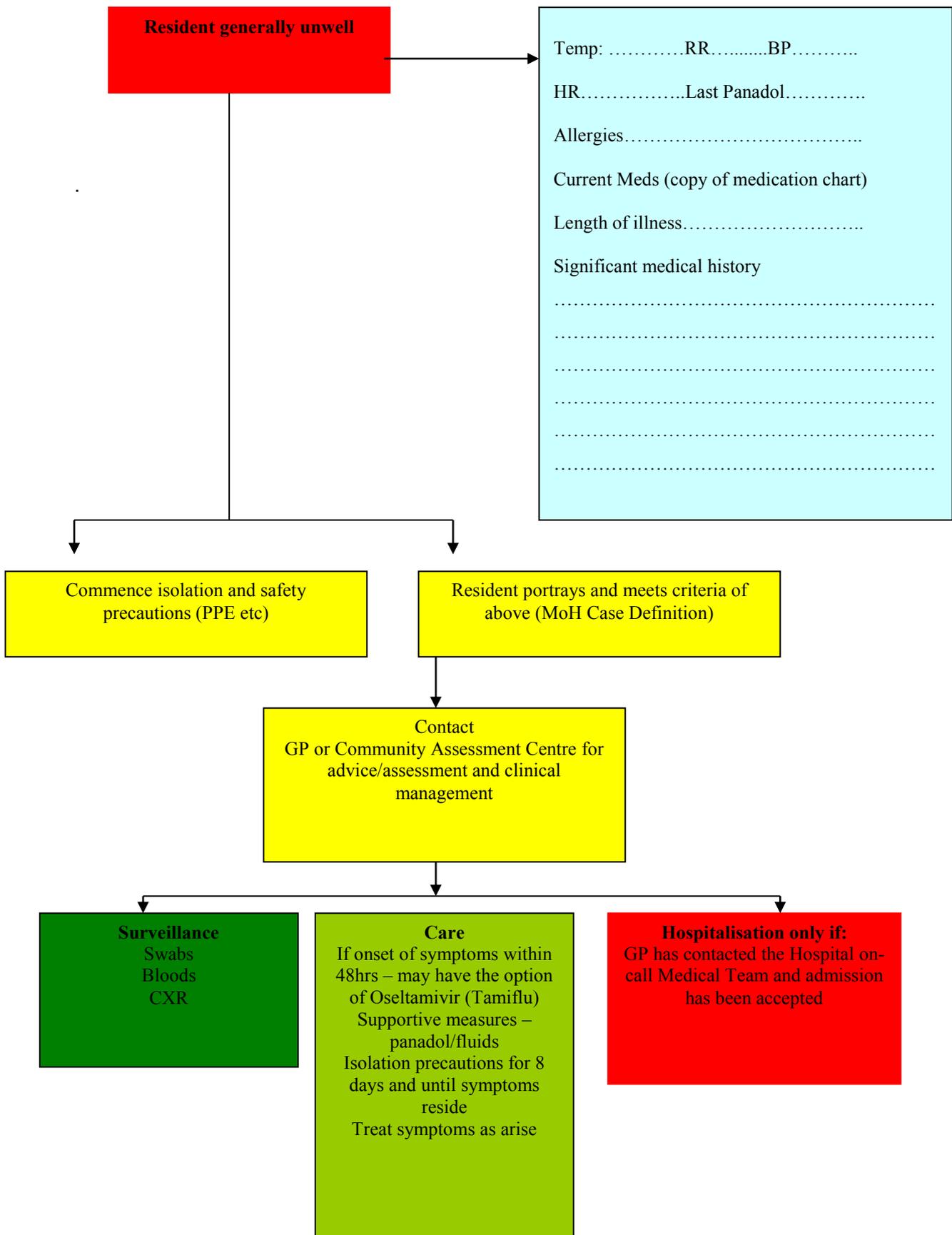
Outbreak definition: Three or more cases of newly acquired respiratory illness in staff and/or residents in the facility within a period of 7 days

Complete the following checklist at first contact with patient, i.e. in triage room or over the telephone.

- Yes
1. History of fever, chills, sweating or clinically documented temperature $\geq 38^{\circ}\text{C}$
- Plus**
2. Cough **or** sore throat

Patients with **both 1 and 2** meet the definition of influenza-like illness.

Clinical Management Guidelines – Resident Care Clinical Pathway



Resident isolation

- Isolating/cohorting suspected resident/s to rooms for 8 days may be essential to contain further spread of disease
- Sign on resident room informing “all” about isolation precautions
- Resident encouraged to wear a surgical mask
- Resident educated to cough/sneeze into a tissue/shoulder and to dispose of the tissue afterwards, then wash hands in warm water with soap or use an antimicrobial hand gel and dry hands thoroughly afterwards
- Restriction of allied health personnel and visitors may be necessary to confine the outbreak

Precautions for staff

- Designated staff only to care for suspected resident/s, (other staff keep a distance of one metre away)
- Shoulder length hair must be clipped or tied back
- Wearing of Personal Protective Equipment (PPE)
- **Recommendations for PPE use**, includes masks, eye/face shields, gloves, gowns and aprons.- refer to appendix 2 for more information
- Rigorous, frequent hand hygiene, (wash in warm water with soap, or use an antimicrobial hand gel, dry hands with paper towels)
- Shoes should cover and protect feet from splashes and dropped equipment and should have wipeable surfaces
- Wearing of street clothes to and from work and work clothes at work

Environment

- Ventilation (keep windows open if possible). There is scientific and medical evidence that influenza can spread in inadequately ventilated internal spaces.
- Disposable thermometers kept in resident room
- Ensure tissues are available
- Ensure supply of soap/antimicrobial hand gel and paper towels are available for drying
- All resident equipment/linen handled with care, (Note: resident/s will be unable to leave their rooms hence use of the hand basin for daily washing and thoroughly cleaning afterwards)

Cleaning

- Frequency increased - additional may be required particularly bathrooms, taps door handles, hand rails, bedroom furniture, commode and shower chairs. Clean all horizontal surfaces and all surfaces that are touched by resident/s and staff.
- Rooms of well residents cleaned first
- Cleaning staff **must wear** PPE
- Use colour coded cleaning equipment (yellow) for cleaning isolation rooms. Cleaning cloths should be disposed of in a biohazard bag.
- Use environmental wipes followed by sodium hypochlorite 100mL/1L of water (1:10).
- Floors are wet mopped with clean water and detergent then the mop rinsed thoroughly on completion and inverted to dry.
- All resident equipment unable to be disposed of should be cleaned with environmental wipes followed by sodium hypochlorite 100mL/1L of water (1:10) and left to dry.
- Removal of magazines, papers from common areas (e.g. tea rooms).

- Staff reminded not to share cups, dishes and cutlery, ensure all dishes are thoroughly washed in dishwasher or soap and hot water after use.

Linen

- A linen skip and a biohazard bag must be kept in a designated area
- Linen should be changed as required taking care not to shake it
- All waste (except sharps) must go into the biohazard bag
- Linen and waste must be emptied daily or when containers are two thirds full
- Laundry is hot water (65°C for not less than 10 minutes of > 71°C for not less than 3 minutes)

Food Service

- Thorough cooking, no pink parts or runny egg yolks
- Proper handling of poultry and poultry products during food preparation
- Frozen and refrigerated poultry requires same careful food handling as virus can survive 1 month at low temperatures

COMMUNICATION PLAN

Immediate notification of the first suspected case/s is crucial This may be done by the General Practitioner or the Manager of the Facility. Phone 834-1815 (seven days). Ask to speak to a Medical Officer of Health (MOH). Do not leave a message. Make sure you speak directly to a MOH. Detailed information will be required about each case and the MOH will work closely with the Facility to formulate an immediate plan of action, including investigation and management of the case and contacts.

Name	Title	Availability	Phone contact	After hours
Hawke's Bay District Health Board				
Sharon Mason	Chief Operating Officer	8-5 Mon-Fri	8788109	N/A
	Emergency Response	On-call	8788109	As contact
Margaret Drury	IPC Advisor	On-call	8788109	As contact
Public Health Unit				
Dr Caroline McElnay	Medical Officer of Health	On-call	8788109	As contact
Dr Rachel Eyre	Medical Officer of Health	On-call	8788109	As contact
Dr Nicholas Jones	Medical Officer of Health	On-call	8788109	As contact

During the Pandemic

Daily reports to Emergency Operations Centre at Hawke's Bay Hospital.

Number of beds in facility	
Occupancy	
Number of very unwell	
Number of deaths	
Number of staff – working	
Number of staff – required for assistance	
Stock requirement	

APPENDIX 1

Information about influenza – FACT SHEET FOR STAFF –

What is influenza?

Influenza (the flu) is a very infectious illness caused by a virus. It is much more serious than a common cold and can leave you ill for up to 10 days.

Symptoms of the flu include: a high fever, headache, muscle aches and pains, fatigue, cough, sore throat, or a runny nose. It may take up to three days to feel symptoms after you catch the flu (the incubation period).

Anyone can get the flu – being fit, active and healthy does not protect you from getting this virus.

Anyone can die from the flu – it kills at least 100 New Zealanders every year, including some young, fit people.

What can you do to prevent getting the flu?

Every year, ask your doctor to vaccinate you against the flu. Because the influenza virus changes frequently, you need to get vaccinated every year to stay immune. Some people can get this free. Vaccination is free for people aged 65 years and over, and adults and children with certain long-term (chronic) conditions. Your GP will know if you are eligible for a free vaccination.

The flu is very easily spread through coughs and sneezes. If you have the flu, avoid public places and close contact with other people. Always cough and sneeze into a disposable tissue. Put the tissue in a rubbish bin and wash your hands well afterwards.

What are the symptoms of pandemic influenza?

Generally, the symptoms are similar to those for people infected with seasonal influenza, although the severity of the illness may differ. Symptoms generally appear three to seven days after exposure and can last up to seven days.

How likely is an influenza pandemic?

It is certain an influenza pandemic will happen one day.

What is New Zealand doing to prepare for an influenza pandemic?

New Zealand has been planning for this for some time. The Ministry of Health has a national pandemic plan, and District Health Boards have local plans. The New Zealand Government, following the advice of the World Health Organization, is stockpiling antiviral medicines to help reduce the impact of a pandemic on New Zealanders.

Is there a vaccine available for a flu pandemic?

The Ministry of Health has a formal arrangement with Australia's CSL Ltd - the only influenza vaccine manufacturer in the Southern Hemisphere - which gives us a guaranteed supply if we need a pandemic vaccine. However, manufacture of such a vaccine can only start once we know the strain of the virus causing the pandemic, and so a vaccine is not currently available.

What could happen in an influenza pandemic?

A pandemic could mean so many people are sick that it will affect workplaces, schools, hospitals and many other services. There would be public announcements on TV, the radio and through other media channels that there is an influenza pandemic. Some workplaces and schools may close. Normal health and other services may not be available for several weeks. You may be asked to care for yourself and others at home.

How can you prepare for an influenza pandemic?

- Talk to your family and friends about health hygiene – hand washing, and safe coughing and sneezing.
- Make sure you have an emergency survival kit. Plan for having about a week's worth of essential supplies such as non-perishable food, as well as plenty of fluids. For further information see the Ministry of Civil Defence and Emergency Management website on What to Do in a disaster.
- Include paracetamol (for fever) in your home emergency survival kit.
- Have a plan for what you and your family would do if you had to stay at home during a pandemic.

How do you care for yourself and your family during an influenza pandemic?

- Stay home if you are sick and keep away from other people – avoid visitors and visiting other people.
- Wash and dry your hands after you cough, sneeze, wipe or blow your nose (or your child's nose), use the bathroom or toilet. Wash and dry your hands before you prepare food and eat, and when you are looking after sick people.
- Keep coughs and sneezes covered. Tissues are best. Put the tissue in a rubbish bin.
- Give people who have a fever and/or diarrhoea plenty to drink.
- Give paracetamol for fever. *Do not give aspirin to children under 12.*
- Try to keep well people and sick people apart.
- Sharing bedding, clothing and utensils may spread infection, but you do not need to wash a sick person's bedding, clothing and utensils separately from the rest of the family's.

Appendix 2 Protection information

Personal Protective Equipment

How is pandemic influenza transmitted?

Primarily, human influenza is transmitted from person to person via virus-laden large droplets (particles >5 µm in diameter), which are generated when an infected person coughs or sneezes. These large droplets can then be directly deposited onto the mucosal surfaces of the upper respiratory tract of susceptible people who are near the infected person (i.e. within 1 metre). Transmission may also occur through direct contact with infectious (wet) respiratory secretions, such as by touching door handles, taps, lift buttons, stairwell railings, keyboards, etc that have deposits of the infected secretions on their surfaces, and then hand-to-face contact.

Health care workers

Health care workers are at a greater risk of pandemic influenza than the general public because they will often be caring for infected people who might be hospitalized or seeking primary health care services.

General and specific infection prevention and control measures

All Residential facilities should have effective policies and processes in place to ensure people with symptoms of respiratory disease do not place others at risk of infection.

Hand hygiene

Hand washing is still the single most important measure to reduce the risks of transmitting infectious organisms from one person to another.

Hands should be washed regularly with soap and water, an alcohol-based hand rub or an antimicrobial hand gel and then thoroughly dried, preferably using disposable tissues or towels.

Hands should always be washed and dried after contact with respiratory secretions or after touching surfaces that have been contaminated with respiratory secretions. Health care workers dealing with respiratory secretions should be wearing gloves as per the Standard Precautions.

See Standard Precautions: www.cdc.gov/ncidod/hip/ISOLAT/std_prec_excerpt.htm

Hand-to-face contact, which occurs during such activities as eating, normal grooming or smoking, presents significant risks because of the potential for transmitting influenza from surfaces contaminated with respiratory secretions, and for this reason, hands should always be washed and dried before any activity that involves hand-to-face contact.

Respiratory hygiene/cough etiquette

People with respiratory infection symptoms should practise the following cough/sneeze etiquette whenever they are in the presence of another person.

All symptomatic people should:

- avoid close contact (less than 1 metre) with other people
- cover their nose and mouth when coughing or sneezing
- use disposable tissues to contain respiratory secretions
- immediately dispose of used tissues in the nearest waste receptacle
- immediately wash and dry their hands

Using masks

People with respiratory infection symptoms should consider using a disposable surgical mask to help prevent exposing others to their respiratory secretions.

Any mask must be disposed of as soon as it becomes moist or after any cough or sneeze, in an appropriate waste receptacle, and hands must be thoroughly washed and dried after the used mask has been discarded.

Patients with respiratory infection symptoms in health care institutions should be masked to contain respiratory secretions at any time they present a potential risk to unprotected people.

Recommendations for PPE use

Personal protection equipment (PPE) includes masks, eye/face shields, gloves, gowns and aprons. Varying levels and types of PPE are required, depending on the level of exposure and the risk of transmission.

Whatever the level of PPE to be used, education and training is necessary to ensure the equipment is used and disposed of correctly, to maintain the equipment's effectiveness.

Using disposable surgical masks, gloves and gowns/aprons

Disposable surgical masks are recommended for first responders and health care/support workers in a health care setting who are at risk from droplet transmission.

Disposable gloves are recommended as a means of reducing the likelihood of influenza transmission when handling objects contaminated with respiratory secretions. Apart from health care settings, the use of gloves is less important than careful hand washing. The use of gloves does not replace the need for hand washing.

Disposable gowns or splash resistant aprons may also reduce opportunities for transmitting influenza.

Gloves and gowns/aprons (full PPE)

Health care workers should wear particulate respirator masks, eye protection, gloves and gowns/aprons (i.e. full PPE) when there is a high risk of direct contact with respiratory secretions, particularly via aerosols.

In most other settings a disposable surgical mask (with or without eye protection and disposable gloves) will provide sufficient protection from droplet transmission for health care workers in close contact and/or providing direct personal care to patients with pandemic influenza.

Using these measures helps comply with the Health and Safety in Employment Act 1992

The Health and Safety in Employment Act 1992 requires the following measures to be taken.

“Section 6: All practicable steps

Every employer shall take all practicable steps to ensure the safety of employees while at work; and in particular shall take all practicable steps to:

- provide and maintain for employees a safe working environment
- provide and maintain for employees while they are at work facilities for their safety and health ...

Section 28: Employees may refuse to perform work likely to cause serious harm

- An employee may refuse to do work if the employee believes that the work that the employee is required to perform is likely to cause serious harm to him or her”

Employers must take all practicable steps to mitigate the risk and protect employees, especially those at high risk, such as health care personnel, support staff and first responders (fire/police/ambulance/other emergency workers) from pandemic influenza.

These workers should be educated in hand hygiene, cough etiquette, social distancing and the use of appropriate PPE and should be provided with the supplies required to carry out these techniques. Employers need to actively plan to cover their risks and the risks to their workers and the public.

The above measures should assist employers with compliance.

TABLE 1: SUMMARY OF PROTECTION MEASURES

Protection measure	Where applicable
Hand hygiene, cough etiquette, ventilation	Everyone, all the time
Organisational policies	Every organisation, all the time
Social distancing	Everyone, whenever practical
Protective barriers	In situations where regular work practice requires unavoidable, relatively close contact with the public
Disposable surgical mask	Workers in any community or health care setting who are caring for the sick (this includes first responders) Also as a possible adjunct to protective barriers
Disposable particulate respirator mask, eye protection, gloves, gown/apron	Health care workers participating directly in close contact patient care when there is a high risk of contact with respiratory secretions, particularly via aerosols (mostly inpatient settings)



Appendix 3 Estimate for PPE stock

Scenario for estimation example:

Estimations based on

Gowns - not being soiled

Mask - 4 hours filtration unless wet

2 Staff members for up to 8 residents per shift

PPE required

2 Gowns per shift x 3 shifts = 6 gowns per 24 hours
= 6 x 7 days = 42 gowns per week
Number of gowns per carton = 50 = average 1 box per week

2 pairs of gloves x 8 residents x 3 shift = 48 pairs of gloves per 24 hours
= 48 x 7 days = 336 gloves per week
Number of gloves per box 100 = average 3.5 boxes

2 duckbill masks x 8 residents x 3 shifts = 48 masks
= 48 x 7 = 336 masks per week
Number of masks per box = 50 = average 6-7 boxes

4 PFR95 Masks per shift x 3 shifts = 12 masks per 24 hours
= 12 x 7 days = 84 PFR95 Masks per week
Number of masks per box = 35 = average 2.5 boxes

NOTE: These numbers are only estimates and may vary during the phases of a pandemic. There are many variables to be considered i.e. practice, resident's acuity (re how much care is required and manual handling etc), potential for contamination of PPE.

Appendix 4
TEMPLATES: EXAMPLES

Template: Influenza Notification

Influenza is a contagious disease. There is currently an increase in the numbers of people in New Zealand with influenza. In order to reduce the spread of influenza in the workplace, the following is required of everybody.

DO NOT COME TO WORK if you have:

Chills, shivering and fever (temp > 38°C)

Onset of muscles aches and pains

Sore throat

Trouble breathing

Sneezing

Tiredness



Template: For entrances

HAVE YOU BEEN FEELING UNWELL?



**Please don't share your bugs with our
residents - love to see you when you're
better**

RESIDENT ISOLATION



Please USE
ALL PROTECTIVE PRECAUTIONS

Visitors must inquire at reception before
entering

ATTENTION ALL VISITORS



Some of our residents are suffering from illness/influenza

We are trying to prevent this illness/influenza from spreading

If you choose to visit we request you only visit the resident you have come to see, wash your hands before and after your visit

Thank you

**Appendix 6
Communication Fax Template**

(Facility logo & contact details) FACSIMILE	
TO	Emergency Operations Centre
FROM	
DATE	
FACSIMILE NO.	
NO. OF PAGES	
<p><u>Data Update:</u></p> <p>Number of beds in facility:</p> <p>Occupancy</p> <p>Number of very unwell</p> <p>Number of staff working</p> <p>Number of staff - required for assistance.....</p> <p>Stock required.....</p> <p>Issues:</p> <p>.....</p> <p>.....</p> <p>.....</p>	

PART THREE PANDEMIC RECOVERY SERVICE CONTINUITY

Recovery

Contingency Plans for equipment failure

Contingency Plans for security failure

SHORTAGES

Shortages of supplies may occur because of increased demand during the pandemic (i.e. cleaning supplies).

Shortages may also occur because of disruptions in transportation systems or inability of suppliers to meet demands. Some New Zealand supplies travel considerable distances by truck, train, ship or aircraft, and are vulnerable to any disruption. Absences of workers/drivers and other transportation staff may affect both the production and delivery of needed supplies. Supply lines may also be affected by mandated or self-imposed travel restrictions (e.g. transporters unwilling to travel through or to infected areas).

BUSINESS RECOVERY – Key focus

Overall aim: Best you can

- Caring for residents/families – communication/debriefs/critical incidents
- Caring for staff – staff breaks/debrief etc
- Stocktake of supplies
- Terminal cleaning
- Finance – lost recovery
- Service continuity - contingency plans

SERVICE CONTINUITY

Contingency Plans for Equipment Failure

Problem	Impact	Contingency
Electricity	Inability to supply normal services Sewage unable to be pumped Water supply failure Hygiene risks Perishable foods at elevated temperatures Failure of ovens Failure of dishwashers Unable to use electrics	Back-up generators Promote stored boiled water Water restrictions Reduced perishable supplies held Promote chilly bins Supply cold food Access other sites for cooking of hot foods Utilise single eating utensils and sanitise trays between use Use gas
Emergency Generator Failures	Limited switching capability	

Lighting failure	Resident and staff compromised	Adequate lighting on essential power Torches and batteries available Ensure areas are always clear of hazards especially Fire Exits
Sewage system failure	Inability to dispose of wastes	Restrict water/sewage usage
Water supply failure	Fire sprinklers and wet risers compromised	Promote hand washing solutions
Oxygen and suction supply	Inability to provide	Portable oxygen Contact DHB
Refrigeration	Unable to store milk and food stuffs	Utilise chilly bins and slicker pads Only essential items refrigerated Contact Pharmacy - re medicine storage
Hot water supply failure	Unable to provide basic hygiene requirements	Heat water on gas
Heating/air conditioner failure	Inability to regulate environment	Essential areas on power Generators for back-up Use of fans Open doors and windows
Failure of call bell systems	Residents/staff unable to call for assistance	Hand bells Increased staff vigilance Increase staff ratio if able)
Pan room – sluice	Unable to clean pans, urinals and bowls properly	Dispose of excretions in toilet Cold water soak disinfecting
Resident hoist inoperable	Risk to resident/staff - staff injuries	Manual hoists (sliding sheets, lifting pads) Additional staff for heavy lifting (if able)

Contingency Plans for Security Systems Failure

Problem	Impact	Contingency
Security systems failure	No knowledge of duress to in-house residents and outlying areas	Utilise a runner system
Security system failure	Loss of ability to secure site and protect residents and staff Residents doors would default to exist mode Security cameras not functioning Swipe cards not functioning	Increase staff vigilance Staff monitoring entrances Utilise volunteers Essential power (Refer to Emergency Plan)
Fire system failure	No knowledge of fire danger No normal system available to alert	Battery back-up for alarms Staff to monitor facility (Refer to Emergency Plan)

PART FOUR

Page Number

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Acknowledgments

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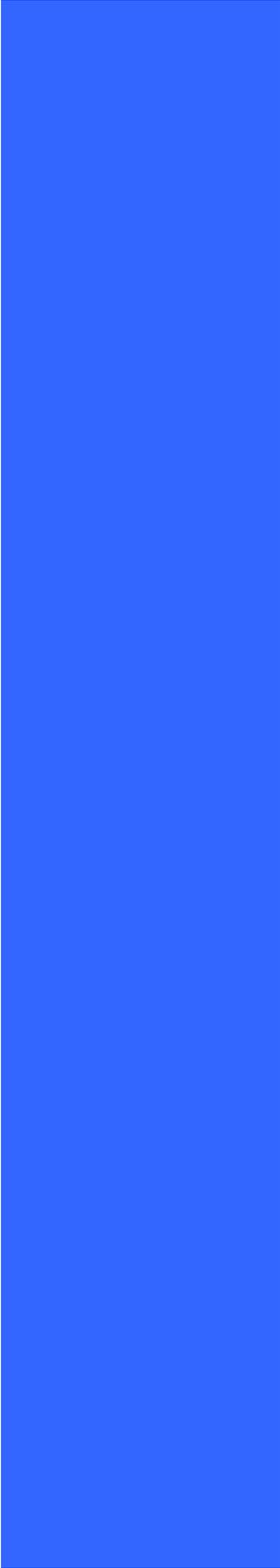
Business Planning Guide: http://www.med.govt.nz/irdev/econ_dev/pandemic-planning/
Ministry of Health <http://www.moh.govt.nz/pandemicinfluenza>

WHO http://www.who.int/csr/disease/avian_influenza/en/

CDC <http://www.cdc.gov/flu/avian/>

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Security Plan

Security Procedures: Pandemic

Preface

This Plan relates to the Hawke's Bay District Health Board area and has been drafted by Police on behalf of the Hawke's Bay District Health Board.

1. Introduction

This Plan serves as a guideline in relation to security issues associated to a pandemic event.

Enabling legislation includes the New Zealand Health Act 1956, the Civil Defence and Emergency Management Act 2002, Crimes Act, Summary Offences Act, The National Civil Defence Plan, the Ministry of Health Influenza Pandemic Action Plan, the Hawke's Bay District Health Board Pandemic Influenza Plan and the Eastern District Police Pandemic Influenza Response Plan.

Consultation occurred with a representative from the Hawke's Bay District Health Board, Pharmacies (local), St Johns Ambulance Service and New Zealand Police.

Therefore the aim of the Plan is to:

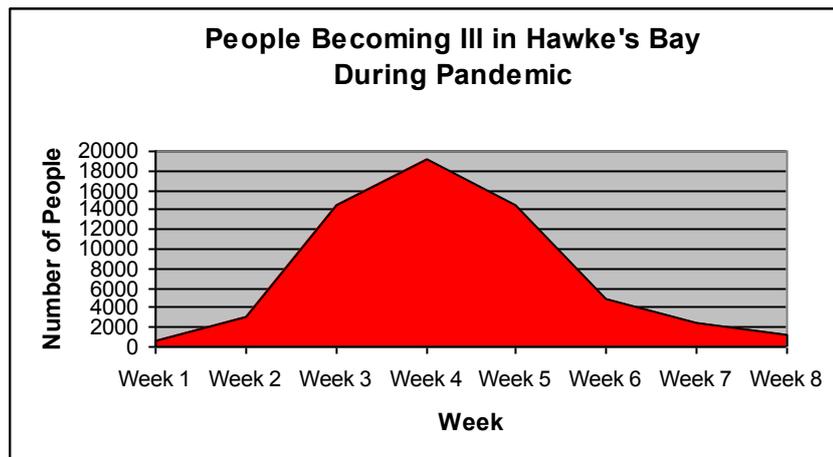
1. Outline roles, responsibilities and procedures to be adopted.
2. Provide effective and timely co-ordination.
3. Provide a generic framework within which key partners can operate and develop contingency plans appropriate to their role during a Pandemic event.

2. Local Situation

Based on considerable information, both nationally and internationally it is evident a proportion of the population will become ill within with influenza should human to human transfer of Pandemic Influenza occur and the Hawke's Bay area be affected. A proportion of the population will require out-patient visits, hospitalisation and some will die as a result of influenza related illness.

Police will support the Medical Officer of Health and deliver upon their core function of maintaining law and order during a pandemic event.

3. Vulnerability and Risk Analysis of local population



The following organisations are likely to be more at risk during this Pandemic due to the resources they hold and/or the level of expertise they have.

Potentially at risk premises, processes and infrastructure include

1. DHB facilities including community assessment centres that may be set up.
 - Targeting of medicines
 - Families, relatives, friends wanting to see patients
 - Bereaved families wanting access to deceased persons
2. DHB personnel.
 - Spokesperson may become target of aggrieved public
3. Pharmacies.
 - Targeting of medicines
4. Supermarkets and food outlets.
 - Public wanting basic food items
 - Targeting of non prescription medicines
5. Petrol stations.
 - Public demand for petrol
6. St John Ambulance Service.
 - Targeting of medicines
 - Risk to personnel as pandemic takes effect

4. Legal and Jurisdictional Responsibilities

Police will operate in support of the Medical Officer of Health and following notification from the Medical Officer of Health that a Pandemic is present in the Hawke's Bay, will respond to calls for service on a priority deployment basis commensurate with risk and capability.

5. Local Emergency Management Resources

The District Health Board will, during this phase, retain the role of lead agency with Police in support.

Police will make every effort to meet their statutory and common law obligations during such an event.

Individual Organisations must, prior to a pandemic event make appropriate provision for security arrangements as a preventative measure.

There may be a need for 24 hour security at certain premises and this will be the responsibility of individual organisation to arrange

6. Police: Eastern District

The NZ Police will aim to provide a "priority one" capability. This is an immediate response to all calls involving actual threat to life or property happening now, violence being used or threatened, serious offence/incident in progress and offenders present or leaving the scene, serious vehicle crashes.

The NZ Police communication centres will be supplied with a current list of high risk facilities to ensure immediate response to any calls for assistance.

The NZ Police will monitor public reaction at each level that the Pandemic passes through and re evaluate at "risk facilities" in relation to security arrangements.

The NZ Police will provide advice on security.

The NZ Police will liaise with local security firms in relation to high priority facilities in terms of need, risk and action required.

The NZ Police will consider swearing in temporary Constables in order to assist with maintaining law and order. The local territorial army force may be a useful source for these staff.

7. Hawke's Bay District Health Board

The DHB will be responsible for the security of all buildings and public access areas within their boundaries and under their control including mortuary facilities.

The DHB will be responsible for the security of all medicines and medical supplies under their care including the movement of medical supplies to other facilities and the storage of medical supplies at Community Assessment Centres.

The DHB will be responsible for the safety of all personnel working for them.

The DHB will immediately inform police of any threats against any of their personnel, facilities or supplies.

8. Pharmacies

Pharmacies will be responsible for the security of their buildings and stock.

Pharmacies will coordinate themselves as to when they may consolidate and share resources.

9. St John Ambulance Service

The ambulance service is responsible for their station, medical and staffs security.

Ambulance staff in the field will use the national communication centre to call for assistance if required.

10. Supermarket/Petrol Stations

These service industries are responsible for their own security. Many already have very good in house security arrangements.

They may take direction from their parent companies that will have a business continuity plan in place for such matters.

11. Structure of local emergency command system

The Company Secretary of HBDHB is the Incident Controller during the response phase and the District Health Board as the lead agency.

The NZ Police will support the DHB along with the Ministry of Civil Defence and Emergency Management and the local Recovery Manager during a Pandemic event.

12. Police Facilities and Deployment

The NZ Police will monitor community activity on a daily basis and allocate policing priorities based on the most recent intelligence through the Police Daily Tasking and Coordination process.

The NZ Police will aim to operate from currently designated Police Stations and Community Policing Centres where able along with a mobile response capability.

13. Arrangements for testing, disseminating and updating the plan

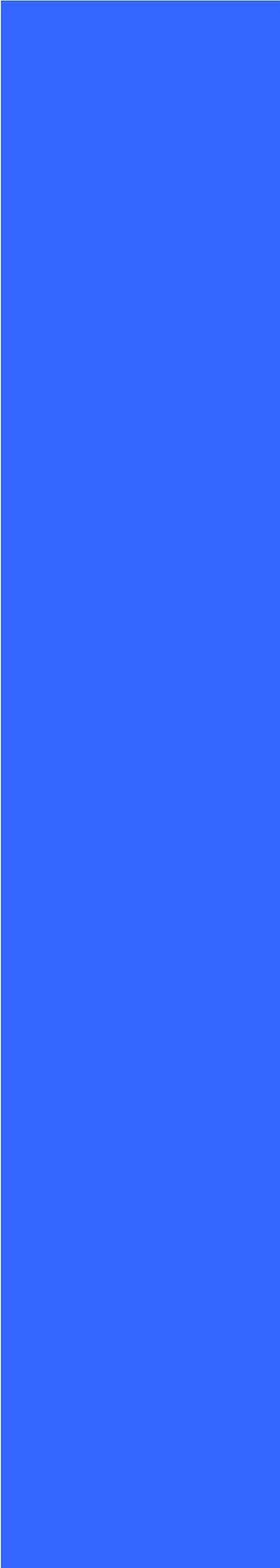
This plan has been prepared and submitted to Hawkes Bay District Health Board following consultation. Distribution of the Plan is the responsibility of HBDHB.

The plan combines practical and academic knowledge and was prepared following a field exercise namely 'Exercise Flubuggers', a DHB led interagency exercise relating to a pandemic event.

The plan should be reviewed annually at the direction of HBDHB. Police will be responsible for completing the review on behalf of HBDHB.

Community Direction and Control

Position	Name/Agency	Telephone
HBDHB Response Coordinator	Kevin Snee HBDHB	878-8109 027-220-3105
HBDHB Incident Controller	Sharon Mason HBDHB	878-8109 027-809-3458
HBDHB Incident Controller	Ken Foote HBDHB	878-8109 027-224-6143
Medical Officer of Health	Dr Rachel Eyre HBDHB	878-8109 027-256-9896
Medical Officer of Health	Dr Caroline McElnay HBDHB	878-8109 027-241-2652
Medical Officer of Health	Dr Nicholas Jones HBDHB	878-8109 027-233-5315
Emergency Response Advisor	HBDHB	878-8109
Infection Control Advisor	Margaret Drury HBDHB	878-8109 027-599-9413
Infectious Disease Physician	Dr Andrew Burns HBDHB	878-8109 Pager 3229
Population Health Manager	Jenny Cawston HBDHB	878-8109
Communications Manager	Anna Kirk HBDHB	027-234-3667
Police	Tania Kura Area Commander NZ Police	831-0721
Fire	Ken Cooper Area Commander Eastern Fire Region	835-2114
Ambulance Service	Brendon Hutchinson Operations Manager HB Ambulance Service	844-1950
Hawkes Bay Regional Council	Andrew Newman General Manager HBRC	835-1961
Hawkes Bay Hospital	Call Centre HBDHB	835-1961
CHB Health Centre	Reception HBDHB	06-858-9090
Wairoa Hospital	Reception HBDHB	06-838-7099
Royston Hospital	Reception	873-1111
Mr Christopher Devonport	Coroner East Coast	870-3116



Training Plan

PANDEMIC TRAINING PLAN

Prior to activation of the training plan a meeting of all involved trainers will be held to ensure preparedness and to update any training material as required. This meeting will be facilitated by HBDHB's Emergency Response Advisor. At this point a plan for session delivery will be formulated.

Package	Facilitator	Target Groups	MoH Code WHO Phase	Method
Pandemic Influenza – An Introduction	Emergency Response	HB Community	Code Yellow WHO Phase 3	Presentation Discussion
Infection Control – Basic Hygiene	Margaret Drury	HB Community	Code Yellow WHO Phase 3	Presentation Discussion
Specimen Collection	Laboratory Scientist	Primary Care Front Line Secondary Care	Code Yellow WHO Phase 4	Discussion Demonstration Practice
Infection Control – Level One	Margaret Drury	Primary Care Secondary Care Ambulance Service Residential Homes Prison Service Police Cleaning Services Community Pharmacy Local Authorities (relevant staff) Education Providers Funeral Directors Child Care Centres	Code Red WHO Phase 5	Presentation Demonstration
Managing Challenging Behaviour	Nicola Prenderville	All staff of involved agencies	Code Red WHO Phase 5	Workshop Discussion
Debriefing and Stress Management	Jane O’Kane	Front line staff of all involved agencies	Code Red WHO Phase 5	Presentation Discussion

Intensive Care Orientation	Dr Michael Park	Registered Nurses relocating to ICU	Code Red WHO Phase 5	Presentation Workshop Demonstration Practice
Cause of Death Certification	Kaye Lafferty	Approved Level 4 Registered Nurses	Code Red WHO Phase 6	Mini Lecture Discussion
Volunteer Orientation	Kaye Lafferty	Volunteers	Code Red WHO Phase 6	Mini Lecture Discussion Workshop Practice
Infection Control – Level Two	Margaret Drury	Primary Care Secondary Care Ambulance Service Residential Homes Prison Service Police	Code Red WHO Phase 6	Demonstration Practice
Patient Management	Infection Control Committee	Primary Care Secondary Care Ambulance Service Residential Homes Prison Service	Code Red WHO Phase 6	Presentation Discussion
Vaccination System Preparation	Public Health Service	All staff involved in mass vaccination campaign	Code Red WHO Phase 6	Discussion Workshop

The facilitators are responsible for the preparation of training sessions. Training may be delivered by a variety of trainers using a train the trainers approach to enable efficient and timely coverage of all individuals and agencies. Resources required will be provided to all agencies with a central database of training attended maintained by the DHB.

Pandemic Training Plan Sessions



Pandemic Influenza An Introduction



PANDEMIC INFLUENZA - AN INTRODUCTION



Sandra Bee
Hawkes Bay District Health Board



Influenza

A highly infectious viral disease recognized by the onset of high fever, sore throat, dry cough, aches/pains, sickness

- Spread by airborne droplets and hand/mouth transfer
- Incubation period 1-3 days, illness 7 days
- Infectious from onset for 3-7 days
- Disease damages respiratory tract linings, secondary pneumonia, meningitis and infections take hold.
- 100 per year die of influenza



Transmission: small and large droplets



Corbis.com



How influenza differs from the common cold?

Influenza	A Cold (commonly referred to as the flu)
Severe illness lasting 7 - 10 days	Symptoms last 1 - 2 days
Usually a high fever	Sometimes a mild fever
Shivering attacks	A runny nose
Muscular pains	No muscular pain
Headache (may be severe)	Mild headache (congested sinuses)
Dry cough may become moist	Sometimes a cough
Vomit occasionally	
Bedridden	

Can suffer severe complications:
hospitalisation
pneumonia, bronchitis
worsening of a chronic disorder
worsening of asthma
diabetes may become unstable

Vaccine available  No Vaccine

Influenza makes you really sick... a cold doesn't.

Influenza Pandemics in the 20th Century



1918: "Spanish Flu"

~50 million deaths

H1N1



1957: "Asian Flu"

1-4 million deaths

H2N2



1968: "Hong Kong Flu"

1-4 million deaths

H3N2



Pandemic Influenza is Different

- Not seasonal – may come any time of year
- May impact on any age group (rather than mostly the young and elderly)
- May have a very high attack rate
- May have a very high case fatality rate
- May come in several waves over months or years
- Can't be predicted - but we might get some warning
- WILL come one day (maybe soon)



Potential impacts of pandemic in modern NZ

- No community history of anything remotely like this
- Immense impact on society and economy
- Health services unable to provide direct care
- Full community mobilisation needed (as in 1918)
- Health service role - coordination and support of community mobilisation, assistance where possible
- All government and many community agencies involved in whole of society response



WHO Pandemic Phases

1	No new subtype
2	New subtype in animals
3	New subtype found in humans but no spread
4	Small clusters of human to human spread
5	Large localised clusters of human to human spread
6	Sustained transmission in human populations



Pandemic Influenza Predicted Impact on Hawke's Bay

OVER A 6 - 8 WEEK PERIOD:

- Between 25 and 50% of population will have severe influenza illness
- 53 000 sick
- 27 000 visit the doctor
- 600 hospital admissions
- 1325 deaths



Projected casualties during an influenza pandemic Hawke's Bay

	Deaths	Hospitalisations	Consultations
Wairoa	82	36	1,678
Napier	497	215	10,100
Hastings	625	271	12,691
CHB	118	51	2,415
Chatham Islands	1	3	135
Total	1325	576	27,019



Roles and Responsibilities During a Pandemic

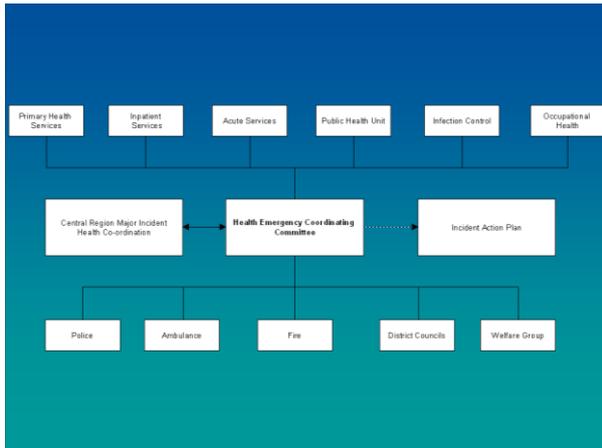
- Hawke's Bay District Health Board – lead agency
 - Primary and secondary care
 - Public health advice
- Ministry of Health – national leadership, surveillance
- CDEM – activation of Welfare Group, manage community response



Issues in a Pandemic

- Increased workload with decreased staffing resource
- Effects are relatively prolonged (weeks to months)
- Effective vaccines and antiviral agents in short supply





Potential Health Care Impact

- Shortfall of ICU beds and critical care resources
- Shortage of medication required
- Need for additional treatment centers
- High demand of mortuary/funeral services
- High demand for social and counseling services

Potential Impact on Society

- Prohibition of public gatherings
- Schools closed and child care provision reduced
- Business hours reduced
- Shortage of foodstuffs
- Vulnerability of infrastructure
- Emergency service response reduced
- Social isolation

Tamiflu

- Antiviral medication used for treatment and prevention
- MOH national stockpile
- Restricted resource
- Prioritised release dependant on recognition and epidemiology of the disease

Vaccines

- Viral strains reviewed twice a year
- Vaccines are virus-specific
- Pandemic vaccine dependant on identification of specific virus
- Current vaccines do not provide protection against a novel influenza virus

Case definition

(simplified)

Person with acute lower respiratory tract illness of abrupt onset, characterised by:

- fever (temperature >38 C); and
- sore throat; and
- cough; and/or
- difficult or laboured breathing;

AND

- contact with a confirmed case or
- recent exposure in an area where there has been an outbreak

<http://www.moh.govt.nz/pandemicinfluenza>

Personal Responsibilities

- Stay at home if unwell
- Good personal hygiene
- Hold a personal survival kit of food and water
- Annual influenza vaccination



Infection Control Precautions

- Handwashing
- Social distancing
- Cough etiquette
- Cleaning
- Ventilation



Surveillance of Personal Wellness

- If you have any of these symptoms:
 - high temperature
 - difficulty breathing
 - cough
 - sore throatcontact your doctor by telephone.



Infection Control

Basic Hygiene



Infection Control

Pandemic Influenza Training Guidelines



Introduction

- This document is intended to provide guidelines to minimise the risk of cross infection in the event of a pandemic
- Guidelines are linked to the MOH pandemic codes
- The level of knowledge and PPE required will depend on the tasks/contact and may be greater as the pandemic progresses



Be Prepared

- Encourage annual influenza vaccine
- Establish a staff wellness policy i.e. personal hygiene, avoiding close contact, stay home if unwell
- Identify personal protection equipment



Education

- Basic infection control principles
 - Hand washing
 - Cough etiquette
 - Social distance
- Transmission of influenza
- Correct use of protective equipment
- Management of waste
- Personal health monitoring



Code White - be prepared

- Pandemic alert phase
- Human infections with a new virus
- No human to human spread
- Review infection control practice and update staff and public education



Code White

- Practice basic hygiene
 - Frequent hand hygiene
 - Cough etiquette
 - Cleaning regime for equipment and environment
- Ventilation
- Stay at home if unwell

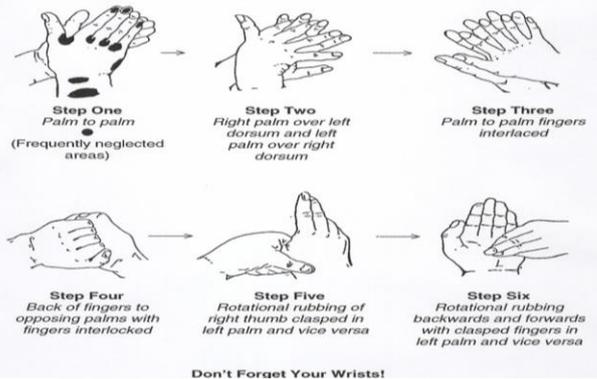


Cough Etiquette

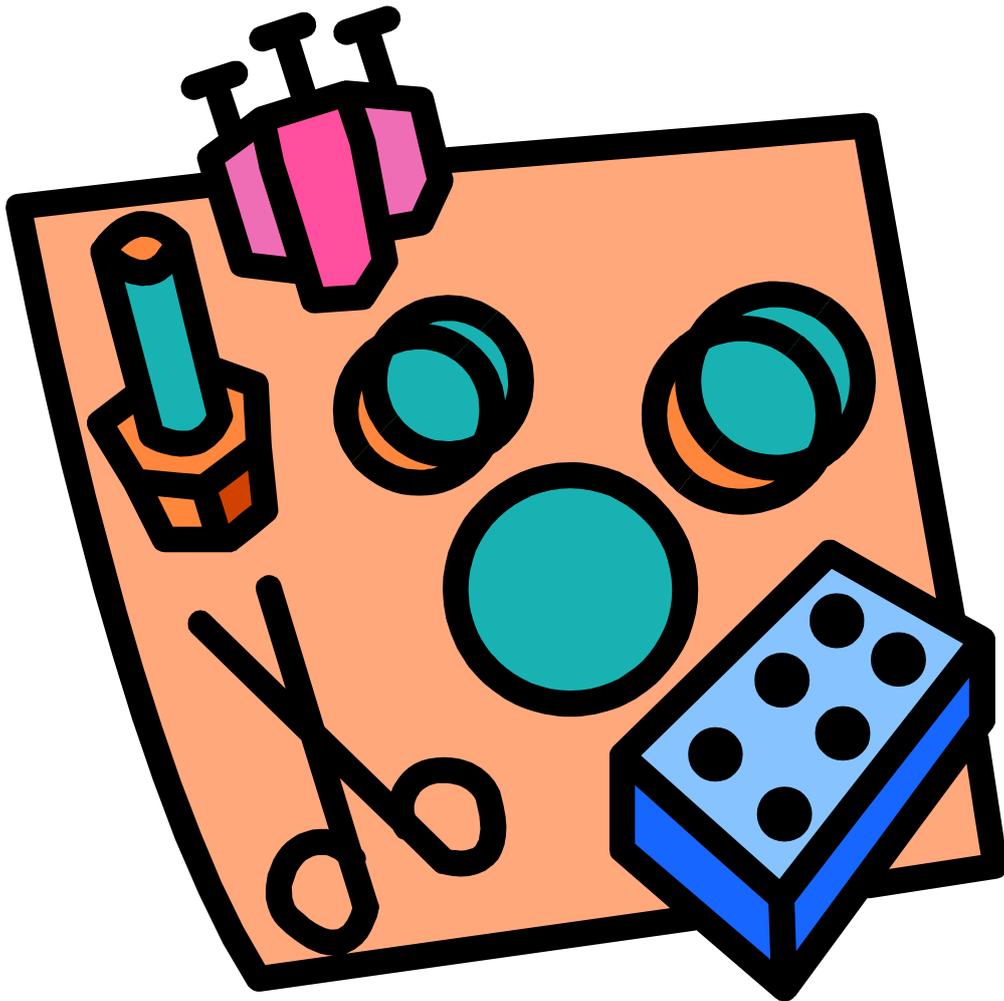
- Cover your nose and mouth when coughing or sneezing
- Use a tissue
- Dispose of tissue into a covered bin after use
- Hand hygiene after coughing/sneezing and using a tissue



Five Finger Technique



Specimen Collection



Session Plan

Client: Pandemic Specimen Collectors

Title: Specimen Collection to Identify Pandemic Influenza

Written by: Ash Fitchett

Date: June 2016

Aim:

To provide front line clinical staff with the skills necessary to collect the specimens required for pandemic influenza diagnosis.

Learning Objectives:

By the end of this session you will have:

- Discussed the specimens required
- Practised the collection of identified specimens
- Discussed the system for specimen handling

Number of participants: 20 to 30

Methods:

Demonstration and Practice, Discussion

Lesson Plan

Teaching Points	Facilitator	Time
Introduction: <ul style="list-style-type: none"> • Course overview • Learning objectives 	Laboratory Technologist	5 mins
The Specimens of Choice: <ul style="list-style-type: none"> • Nasopharyngeal swabs • Throat swabs • Blood for serology (acute and convalescent) 	Laboratory Technologist	10 mins
Specimen Collection: <ul style="list-style-type: none"> • Precautions • Practical demonstration 	Laboratory Technologist	30 mins
System for Handling: <ul style="list-style-type: none"> • Infection control precautions • Packaging • Transport to HBH 	Laboratory Technologist	10 mins
Conclusion: <ul style="list-style-type: none"> • Learning objectives attained? • Questions? 	Laboratory Technologist	5 mins

Laboratory

Pandemic Training



Introduction

- Specimens required
- Collection of specimens
- Handling of specimens-Infection control precautions
- Packaging
- Transport to HBH laboratory



Specimens Required

- Blood
- Nasopharyngeal swabs
- Throat swabs



Collection of Blood

- Use protective equipment i.e. gloves, PFR95 mask, gown and face shield
- Collect sufficient blood using normal process
- Blood request form for culture, full blood count U & E and creatinine



Nasopharyngeal Swab- collection of

- Use only sterile dacron or rayon swabs with plastic shafts
- Insert swab into nostril parallel to the palate
- Leave for a few seconds to absorb secretions
- Swab both nostrils
- Place into vial with 2mL sterile transport media
- Break applicator stick off
- Seal tightly with cap



Handling of specimens

- Staff involved in handling of specimens must observe routine precautions i.e. gloves, and prevent aerosol production
- Face protection in addition to normal protective laboratory clothing must be worn while processing specimens



Handling of specimens cont.

- Respiratory
 - place in Class 2 Biohazard cabinet, turn cabinet on and register specimen as usual.
- Blood
 - use gloves and prevent aerosols. All bloods requiring centrifuge are spun in capped buckets.



Packaging for Transport

- All specimens must be double bagged in biohazard bag
- Place specimens in labelled chillibin
- Blood cultures must be protected with bubble wrap or similar
- Respiratory specimens must be transported with ice



Transport to HB Hospital

- Notify laboratory of impending arrival of specimens
- Contact courier re transport
- Courier to hand deliver specimens directly to laboratory registration



Infection Control Level One



Infection Control

Pandemic Influenza Training Guidelines



Introduction

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- Guidelines are linked to the MOH pandemic codes
- The level of knowledge and PPE required will depend on the tasks/contact and may be greater as the pandemic progresses



Be Prepared

- Encourage annual influenza vaccine
- Establish a staff wellness policy i.e. personal hygiene, avoiding close contact, stay home if unwell
- Identify personal protection equipment



Education

- Basic infection control principles
 - Hand hygiene
 - Cough etiquette
 - Social distance
- Transmission of influenza
- Correct use of PPE
- Management of waste
- Personal health monitoring



Code White - be prepared

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- Human infections with a new virus
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Code White

- Practice basic hygiene
 - Frequent hand hygiene
 - Cough etiquette
 - Cleaning regime for equipment and environment
- Ventilation
- Stay at home if unwell

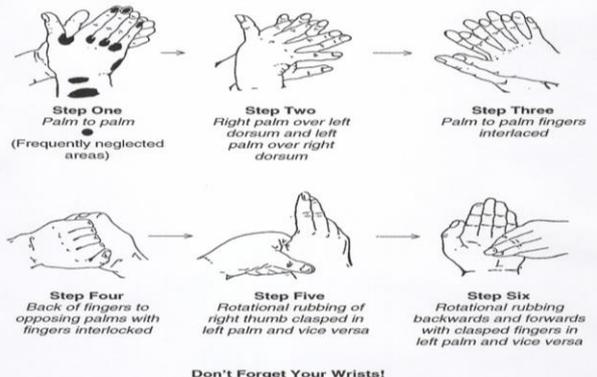


Cough Etiquette

- Cover your nose and mouth when coughing or sneezing
- Use a tissue
- Dispose of tissue into a covered bin after use
- Hand hygiene after coughing/sneezing and using a tissue



Five Finger Technique



Code Yellow - standby

- Standby period
- Human infections with new virus
- Rare instances of spread to a close contact
- Review essential supplies and plans for management
- Education on use of PPE

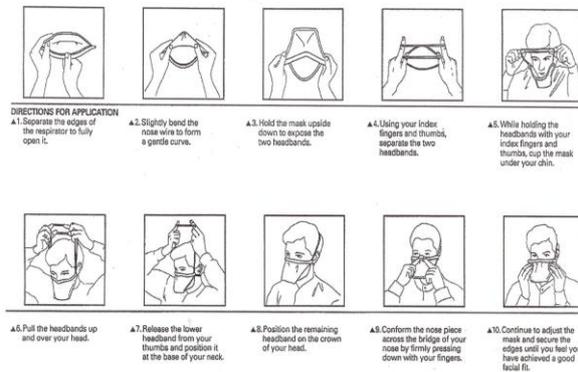


Essential Supplies

- Gloves
- Masks - PFR95, duckbill (surgical) masks
- Tissues
- Rubbish bins with lids
- Biohazard bags with high tensile ties
- Access to hand washing facilities/hand hygiene products



How to use a mask



Managing Challenging Behaviour



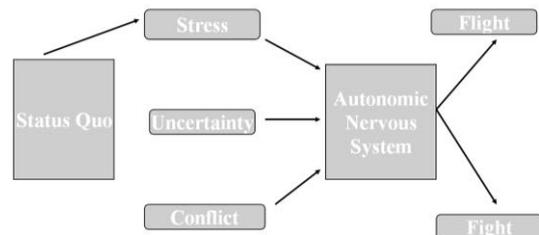
Healthy Workplace

Understanding Violence & Aggression & De-escalation

1



Understanding Violence



2



From Calm to Violent



3



De-escalation

- ◆ Verbal Intervention
- ◆ Personal Space
- ◆ Body Language

4



Calming Aspects

- ◆ Calm manner
- ◆ Consistency
- ◆ Continuous observation
- ◆ Allow freedom
- ◆ Encourage client to take deep breaths
- ◆ Recognition of own feelings
- ◆ Offer hope
- ◆ Maintain eye contact
- ◆ Consider your stance
- ◆ Use hands & sense of touch
- ◆ Try not to cover exits
- ◆ Empowerment
- ◆ Good rapport

5



Calming Aspects

- ◆ Partnership
- ◆ Open body language
- ◆ Active listening
Reflection/paraphrasing
- ◆ Options/reasons/choices
- ◆ Look for cues, signs of change
- ◆ Show: Confidence
Concern
Empathy
Efficiency
- ◆ Model Behaviour
- ◆ Mirroring vs contrast
- ◆ Patience
- ◆ Continual Assessment
re-evaluate
- ◆ Diversion
- ◆ Re-direction
- ◆ Be calm yourself
- ◆ Use environment/staff
- ◆ Awareness of safety

6



Setting Limits

◆ Setting Limits – Directive

An approach in which a staff member takes control of a potentially escalating situation by setting limits.

7



The Art of Setting Limits

- ◆ When you set limits you are offering choices, as well as stating the consequences of those choices
- ◆ Limits usually are better received when the positive choice and consequence are stated first
- ◆ Limits are most effective when they are:
 - Simple/Clear
 - Reasonable
 - Enforceable

8



The Art of Setting Limits

- ◆ Explain to the person exactly what type of behaviour is acceptable
- ◆ Explain why the other behaviour is inappropriate
- ◆ Give reasonable choices and explain consequences
- ◆ Allow time for them to decide
- ◆ Enforce consequences

9



Crisis Development

Escalating Behaviour	De-escalating Behaviour
1. Anxiety	1. Verbal Intervention
2. Threatening	2. Setting Limits
3. Acting Out	3. Physical Management
4. Tension Reduction	4. Re-establish Rapport

10



Integrated Experience

The concept that the behaviour and attitude of staff has an impact on the behaviour and attitude of the client and visa versa.

11



Personal Space

- ◆ Personal space varies depending on who is approaching
- ◆ The invasion of an individual's personal space will increase that person's anxiety

12



Body Language

- ◆ This includes facial expressions, gestures, posture and movement
- ◆ Our behaviour can serve to escalate or de-escalate a given situation

13



Safe Stance

- ◆ Communicates respect
- ◆ Non-threatening and offers an escape route
- ◆ Assists with personal safety



14



Paraverbal Communication

Tone = Total

- ◆ Try to avoid inflections of impatience, condescension, inattention, etc

15



Paraverbal Communication

Volume = Voice

- ◆ Keep the volume appropriate for the distance and the situation.

16



Paraverbal Communication

Cadence = Control

- ◆ Deliver your message using an even rate and rhythm.

17

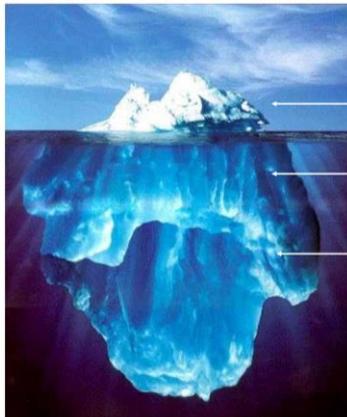


Communication

It is essential to be aware of not only **what we say** to an individual, but **how we say it**.

How is equally, if not more important, than the words we use.

18



- ◆ 7% Verbal (words)
- ◆ 38% Para verbal (how it is said)
- ◆ 55% Non verbal (body language)

19



Verbal Escalation

Questioning

Information Seeking

- ◆ A rational question seeking a rational answer

Intervention

- ◆ Give a rational response

20



Verbal Escalation

Questioning

Challenging

- ◆ Questioning authority or being evasive

Intervention

- ◆ Stick to the topic (redirect), set limits if individual persists

21



Verbal Escalation

Refusal

- ◆ Non compliance, slight loss of rationalisation

Intervention

- ◆ Set limits

22



Verbal Escalation

Release

- ◆ Acting out, emotional outburst, loss of rationalisation. Blowing off steam, screaming, swearing. High energy output.

Intervention

- ◆ Allow to let off steam.
- ◆ Remove audience or acting out individual
- ◆ Use an understanding, reasonable approach.
- ◆ Be prepared to enforce limits.

23



Verbal Escalation

Intimidation

- ◆ Individual is verbally or non verbally threatening staff in some manner

Intervention

- ◆ Seek Assistance
- ◆ Avoid individual intervention
- ◆ Take seriously

24



Verbal Escalation

Tension Reduction

- ◆ Drop in energy levels.

Intervention

- ◆ Re-establish rapport with the person

25



Empathic Listening

Key Elements

- ◆ Be non-judgemental
- ◆ Give undivided attention
- ◆ Listen carefully to what the person is saying (focus on feelings, not just facts)
- ◆ Allow silence for reflection
- ◆ Use restatement to clarify messages

26



Precipitating Factors

- ◆ Loss of personal power
- ◆ Need to maintain self-esteem
- ◆ Fear
- ◆ Failure
- ◆ Attention seeking
- ◆ Displaced anger
- ◆ Psychological/physiological causes

27



Precipitating Factors

Understanding these can help staff:

- ◆ Prevent aggressive behaviour
- ◆ Depersonalise crisis situations
- ◆ Avoid becoming a precipitating factor ourselves

28



Rational Detachment

The ability to remain in control of our own behaviour

1. Controlling our response to aggressive behaviour
2. Maintaining a professional attitude
3. Finding a positive way to release our own feelings after the event

29



Staff Fear & Anxiety

Fear and anxiety are universal human emotions. Our response to them is both psychological and physiological.

- ◆ Non-productive reactions
- ◆ Productive Reactions

30



Non-productive Reactions

- ◆ Freezing
- ◆ Overreacting
- ◆ Responding Inappropriately

31



Productive Reactions

- ◆ Increased speed and strength
- ◆ Increased sensory acuteness
- ◆ Decreased reaction time

32



Ways to Control Fear and Anxiety

1. Understand what makes us afraid.
2. Learn techniques to protect both ourselves and acting out individuals in a crisis.
3. Use a team approach – don't respond alone.
4. Learn techniques to control acting out individuals, if necessary

33



Making Request Effectively

- ◆ Gain & maintain attention
- ◆ Use the person's name at the beginning
- ◆ Be courteous
- ◆ Rule of 5
- ◆ Explain why a request is made
- ◆ State what the behaviour requested is
- ◆ Use a calm, firm voice
- ◆ Make appropriate eye contact
- ◆ Re-direct the person to an alternative behaviour
- ◆ Where possible give the person a choice

34



Tips and Techniques

DO'S

- ◆ Remain calm
- ◆ Isolate the situation
- ◆ Enforce limits
- ◆ Listen
- ◆ Be aware of nonverbals
- ◆ Be consistent

DON'TS

- ◆ Overreact
- ◆ Get into a power struggle
- ◆ Make false promises
- ◆ Fake attention
- ◆ Be threatening
- ◆ Use jargon (it tends to confuse and frustrate)

35



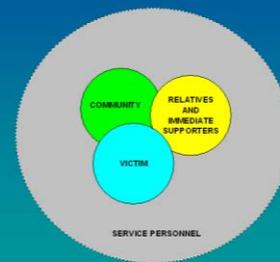
Debriefing and Stress Management



DEBRIEFING AND STRESS MANAGEMENT



Impact of a Traumatic Event



Critical Incident Stress is:

- The reaction a person or group has to a critical incident and is characterised by a wide range of cognitive, physical, emotional and behavioural signs and symptoms.
- This response is seen as "normal" human behaviour.



Post Traumatic Stress Disorder

- The person has been exposed to a traumatic event.
- The event is persistently re-experienced.
- There is persistent symptoms of increased arousal.
- The above lasts for at least 1 month.
- The disturbance causes significant distress in social, occupational or other areas of functioning.



Symptoms of Post Traumatic Stress Disorder

- Tension – general agitation
- Sleep disturbances
- Dreams and nightmares
- Fearfulness
- Intrusive memories and feelings
- Numbing
- Irritability
- Depression and/or anxiety



Symptoms of Post Traumatic Stress Disorder

- Social withdrawal
- Physical sensations – headaches, nausea etc
- Poor concentration
- Self medication



Psychological Debriefing

Psychological debriefing is:

“A structured group meeting, emphasising ventilation of feelings, discussion of reactions to the event, and education and information about the coping strategies”.



Debriefing is:

1. Expression of feelings, thoughts, impressions, reactions.
2. Clarify how others saw the event to get perspective.
3. Decrease level of tension in individuals and group.
4. Increase coping skills by sharing.
5. Promote acceptance of each person's reactions as “normal”.
6. Build our own understanding of stress and its effects on us



What is stress?

Stress is the adverse reaction people have to excessive pressures or other types of demand placed on them.

Stress is not a disease in itself, but can lead to ill-health (physical and mental).

It is the result of the interaction between the individual and the working environment, (both physical and psychosocial).



Primary Sources of Stress at Work

- Job type, e.g. police work, health, dealing with violence/emotive material
- Demands such as workload
- Control of the way we work
- Support from others
- Relationships with others
- Role clarity
- Change management
- Personal factors can contribute, e.g. health, relationships, financial circumstances, personality type



Managing Your Stress

- Identify your stressors, and report them
- Recognize what you can change
- Reduce the intensity of your emotional reactions
- Learn to moderate your physical reactions
- Build your physical reserves
- Maintain your emotional reserves



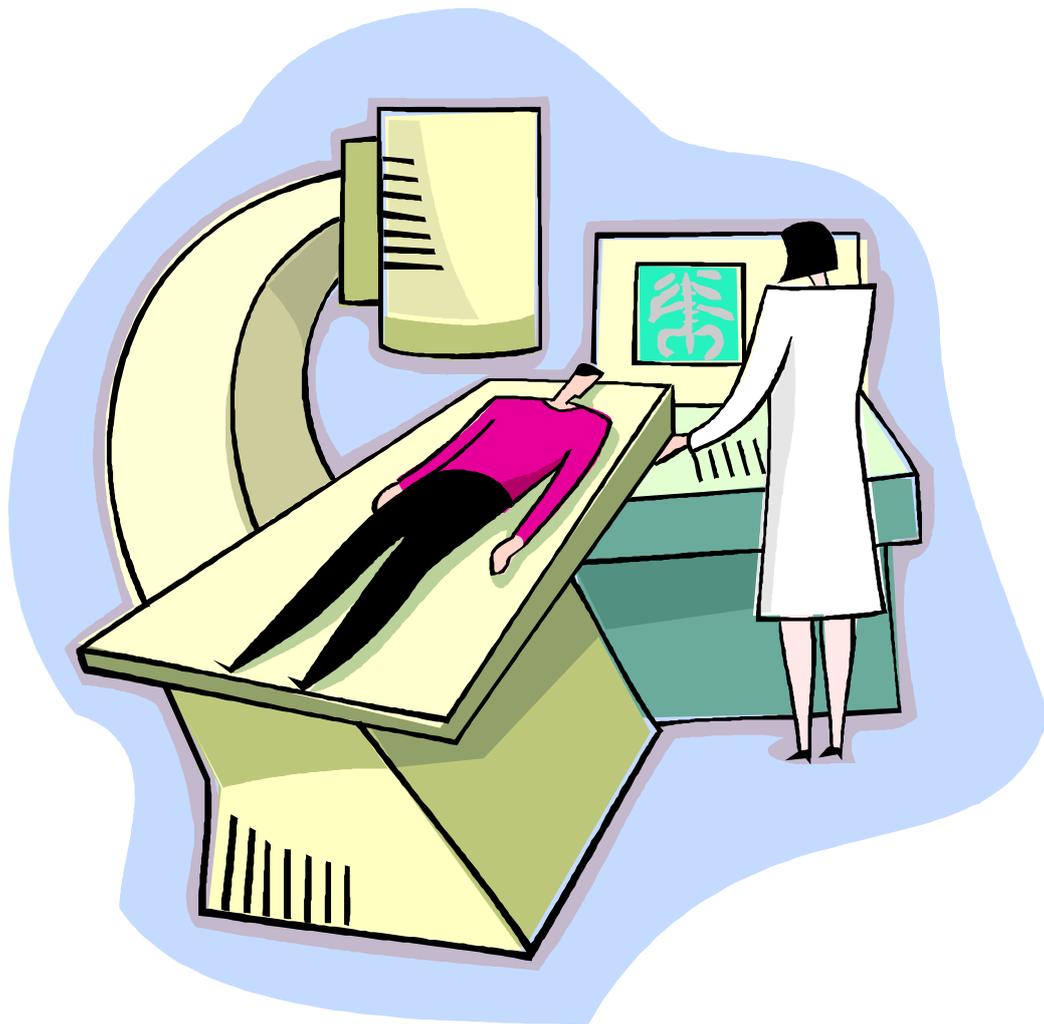
Managing Your Stress

- Learn from mistakes and errors when they occur – not apportion blame.
- Finish tasks or take a break if unable to complete.
- Meet with manager to discuss stressors.
- Seek assistance/support from Occupational Health or EAP Service (external confidential staff support service) etc.



Intensive Care Orientation

(To be completed on human to human transmission)



Cause of Death Certification System



Session Plan

Client: Registered Nurses Certifying Cause of Death

Title: Cause of Death Certification

Written by: Sandra Bee

Date: September 2016

Aim:

To provide approved Level 4 registered nurses with the skills necessary to certify life extinct and cause of death.

Learning Objectives:

By the end of this session you will have:

- Discussed the legal requirements for life extinct and cause of death certification
- Examined the documentation required
- Discussed the process required

Number of participants: 20 to 30

Methods:

Mini Lecture, Discussion

Lesson Plan

Teaching Points	Facilitator	Time
Introduction: <ul style="list-style-type: none"> • Course overview • Learning objectives 	Q&R Team	5 mins
Legal Requirements: <ul style="list-style-type: none"> • Relevant legislation • The role of the coroner 	NZ Police	20 mins
Documentation: <ul style="list-style-type: none"> • Certificate of life extinct • Death certificate 	Medical Director	10 mins
Process: <ul style="list-style-type: none"> • Life extinct determination • History taking • Determining cause of death 	Medical Director	20 mins
Conclusion: <ul style="list-style-type: none"> • Learning objectives attained? • Questions? 	Q&R Team	5 mins

Volunteer Orientation



Session Plan

Client: Pandemic Volunteers

Title: Orientation to Healthcare

Written by: Sandra Bee

Date: September 2016

Aim:

To provide volunteers to healthcare during a pandemic with the skills and confidence necessary to assist in the healthcare response. This is an introductory session only, to be followed by area specific orientation when the volunteer is allocated.

Learning Objectives:

By the end of this session you will have:

- Discussed the healthcare environment, its hierarchy, systems and general layout
- Discussed the tasks allocated to volunteers
- Demonstrated an understanding of the alarms present and response to these
- Examined an action plan for a fire event
- Practised cardiopulmonary resuscitation and basic first aid
- Discussed relevant health and safety issues
- Demonstrated an understanding of the use of the occupational health service and access to same
- Discussed infection control principles and practice and demonstrated an understanding of same
- Demonstrated an understanding of customer service
- Practised basic patient care and manual handling techniques (if applicable)

Number of participants: 20 to 30

Methods:

Buzz Groups, Demonstration and Practice, Mini Lecture, CPR Audit, Video Presentation, Discussion

Lesson Plan

Teaching Points	Facilitator	Time
Introduction: <ul style="list-style-type: none"> • Course overview • Learning objectives 	Clinical Risk Team	5 mins
The Healthcare Environment: <ul style="list-style-type: none"> • Layout of facility • Management structure • Uniforms, identification • Access to areas • Confidentiality 	Clinical Risk Team	20 mins
Volunteer Tasks: <ul style="list-style-type: none"> • Task list • Supervision and delegation • Limits of authority 	Clinical Risk Team	15 mins
Alarms: <ul style="list-style-type: none"> • Types • Response required 	Sandra Bee	10 mins
Fire: <ul style="list-style-type: none"> • Alarm systems • Fire protection systems • Floor and building wardens • Action plan 	Sandra Bee	15 mins
Cardiopulmonary Resuscitation: <ul style="list-style-type: none"> • Steps of CPR - Safety, Airway, Breathing, Circulation • Ratios and rates - adult 30 to 2, 100, child 30 to 2, 100, infant 30 to 2, 100-120/minute • Reasons to stop CPR – recovery, medical assistance, exhaustion • Recovery position • Obstructed airway • Barrier devices First Aid: <ul style="list-style-type: none"> • Unconsciousness • Bleeding • Burns • Fractures • Medical emergencies 	Sandra Bee	60 mins

<p>Health and Safety:</p> <ul style="list-style-type: none"> • Hazards and reporting of same • Safe working practice 	Jane O'Kane	20 mins
<p>Occupational Health Service:</p> <ul style="list-style-type: none"> • How to contact • Service available • Reporting of injuries or illness • Employee Assistance Program • Hospital chaplains 	Jane O'Kane	10 mins
<p>Infection Prevention and Control:</p> <ul style="list-style-type: none"> • Handwashing • Cough etiquette • Social distance • Transmission of influenza • Personal health monitoring • Personal protective equipment • Management of waste 	Margaret Drury	50 mins
<p>Customer Service:</p> <ul style="list-style-type: none"> • Answering the telephone • Taking messages • Dealing with the difficult enquiry 	Jeanette Rendle	30 mins
<p>Basic Patient Care:</p> <ul style="list-style-type: none"> • Washing a patient • Feeding a patient • Toileting • Manual handling • Assisting the registered nurse • Bedmaking 	Nurse Educators	120 mins
<p>Conclusion:</p> <ul style="list-style-type: none"> • Learning objectives attained? • Questions? 	Clinical Risk Team	5 mins

Infection Control Level Two



Infection Control

Pandemic Influenza Training Guidelines



Introduction

- This document is intended to provide guidelines to minimise the risk of cross infection in the event of a pandemic
- Guidelines are linked to the MOH pandemic codes
- The level of knowledge and PPE required will depend on the tasks/contact and may be greater as the pandemic progresses



Be Prepared

- Encourage annual influenza vaccine
- Establish a staff wellness policy i.e. personal hygiene, avoiding close contact, stay home if unwell
- Identify personal protection equipment



Education

- Basic infection control principles
 - Hand hygiene
 - Cough etiquette
 - Social distance
- Transmission of influenza
- Correct use of PPE
- Management of waste
- Personal health monitoring



Code White - be prepared

- Pandemic alert phase
- Human infections with a new virus
- No human to human spread
- Review infection control practice and update staff and public education



Code White

- Practice basic hygiene
 - Frequent hand hygiene
 - Cough etiquette
 - Cleaning regime for equipment and environment
- Ventilation
- Stay at home if unwell

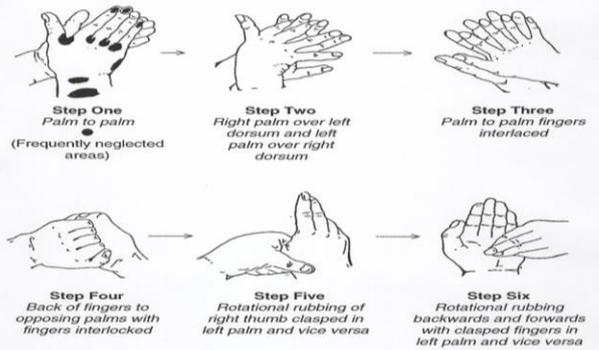


Cough Etiquette

- Cover your nose and mouth when coughing or sneezing
- Use a tissue
- Dispose of tissue into a covered bin after use
- Hand hygiene after coughing/sneezing and using a tissue



Five Finger Technique



Don't Forget Your Wrists!

Code Yellow - standby

- Standby period
- Human infections with new virus
- Rare instances of spread to a close contact
- Review essential supplies and plans for management
- Education on use of PPE

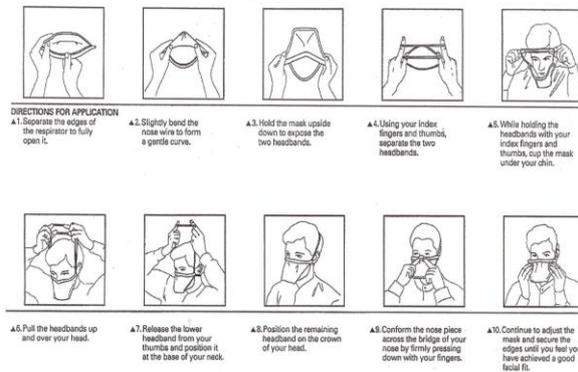


Essential Supplies

- Gloves
- Masks - PFR95, duckbill (surgical) masks
- Tissues
- Rubbish bins with lids
- Biohazard bags with high tensile ties
- Access to hand washing facilities/hand hygiene products



How to use a mask



Red Phase - action

- Clusters with human to human spread
- Progressing to larger clusters of human to human spread
- Leading to increased transmission in the general population
- Increased education for frontline workers in use of protective equipment



Level of Risk

- Level of PPE depends on level of risk and workplace situation
 - Low risk - may be able to keep distance
 - Medium risk - duckbill mask, gloves, gown
 - High risk - PFR95 mask, face shield, gown



Donning PPE - Order

- Perform hand hygiene
- Gown
- Mask, PFR95 or duckbill-fit test to ensure seal
- Face shield
- Disposable gloves - ensure correct fit and wrists are covered



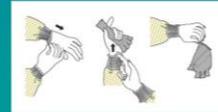
Removal of PPE - Order

- Remove gloves
- Perform hand hygiene
- Remove gown-fold inwards and roll up
- Perform hand hygiene
- Remove face shield
- Remove mask using strings
- Perform hand hygiene



Gloves - removal of

- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand, slide fingers of un-gloved hand under remaining glove at wrist
- Peel glove off over first glove
- Discard gloves in waste container
- Perform hand hygiene



Gown - removal of

- Unfasten ties
- Pull away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard



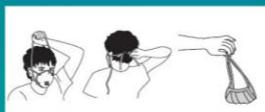
Face shield

- To remove, touch only the head band
- Place in designated receptacle for reprocessing or in waste container
- Perform hand hygiene



Mask - removal of

- Grasp bottom, then top ties or elastics and remove
- Discard in waste container
- Perform hand hygiene



Disposal of Used Equipment

- Used supplies i.e. clothing and other disposables should be placed into a yellow biohazard bag
- Tie these off with high tensile ties when $\frac{3}{4}$ full
- Store apart from clean supplies for collection and disposal



Disposal of Sharps

- Used needles, syringes and other sharps should be disposed of into a hard shell sharps container
- Hard shell containers are to be replaced when $\frac{3}{4}$ full
- Secure lid in approved manner
- Store for collection apart from clean supplies



Cleaning and disinfection

- All surfaces should be cleaned first with environmental wipes
- Surfaces should then be wiped with sodium hypochlorite (household bleach) 100mL/1L and left to dry



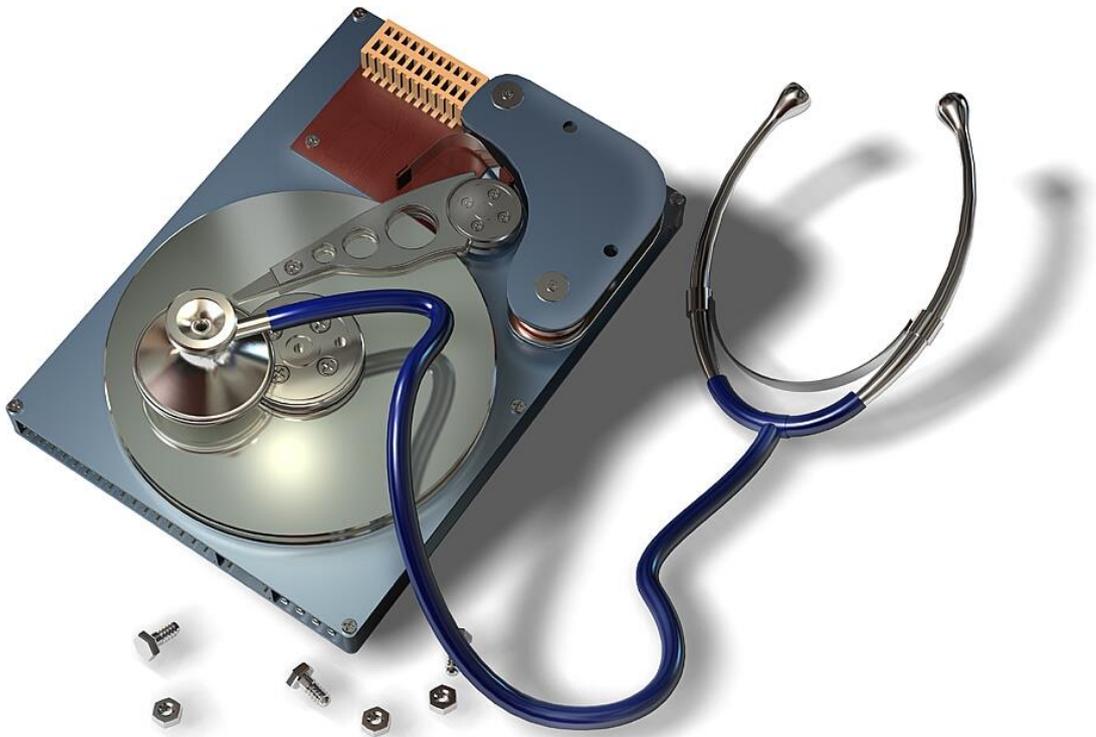
Personal Monitoring

- Keep safe by practicing good hygiene
- Report any possible contamination when donning/removing protective clothing
- Report any blood/body fluid exposure
- Report any personal symptoms i.e. temperature, cough

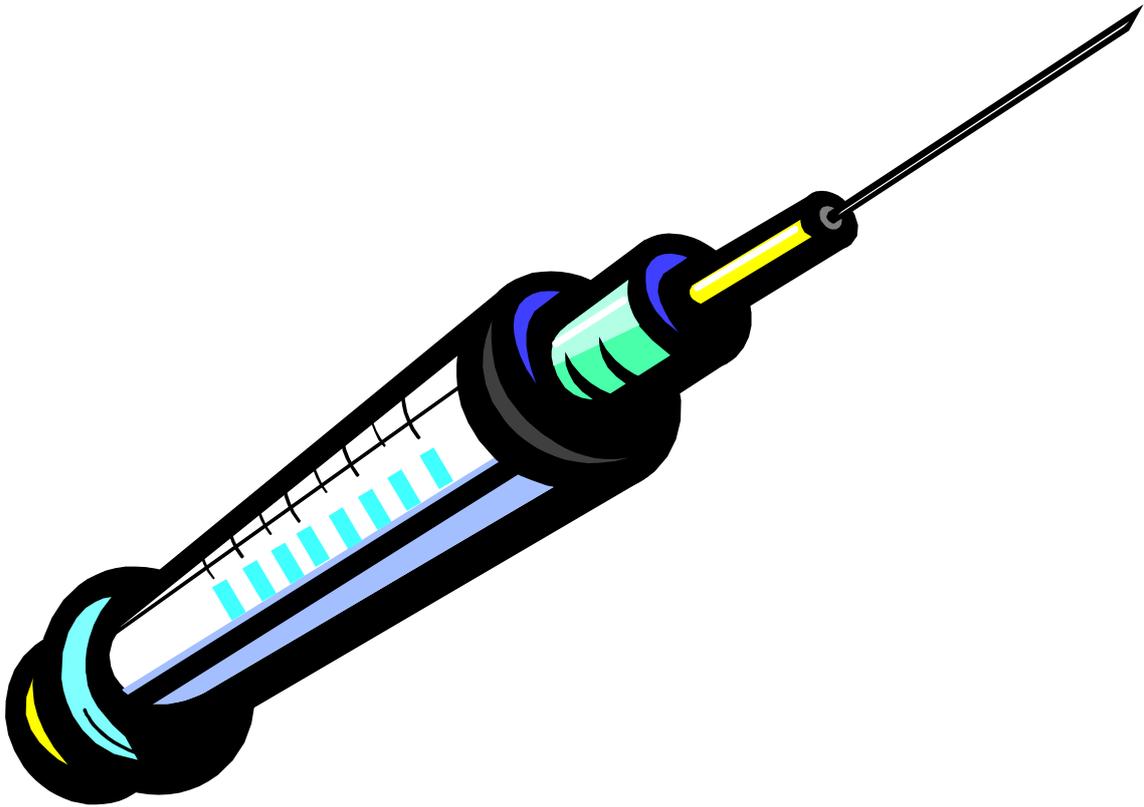


Patient Management

(To be completed on human to human transmission)



Vaccination Campaign Systems



Session Plan

Client: Vaccination Program Staff

Title: Vaccination Campaign Systems

Written by: Dr Caroline McElnay

Date: September 2016

Aim:

To provide staff responsible for the pandemic influenza vaccination program with the knowledge and skills necessary to carry out the campaign.

Learning Objectives:

By the end of this session you will have:

- Reviewed the immune system
- Discussed pandemic influenza and related legislation
- Demonstrated the skills required to prepare and administer the vaccine
- Discussed the recognition and management of anaphylaxis
- Discussed informed consent and documentation requirements
- Discussed the system and process required and demonstrated an understanding of same
- Practised cardiopulmonary resuscitation and basic emergency care

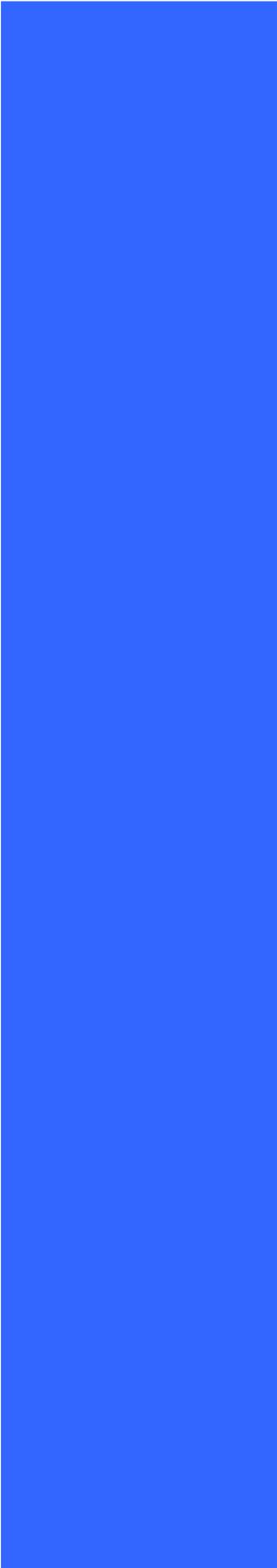
Number of participants: 20 to 30

Methods:

Discussion, Demonstration, Mini Lecture, CPR Audit

Lesson Plan

Teaching Points	Facilitator	Time
Introduction: <ul style="list-style-type: none"> • Course overview • Learning objectives 	PHU Team	5 mins
Overview: <ul style="list-style-type: none"> • The immune system • Pandemic influenza – the disease, NZ epidemiology, vaccination strategy • Legislation 	PHU Team	40 mins
The Pandemic Vaccine: <ul style="list-style-type: none"> • The vaccine • Storage and handling • Drawing up, labelling • Vaccine administration 	PHU Team	40 mins
Anaphylaxis: <ul style="list-style-type: none"> • Recognition • Management 	PHU Team	15 mins
Informed Consent: <ul style="list-style-type: none"> • Process • Legal requirements • Documentation 	PHU Team	15 mins
Documentation: <ul style="list-style-type: none"> • Forms required • Completion of forms • Legal requirements 	PHU Team	30 mins
System: <ul style="list-style-type: none"> • Scheduling • Rostering • Team roles 	PHU Team	30 mins
Process: <ul style="list-style-type: none"> • Set up of area • Equipment required 	PHU Team	30 mins
Emergency Procedures: <ul style="list-style-type: none"> • CPR • Emergency care • Calling for help 	PHU Team	60 mins
Conclusion: <ul style="list-style-type: none"> • Learning objectives attained? • Questions? 	PHU Team	5 mins



Vaccination Plan

Vaccination Plan

Introduction

Related legislation

Medicines Regulations, Regulation 44a (Authorised Vaccinators)

Aims and general purpose

To develop a contingency plan for the mass vaccination of the population of Hawke's Bay in the event that a vaccination against pandemic influenza becomes available.

Assumptions

1. There may be a delay of 3-6 months in the availability of a vaccine following human-to-human transmission of the novel influenza.
2. New Zealand may, or may not be disease-free when the vaccine becomes available, but it is unlikely that New Zealand would remain disease-free for as long as six months.
3. Given the above, there will be implications for:
 - workforce availability
 - prioritisation for administration of the vaccine
 - development of a plan for mass vaccination to gain maximum coverage in the shortest possible time

Conditions under which the plan comes into force

The plan will come into force when it is advised that a vaccine will be made available. It is expected that there will be time to make a detailed plan once advice is received that a vaccine is in production.

It is expected that any mass vaccination plan will be directed by the Ministry of Health.

Operational Structure:

The Public Health Service will be responsible for planning and implementation of a mass vaccination programme.

This will form part of the HBDHB's operational response and reporting will flow from the Public Health Coordinator to the Incident Controller as indicated on the HBDHB Incident Plan.

Clear guidance and direction is expected from the Ministry of Health.

Communication Plan/Issues:

A variety of media will need to be employed to communicate:

- Information about the disease
- How to protect self and others from disease
- About the vaccination

- How and where to get the vaccination

The communication methods will need to be in formats that will reach target or prioritised groups, and take into account cultural/ethnic differences, and geographical spread of the population.

A dedicated communications advisor will be required to achieve this level of community awareness raising, in conjunction with media and key community groups such as Maori and Pacific providers.

Preparedness

Relationships required

Good communications with Authorised Vaccinators (Immunisation Facilitator holds a register)

Pandemic preparedness as part of the regular Authorised Vaccinator Updates

Communication with nurses, and support workers, who participated in the MeNZB B campaign (Child Health Team Leader)

Contact with Primary Health Organisations, Practice Nurses and Maori and Pacific Health Providers

Linkages with the National Immunisation Register and the Immunisation Coordinator

Linkages with the Ministry of Health Immunisation Team, and IMAC

Linkages with Child Health Team Leader and Public Health Nurses

Identification of other occupational groups who may be trained to vaccinate (see Appendix 5)

Responsibilities of different agencies

All health agencies need to maintain the professional development of their staff so that there are adequate Authorised Vaccinators within their services.

Authorised Vaccinators are required to attend annual updates.

Risk assessment

1. If New Zealand is disease-free when the vaccine becomes available, there may be insufficient time to vaccinate the whole population to prevent occurrence of the disease.
2. If there is disease present when the vaccine becomes available, there may be issues around staff shortages, and prioritising the administration of the vaccine, adding considerable complexity to the planning and implementation.
3. Demand for the vaccine outstrips the supply, creating a need for “rationing”.
4. The security of the vaccine is threatened at delivery, storage and vaccinating centres.
5. The vaccine arrives too late to be effective against disease spread.
6. Inadequate information systems may jeopardise the collection and accuracy of vaccine administration details, particularly in the event that multiples doses are required.

Operational Procedures

- These roles are specific to the Pandemic Vaccination Plan.

Role	Responsibility
Vaccination Coordinator	Manage planning and implementation Report strategy to Incident Controller

Planning Coordinator	Plan vaccine delivery details
Operations Coordinator ➤ Information and Communications Coordinator	Organise vaccine delivery Manage community awareness campaign e.g. road shows, media Provide and receive information via HBDHB Communications Advisor
Logistics Coordinator ➤ Human Resources Coordinator	Resource vaccine, equipment, transport, facilities Support logistics coordinator in resourcing staff

Action required at different alert phases

The decision to vaccinate may occur at any stage of the alert phases.

On the announcement of the vaccine being in production:

- Activate operational procedures
- Delegate tasks and roles
- Develop a vaccination plan
- Plan the logistics
- Begin operationalising the plan to at least include:
 - Implement Training Plan
 - Implement community awareness raising plan, including early engagement with cultural/ethnic groups
 - Resource nursing and support staff
 - Develop information system to record vaccination administration information

Resources

See Appendix 1 Population and Logistics.

Workforce Issues

It is possible that the available workforce (nurse vaccinators) will be affected by the need for staff to care for sick people, sickness within the family, or unwillingness to put self at risk. See Appendix 1 Population and Logistics.

Reporting

Internal reporting to the HBDHB using CIMS procedure.

Other reporting as required to HBDHB, Ministry of Health and key community agencies.

Vaccine/equipment storage and distribution

- There may be a need for a storage site depending on whether the vaccine is delivered to a single regional site or a wide distribution network (e.g. to GP surgeries)
- Security will be an issue

Information centres

- Telephone, web site, written information
- Advice on locations and availability of vaccine

Vaccine delivery centres

- A decision will need to be made on whether vaccination will occur through GPs and/or in community locations

- Requires space for reception/administration/data entry, informed consent process, vaccination, and post-vaccination observation areas, secure storage and cold chain facilities
- Mobile facilities will be required for population who are homebound, or live in remote locations
- Electoral Voting Centres could provide suitable facilities

Appendices:

Appendix 1 Population Data and Logistics

Appendix 2 Cold Chain Management

Appendix 3 Training Requirements

Appendix 4 Other Occupational Groups who may be trained to vaccinate

Appendix 1

Projected Population and Logistics

Assumptions

1. Not all people will have the vaccination (anti-immunisation, history of anaphylaxis, not well enough at the time, allergy to component of the vaccine)
2. There will not be enough vaccine for all
3. Calculations are based on 80% uptake

**Table 1. Population Projection for 2006 and 2011
(assuming medium fertility, medium mortality and medium migration)**

	0-4 years	5-19 years	20-65 years	65+ years	Total
2006	10640	35320	83280	21180	150420
2011	9660	33620	84430	23520	151230

(NZ Statistics Department)

Vaccinating rates

Table 2. Hours to Vaccinate 80% of Population

(Based on the principles that younger children can take longer, and that some environments or circumstances may slow the rates.)

No. of vaccinations per hour/vaccinator	Hours to vaccinate 80% of population (120,000)	Hours to vaccinate 120,000 using 50 vaccinators	Hours to vaccinate 120,000 using 100 vaccinators
20	6000	120	60
25	4800	96	48
30	4000	80	40

Vaccinating could occur for example, for a fifteen hour day (8am to 11pm), rostering staff through these time frames, and catering for peak demand times.

In addition to vaccinating time, there may be a requirement for drawing up time if the vaccine does not come in a pre-filled syringe. A nurse can draw up approximately 120 vaccinations in an hour.

Factors affecting rates include

- Frightened or distressed children
- Interruption to supply of vaccine
- "Quiet" periods
- Rostered staff shortage/sickness
- Down time e.g. fire alarm, power cut, other unplanned interruption

Staff and Roles

The Meningococcal B School Campaign developed teams and roles to manage the entire operation.

1. Site Coordinator - Overall responsibility for the site, leadership, liaison with school, briefing and debriefing.
2. Triage - Assess people unwell on the day.
3. Recovery - Manages post-vaccination waiting time (20 minutes) 1 nurse to 20 people.
4. Vaccinators - Prepare vaccine, vaccinate consented people.
5. Float - Overview of progress, support people being vaccinated, manage flow of people, draw up additional vaccines, communication with administration team.
6. Administration/Support - Documentation of vaccination.
7. Administrator/Support - Meet/greet, removal of clothing from arm, check health status, positive identification of individuals.
8. Cold Chain Manager - Manage cold chain, monitor vaccine distribution, count of vaccine, associated documentation.

For a high school of approximately 1000 students, vaccinating over a school day, a team would comprise:

Site Coordinator – 1 RN

Triage – 1 RN

Recovery – 4 RN (some could be 1st aiders)

Vaccinators – 6 RN

Float – 2 RN

Administrators – (pre- and post- vaccination) – 4

Cold Chain Manager – 1 (non RN)

Additional staff and facilities would be required to manage data entry and other administrative tasks at a central location.

In the event of a pandemic vaccination programme, the need for security staff and parking attendants needs to be evaluated.

Equipment and Supplies

Facilities are required for bulk storage and security of supplies at a central point.

PPE could be required in addition to other equipment and supplies.

Emergency resuscitation equipment is required at each vaccinating centre.

Daily packing of supplies, and unpacking at the end of the day, is an exacting task, requiring dedicated staff resources.

Transport of supplies, messages/errands, waste, sharps, and biohazard bag disposal also requires dedicated resource, and access to suitable transport.

See “*Equipment List-MeNZB Programme*” and “*Supplies-MeNZB Schools*”.

References

Meningococcal B School Based Vaccination Programme, Team Roles for School Vaccination Day, Public Health Nurses, Child Health Unit, 2005.

Equipment List-MeNZB Programme, Public Health Nurses, Child Health Unit, 2005 (daily packing list).

Supplies-MeNZB Schools, Gaynor Anderson, Procurement, 2005 (list and costings).

Appendix 2

Cold Chain Management for an Influenza Pandemic Vaccination Programme for the Hawkes Bay District Health Board

The success of an immunisation programme is dependent on the maintenance of vaccine potency. To achieve this, the recommended temperature must be maintained during storage and distribution to avoid cumulative irreversible loss of potency from thermal insult (heat or freezing). The cold chain is the system of transporting and storing vaccines at 2-8°C from the place of manufacture to the point of vaccine administration (the patient)". (Immunisation Handbook 2002)

Cold Chain Accreditation:

Cold chain accreditation was carried out in Hawkes Bay in 2005 for all GP practices and Maori providers. The aim of cold chain accreditation (CCA) was to assist providers to take responsibility for vaccine and cold chain management (as per the existing standards). All providers gained accreditation with varying timeframes from 1 to 3 years. Ongoing audit and reaccreditation is in progress by the Immunisation Coordinator.

Vaccine Pharmaceutical Fridges:

In 2005 the HBDHB purchased a bulk order of "Skope" vaccine pharmaceutical fridges for the MeNZB vaccination campaign.

These included:

- 4 large 550 litre fridges (based at The Doctors Napier, The Doctors Hastings, Hastings Health Centre and Tamatea Medical Centre).
- 35 medium 310 litre fridges (in most GP practices in HB including Wairoa and Central Hawkes Bay, 2 Maori providers Te Kupenga Hauora-Ahuriri and Choices, and Public Health Nurses were provided with 2. These 2 have now been placed in Flaxmere Community Health and the Wairoa Health Centre).
- 6 small 170 litres were delivered to small practices and the Takapau Health Centre.

These fridges have an electronic controller and data logger to provide up to date information on the cold chain process.

In addition The Napier Health Centre, Maraenui Medical Centre, Totara Health Flaxmere and Nelson St have a "Rollex" vaccine pharmaceutical fridge.

Providers of Immunisation:

All authorised vaccinators have a clear understanding of the cold chain process and other nurses involved with immunisation should also work within the cold chain standards.

There is a data base recording information of all authorised vaccinators within the Hawkes Bay District Health Boards region. (H drive/phshare/Vaccinators/Vaccinators/Authorised Vaccinators table).

Transport of Vaccine:

Vaccines are transported from distribution depots which are currently based in Wellington and Auckland. Courier services are used to deliver the vaccines, packed within the cold chain standards.

For transport to vaccinating venues in the MeNZB campaign the HBDHB purchased chilly-bins fitted with data loggers. These are stored in Cashmore Hostel, Napier Health Centre and Flaxmere Community Health.

Appendix 3

Training Requirements for Vaccinators and Support Staff Participating in a Mass Vaccination Campaign

1. Introduction and Overview

Immune System

Pandemic Influenza (the disease, NZ epidemiology, vaccination strategy)

Legislation

2. The Pandemic Vaccine

The vaccine

Storage and handling

Drawing up, labelling

Vaccine administration

3. Anaphylaxis-recognition and management

4. Informed Consent

5. Documentation Process

6. Scheduling, Rostering, Team Roles

7. Process, Set-up, Equipment

8. Emergency Procedures

References:

Vaccinator Training Courses for Non Medical Vaccinators, Course Participant's Information Folder, Immunisation Advisory Centre (IMAC) University of Auckland, February 2005.

Meningococcal B Orientation/Vaccinator Training Course, School Based Campaign, Child Health Team, Public Health Unit, February 2005.

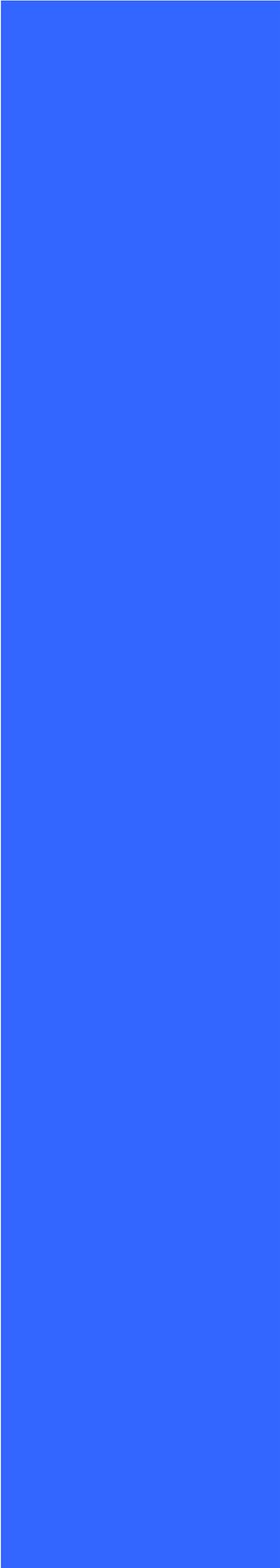
Meningococcal B Immunisation Programme, Vaccinator Training Course Standards, School Based Campaign, Ministry of Health, March 2004.

Appendix 4

Other Occupational Groups who could be trained to vaccinate in a pandemic campaign.

Community Pharmacists
Plunket Nurses
Dentists, Dental Therapists
MeNZB Nurses
Student Nurses
Occupational Health Nurses
Other health practitioners (e.g. PTs, OTs)
Defence Forces
Vets
Farmers

The range of other occupational groups who could be trained would depend on the mode of administration-oral, sub-cut etc.



Volunteer Plan

Volunteer Management

A volunteer is a person who freely chooses to perform work, unpaid, for the common good.

Volunteers will be an essential resource during pandemic response, nevertheless, the safety of patients/consumers and staff is paramount.

Agency Commitment and Responsibility

An important component of volunteer involvement is the consideration of agency responsibility for providing services that are safe, sensitive to the needs of end users, and provide quality training and support for volunteers.

Job descriptions are the best and easiest way of keeping all workers, paid or voluntary, clear about their roles and “on track” with their tasks. Job descriptions are one of the best ways of eliminating the problem of lack of role clarity that is commonly identified by volunteers. Job descriptions are also the principal means by which an agency can check for acceptable standards of performance, both individually and over the whole service. They are therefore a major means of meeting accountability requirements and managing risks.

The job description will include the following elements:

- Job title
- Primary objectives (these should be easily understood, specific, practical, attainable and measurable)
- Key tasks
- Skills required
- Limits of authority

Agreements are the method by which the agency clarifies the mutual commitments between the volunteer and the organisation. When properly formulated they are a clear, two-way agreement that not only asks a commitment of the volunteer, but also demonstrates the commitment of the agency to the volunteer.

The types of things that could be included in an agreement are undertakings by the volunteer to:

- Undertake in-service training requirements
- Fulfil administrative procedures required of them
- Honour confidentiality requirements

And undertakings by the agency to:

- Reimburse approved expenses
- Provide in-service training and personal development opportunities

Selecting Volunteers

Although it can be tempting to accept any offers of help, a little time and thought at this stage will go a long way towards ensuring volunteers are well matched to the organisation.

An application will provide an initial screening of the volunteer, which should be followed by vetting by the Police and a health check if required.

Obtaining details about whether a potential volunteer has a criminal record requires first obtaining the person's permission to ask for this information and then seeking this information by sending the signed disclaimer to the NZ Police at the local station.

Procedure

- Maintain a record of all people who enquire about volunteering, even if they cannot be used at the time
- Request the volunteer to complete an application form (appendix 1)
- Complete the volunteer register (appendix 2) for all potential candidates documenting skills
- Ensure the health clearance question on the application form is completed, if doubt as to suitability occurs contact the Occupational Health Service
- Request permission to conduct a criminal record check if required (appendix 3)
- Confirm volunteer status and agency/area of work, provide job description (appendix 4) and written agreement (appendix 5) and certificate of acceptance (appendix 6)
- Book onto generic orientation programme
- Provide organisation identification and uniform if required
- Inform nominated person in proposed work area and ensure briefing and area specific orientation prepared (appendix 7)
- Appoint a supervisor

Reception and recruitment of volunteers will be carried out centrally with placement of volunteers being made according to the information supplied by each agency detailing tasks that may be allocated, skills required and exclusion criteria.

Legal Considerations

There are a number of legislative areas that need to be taken into consideration when setting policies and practices for volunteers. The main areas are:

- The Privacy Act 1993
- The Human Rights Act 1993
- The Health and Safety at Work Act 2015

The Accident and Rehabilitation and Compensation Insurance Act 1992 has some provisions which volunteers should be aware of.

The legislation protects a volunteer who personally suffers an accident. Payments are limited to medical expenses, assistance under social rehabilitation regulations and the independence allowance. Earnings-related compensation is not payable, as volunteers are not seen as being involved in economic activities under the definition of the act.

In many circumstances an organisation is responsible for the conduct of its employees and volunteers. It can be liable for negligence for other "torts" or "civil wrongs" if one of its employees or volunteers act negligently in the course of his/her activities on behalf of the

organisation. This applies even if the organisation has not committed a wrongful act or omission.

A tort is a civil wrong which breaches the duty of care between citizens and organisations to respect others' rights. A civil wrong can occur even if there is no contract between those affected or no statute (law) is breached. Torts include negligence (failure to take reasonable care), nuisance (causing an annoyance), defamation and passing off (misrepresenting the source of goods or services).

It is irrelevant whether the employee or volunteer is being paid for his or her services or has a contract of engagement with the organisation. The key issue is whether or not the person is acting on behalf of the organisation in the course of his or her commitment to it.

Protection for Agencies

If agencies are apprehensive about possible difficulties and liabilities where their volunteers are concerned, it is suggested they look at a range of insurance options which would provide them with protection.

These options could be by means of:

- Public liability insurance: this indemnifies agencies against claims for injury, accidents or property damage and covers against claims for all persons other than employees. It should protect individually volunteers from claims from clients or the public and other agency members, either volunteers or employees.
- Employers liability insurance: this involves obtaining an extension on an existing policy to cover liability from claims from volunteers.
- Personal accident insurance: this is for volunteers. It provides payments of injuries or death in the course of work for the agency, thus providing protection where the Accident and Rehabilitation and Compensation Insurance Act does not apply.
- Professional indemnity insurance: this applies where agencies offer advice to clients or members of the public and clients take action to recover resultant financial loss. To avoid liability, the agency would need to prove reasonable care was taken to give correct advice. This is an expensive insurance, the need for which would need to be balanced against perceived risk.

As with all legal matters agencies should consult with their legal representative when making decisions about insurance and related policies.

Supporting Legislation

Privacy Act 1993

The Privacy Act governs the responsibilities of a person who is collecting, or who has in their possession, personal information about another individual. It applies to any organisation that collects, stores, discloses or uses personal information about identifiable individuals.

Special rules apply when the information collected, stored, disclosed or used by an organisation relates to the health or disabilities of identifiable individuals.

The Privacy Act applies only to personal information about an identifiable individual. It does not apply to information about organisations, companies or other bodies.

Clean Slate Act 2004

Under the Criminal Records (Clean Slate) Act, an individual who has a minor conviction and has not re-offended for seven years does not have to declare this information in some circumstances. This excludes all sexual offending. Full criminal records will still be available during police investigations or court proceedings, when applying for a firearms licence or for sensitive types of employment, such as the care of children or national security.

Health and Safety at Work Act 2015

Its principal aim is to provide for the prevention of harm to employees at work. The act covers volunteers who work for an employer on an ongoing/regular basis and whose work is an integral part of the business of the employer.

Volunteers need to have sufficient knowledge and experience to work safely, or an experienced person should supervise them. Organisations or groups should train and supervise volunteers if appropriate.

Only volunteers properly trained in using certain kinds of machinery, equipment or chemicals should be permitted to use them.

Volunteers should be informed of:

- All existing potential hazards
- Emergency procedures and location of emergency equipment
- Hazards the volunteer may be exposed to while at work
- Hazards the volunteer may create while at work which could harm others
- Ways to minimise the likelihood of those hazards becoming a source of harm
- Appropriate policies and procedures

this information should be provided verbally before work starts.

Practicable steps ensuring the safety of employees and volunteers include:

- Identifying and controlling hazards in the workplace (eliminate, isolate, minimise)
- Providing information to ensure that employees can work safely
- Having emergency procedures and ensuring people know about them
- Recording accidents/incidents and near misses properly
- Giving training for tasks that volunteers and employees carry out with appropriate documentation to demonstrate competence

Appendix 1

Health

Are there any health problems, physical limitations which might limit your ability to work as a Volunteer? Yes No

Signature _____ Date _____

All information given on this form will be absolutely confidential to the Volunteer Management Team and the agency to whom you are assigned.

Appendix 4

Consent to Disclosure of Information

I, _____
(Surname) (Forename/s)

(Maiden or other names used)

Sex ___ (M/F) Date and place of birth _____

Nationality _____ Residential Address _____

Suburb _____ City _____

NZ Driver Licence Number _____

hereby consent to the disclosure by the New Zealand Police of any information they may have pursuant to this application, to _____. I understand that any record of criminal convictions I might have will be automatically be concealed if I meet the eligibility criteria stipulated in Section 7 of the Criminal Records (Clean Slate) Act 2004.

Signed _____ Date _____

Position Applied for: Volunteer

COMMENTS OF THE NEW ZEALAND POLICE:

PLEASE RETURN TO: Volunteer Coordinator
Emergency Operations Centre
Hawke's Bay Hospital

Appendix 4

Job Description

Agency _____

Job Title _____

Responsible to nominated supervisor.

Primary Objective

To increase the capacity of the agency to respond to the pandemic event.

Key Tasks

- To meet the agency's professional standards therefore minimising the risk of harm to consumers, staff and others.
- To be responsive to the needs of consumers and staff.

Specific tasks to be added by each agency.

Skills Required

Specific skills to be added by each agency.

Limits of Authority

The volunteer is to work within the limits set by the agency they are assigned to and under the specific direction of their assigned supervisor.

Training

The volunteer must be prepared to attend the generic orientation programme provided by Hawke's Bay District Health Board and related training provided by the agency they are assigned to.

Acceptance

Acceptance of volunteer status implies acceptance of this job description.

Appendix 5

Agreement

We require volunteers to follow the standards below. Please do not sign this agreement until all your questions relating to this agreement have been answered to your satisfaction. Each agency reserves the right to decline an application to be a volunteer. Volunteers must be 18 years of age or over.

1. Advice should be sought before commencing any activity with which the Volunteer is unfamiliar or about which he/she is unsure.
2. Safety concerns or injury, accident or significant near-miss event, or identification of a hazard must be reported to the supervisor as soon as possible.
3. Authority to perform the work of a Volunteer may be immediately revoked without a reason being given but especially if safety is compromised.
4. All information which may be divulged to you, or that you might hear, is to be treated as confidential. Relevant information may be shared with your supervisor.
5. The Volunteer will not comment or pass opinion on actions made by the agency they have been assigned to.
6. Volunteers are not expected to perform professional duties for the agency they have been assigned to rather to support the actions taken by completing tasks as assigned by their supervisor.
7. Volunteers are expected to be sensitive to a person's religious, spiritual, cultural and individual needs and views and are to refrain from imposing their own views or beliefs on others.
8. Volunteers are expected to maintain a reasonable standard of dress, hygiene and conduct and to wear identification provided by the agency they have been assigned to.
9. Volunteers are not to accept personal gratuities/gifts/monies.
10. If a volunteer is required to transport people, resources or information they agree to comply with all traffic and other regulations and exercise all care.
11. Volunteers must complete a timesheet at the completion of each period of work.
12. Volunteers will receive no remuneration, whether salary or wages of any kind.

Declaration

I have read and understand the Volunteer Service's Standards for Voluntary Workers. I agree to abide by them.

Volunteer Name: _____
(please print)

Signature: _____ Date: _____

Agency Representative: _____
(please print)

Signature: _____ Date: _____

Appendix 6

Certification of Acceptance

Personal Details

Name: _____

Volunteer Status: Meets criteria

Skills:

Clerical	<input type="checkbox"/>	HT License	<input type="checkbox"/>
Typing	<input type="checkbox"/>	Forklift License	<input type="checkbox"/>
Database Entry	<input type="checkbox"/>	Gun License	<input type="checkbox"/>
Reception	<input type="checkbox"/>	Manual Labour	<input type="checkbox"/>
Information Systems	<input type="checkbox"/>	Tradesman	<input type="checkbox"/>
Telecommunications	<input type="checkbox"/>	Domestic	<input type="checkbox"/>
Finance	<input type="checkbox"/>	Food Preparation	<input type="checkbox"/>
Caregiving	<input type="checkbox"/>	Security	<input type="checkbox"/>

Signature: _____ Date: _____
(Volunteer Management Team)

Appendix 7

Induction Checklist

Name of Volunteer: _____

Supervisor Responsible for Volunteer: _____

Staff Member Conducting Induction: _____

The staff member conducting the induction and the Volunteer are to initial and date only when both are satisfied the Volunteer understands and can locate and correctly use the facilities. Further training must be provided if that understanding is incomplete. This completed form will be retained as a record of safety induction completion.

Facilities	___/___/___	Volunteer _____	Inductor _____
• Toilets		Yes	No
• Cafeteria/kitchen		Yes	No
• Smoke-free policy		Yes	No

First Aid	___/___/___	Volunteer _____	Inductor _____
• First aid facilities/location		Yes	No
• Avoiding contact with body fluids		Yes	No

Accident and Hazard Reporting	___/___/___	Volunteer _____	Inductor _____
• Agency health and safety policy		Yes	No
• Reporting hazards and accidents		Yes	No

Building Emergency Plan	___/___/___	Volunteer _____	Inductor _____
• Evacuation procedures		Yes	No

Instructions	___/___/___	Volunteer _____	Inductor _____
• Confirm limits of tasks		Yes	No
• Confirm emergency procedures		Yes	No