

GRAMPIANS REGION HEALTH EMERGENCY MANAGERS NETWORK

EMERGENCY MANAGEMENT MANUAL/PLAN



Supported by the GR Department of Health & Human Services

GRAMPIANS REGION CODE BROWN SUB PLAN

Health Management Plan for Pandemic Influenza

THIS PLAN DESCRIBES THE ACTIONS *YOUR HEALTH FACILITY* STAFF TAKE IN THE EVENT OF AN INFLUENZA PANDEMIC IMPACTING ON *YOUR HEALTH FACILITY*

WHERE REQUIRED DETAILED ACTIONS FOR SPECIFIC STAFF ARE OUTLINED IN THE ACTION CARD SECTION.

NOTE: THERE ARE ADDITIONAL CONSIDERATIONS FOR THIS EVENT WITHIN THIS PLAN NOT ADDRESSED ON YOUR LAMINATED ACTION CARDS AVAILABLE IN EACH FACILITY FOR A CODE BROWN

PLEASE NOTE

THIS PLAN SHOULD BE READ *BEFORE* ANY INCIDENTS OCCUR
DURING AN INCIDENT IS NOT THE TIME TO READ THIS DOCUMENT
PLEASE REFER TO THE APPROPRIATE ACTION CARD

How to use this Template

Any public or private hospital/health service/nursing home/health facility is invited to use this template to develop a Code Brown Plan to suit their needs. This sub-plan for Pandemic Influenza is also a template that can be adjusted to suit your needs.

You can simply insert your facilities name in the appropriate places, add information that you feel you need to form part of the plan or delete information that you feel is not relevant to you. In some parts of the template you will see the phrase "YOUR HEALTH FACILITY". Simply replace this phrase with your facility/health services name.

The Hospital/Health Service Incident Management Team (HoIMT) structures, roles and action cards are examples. You may wish to alter the HoIMT structure, reassign actions to different roles, add or delete roles to suit your health facilities capacity and capabilities. Just remember that in all circumstances you will need a Hospital Commander (HC), an Operations Manager (OM), Planning Manager (PM) and Logistics Manager (LM) as a minimum.

If you do use this template please contact the Chair of the Grampians Region Health Emergency Managers Network via the Grampians Region Department of Health (contact numbers can be located on <http://grhc.org.au/em-main>) and remember to acknowledge/reference the template in your plan.

The Grampians Region Code Brown Template integrates best Emergency Management practices, the State Health Emergency Response Plan (SHERP), local Health Services Emergency Management Policies, Procedures, Manuals and Plans, the Department of Health & Human Services (Victoria) policies and guidelines and is in line with Australian Standards AS 3745 and AS 4083. The Code Brown template has been reviewed and approved by the Grampians Region Health Emergency Managers Network, and adapted by the Grampians Region Infection Control Group as a sub plan for Pandemic Influenza in May 2015

Pandemic Influenza is a Class 2 Emergency

Copies of the template can be located on the Grampians Region Health Alliance webpage under Infection Control:

<http://infectioncontrol.grampianshealth.org.au/index.php>

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Introduction

Under Australian Standards 3745-2010 (p.29) and 4083-2010 (p.8), health facilities such as hospitals and nursing homes have a standard method of identification, notification and activation systems to be used in certain defined emergencies. This arrangement is known as the Emergency Response System and the response to any specific emergency is given a colour to identify it from other emergencies. These specific emergency colour responses are identified as Emergency Response Codes or simply Codes

A Code Brown is a hospital emergency response code used to manage any external incident that threatens to overwhelm or disrupt a hospital or health service capability. An external incident is defined as one that originates outside the hospital. External incidents can involve loss of power or communications originating outside a facility, a natural disaster (such as flood or bushfire or pandemic) that threatens a facility or an external mass casualty incident that will result in large numbers of Influenza cases presenting to a health facility.

The Code Brown Plan is a formal record of agreed management roles, responsibilities, strategies, systems and arrangements.

Acronyms

Emergency management has its own language and culture, much like all workplaces and groups. Some common emergency management acronyms are listed below:

AV	Ambulance Victoria
CBR	Chemical, Biological or Radiological
CEO	Chief Executive Officer
CFA	Country Fire Authority
CSSD	Central Sterilizing Supply Department
CHO	Chief Health Officer
DHS	Department of Human Services
DMS	Director Medical Services
DoH	Department of Health
EM	Emergency Management
EOC	Emergency Operations Centre (EOC)
ESO	Emergency Services Organisation
FEMO	Field Emergency Medical Officer
FRU	Register.Find.Unite.
HC	Health Commander (AV)
HoIC	Hospital Commander or Hospital Incident Commander (both terms used)
HoIMC	Hospital Incident Management Centre
HoIMT	Hospital Incident Management Team
HSEPC	Health Service Emergency Planning Committee
HSSC	Health Service Support Centre
IAP	Incident Action Plan
ICS	Incident Control (Command) System
LGA	Local Government Authority
MECC	Municipal Emergency Coordination Centre
NCTC	National Counter Terrorism Committee
NRIS	National Registration and Inquiry System (now FRU)
OP	Outpatients
PPE	Personal Protective Equipment
REOC	Regional Emergency Operations Centre
SES	State Emergency Services
SHERP	State Health Emergency Response Plan (Health Displan)
VMO	Visiting Medical Officer
VHMPPI	Victoria Health management Plan for Pandemic Influenza
AHMPPI	Australian Health management Plan for Pandemic Influenza

Code Brown Risk Analysis

(Refer Appendix 1)

Emergency management can be considered as a group of activities designed to mitigate the effects of emergencies or disasters. The “Comprehensive Approach” to emergency management is a standardised methodology to ensure agencies and individuals cover off all aspects. The comprehensive approach is known by its acronym “PPRR”. That is Planning, Preparedness, Response and Recovery. This template represents part of the planning phase of emergency management, as does a risk analysis of your organisation.

A risk analysis is an important component of any Code Brown Plan. Understanding the threats that *YOUR HEALTH FACILITY* is exposed to ensures that plans to mitigate and manage the risks are specific to the hazards. The risk analysis should be conducted in a group setting with senior *YOUR HEALTH FACILITY* staff members and where possible with local Emergency Service and Department of Health representatives.

Following the analysis note *YOUR HEALTH FACILITY* risks *here*.

Business Continuity Planning

Business continuity (BC) addresses organisational recovery following a disruption to normal business, often due to an event that causes significant impact on part or the whole of an organisation. It assumes that internal and external prevention arrangements have failed which has interrupted normal business to the extent that corrective action is required.

The Business Continuity Plan (BCP) is a plan that describes a sequence of actions, and the parties responsible for carrying them out, in response to a series of identified risks, with the objective of restoring normal business operation as soon as possible. Planning for Code Brown should be undertaken as part of Business Continuity Planning, where any risk to service operations is identified, documented, tested and plans put in place.

YOUR HEALTH FACILITY BCP, although linked to the Code Brown plan, is a separate plan. *YOUR HEALTH FACILITY* BCP is used for service interruptions regardless of the cause.

Incident Alert

Under Victoria’s new *Emergency Management Act 2013* a pandemic would be classified as a Class 2 emergency. As it relates to communicable disease control and has links to national structures and arrangements, the department would fill the role of lead agency within Victoria. The Chief Health Officer or delegate would assume the role of State Controller and liaise closely with the Emergency Management Commissioner.

The Act identifies ‘class 1’ and ‘class 2’ emergencies. A class 1 emergency is a major fire or any major emergency where the MFB, CFA or Victoria SES are the designated control agency. All other emergencies are ‘class 2’ (s 3).

“major emergency” means—

(a) a large or complex emergency (however caused) which—

(i) has the potential to cause or is causing loss of life and extensive damage to property, infrastructure or the environment; or

(ii) has the potential to have or is having significant adverse consequences for the Victorian community or a part of the Victorian community; or

(iii) requires the involvement of 2 or more agencies to respond to the emergency; or

(b) a Class 1 emergency; or

(c) a Class 2 emergency;

The Chief Health Officer (CHO) in Victoria holds the authority to activate the Victorian Health Management Plan for Pandemic Influenza (VHMPPi). The plan will be implemented under the framework of the Australian health management Plan for Pandemic Influenza (AHMPPi) and the State Controller will establish an incident control system to support implementation. The State Controller will liaise with the AHPPC and pursue actions based on consensus positions established at this committee for rollout in Victoria.

Response is three levels:

1. Standby
2. Action (initial and targeted)
3. Stand down

During the ‘standby’ stage the State Emergency Management Centre will be established to provide support to the State Controller. During the ‘initial and targeted action’ stage it is likely that the State Control Centre will be established to provide support to the State Controller. The support required in these response stages (standby and initial and targeted action) will be specifically in investigation, intelligence, planning, operations, public information, logistics, finance and administration of the response.

Refer to table on the following page for the Victorian pandemic stages and actions.

Code Brown (Emergency Response) Phases

The operational priorities will form the basis of the State Controller's (Chief Health Officer) intent for each stage.

Table 2: Victorian pandemic stages and actions

Stage		Description	Key actions
Prevention		<i>Prevention is not the primary focus of this plan</i>	
Preparedness		No novel strain detected (or emerging strain under initial detection)	<ul style="list-style-type: none"> Establish pre-agreed agreements by developing and maintaining plans Research pandemic-specific influenza management strategies Ensure resources are available and ready for rapid response Monitor the emergence of diseases with pandemic potential, and investigate outbreaks if they occur
Response	Standby	Sustained community person-to-person transmission detected overseas	<ul style="list-style-type: none"> Prepare to commence enhanced arrangements Identify and characterise the nature of the disease (commenced in preparedness) Communicate measures to raise awareness and confirm governance arrangements
	Action (initial and targeted)	Cases detected in Australia	<p>Initial (when information about the disease is scarce)</p> <ul style="list-style-type: none"> Prepare and support health system needs Manage initial cases Identify and characterise the nature of the disease within the Australian context Provide information to support best practice healthcare and to empower the community and responders to manage their own risk of exposure Support effective governance <p>Targeted (when enough is known about the disease to tailor measures to specific needs)</p> <ul style="list-style-type: none"> Support and maintain quality care Ensure a proportionate response Communicate to engage, empower and build confidence in the community Provide a coordinated and consistent approach
	Standdown	Public health threat can be managed within normal arrangements Monitoring for change is in place	<ul style="list-style-type: none"> Support and maintain quality care Cease activities that are no longer needed, and transition activities to seasonal or interim arrangement Monitor for a second wave of the outbreak Monitor for the development of antiviral resistance Communicate activities to support the return from pandemic to normal business services Evaluate systems and revise plans and procedures
Recovery		<i>Recovery is not the primary focus of this plan</i>	

Source: Victorian Health Management Plan for Pandemic Influenza October 2014

Code Brown Incident: Pandemic Influenza Background

Source: Victorian Health Management Plan for Pandemic Influenza October 2014

Definition

An influenza pandemic occurs when a new influenza virus emerges and spreads around the world, and most people do not have immunity (WHO 2013b).

Influenza is a viral illness that attacks the respiratory tract (nose, throat and lungs) in humans. The virus is transmitted in most cases by droplets, but it can also be transmitted in certain situations by direct contact or aerosols. Although mild cases may be similar to an upper respiratory tract infection, influenza is typically much more severe, usually comes on suddenly, and may include fever, headache, tiredness, cough, sore throat, nasal congestion and body aches. It can result in complications such as pneumonia. Seasonal influenza occurs annually and primarily causes complications and/or death in people aged over 65 years and those with chronic medical conditions. The vast majority of people exposed will recover and develop immunity to that strain of virus.

Since 2003, documents produced by the World Health Organization (WHO) have stated an influenza pandemic occurs 'when a new influenza virus appears against which the human population has no immunity, resulting in several, simultaneous epidemics worldwide with enormous numbers of deaths and illness' (WHO 2013c). However, following the emergence of influenza A(H1N1)pdm09, initially referred to as 'swine flu', this description became controversial and was amended as evidence indicated the majority of cases had a generally mild clinical course and the presence of protective immunity in older people, and questions were raised as to whether influenza A(H1N1)pdm09 constituted a pandemic at all (Doshi 2011).

Pandemic influenza history

Three pandemics of influenza caused by different subtypes of influenza A virus occurred in the 20th century: an H1N1 virus in 1918; an H2N2 virus in 1957; and an H3N2 virus in 1968. Estimates of the number of cases and deaths in each pandemic vary and reflect the difficulty in using historical data to ascertain absolute numbers. However, each pandemic was characterised by a shift in the virus subtype, a high symptomatic infection risk, elevated mortality risks that were highest in young adults, an onset not restricted to the typical influenza season with successive pandemic waves, and replacement of the seasonal influenza A virus subtype with the pandemic strain as the dominant strain circulating (Kilbourne 2006; Mathews et al. 2009; Miller et al. 2009).

The influenza pandemic of 1918–1919 is widely regarded as the most serious, with estimated symptomatic infection rates of 20–60 per cent in most countries and between 20 and 50 million deaths, or 1–2.5 per cent of the world's population. The pandemics of 1957 and 1968–1969 were comparatively milder with respect to estimated symptomatic infection and mortality risks; there were two to three million excess deaths worldwide (about 0.7 per cent of the global population) in 1957 and one million deaths (0.3 per cent) in 1968–1969 (Johnson & Mueller 2002; Mathews et al. 2009). The age distribution of symptomatic infection rates also varied between the three pandemics: in 1918–1919 proportions were highest among children and young adults and declined with increasing age over the age of 30; in 1957

proportions were highest in school-aged children, intermediate in young and middle-aged adults and lowest among adults aged 50 years or older; in 1968–1969 symptomatic infection risks were stable across all age groups (Brundage 2006).

Influenza A(H1N1) virus was reintroduced into the human population in 1977. Although disease was characterised by classical influenza symptoms, cases were generally mild and almost entirely restricted to people aged 25 years or younger. The age distribution has been attributed to the absence of circulating H1N1 since 1957 (when it was replaced by H2N2) and a corresponding lack of exposure and immunity to H1N1 viruses in those born after then. Furthermore, the H1N1 strain did not replace the H3N2 that emerged in the 1968–1969 pandemic and thus strains of both subtypes have co-circulated in humans since 1977 (Kilbourne 2006).

The 'swine flu' pandemic of 2009 was the first pandemic of the 21st century and also differed virologically and epidemiologically from the three 20th-century pandemics. The pandemic virus, designated influenza A(H1N1)pdm09, emerged from a triple (avian, swine and human) reassortment rather than antigenic shift (Garten et al. 2009). Furthermore, it replaced only the previously circulating seasonal H1N1 and not the H3N2 subtype. The cumulative incidence of infection was estimated by serological studies to be in the range of 11–21 per cent (Kelly et al. 2011) and the majority of infections were relatively mild; between 30 and 50 per cent of infections were estimated to be asymptomatic (Bandaranayake et al. 2010; Cowling et al. 2010; Jackson et al. 2011), with approximately 0.25 per cent and 0.04 per cent hospitalised and fatal respectively (Darwood et al. 2012; McVernon et al. 2010). Exposure to H1N1 viruses prior to the 1957 pandemic is believed to account for the very low proportion of adults aged over 60 years infected with influenza A(H1N1)pdm09 (Kelly et al. 2011).

A challenge during the initial stages of the pandemic was to reassess assumptions regarding clinical severity and transmissibility, and hence strategies to best control the disease. The 2009 H1N1 pandemic reinforced the idea that the impact of a pandemic cannot be predicted precisely because it will depend on the virulence of the virus, its transmissibility, the availability of vaccines and antiviral medications, and the effectiveness of pharmaceutical and non-pharmaceutical community containment measures. The lessons learnt from 2009 have been valuable in helping to shape influenza pandemic planning to better reflect the flexibility required to respond to a high probability threat in an ever-changing, and often unpredictable, environment.

The Department of Health will function under the pandemic stages detailed in Table 2 (see section 4). This plan takes an emergency response approach as its framework, to allow it to be integrated into broader emergency arrangements. Consistent with Victoria's strategic approaches to emergency management the VHMPPi acknowledges the importance of seeing the management of an influenza pandemic like any hazard, with an ongoing cycle of activities in the four areas of prevention, preparedness, response and recovery.

The focus of this plan is mainly in preparedness and response, to reflect the changes in priorities as the pandemic progresses and to facilitate the more detailed planning required. Response activities will be further developed into three stages: standby; initial action and targeted action; and standdown.

Planning Assumptions

Source: Victorian Health Management Plan for Pandemic Influenza October 2014

Table 1: Pandemic impact, unprepared vs prepared

	Pandemic as severe as the one that occurred in 1918 and we were not prepared and unable to respond	Pandemic as severe as that in 1918, but we were prepared and were able to respond effectively
Estimated population showing clinical signs of infection	40 per cent (2.2 million people)	10 per cent (540,000 people)
Estimated deaths	2.4 per cent of those affected would die (around 53,000 people)	1.2 per cent of those clinically affected would die (around 6,500 people)
Work absenteeism	50 per cent	30–50 per cent
Duration of the pandemic	Several waves each, lasting up to 12 weeks	7–10 months, in a single wave
Disruption of services	As long as two years	7–10 months

These figures are based on the Australian Bureau of Statistics 2011 census data for Victoria.

To put the mortality figures in context, about 2,800 Australians (mainly older people) die each year from seasonal influenza and pneumonia.

Incident Response Flow Chart

This chart details the basic actions that *YOUR HEALTH FACILITY* should ensure occurs at the different phases of an external incident.

Notification (Alert)	<ul style="list-style-type: none"> • <i>YOUR HEALTH FACILITY</i> notified via internal or external sources
Code Brown Stand By	<ul style="list-style-type: none"> • <i>YOUR HEALTH FACILITY</i> Hospital Commander (HoC) liaises with senior hospital clinician &/or executive staff member to review information received. • Determine any special concerns <ul style="list-style-type: none"> ◦ Chemical, Biological and Radiological (CBR) contamination ◦ Threat to facility • Determine if Code Brown activation is required. • <i>YOUR HEALTH FACILITY</i> staff members prepare for activation.
Initial Response/ Action	<ul style="list-style-type: none"> • Information about the incident can be obtained from the Regional Health Commander (usually an Ambulance Victoria duty manager) on 1800 010 080 (24/7) • Ongoing situation reports and information from the incident site should be provided by Health Commander (AV).
Code Brown Activation Targeted Action	<ul style="list-style-type: none"> • <i>YOUR HEALTH FACILITY</i> Hospital Commander (HoC) activates Code Brown plan & ensures notification to all <i>YOUR HEALTH FACILITY</i> staff sent. • Notify the DHHS Regional Emergency Operations Centre on 5338 7928 • Activate <i>YOUR HEALTH FACILITY</i> Hospital Incident Management Centre (HoIMC). • Assemble <i>YOUR HEALTH FACILITY</i> Hospital Incident Management Team (HoIMT). • <i>YOUR HEALTH FACILITY</i> staff members follow Code Brown plan procedures.
Code Brown Stand Down	<ul style="list-style-type: none"> • <i>YOUR HEALTH FACILITY</i> Hospital Commander (HoC) in consultation with HoIMT determines the situation is returning to or is back to normal business.
Hot Debrief	<ul style="list-style-type: none"> • <i>YOUR HEALTH FACILITY</i> Hospital Commander (HoC) should ensure that a hot debrief is conducted immediately following the Stand Down. <ul style="list-style-type: none"> ◦ <i>All staff should be allowed a brief rest, food and water if required prior to debrief.</i> • Ensure debrief is documented. • Ensure peer support is available.
Operational Debrief	<ul style="list-style-type: none"> • <i>YOUR HEALTH FACILITY</i> Hospital Commander (HoC) should attend any operational debriefs that occur. • Contact the Health Commander (AV) to ensure any invitations to operational debriefs are extended to <i>YOUR HEALTH FACILITY</i>

Pandemic Influenza Code Brown Key Actions by Stage

Source: Victorian Health Management Plan for Pandemic Influenza October 2014

Standby

The standby stage is characterised by activities that focus on commencing preparation for an impending pandemic and increased vigilance for case detection. Relevant staff should be made aware of the changing global and local influenza situation, and be aware of the impact that a pandemic will have on them in the workforce. Health services should do the following:

- Participate in enhanced influenza reporting and surveillance activity.
- Communicate with staff on matters relating to workplace policies and arrangements that are likely to be affected or altered in the event of a pandemic, such as compulsory exclusion due to influenza-like illness,⁶ cancellation of personal leave, increased overtime, and use of sick and carer's leave.
- Monitor and maintain stocks of antivirals, antibiotics and PPE within the hospital
- Ensure that staff with direct patient contact are appropriately trained to use PPE (especially staff performing intubation and other 'high-risk' activities).
- Ensure that arrangements have been made to protect staff at 'high risk' of complications from influenza.
- Ensure that triage plans including influenza streams in emergency departments are in place and that staff are issued with up-to-date case definitions.
- Manage suspected cases by implementing advice in Chief Health Officer alerts.
- Report all suspected cases to the department's Communicable Disease Prevention and Control section on 1300 651 160.

Initial response

The initial response stage is characterised by activities that focus on minimising transmission, morbidity and mortality given limited information on the novel influenza virus. Health services will need to do the following:

- Participate in enhanced influenza reporting and surveillance activity.
- Implement emergency plans for an influenza pandemic, mass casualties, business continuity and surge capacity. Begin to consider reductions in elective procedures, particularly those who present a higher risk of needing post-surgical intensive or high-dependency care.
- The Department of Health will provide advice on antiviral distribution for cases and post-exposure prophylaxis for contacts. In most cases, in the initial response stage, exposed healthcare workers will be provided with post-exposure prophylaxis (see **Appendix 2: Antivirals**).
- Ensure staff members correctly use appropriate PPE (see **Appendix 4: Infection prevention and control measures**).
- Manage suspected cases by following the advice in Chief Health Officer alerts. Notify cases to the department's Communicable Disease Prevention and Control section on 1300 651 160 as per surveillance instructions.
- Prepare for negative pressure isolation rooms to be overwhelmed. If necessary, implement additional measures such influenza wards, streams and clinics where appropriate.
- Consider discharging patients with mild presentations of pandemic influenza to isolation at home.
- Designated influenza hospitals may be nominated by the department if appropriate.
- Restrict visitors and staff members with influenza-like illness.
- Report to the State Health Coordinator as required.
- Strengthen cross-referrals for healthcare and community support

Targeted response

The targeted response stage is characterised by activities that focus on minimising transmission, morbidity and mortality with enhanced understanding of the novel influenza virus. Demand for acute clinical services, combined with staff absenteeism, is likely to be high. Health services will need to do the following:

- Participate in necessary enhanced influenza reporting and surveillance activity.
- Implement emergency plans for influenza pandemic, mass casualties, business continuity and surge capacity. Adapt and review if necessary. Minimise elective procedures, particularly for those who present a higher risk of needing post-surgical intensive or high-dependency care.
- Manage suspected cases by following the advice in Chief Health Officer alerts. Notify all cases to the department's Communicable Disease Prevention and Control section on 1300 651 160 as per surveillance instructions.
- Distribute antivirals to staff members according to advice in Chief Health Officer alerts (see **Appendix 2: Antivirals**).
- Ensure staff members use appropriate PPE (see **Appendix 4: Infection prevention and control measures**).
- In-house pharmacies should monitor internal stocks of antivirals, antibiotics and PPE and replace as necessary.
- If negative pressure isolation rooms are overwhelmed implement additional measures such as influenza wards, streams and clinics where appropriate.
- Discharge patients with mild presentations of pandemic influenza to isolation at home. Liaise with local government to provide community care if required.
- Implement plans to support an increase in demand for intensive care unit beds and associated services.
- Implement designated influenza hospitals at the direction of the department if requested.
- Restrict visitors and staff members with influenza-like illness.
- Report to the State Health Coordinator as required.

Standdown

Vigilance must still be maintained to detect a possible subsequent wave of pandemic influenza. The standdown stage is characterised by returning to business as usual activities practised in a typical seasonal influenza period. Time should be dedicated to examining and reviewing the pandemic response through debriefs; plans and protocols should be updated to reflect any lessons learnt. Health services will need to replenish and maintain essential stocks of PPE, antivirals and antibiotics.

<i>Grampians Region Department of Health & Human Services</i>
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DHHS notification process

Note that emergency management in Grampians Region is a shared Department of Health & Human Services (DHHS) service.

In any incident that requires, or may require, a Code Brown response from *YOUR HEALTH FACILITY* contact must be established with DHHS via:

Rural and Regional Health Services and Facilities Division Emergency Contact West Division	1800 780 354
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Incident Documentation

A full record of events and decisions made during the incident is essential for effective management of the incident, handover between teams during an incident, debriefing and enquiries.

Any person with reporting responsibility is required to complete regular situation reports.

These reports may be required for:

- the next level in the chain of command,
- external participating agencies, and/or
- relevant stake holders.

It is a legal requirement to document and preserve all records of actions, requests and decisions made during an incident response.

There should be contingency plans in the event of computer and/or power failure - including subsequent data entry once power/IT restored (this should be linked to the business continuity plan).

Record of event

There are several ways an event should be documented. These include the use of scribes, situation reports and incident logs. In addition evidence logs should be maintained for all events unless Victoria Police deem it unnecessary.

Scribes

Scribes should be non-critical staff members that can be freed up from normal duties to perform the role. If there are sufficient numbers available *YOUR HEALTH FACILITY* should have the following:

- HoIMT scribe (includes scribing for Hospital Commander (HoC)),
- Bed Management and Patient Tracking scribe/s, and
- Individual Team Leader scribes (those involved in event management)

Situation Reports (SITREP)

(Refer Appendix 2)

All *YOUR HEALTH FACILITY* HoIMT & Team Leaders should maintain their own Situation Reports to provide briefings to others (superiors/subordinates) and as a record of the incident.

A SITREP will be required to include:

- Incident description,
- Sit Rep descriptor (e.g. Sit Rep #3 ED Team Leader),
- Date/time of preparation,
- Contact details,
- Signature and name of reporter,
- Current issues,
- Resource status (current and anticipated), and
- Risks identified.

Incident Logs

(Refer Appendix 5)

All *YOUR HEALTH FACILITY* HoIC, HoIMT & Team Leaders should maintain their own log throughout the incident response.

The incident log will:

- keep track of outstanding issues,
- maintain a record of all actions requests and decisions made,
- key communications issues both outstanding and completed, and
- provide a legal record of the incident response that may be used at post incident evaluation (which may include legal scrutiny)

Property and Evidence Log

Evidentiary Recovery (Refer Appendix 6)

Physical evidence is the silent witness at any crime scene scenario. All mass casualty incidents should be regarded as a crime unless *YOUR HEALTH FACILITY* is notified otherwise. The recovery of physical evidence is crucial in assisting investigators to establish a multitude of avenues of enquiry. This is even more pertinent in incidents where witnesses may be incapacitated and unable to give a verbal account. Perpetrator(s) may be amongst the deceased or injured.

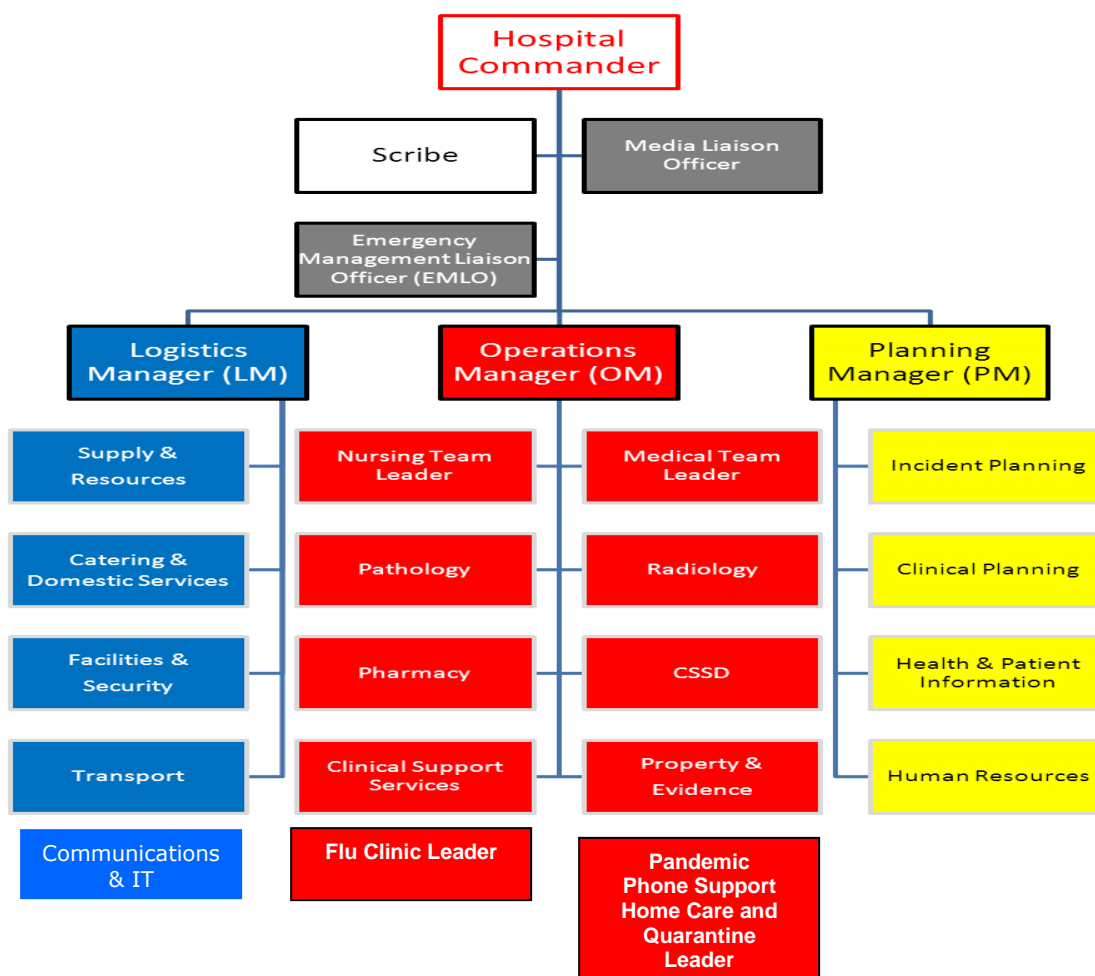
Early isolation of that physical evidence, with a continuity chain linking it to its place in the scene, is the best result for investigators. This can be summarized into the catch-phrase – “**BAG, TAG, SEAL and SECURE**”.

Hospital Incident Management Team (HoIMT)

The HoIMT is responsible managing *YOUR HEALTH FACILITY* during a Code Brown incident. The HoIMT structure is developed from the Australasian Inter-service Incident Management System (AIIMS) a scalable command and control structure used by emergency services and other agencies during emergencies. In Low Incidents the HoIMT may consist of one person fulfilling a number of AIIMS functions (for example a Chief Warden or Incident Commander in a fire alarm) whilst in more significant incidents the HoIMT may consist of large numbers of personnel and roles (dependent upon availability).

As well as providing direction to *YOUR HEALTH FACILITY* personnel the HoIMT is responsible for receiving and reporting on operational information relating to the incident. This will include aspects such as:

- determining the numbers of Influenza cases that can be accommodated,
- identifying existing available beds,
- considering alternative bedding arrangements,
- considering changes to normal work practices e.g. cancel elective operations, outpatients, etc.,
- determining staffing requirements and redirecting existing staff, and
- ensuring business continuity for critical operations and utilities.



Incident command structure for a HIGH INCIDENT that may be used by YOUR HEALTH FACILITY

Hospital Incident Management Team (HoIMT) Action Cards

The following action cards are examples of roles, functions and actions that *YOUR HEALTH FACILITY* may use as part of your Code Brown response. Go through each action card and add or delete actions as they relate to *YOUR HEALTH FACILITY*.

Hospital Commander (HoC)

Mission: Organise and direct Hospital Incident Management Team (HoIMT). Provide overall direction for hospital operations during Code Brown response.

Initial

- Initiate the Hospital Pandemic Influenza Code Brown Plan and assume role of Hospital Commander (HoC)
- Put on position identification tabard (Appendix 7)
- Document actions and decisions on a continual basis
 - Obtain the assistance of a scribe if necessary
- Notify *YOUR HEALTH FACILITY* CEO, executive and staff of 'Code Brown Stand By'
- Notify DHHS of 'Code Brown Stand By'
- Ensure relevant staff required for HoIMT are notified and requested to attend the Hospital/Health Service Incident Management Centre (HoIMC)
- Appoint staff to undertake roles within HoIMT:
- Roles to be filled (*Note that one person may fulfil more than one of these roles*):
 - Scribe
 - Logistics Manager
 - Operations Manager
 - Planning Manager
- Distribute Action Cards for each position. Note: Additional actions are outlined in this plan for consideration. Provide plan to each role.
- Distribute Identification tabard for each position (Appendix 7)
- Distribute relevant situation reports, log sheets and tracking lists
- Establish suitable times and locations for briefings and meetings with HoIMT & Team Leaders
- Receive status/situation report from relevant clinical areas within hospital and discuss response plans with HoIMT members
- Determine appropriate level of service for organisation during immediate response
- Ensure appropriate numbers of staff for clinical areas, switchboard & communication functions (utilise runners if required)
- Order cessation of normal activities as indicated. (E.g. decide whether OP Clinics, elective admissions, elective surgery, etc should continue.)
- Determine hospital capacity
- Ensure Operations Manager initiates processes, such as appropriate early patient discharge, if additional beds needed and has considered phone support for home care and/or quarantine.
- Ensure that Planning Manager develops an Incident Action Plan (IAP) and approve the IAP (Appendix 3)
- Ensure that contact has been established with relevant outside agencies such as DHHS/Local Government Authorities (LGA)
- Participate as a member of the (pre Hospital) Incident Level Health Incident Management Team (I-HIMT) and liaise directly with the Health Commander (Ambulance Victoria)
- Communicate any issues or concerns to the Regional Health Coordinator (GR DHHS) identified by the HoIMT that may require coordination with the wider health system and/or emergency services
- Provide timely verbal and/or written situation reports to the Regional Health Coordinator (GR DHHS) to enable effective coordination within and outside the health system. Refer to page 16 of this plan for contact details.

Ongoing:

- Authorise resources as needed or requested by HoIMT members
- Designate routine briefings with HoIMT members to receive status reports and update the IAP
- Contact Board of Management if required
- Authorise IAP (Appendix 3)
- Maintain an Incident Log (Appendix 5)
- Communicate any issues or concerns to the Regional Health Coordinator (GR DHHS) identified by the HoIMT that may require coordination with the wider health system and/or emergency services
- Provide timely verbal and/or written situation reports to the Regional Health Coordinator (GR DHHS) to enable effective coordination within and outside the health system
-

Extended:

- Organise relevant media releases. Approve media releases submitted by Liaison Manager on agency status, and combined media releases with municipality concerning location and hours of Flu Clinic, Medical Practices, telephone enquiries, provision of Home Quarantine supplies; and Mass Vaccination Clinics
- Ensure provision of staff rest periods and relief
- Ensure a list of all staff involved is completed for each area
- Ensure all staff have access to psychological support during and after the emergency situation as required
- Monitor length of staff shifts to maintain shifts not longer than 12 hours including HoIMT members.
- Stand staff down when appropriate

Stand Down:

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities
- Participate in the evaluation of the incident response that will be arranged once the emergency situation has resolved

Refer to list of appendices on page 52 for further information that may be related to your role

Logistics Manager (LM)

You Report To: Hospital Commander (HoC)

Mission: Liaise with members of the HoIMT to organise and direct those operations associated with maintenance of the physical environment, adequate levels of food, shelter, transport, and supplies necessary to support the incident response.

Initial

- Put on position identification tabard & obtain briefing from Hospital Commander (Appendix 7)
- Document actions and decisions on a continual basis
 - Obtain the assistance of a scribe if necessary
- On receipt of the Incident Action Plan (IAP – Appendix 3), develop plans with each team member, identifying physical and human resource requirements and how your team will meet them
- Brief appropriate staff on current situation, outline IAP and designate time for next briefing
- Ensure that staff are provided with personal identification
- Identify a briefing area in proximity to HoIMC and ensure supply and resources personnel are aware of location and communication means
- Ensure that matters outside of HoIMT capacity and requiring external assistance are communicated through the HoIMC to the Municipal Emergency Coordination Centre (MECC), the GR REOC and/or external agencies (as required)
- Assign relevant logistics leaders for following areas as appropriate:
 - Facilities Maintenance and Security
 - Communications & IT
 - Transportation
 - Supplies and Resources
 - Catering and Domestic Services including clinical waste management

Ongoing:

- Obtain regular information and updates from logistics team members; pass status information on to Hospital Commander
- Identify and communicate to the Hospital Commander any issues or concerns that may require coordination with the wider health system, external agencies and/or emergency services
- Monitor and record financial commitments
- Maintain an Incident Log
- Carry out the necessary operational strategies outlined in the IAP

Extended:

- Document actions and decisions on a continual basis
- Provide for staff rest periods and relief
- Ensure all departments provide regular updates of status via SITREPS
- Keep Hospital Commander apprised of status
- Keep staff alert to identify and report all hazards/unsafe conditions to the HoC

Stand Down:

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Operations Manager (OM)

You Report To: Hospital Commander (HoC)

Mission: To direct and coordinate all operational activity within the Hospital to support the incident response.

Initial:

- Put on position identification tabard & obtain briefing from Hospital Commander (Appendix 7)
- Document actions and decisions on a continual basis
- Obtain the assistance of a scribe if necessary
- Establish contact with affected hospital area/s
- Request situation report from relevant affected hospital area/s
- Make rapid assessment of potential of incident to impact on hospital
- Establish contact with Infection Control Manager/ Coordinator
- Establish availability of Visiting Medical Officers (VMOs)
- Establish contact with Consultant Director of Medical Services (DMS) if relevant
- Brief all relevant hospital areas on current Incident Action Plan (IAP – Appendix 3)) and outline chain of command structure
- Assign relevant operational staff for following areas as appropriate:
 - Nurse In Charge and After Hours Supervisor,
 - On site Nurse Unit Manager/s or other senior nurse/s for immediate support,
 - Flu Clinic Manager
 - Immunisation Coordinator and/or Accredited Nurse Immunisers
 - Medical records and surveillance
 - Counselling, staff health monitoring and support
 - Pharmacy supply and transport
 - Phone Support Manager for homecare and/or home quarantine for patients and staff.
- Establish the timing, process and location of regular briefings with clinical staff
- Prepare a situation report including patient census for the HoIMT – attend regular update meetings with Hospital Commander. (Fwd to Planning Manager)
- If multiple Influenza cases expected, consider patient placement, flow and segregation including systems to separate suspected and confirmed influenza cases, patient isolation and potential cohorting of confirmed cases, separate clinical staff for influenza and non-influenza patients to limit cross infection. Inform HoIMT & senior staff of decisions
- Determine resources required (eg additional space, clinical staff and protective equipment)
- Notify nearest Radiology, Pathology and Pharmacy services
- Consider support services (orderly/security, telephone, transport, computer clerks etc).
- Liaison with Planning and Logistics staff to effect appropriate to affect:
 - discharge planning
 - Transfer of patients
 - Flu clinic setup, equipment, transport, security, IT systems
 - Pharmacy supplies of antiviral/ vaccines and patient medications and transportation to flu clinic
 - Set up additional patient accommodation
 - Appropriate protective equipment availability
- Advise all Managers to maintain a high level of vigilance for the development of influenza-like illness among staff, and report these rapidly to appointed staff health monitoring and support person.

Ongoing:

- Ensure that basic patient services in the wards are maintained as long as possible
- Obtain regular information and updates from operations team members and pass information on to Hospital Commander
- Consider the possible need for an area for an Intermediate Level of Care, i.e. motel for recovering patients requesting only low levels of care
- Activate phone support for those in an intermediate level of care as above
- Identify and communicate to the Hospital Commander any issues or concerns that may require coordination with the wider health system, external agencies and/or emergency services
- Consider requesting the cessation of normal activities as indicated – request to be made to Hospital Commander regarding such areas as elective admissions, elective surgery, early discharges and decide whether other services should continue
- Approve and facilitate establishment of a dedicated Flu Clinic
- Consider additional long term staffing requirements – forward requests to Planning Manager.
- Carry out the necessary operational strategies outlined in the IAP (Appendix 3)
- Maintain an Incident Log
- Arrange for staff to participate in 'hot' debrief
- Facilitate for participation in psychological debriefs as required

Extended:

- Ensure a list of all staff involved is completed for each area. (Liaison with Planning Manager to maintain Emergency Management Structure Diagram)
- Ensure that all staff, volunteers and patients are observed for signs of stress or influenza-like illness
- Ensure decision made regarding home quarantine for patients and staff unwell with influenza-like illness are made using the Home Isolation Assessment Tool (Appendix 18)
- Ensure provision of staff rest periods and relief
- Ensure all departments provide and receive regular updates of incident status
- Keep Hospital Commander informed of operational situation
- Keep staff alert to identify and report all hazards/unsafe conditions to the HoC

Stand Down:

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Planning Manager (PM)

You Report To: Hospital Commander (HoC)

Mission: Organise and direct all aspects of planning related to incident response. Ensure the distribution of critical information/data. Compile scenario/resource projections from all areas and effect long range planning in conjunction with the wider HoIMT. Document and distribute Incident Action Plan (IAP – Appendix 3)

Initial:

- Put on position identification tabard (Appendix 7)
- Obtain briefing from Hospital Commander
- Document actions and decisions on a continual basis
 - Obtain the assistance of a scribe if necessary
- Establish a suitable location for a Planning Centre in proximity to HoIMT
- Create a Draft IAP (Appendix 3 including subsequent versions) and distribute copies to Hospital Commander, HoIMT members and all other relevant staff in preparation for Hospital Commander approval
- Disseminate the Approved IAP to all relevant parties
- Assign relevant planning officers for following areas:
 - Incident Planning Officer
 - Human Resources
 - Clinical Planning
 - Health Information / Patient Enquiries

Ongoing:

- Communicate frequently with Hospital Commander
- Identify and communicate to the Hospital Commander any issues or concerns that may require coordination with the wider health system, external agencies and/or emergency services
- Obtain regular information and updates from planning team members
- Schedule planning meetings for continued update of the IAP
- Develop Action Plans for scenarios 4, 8, 24 & 48 hours (etc) from time of commencement of incident
- Maintain an Incident Log
- Carry out the necessary operational strategies outlined in the IAP
- Arrange for staff to participate in 'hot' debrief
- Facilitate for participation in psychological debriefs as required
 - Keep staff alert to identify and report all hazards and unsafe conditions to the Hospital Commander

Extended:

- Monitor staff and volunteers for signs of stress, inappropriate behaviour and influenza-like illness
- Provide for staff and volunteers rest periods and relief

Stand Down:

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Scribe

You Report To: Hospital Commander (HoC) or other designated member of the HoIMT

Mission: Maintain current information and ensure a written record is maintained.

Note: that each role of the HoIMT will have specific requirements that relate to the position of Scribe.

Initial:

- Put on position identification tabard (Appendix 7)
- Obtain Incident log sheet and relevant Situation Report sheets (Appendix 2 and 5)
- Commence all documentation on Hospital Incident Log sheet
- Establish a status/capacity board in Hospital/Health Service Incident Management Centre/area – using electronic white board if possible (If assigned to HoC)

Ongoing:

- Document any requests, decisions, & actions related to incident management in assigned areas
 - This record should provide a clear overview of incident management when reviewed post incident and is a legal requirement
- Ensure the security and prevent the loss of incident log sheets, situation reports and other relevant documentation
- Ensure an ongoing supply of incident log sheets and situation reports for HoIMT members

Extended:

- Once the decision has been made to end the response, ensure time of stand down notification is recorded

Stand Down:

- Facilitate smooth transition into normal business activities
- Attend final team meetings & hot debriefs
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities
- Participate in the evaluation of the incident response that will be arranged once the emergency situation has resolved

Refer to list of appendices on page 52 for further information that may be related to your role

Unit/Department Action Cards

These action cards are for functions suggested by this template. Use the template to develop actions cards appropriate to roles for *YOUR HEALTH FACILITY*.

These action cards are slightly different to the HoIMT action cards. They are divided into 3 parts being "STAND BY", "ACTIVATE", and "STAND DOWN" for ease of use.

Supplies and Resources

You Report To: Logistics Manager (LM)

Mission: Organise and supply medical and non-medical care equipment and supplies.

Stand By

- Put on position identification tabard (Appendix 7)
- Request that all staff on duty remain on duty to assist if required.
- Obtain a briefing from Logistics Manager
- Designate staff member to contact off duty staff and place them on standby noting their availability.
- Review supply stocks in anticipation of requests

Activate

- Liaise with the Logistics Manager regarding:
 - Number of people involved
 - How long the situation is likely to continue
 - What services will be required
- Order and arrange delivery of supplies and resources that are required
- Call in staff placed on stand by, as required
- Respond to requests for additional equipment and supply needs including PPE
- Identify future supply requirements in consultation with Planning
- Receive and distribute essential medical equipment and supplies
- Process requests for resources as per normal supply chain
 - If unable to access required resources notify Logistics Manager &/or Hospital Commander
 - GR Regional Health Coordinator may be able to assist
 - The local Municipal Emergency Coordination Centre (MECC) may be able to assist
- Ensure maintenance of records related to material supplies (Appendix 9)
- Provide support to other areas as required
- Keep staff alert to identify and report all hazards/unsafe conditions to the LM

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Catering and Domestic Services

You Report To: Logistics Manager (LM)

Mission: Provide catering and cleaning services

Stand By

- Put on position identification tabard (Appendix 7)
- Request that all staff on duty remain on duty to assist if required
- Obtain a briefing from Logistics Manager
- Assess current food supplies and begin to prepare list of goods that may be required
- Designate staff member to contact off duty staff and place them on standby noting their availability

Activate

- Liaise with the Logistics Manager to determine:
 - Number of people involved
 - How long the situation is likely to continue
 - What services will be required
- Estimate the number of meals that can be served utilising existing food stores and order additional supplies as required in consultation with Planning
- Develop appropriate menu(s)
- Order and arrange delivery of supplies that are required
- Allocate a staff meal area and process for distribution of patient meals
- Provide domestic services as required
- Call in staff placed on stand by, as required
- Allocate staff to designated areas to liaise with the areas and provide refreshments as required. Areas may include:
 - Emergency (Patients and Staff)
 - Patient Transit Area
 - Acute Ward
 - Relatives Area
 - Hospital Incident Management Team (HoIMT)
 - Emergency Services Personnel
 - Flu Clinic
- Provide support to other areas as required
- Maintain patient services
- Ensure appropriate systems in place to maintain appropriate hygiene and food handling standards
- Determine strategy for collection and secure storage for increased volumes of clinical waste
- Liaise with Logistics Manager regarding current needs and additional requirements for staffing and supplies
- Keep staff alert to identify and report all hazards/unsafe conditions to the LM

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Facilities Maintenance and Security

You Report To: Logistics Manager (LM)

Mission: Maintain the integrity and security of the facility

Stand By

- Put on position identification tabard (Appendix 7)
- Request that all staff on duty remain on duty to assist if required
- Obtain a briefing from Logistics Manager
- Designate staff member to contact off duty staff and place them on stand by noting their availability
- Prepare to implement the facility's emergency lockdown position if necessary and personnel identification policy. (i.e. move from day-time operating position to night-time operating position)

Activate

- Liaise with the Logistics Manager regarding:
 - Number of people involved
 - How long the situation is likely to continue
 - What services will be required
- Implement the facility's emergency lockdown position if necessary and personnel identification policy. (i.e. move from day-time operating position to night-time operating position)
- Call in staff placed on stand by, as required
- Monitor and maintain facilities
- Establish mortuary facility
- Remove unauthorised persons from restricted areas
- Maintain hospital access for authorised vehicles only
- Secure patient care areas, ED and triage areas, morgue, flu clinic, pharmacy and all other areas where vaccines and antiviral medication may be kept, and other sensitive or strategic areas from unauthorised access
- Initiate contact with fire, police agencies through the Planning Manager, when necessary
- Confer with Media Liaison Officer to establish areas for media personnel
- Ensure security of food, water and medical resources
- Ensure maintenance of records
- Provide support to other areas as required
- Keep staff alert to identify and report all hazards/unsafe conditions to the LM
- Maintain functioning of all necessary plant and medical equipment
- Provide reserve oxygen cylinders for portable oxygen units
- Ban the use of oxygen-actuated suction units as they rapidly deplete oxygen scarce cylinders

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Transportation

You Report To: Logistics Manager (LM)

Mission: Organise and coordinate the transportation of all patients, ambulatory and non-ambulatory. Arrange for the transportation of human and material resources to and from the facility

Stand By

- Put on position identification tabard (Appendix 7)
- Request that all staff on duty remain on duty to assist if required
- Obtain a briefing from Logistics Manager
- Designate staff member to contact off duty staff and place them on standby noting their availability

Activate

- Liaise with the Logistics Manager regarding:
 - Number of people involved
 - How long the situation is likely to continue
 - What services will be required
- Call in staff placed on stand by, as required
- Assess transportation requirements and needs for patients, personnel and materials; request appropriate transport
- Establish patient off-loading area
- Ensure patient trolleys, lifters, wheelchairs, chairs and stretchers in proximity to patient off-loading area and transfer area
- Establish in-patient transfer loading area for outward bound patients
- Establish patient transport means for short and long term hospital discharge's
- Establish transport to and from mortuary
- Contact Security Manager regarding security needs of loading areas
- Provide for the transportation/shipment of resources into and out of the facility
- Ensure maintenance of transportation record for all patient movement
- Ensure maintenance of records
- Provide support to other areas as required
- Keep staff alert to identify and report all hazards/unsafe conditions to the LM

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

You Report To: Logistics Manager (LM)

Mission: Organise and coordinate internal and external communications

Stand By

- Put on position identification tabard (Appendix 7)
- Request that all staff on duty remain on duty to assist if required
- Obtain a briefing from Logistics Manager
- Designate staff member to contact off duty staff and place them on standby noting their availability

Activate

- Liaise with the Logistics Manager regarding:
 - Number of people involved
 - How long the situation is likely to continue
 - What services will be required
- Call in staff placed on stand by, as required
- Establish a communications strategy for Hospital Incident Management Team (HoIMT) use through the Incident Action Plan (IAP) in relation to the incident response
- Ensure all communications / IT equipment is functional
- Assess staffing requirements for communications / IT strategy and forward information regarding future anticipated staffing needs to Planning Manager
- Ensure all communication, times messages sent, acknowledgement times etc are documented – consider scribe requirement
- Manage and maintain effective telecommunications such as landlines, VOIP systems, satellite phones, State Mobile Radio systems, etc.
- Liaise with Logistics Manager to secure alternate external modes of communication – if required
- Ensure maintenance of records
- Provide support to other areas as required
- Keep staff alert to identify and report all hazards/unsafe conditions to the LM

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Nursing Team Leader

You Report To: Operations Manager (OM)

Mission: Organise and coordinate ward/unit response

Stand By

- Put on position identification tabard (Appendix 7)
- Request that all staff on duty remain on duty to assist if required
- Obtain a briefing from Operational Manager
- Designate staff member to contact off duty staff and place them on standby noting their availability
- Determine the following information:
 - Number of patients that can be discharged.
 - Number of available beds.
 - Number of staff available for redeployment
 - Estimate clinical capacity
 - Advise Operations Manager (for discussion with Logistics) regarding potential overload and transfer contingency requirements
- Undertake assessment of current ward/department status
- Prioritise clinical care requirements of current ward/department inpatients
- Undertake set-up for potential influx of Influenza cases
- Prepare to transfer patients out to other locations
- Arrange telephone home support services for those patients to be discharged
- Assess current stocks of relevant supplies and prepare list:
 - Pharmacy supplies
 - Medical consumables
 - Oxygen
 - PPE
- Liaise with Infection Control manager regarding infection prevention strategies.
- Ensure staff are aware of appropriate infection control precautions, including mask type and fit check
- Be aware of protocols for care of the deceased (Appendix 22)

Activate

- Provide Situation Report to Operations Manager, including patient information.
- Arrange for notification of existing inpatient next of kin / carers about current situation
- Designate staff member to:
 - Call in staff placed on stand by, as required
 - Allocate Nursing staff to appropriate areas
- Consult with VMO regarding clinical requirements
- Arrange for discharge / transfer patients using designated transit areas
- Liaise with nursing staff regarding current bed status and of additional requirements for staffing and supplies
- Arrange for reception of patients as allocated, recording all information
 - Note: Record accurate documentation as care provided
 - Records may need to be located with patients/Influenza cases
- Collect reports from staff of any issues
- Maintain adequate stock levels
- Ensure maintenance of essential ward/department functions
- Monitor staff for appropriate use of PPE, liaise with Infection Control manager to discuss concerns is required
- Monitor staff for signs of influenza-like illness, liaise with Infection Control manager to discuss concerns is required
- Keep staff alert to identify and report all hazards/unsafe conditions to the OM

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Medical Team Leader

You Report To: Operations Manager (OM)

Mission: Organise and coordinate medical response. Works closely with Infection Control Manager

Note: This position is likely to be a Visiting Medical Officer in regional health facilities

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Operations Manager
- Delegate or make alternate arrangements for Practice Management
- Liaise closely with Infection Control Manager
- Liaise with Nurse In-Charge regarding current In-Patient requirements, discharges or transfers
- Undertake assessment of current ward/department status and flu clinic with the Infection Control Manager
- Prioritise clinical care requirements of current ward/department inpatients
- Liaise with other Medical staff/General Practitioners as required

Activate

- Liaise with Medical staff at Receiving Hospitals regarding patient transfers
- Assess incoming emergency patients in conjunction with nursing staff
- Provide Situation Reports to the Operations Manager and/or Hospital Commander
 - May liaise with the Field Emergency Medical Officer in regards to incoming Influenza cases
- Access medical support as required
- Provide briefing to Medical staff/General Practitioners and allocate responsibilities
- Provide advice to Flu Clinic and home phone support unit as required
- Provide advice to Infection Control and Staff Monitoring Officer regarding staff who report personal features of respiratory illness: rapid PCR testing? Commencement of treatment with Tamiflu, send home? (Appendix 20)
- Provide regular Situation Reports to Operations Manager

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Pathology (External provider – limited service)

You Report To: Operations Manager (OM)

Mission: Organise and coordinate pathology response.

Stand By

- Be prepared to attend health facility

Activate

- Receive Situation Report from Operations Manager
- Contact Service Provider and activate emergency arrangements
 - Arrange for transfer of specimens
 - Access blood products as required
- Distribute products as required
- Provide regular Situation Reports to Operations Manager

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Radiology (External provider – limited service)

You Report To: Operations Manager (OM)

Mission: Organise and coordinate radiology response.

Stand By

- Be prepared to attend health facility

Activate

- Receive Situation Report from Operations Manager
- Contact Service Provider and activate emergency arrangements
 - Provide Radiology services
- Provide regular Situation Reports to Operations Manager

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Pharmacy

You Report To: Operations Manager (OM)

Mission: Organise and coordinate pharmacy response.

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Operations Manager
- Undertake assessment of current Pharmacy needs and anticipated demand for antivirals, antibiotics, nebulised solutions, pneumococcal vaccine, pandemic vaccine and IV solutions (in addition to Oseltamivir some supplies of Zanamivir are required for use in persons who cannot tolerate Oseltamivir) (Appendix 20 and 21)
- **Note: informed consent forms for chemoprophylaxis are required to accompany each course of antivirals/pandemic influenza vaccine, signed by the recipient, and filed in their unit medical record/ staff health file**
- Assess current stock supplies across the Health Service
- Preparation of list of requirements
- When Pandemic vaccine becomes available order requirements based on National Guidelines
- Ensure “Cold Chain” is maintained during vaccine storage/ transport/distribution
- Assess staffing needs

Activate

- Liaison with Logistics Manager to secure additional stock locally
- Source and deliver pharmacy requirements in line with requisitions
- Maintain **security** of all pharmacy items
- Provide regular Situation Reports to Operations Manager

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Restock all relevant medications if further pandemic wave expected
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

You Report To: Operations Manager (OM)

Mission: Organise and coordinate CSSD response

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Operations Manager
- Undertake assessment of current sterile supply needs
- Assess current stock supplies across the Health Service
- Preparation of list of requirements
- Assess staffing needs

Activate

- Access supplies from alternate internal sources and from local medical practices
- Liaise with Logistics Manager regarding supplies that cannot be sourced locally
- Undertake additional sterilization of equipment and supplies
- Deliver CSSD stock where needed
- Provide regular Situation Reports to Operations Manager

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Property and Evidence Officer

You Report To: Operations Manager (OM)

Mission: Secure belongings, equipment and property that may be needed as evidence in any investigation

Note: This position may be under Logistics

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Operations Manager

Activate

- Identify property and/or evidence as a part of incident response
- Liaise with Victoria Police representative
- Appropriately bag, tag, record and store evidence in line with Incident Property and Evidentiary Log (Appendix 6)
- Appropriately record and store patient property
- Maintain supporting documentation
- Arrange for hand-over of property and/or evidence to relevant persons/authority
 - Handover to include formal documentation to ensure maintenance of chain of custody
- Provide regular Situation Reports to Operations Manager

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Clinical Support Services

You Report To: Operations Manager (OM)

Mission: Provide allied health, primary care and/or personnel to assist the response

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Operations Manager
- Assess Clinical Support Service's needs
- Contact off duty staff and place them on standby noting their availability

Activate

- Liaise with the Operations Manager to identify and secure additional psychosocial support staff from external agencies
- Provide briefing and allocate responsibilities to staff
- Provide Clinical Support services as required
- Provide regular Situation Reports to Operations Manager

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Flu Clinic Leader

Reports to: Operations Manager (OM)

Mission: Manages the Flu Clinic to maximise client throughput in a manner that protects uninfected client and staff from infection transmission. Manages client assessment in a timely manner. Refers infected clients for inpatient care, intermediate care or home care based on acuity level.

Standby

- Put on position identification tabard (Appendix 7)
- Receive briefing from Operations Manager
- Activate Flu Clinic Establishment Plan through Operations Manager (Appendix 19)
 - Operations Manager- establish hours of operation in consultation with Medical Practices and advise Liaison Manager to provide local media release
 - Logistics Manager – provide set-up equipment, requisites, communication and IT
 - Operations Manager – establish short-term staff supply: clinical, administrative, cleaning and security
- Obtain and circulate phone numbers for the Home Monitoring Officer, Nursing Team Leader, and Medical Team Leader
- Educate Reception and Nursing Staff on:
 - patient flows
 - social distancing and respiratory etiquette
- Obtain copies of pandemic Influenza fever and Symptom Log for home monitoring (Appendix 17)
- Obtain copies of Home Isolation/Quarantine Assessment Tool (Appendix 18)
- Be aware of protocols for care of the deceased (Appendix 22)

Activate

- Provide periodic reports to Operations Manager, documenting activity status, staffing, equipment, and pharmacy requirements such as antivirals, vaccines, patient medication supplies (Appendix 20 and 21)
- Attend HoICT briefing and action any Incident Action plans received
- Liaise with Nursing Team Leader regarding patients requiring inpatient admission
- Advise Planning Manager of Intermediate Period staffing needs
- Advise Operation Manager of any incidents; e.g. security, using Incident Log Sheet (Appendix 5)
- Maintain copies of all decision made
- Request Operations Manager to have a media release regarding any alteration in Flu Clinic hours of operation
- Advise Operations Manager of any OH&S issues

Stand Down

- Participate in operational debrief
- Advise Operations Manager when return to normal operations is expected, i.e. need for specialised medications abating
- Request Operations Manager to have a media release regarding closure of Flu Clinic
- Have all equipment and supplies returned to the relevant hospital departments
- Participate in the evaluation of the incident response that will be arranged once the emergency situation has been resolved
- Document all actions and observations.

Refer to list of appendices on page 52 for further information that may be related to your role

Phone Support Home Care

Report to: Operations Manager (OM)

Mission: Maintain contact with clients suffering from mild influenza, and contacts in Home Quarantine who are on Home Monitoring.
This function could be staffed by adequately briefed, retired RN1s, working to guidelines provided.

Standby

- Put on position incident tabard (Appendix 7)
- Obtain a briefing from Operations Manager
- Assist Communications/IT with set up of Phone support Office
- Photocopy Fever and Symptom Logs (Appendix 17) ready for use, or computer data base
- Provide report on preparedness status to Operations Manager

Activate

- Phone all clients on Home Care Support Program and record status daily
- Receive and answer emails from clients who are on Home Care Support Program
- Provide a 24/7 phone contact advice service for reporting complications from clients in Home Care
- Obtain advice regarding clients whose condition appears to be deteriorating from Medical Team Leader and arrange admission when necessary
- Maintain an Incident Log
- Receive relevant and action Incident Action Plans from Operations Manager

Stand Down

- Collect relevant reports from staff
- Participate in the evaluation of the incident response that will be arranged once the emergency situation has been resolved
- Document all actions and observations.

Refer to list of appendices on page 52 for further information that may be related to your role

Incident Planning Officer

You Report To: Planning Manager (PM)

Mission: Assist the Planning Manager to create Incident Action Plans (IAP)
Distribute IAPs to Hospital Commander, Hospital Incident Management Team (HoIMT) members and all other relevant

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Planning Manager

Activate

- Liaise with relevant personnel such as Operations Manager, Logistics Manager and other Team Leaders to obtain situation reports, identify needs and gaps, and document issues that are resolved, being resolved or need addressing
- Identify and communicate to the Planning Manager any issues or concerns that may require coordination with the wider health system, external agencies and/or emergency services
- Assist Planning Manager to develop IAPs (Appendix 3)
- Disseminate the approved IAP to all relevant parties
- Provide regular situation reports to Planning Manager

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Human Resources Officer

You Report To: Planning Manager (PM)

Mission: Management & maintenance of staff & volunteer requirements throughout the duration of the incident

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Planning Manager
- Organise an inventory of available staff & volunteers (Appendix 10, 10A, 11)
- If required gather available staff & volunteers at a specific area and assign as required

Activate

- Manage associated time sheets/rosters
- Assist the Planning Manager with recovery planning
- Establish staff briefing area and communicate operational status to HoIMT and all staff areas
- Establish a registration and screening desk for volunteers not employed or associated with the hospital
- Maintain adequate numbers of both medical and non-medical personnel
- Consider needs for staff dependents/families if required (e.g. staff unable to leave workplace)
- Address individual staff welfare needs that impact on staff during a major incident
- Consider psychosocial support needs for staff during and after the incident
- Keep staff alert to identify and report all hazards/unsafe conditions to the PM

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Clinical Planning Officer:

You Report To: Planning Manager (PM)

Mission: Support the medical response staffing needs

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Planning Manager
- Ensure all direct care staff have commenced "Direct Care Staff Record Sheet" (Appendix 16)
- Arrange basic infection prevention training for PPE if required

Activate

- Screen volunteer clinical and first aid staff as necessary
- Assist in the assignment of available clinical staff as needed
- Meet with Planning Manager regarding clinical personnel to coordinate short to long term staffing needs
- Liaise with Planning Manager to confirm status of patient discharges
- Keep staff alert to identify and report all hazards/unsafe conditions to the PM
- Provide regular Situation Reports to Planning Manager
- Ensure all direct care staff maintain "Direct Care Staff Record Sheet" (Appendix 16)

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation including review and file Direct Care Staff Record Sheets.
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Health and Patient Information Officer

You Report To: Planning Manager (PM)

Mission: Track and document location of Influenza cases & patients at all times within the hospital's patient care system. Ensure appropriate patient identification system is maintained.

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Planning Manager

Activate

- Establish an area to track casualty/patient arrivals, locations and departures
- Meet with Planning Manager to coordinate staffing needs
- Obtain sufficient assistance to document current and accurate patient demographic information
- Assist Australian Red Cross representative(s) to implement the National Registration Inquiry System (NRIS) if necessary (Appendix 4)
- Provide information to visitors and families regarding location of Influenza cases/patients
- Direct patient related news releases through Liaison Manager
- Keep staff alert to identify and report all hazards/unsafe conditions to the PM
- Provide regular Situation Reports to Planning Manager

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Media Liaison Officer

You Report To: Hospital Commander (HoC)

Mission: To manage the media response to the incident

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Hospital Commander

Activate

- Maintain an activity log of all communication and actions arising from Media Liaison activities
- Receive telephone calls from the media
- Meet and manage media representatives on behalf of the health service/hospital
- Ensure that media representatives do not hinder the clinical activities of the hospitals or invade the privacy of patients and relatives
- Liaise with the Planning Manager to prepare media releases
 - Determine requests to be made to the public via the media
- Liaise with the Health and Patient Information Officer regarding information for relatives, friends and the community
 - **Ensure that all media releases have the approval of the Hospital Commander**
 - Forward all media releases to the GR REOC
- Brief Hospital Commander on issues arising from the media
- Inform on-site media of the physical areas that they have access to, and those that are restricted
- Contact other agencies to coordinate information release with respective public affairs officers (e.g. Victoria Police media liaison unit)
- In major incidents ensure effective liaison with the DHHS Media Unit
- Keep staff alert to identify and report all hazards/unsafe conditions to the Hospital Commander
- Provide regular Situation Reports to Hospital Commander

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Emergency Management Liaison Officer

You Report To: Hospital Commander (HoC)

Mission: To represent the health service/hospital at multi-agency briefings and/or in Incident Control Centres (ICC)/Municipal Emergency Coordination Centres (MECC)

Note: The staff member fulfilling this role must have the authority to make decisions on behalf of the health service/hospital. An understanding of infectious diseases management is beneficial in a pandemic situation.

Stand By

- Put on position identification tabard (Appendix 7)
- Receive briefing from Hospital Commander
- Obtain contact phone numbers of relevant emergency service and/or municipal representatives

Activate

- Maintain an activity log of all communication and actions arising from liaison activities with external agencies
- Receive telephone calls and liaise with representatives of external agencies on behalf of the hospital
- Liaise with the Health and Patient Information Officer regarding information for relatives, friends and the community
- Provide ongoing situation reports to external agencies with the approval of the Hospital Commander
- Communicate requests from external agencies to the Hospital Incident Management Team (HoIMT) and Hospital Commander
- Attend multi-agency briefings and/or the Incident Control Centre (ICC)/Municipal Emergency Coordination Centre (MECC)
- Keep staff alert to identify and report all hazards/unsafe conditions to the Hospital Commander
- Provide regular Situation Reports to Hospital Commander

Stand Down

- Ensure that all staff are informed of stand down
- Facilitate smooth transition into normal business activities
- Attend final team meetings & conduct hot debriefs
- Debrief staff and note any issues that have arisen from the incident
- Complete and collect all documentation
- Return all emergency management equipment to correct storage area
- Ensure all equipment, assets and personnel in place to maintain normal activities

Refer to list of appendices on page 52 for further information that may be related to your role

Residential Aged Care

Planning Assumptions

- Where the Residential Aged Care unit (RAC) is part of an Area Health Service, and co-located; the Pandemic influenza Plan for all units should be an integrated plan to facilitate “whole of agency” coordination
- Elderly residents are particularly prone to complications caused by influenza, including secondary bacterial pneumonia
- In the early stages of a pandemic an isolated case of Pandemic Influenza may be best managed by transfer to an Acute Hospital. However, the agency plan should not rely on this provision when Pandemic Influenza becomes more widespread. For a variety of reasons affected residents would be best managed by implementation of a pre-planned response providing a “Hospital in the Nursing Home” response.

Planning

- During the Early Pandemic Alert Phase the RAC Nurse Unit Manager, the Unit Infection Control Liaison Nurse and agency Infection Control Manager will:
 - assess care areas and equipment for adequacy of a “Hospital in the Nursing Home” response, in case it becomes necessary
 - provide staff education in infection control, and staff/ augmented staff skills to conduct “Hospital in the Nursing Home”, in case it becomes necessary
 - identify residents who could be temporarily discharged to home care by family members, or with home care services

Optimising Resident Protection to Respiratory Infections

- Implement Respiratory Etiquette for staff, residents and visitors by provision of signage, supplies and training
- Strongly encourage Seasonal Influenza and Pneumococcal immunisation for residents, staff, and volunteers (*Pneumococcal immunisation for staff / volunteers over 65 years*)
- Encourage staff, relatives, and volunteers to develop the practice of wearing masks if coughing / sneezing in Seasonal Influenza period

Preparing the Residential Aged Care Unit Environment

- Stockpile disposable gowns and P2/N95 masks based on risk assessment for that facility (Appendix 1)
- Decide which rooms could be used for single or cohorted residents with Pandemic Influenza, considering ability to enhance ventilation, by exhausting air to exterior or natural ventilation
- Ascertain availability of portable oxygen/suction setups – several additional setups required
- Provide and test a “remote visitation” strategy whereby residents and visitors could talk to each other over computer link or CCTV setup from a distant computer or a waiting room external to the RAC Unit
- If a “hospital in the nursing home” system of care is to be utilised in the epidemic situation form a plan to address the issues of extra staffing, staff skills levels, and equipment required, e.g.: IV requisites, antibiotics, and where chest radiographs would be performed .

Business Continuity - Conjointly with “whole of agency” Pandemic Planning Team:

- Compile contact lists, and keep them current
- Ensure contracts for hotel services, waste disposal and laundry services have continuity clauses, or/and detail alternative “epidemic-proof” arrangements
- Arrange additional volunteers in case a staffing shortfall occurs. All volunteers require training for their roles, and in infection control. All volunteers must be chosen from non-vulnerable persons (i.e.; no

diseases which predispose to respiratory infection), and have current Seasonal Influenza; and if necessary, Pneumococcal immunization

- All staff must be trained in standard and transmission based infection control measures and be updated as required with changes identified during a pandemic

Pandemic in Australia (in our region or Australia-wide)

- Implement your agency Human Influenza Pandemic Management Plan including Suspect Influenza Patient protocol
- Refer to requirements for all phases – phases may not occur in a logical sequence
- Implement “Hospital in the nursing Home” for affected residents
- Administer treatment antivirals and antibiotics prescribed to affected residents, also supportive treatment
- Administer prophylactic antivirals as prescribed for unaffected residents and staff while Influenza is present in the unit
- Visitation of residents by relatives will probably not be possible routinely as supplies of PPE will be very limited. Therefore, implement “remote visitation” strategy.

Refer to list of appendices on page 52 for further information that may be related to your role

Patient Tracking & Registration

(Refer to Appendix 8)

It is preferable that *YOUR HEALTH FACILITY* continues to use their normal electronic patient registration processes. *YOUR HEALTH FACILITY* business continuity plan should have contingencies to manage any surge in use.

In the event of failure of electronic patient management system staff will need to enact a manual registration system. Appendix 8 is an example of a patient tracking form.

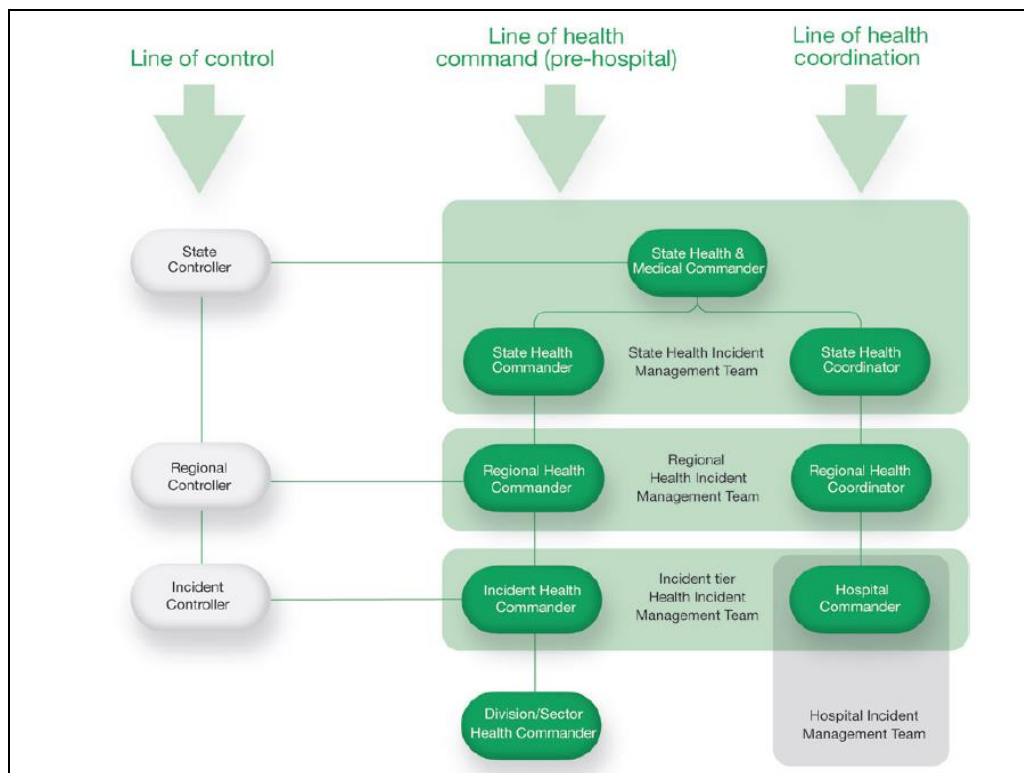
State Health Emergency Response Plan

The *State health emergency response plan* (SHERP) outlines the arrangements for coordinating the health response to emergency incidents that go beyond day-to-day business arrangements.

SHERP is a sub plan of the Victorian *State emergency response plan* (SERP). It is an all-hazard, scalable plan and that details the arrangements for regional and state health responses.

SHERP not only describes the pre hospital (incident site) arrangements related to mass casualty events but it is also used for managing events that have significant impact on the health of Victorians and health facilities. The command and control arrangements are used in bushfire, flood and infectious diseases outbreaks, for example. SHERP also contains a section on Code Brown planning for health care facilities.

All members of *YOUR HEALTH FACILITY* Hospital/Health Service Incident Management Team should be familiar with SHERP, roles such as the Health Commander and Field Emergency Medical officer and the command/control arrangements it details. Copies of SHERP can be located on the Department of Health website: <http://www.health.vic.gov.au/sherp/>



Reporting relationships as detailed in SHERP (2013, p.9)

Medical Team Field Deployment

YOUR HEALTH FACILITY does not have the capacity or equipment to assemble and deploy a Victorian Medical Assistance Team (VMAT). *YOUR HEALTH FACILITY* personnel must not leave the facility to attend the scene of an incident and must direct all enquiries regarding an external emergency to the most senior person available within the organisation (usually the Hospital Commander).

Victorian Medical Assistance Teams (VMAT) are small squads of properly trained and equipped medical and nursing staff members who may be deployed from metropolitan or large regional health services at the request of the Health Commander (AV).

YOUR HEALTH FACILITY may request medical assistance if needed. The Hospital Commander or Emergency Management Liaison Officer can request a VMAT Team through the Field Emergency Medical Officer (FEMO) or the Health Commander (AV).

Post Event Recovery & Reporting

Recovery is about returning *YOUR HEALTH FACILITY* back to normal business as the effects of the incident start to dissipate.

Capturing information and learnings from the event are essential to provide ongoing improvement as well as allowing staff to understand issues that may have occurred during the event.

Hot Debrief

A hot debrief is a meeting that occurs almost immediately after the stand down is called or at a shift change for prolonged events. Its purpose is to capture the more immediate problems and concerns that personnel had during the event.

The Hospital Commander and/or team leaders facilitate the meeting in a non-threatening environment. Personnel should have access to food, water and ablutions prior to the debrief taking place.

Psychological Debriefing

Psychological debriefing should only be conducted by trained professionals. The Hospital Commander must ensure that Psychological debriefing is available for any staff member that requires it.

Psychological debriefing is confidential and is not used to form reports.

Operational Debriefing

Operational debriefing (sometimes known as a cold debrief) is conducted to examine the organisational response to the incident. It should be held within two weeks of the incident and is compulsory for key personnel involved in the incident response.

The purpose of an operational debrief is to:

- Identify how plans and systems functioned rather than individual performance (no blame appropriate)
- Identify gaps and capture lessons learned
- Inform future training
- Improve plans, procedures and processes
- Collect evidence for any enquiry
- Identify and respond to the needs of staff
- Provide an opportunity for comments/feedback

A record of the debriefing session must be attached to the formal Incident Report produced for the organisation.

Wherever possible, debrief is to be conducted away from clinical areas and should cover the following issues:

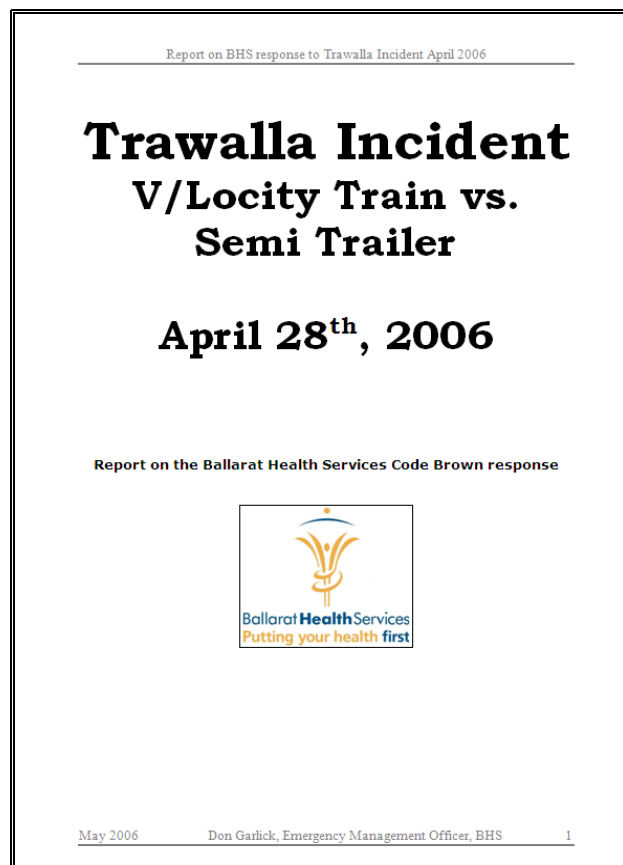
- What happened
- Where it happened
- How it happened (if known)
- How it was reported/alarm raised
- The sequence of events
- Who were involved in the incident
- What went wrong
- Need for changes to procedures or equipment etc
- What went right
- Recommendations

The operational debrief is an opportunity to promote peer support and/or formal psychological counselling to staff. It is often the case that once the emergency is over stress can manifest day, weeks and months after the event.

Organisation Incident Report

The Hospital Commander is responsible for preparation of a report for *YOUR HEALTH FACILITY* Emergency Planning Committee. Recommendations in this report will form the basis of revisions to the Code Brown plan.

Issues raised, lessons learned and changes made to practices detailed in the report can form the basis of conference or seminar presentations; *remember a lesson shared is a failure prevented!*



An example of an Organisation Incident Report

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Appendix 1: Risk Assessment Guide

This Appendix demonstrates the process by which a risk/hazard analysis is performed when preparing for the management of a major incident. The purpose is to minimise loss to life, property and environment. There are a number of tools that can be used to generate this type of information. Any risk management assessment should follow the **Australian Standards ISO31000:2009 Risk Management Principles and Guidelines**.

The risk analysis process identifies the likelihood and consequence of an external threat and is the first part of the risk management process that includes:

- Identification of risks/hazards
- Analysis of risks/hazards
- Evaluation and ranking of risk
- Treatment options/contingencies to manage risks
- Monitoring process
- Accountability and documentation

Definition of Risk: RISK = LIKELIHOOD X CONSEQUENCE (you cannot consider one without the other)

Likelihood: Rare: Could happen but probably never will Unlikely: Could happen Moderate: Could occur at some stage Likely: Will probably occur Almost certain: Could easily happen	Consequence: 1: Insignificant 2: Minor 3: Moderate 4: Major 5: Catastrophic
---	---

YOUR HEALTH SERVICE can construct a risk matrix with likelihood (times) and consequences (impacts) that vary depending on the type of risks being reviewed, as long as the parameters are agreed by the people undertaking the process.

Code Brown Plan

Risks Log

Version Number:

Date last Updated:

Prepared by:

Likelihood

5 Almost Certain

4 Likely

3 Possible

2 Unlikely

1 Rare

Consequence

5 Extreme

4 Major

3 Moderate

2 Low

1 Negligible

Risk Rating

	5	4	3	2	1
5	Extreme	Extreme	High	Medium	Medium
4	Extreme	High	High	Medium	Low
3	High	High	Medium	Medium	Low
2	Medium	Medium	Medium	Low	Low
1	Medium	Low	Low	Low	Low

Status

A Addressed

IP In Progress

NA Not Addressed

Risk No:	Description	Likelihood	Consequence	Risk Rating	Strategies for mitigating risk	Action (Name/Date)	Status
	Fire						
	• Building						
	• Bush Fire						
	Explosion (eg Silo)						
	Chemical Incident (eg Farming/Silo etc)						
	Road Accident						
	• Car						
	• Chemical Transport						
	• Bus						
	Train Accident						
	Major disease outbreak						
	Severe Weather Conditions						
	• Flood						
	• Wind Storm						

An example of a Code Brown risk assessment form

Likelihood of Failure	5. Highly Likely: within a month	L 5	M 10	H 15	E 20	E 25	BHS RESPONSE E = Extreme Risk Immediate action H = High Risk High priority action M = Moderate Risk Develop procedures to manage risks L = Low Risk Monitor Risk L1 Check cause L2 Contingency plans N = Negligible Risk No action required
	4. Likely: incidence between 1-6 months	L 4	L 8	H 12	H 16	E 20	
	3. Moderate: incidence between 6-12 months	N 3	L 6	M 9	H 12	H 15	
	2. Unlikely: incidence between 1-5 years	N 2	L 4	L 6	M 8	M 10	
	1. Rare: incidence less than once in 5 years.	N 1	N 2	L 3	L 4	L 5	
Consequence of failure							
	1 - Insignificant The consequences are dealt with by routine operations.	2 - Minor The consequences would threaten the efficiency or effectiveness of some aspects of a division or service stream, but would be dealt with internally.	3 - Moderate The consequences would be serious for the organisation or its divisions/streams either financially or politically. Would not threaten survival of a division or stream, but could be subject to significant review or changed way of operating.	4 - Major The consequences would threaten continued effective function or survival of a stream(s) or division(s). Would have very serious consequences for the organisation both financially and politically.	5 - Catastrophic The consequences would threaten the survival of the organisation, causing major problems for clients, the administration of the organisation or for a large part of the public sector. Would have extreme consequences for the organisation both financially and politically.		
Legal	Locally resolved	Improvement notice served	Criminal prosecution of staff. Police investigation	Executive members dismissed.	Board of Management terminate Administrator appointed		
Staff/Client Impact	Minor short term loss; first aid response	Short-term incapacity but recoverable physical or emotional disability	Semi-permanent physical or emotional disability	Fatality or permanent physical or emotional disability	Multiple fatalities or multiple permanent physical or emotional disability		
Commercial/Financial loss	Up to \$50,000	\$50,000- \$250,000	\$250,000- \$1M	\$1M-\$5 M	> \$5 M		
Environment	Slight leak/spill or contamination. Minimal building destruction/damage	Minor leak/spill or contamination. Minor building destruction/damage	Localised leak/spill or contamination. Moderate building destruction/damage	Major leak/spill or contamination. Major building destruction/damage	Massive leak/spill or contamination. Extreme building destruction/damage		
Reputation	No public concern	Minimal media concern, manageable at a local level	Multiple targeted complaints. Local media coverage	Extended local media coverage. Ombudsman investigation	Parliamentary Enquiry. Loss of Ministerial confidence		

An example of a risk matrix from Ballarat Health Services.

Appendix 2: Situation Report (SITREP)

Your Health Service - Situation Report

Report sent to:

Incident:	Report No:
	Date:
	Time:
Prepared by:	Signature:
Contact Details: Ph no:	Fax no:
Operational Status: (General Comments)	
Operations – Nursing Specific Patient Bed Status: Number of Influenza cases being treated: Estimated total patient capacity currently: No of beds occupied: No of beds available: No awaiting discharges/transfers:	
Current resource status: Staffing: Equipment: Supplies:	Anticipated resource requirements: Staffing: Equipment: Supplies:
Risk Factors:	

Appendix 3: Incident Action Plan

Health Service – Incident Action Plan

Incident Name:		Situation Summary:	
Location:			
Date:			
Time:			
EOC Location:		Overall Incident Objective: (eg: manage all Influenza cases)	
Contact Details:			
Goals/objectives: (eg: increase hospital capacity)	Strategies: (Note what must happen, when it is required and who is responsible):	Resource needs (Note who will provide what and when they will do it):	Resources obtained from
Information Flow (who needs to know and who has the information we need):	Communications plan (Technical ie frequencies, mobile phone numbers, etc):	Plan to be updated:	
		Date and Time:	
		Plan prepared by:	
		Plan approved by:	
		Hospital Commander:	

Appendix 4: Register.Find.Unite (RFU) Service

The Register.Find.Unite (RFU) service is used throughout Australia to unite families and close friends of persons affected by an emergency. The RFU service replaced the National Registration and Inquiry System (NRIS) system in 2013 but it remains functionally unchanged.

NRIS was first used in 1983 after the Ash Wednesday Bushfires in South Australia and Victoria. More recently, it was used in the 2009 Victorian Bushfires during which more than 22,000 registrations and 21,000 inquiries were logged using NRIS. The success rate for NRIS after the Victorian Bushfires was over 31%. NRIS was also used in February 2011 after Cyclone Yasi in Queensland.

Victoria Polices has the responsibility to provide advice to the general public regarding the location of Influenza cases/evacuees. While overall responsibility for control and coordination of registration and inquiry rests with Victoria Police, the management of the RFU system in Victoria is the responsibility of the Australian Red Cross.

RFU is a computer based filling and retrieval system designed to provide families and close friends with basic details on the whereabouts and safety of persons affected by an emergency.

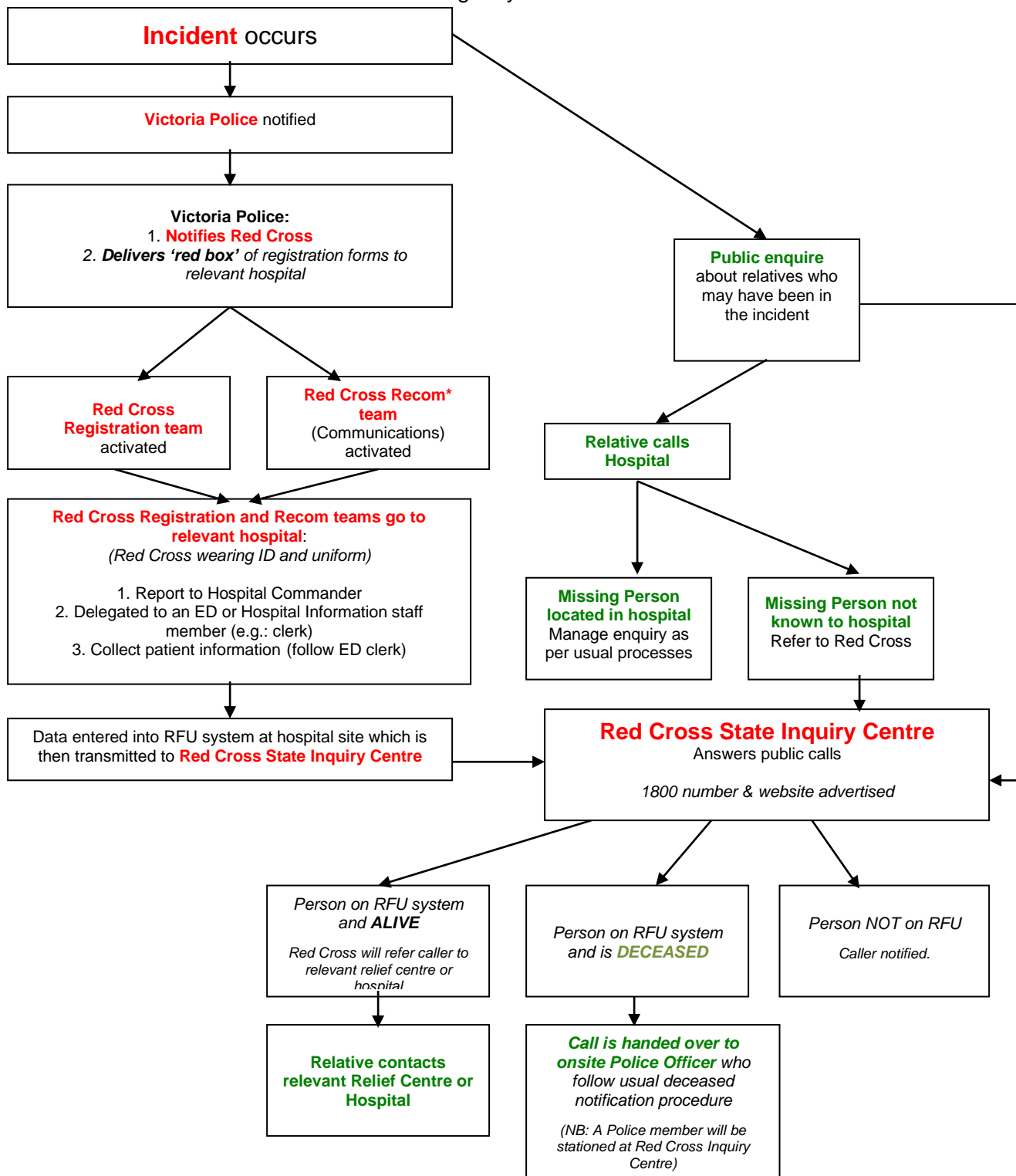
In significant emergencies Red Cross would establishes the State Inquiry Centre (1800 727 077) for all enquiries from the public. The current system for collecting information would require Red Cross staff to attend the individual hospital(s) to obtain the data.

Patient/Casualty confidentiality is not breached by providing basic details to Red Cross RFU representatives. *YOUR HEALTH FACILITY* should ensure that there is a process to provide Red Cross RFU representatives basic details of relevant patients/Influenza cases. The RFU system assists *YOUR HEALTH FACILITY* in reuniting patients/Influenza cases with their families.

Note: If an individual called regarding a family member's (patient/casualty) wellbeing, YOUR HEALTH FACILITY staff members should follow their current protocols.

Red Cross – Register.Find.Unite (RFU) System Flowchart

* Red Cross Recom team = Red Cross Emergency Communication



Appendix 5: Incident Log Sheet

Your Health Service - Incident Log Sheet

Location:

Completed by:

Signature:

DATE:	TIME:	Action Register (e.g. request, decision, problem, situation)	Action:	By whom:	Status: o = ongoing Ø = completed

Appendix 6: Hospital Emergency Incident Property and Evidence Log

Location:

Note: Use only one Evidence Log Form per person

Date of incident:

Unique Identifier	Property or Evidence Receptacle Number	Item collected as Property or Evidence	Location of Storage

Chain of Custody:

Name of person who collected item(s) (i.e. person who has initially collected these items from the patient)		Date:	
Signature		Time:	
Organisation / Position			

Name of person who received item(s)		Date:	
Signature		Time:	
Organisation / Position			

Name of person who received item(s)		Date:	
Signature		Time:	
Organisation / Position			

Appendix 7: Hospital Tabard List

Tabards have been introduced into Victorian Health Services to assist identification of key leaders during large responses such as a Mass Casualty Incident (Code Brown). It replicates the emergency management practices of emergency services organisations such as police and fire utilising the Incident Control System form of standard identification allowing key personnel to be identified.

The role & colours listed below are now standard across Victorian Health Services.

TITLE	COLOUR/TYPE
Hospital Commander	White tabard with red writing
Planning Manager	Yellow tabard with black writing
Planning Team	Yellow tabard with black writing
Logistics Manager	Blue tabard with white writing Safety reflective tape
Logistics Team	Blue tabard with white writing Safety reflective tape
Operations Manager	Red tabard with white writing
Operations Team	Red tabard with white writing
Liaison Manager	Grey tabard with black writing
Liaison Team	Grey tabard with black writing
Scribe	White tabard with black writing
Nurse	Lime tabard with black writing
Doctor	Lime tabard with black writing



Examples of health service/hospital tabards



Examples of tabards in a HoIMT

Appendix 8: Patient Tracking Form

Your Health Service: Patient Tracking Form

Location:

Incident Name:

Date:

This log is to be maintained at each care area that receives a patient

Number (Sequence)	Disaster Patient Ur Number	Name	Date of Birth	Patient Registration Number	Received From	Destination	Triage Tag/ Priority On Arrival

Appendix 9: Movement of Equipment Log Sheet

Your Health Service: Equipment Log

Location: _____ Incident Name: _____
Date: _____

Equipment Description	Rec'd From	Dispensed To	Signature

Comments: _____

Certifying Manager: _____
Date: _____ Time: _____

Appendix 10: Volunteer Registration List

Your Health Service: Volunteer Registration List

Location:

Incident Name:

Date:

No	Name (Print)	Address	Signature	Drivers License No	Prof/Tech Licence	Specialty Skills	Employer Address	Time In	Time Out	Signature Authorising Officer

Appendix 10A: Pandemic Influenza Volunteer Experience Requisites

SAMPLE FORM FOR LISTING VOLUNTEER TRAINING AND EXPERIENCE REQUISITES

Role	Training and Experience Requisites	Necessary Immunisation Cover	Training Required by our Agency
Food Services Assistant	Food Handlers Course preferable Food handling in food shop, CWA or Red Cross	Hepatitis A/B, Seasonal Influenza	Food Handlers Course preferable Basic OH&S PPE
Cook	Food Handlers Course. Food Supervisors preferable Cooking experience in commercial kitchen eg: motel/hotel, or institution	Hepatitis A/B, Seasonal Influenza	Food Handlers Course Basic OH&S
Cleaner	Experience in commercial cleaning	Hepatitis A/B, Seasonal Influenza	Basic OH&S Our agency Cleaning Routines, PPE Isolation precautions
Transport – Ute driver	Appropriate Licensing	Hepatitis B, Seasonal Influenza	Basic OH&S PPE
Transport – Day Centre Bus	Appropriate Bus License Recent bus driving experience	Hepatitis B, Seasonal Influenza	Basic OH&S Assisting with patient movement PPE
Porter	Experience in hospital or disability fields	Hepatitis B, Seasonal Influenza	Basic OH&S Assisting with patient movement PPE
Counselling	Counselling course and experience in bereavement /post-traumatic stress counselling, Minister of Religion		PPE
Nursing Assistant	St. Johns Home Nursing Course Experience as a Nursing Assistant Cert III in Aged Care	Hepatitis B, Seasonal Influenza	Basic OH&S Smartlift equivalent Assisting with patient movement PPE

Appendix 11: Capacity and Capability Proforma

An example of a quick look form that provides basic information about equipment and key contacts.

<p>Bed Availability XX acute beds Capacity for XX extra beds if needed</p> <p>Resources Pharmacy on site Pathology on site Radiology on site</p> <p>Equipment IMED pumps x XX Cardiac Monitor (Manual) x XX SAED x XX ECG machine x XX Resuscitation equipment including portable oxygen & suction x XXX Oximeter x XX PPE XXXX Gown Gloves P2Mask Protective Eyewear/ Face Shield</p>	<p>Staffing</p> <p>Nursing SHIFT TIMES</p> <p>ADDITIONAL STAFF SITES</p> <p>Medical AVAILABILITY OF VMO</p> <p>Other Staff</p>
---	--

PHONE CONTACT LIST:YOUR HEALTH FACILITY

CHIEF EXECUTIVE	
EXECUTIVE	
NURSE UNIT MANAGER/S	
NURSES STATION	
RECEPTION	
MAINTENANCE	
STAFF ROOM	
DAY ROOM	
HoIMC (Incident Management Centre)	
URGENT CARE CENTRE	
VMO TREATMENT ROOM	
INFECTION CONTROL	
KITCHEN	
MEDICAL / Flu CLINIC	
FAX	

Appendix 12: Plan Distribution List

YOUR HEALTH FACILITY Code Brown Plan should be distributed to key stakeholders. This information needs to be documented.

Stakeholder Agency	Representative Name	Address	Phone	Email
Ambulance Victoria				
Victoria Police				
CFA				
SES				
Municipality				
GR Department of Health				
Other Health Facilities				

Appendix 13: Glossary of Terms

Alert	Recognition that resources are required to enable an increased level of preparedness.
"All Hazards" approach	The range of situations that could possibly involve emergency management is extensive. An "all hazards" approach requires a form of emergency planning adaptable to a wide range of agencies.
Ambulance Victoria	Ambulance Victoria will usually be the first health agency responder on the scene and in partnership with the Health Commander (AV), will decide where Influenza cases should be taken and provide immediate treatment, transport and coordinate communications between different parts of the health response.
Business Continuity Management	Ensuring critical business functions can continue after an unexpected event. It is about planning activities to ensure speedy resumption of business.
Capacity	The volume of patients a hospital/Health Service can manage under normal operating conditions. E.g.: funded/budgeted beds/"partner" beds etc See also "surge capacity"
Capability	Capability encompasses personnel, equipment, training and operations. See also "surge capability"
Code Brown	Hospital recognized code for an external emergency.
Casualty	An injured person. Used to differentiate between Hospital In-Patients and a person injured in an external mass casualty event
Command	Directing the people and resources of an agency in the performance of its role and tasks. Authority is vertical within the agency.
Consequence	The outcome of an event or situation expressed qualitatively or quantitatively, being a loss, injury, disadvantage or gain.
Control	Overall direction of response activities in an emergency situation. Control operates horizontally across agencies or groups as it can carry the responsibility for tasking other agencies.
Control Agency	An agency nominated through the authority of the Emergency Management Manual Victoria to control response activities for a specific emergency.
Coordinate/Coordination	Bringing together agencies and elements to ensure effective response to and recovery from emergencies. Involves systematic acquisition and application of resources (agencies, personnel and equipment).
Cost	Activities, both direct and indirect, involving any negative impact, including money, time, labour, disruption, and goodwill, political and intangible losses.
Debrief (Operational)	A comprehensive, objective examination of the response to an incident or an exercise, to evaluate what was done well and where improvements can be made. It may result in a new action plan or revisions or updates to an existing plan.
Disaster	'Disaster' and 'emergency' are often used synonymously, because distinctions between the two are not sufficiently precise. It is an event that demands substantial crisis response, requiring government powers and resources beyond the scope of just one line agency or service.
Emergency	Is the result of any happening, whether natural or otherwise? May include fire, flood, cyclone, leakage or spillage of a dangerous gas or substance, infestation, plague, epidemic, disruption to an emergency service or a terrorist or warlike act, hi-jack, siege or riot. It may also be the disruption to an essential service. May cause loss of life, injury or illness or endanger the safety of the public or property in Victoria or Australia
Incident Control Centre	An Incident Control Centre is implemented in response to a major incident, which requires higher than normal coordination and support of the overall emergency effort. It will usually have established communication, administration and service facilities.
Escalation	A process whereby a critical incident requiring health intervention intensifies and may overwhelm the response capacity of a single service, thus needing to expand into alternative health services.
Evacuation	The removal of people or services from an area.
Event	An incident or situation, which occurs in a particular place during a particular interval of time.
EWIS	Emergency Warning Intercom System.

External Emergency (Code Brown) Plan	A plan developed to guide staff in roles and responsibilities in the event of a major incident. It should delineate functions for personnel, facilities and supplies.
Facility	The physical location, site or building within, or from which, the service is provided (eg, an emergency department of a hospital)
Field Emergency Medical Officer (FEMO)	Reports to Health Commander (AV) Health Incident Management Team member Provide command role for medical and nursing function Provide information on local medical and nursing resources (including health services) Provide clinical advice
Governance	Taking responsibility for the overall direction of the organisation, including the development of policy, which determines the purpose and goals of the service.
Hazard	A condition or event with the potential to cause harm to the community or environment. Natural hazards are phenomena such as disease, floods, earthquakes, bushfires, severe storms and temperature extremes. Technical hazards include transport accidents, industrial accidents and hazardous material incidents. Conflict hazards include riots, civil unrest, terrorism and war.
Hazard Analysis	Part of planning and identifies and describes risks and their potential outcomes.
Health care/health sector	Those services provided to individuals or communities by agents of the health sector or health professions, for the purpose of promoting, maintaining, monitoring or restoring health. Health care is broader than medical care, which implies therapeutic action by or under the supervision of a medical practitioner. The term is sometimes extended to include self-care.
Health Commander (AV)	Ambulance Victoria deploy a Health Commander to direct the operational health response, assemble and lead the Health Incident Management Team Represent health as a member of the Emergency Management Team Activate other key SHERP position holders or mobile specialist teams Initially notify casualty-receiving hospitals Support the Evacuation Manager in evacuating vulnerable people
Health Service	For the purpose of this document, a Health Service is the legal entity managing a group of health functions within metropolitan Melbourne.
Health Response	Immediate and ongoing reactions to save lives and meet basic human needs.
Hospital Commander	Hospital Commander is used to identify the chief executive officer or delegated member of staff who leads the health service or residential aged care service response under their site-specific response plan for external emergencies (known as a Code Brown plan). The Hospital Commander leads the Hospital Incident Management Team (HoIMT). Hospital Commanders are responsible to their organisation's chief executive and board but also have a reporting relationship to the Regional Health Coordinator during an incident. Hospital Commanders will also participate as a member of the I-HIMT and liaise directly with the Incident Health Commander (AV).
Hospital Management Centre (HoIMC)	Health service Code Brown plans should specify a room that can be used as an emergency operations centre (EOC) or similar. This area will be used for additional administration, coordination and communication functions. An alternative site should be identified in case the EOC is unavailable or unsuitable. The area should be large enough to accommodate the HoIMT and equipment. This room should either be dedicated to this purpose or able to be commandeered with minimal disruption. The HoIMT should have priority access to the room in the event of an incident.
Hospital Incident Management Team (HoIMT)	Led by the Hospital Commander, the Hospital (or health service) Incident Management Team (HoIMT) is responsible for receiving and managing all operational information related to an emergency incident. The team manage the incident from the EOC and work from the ICS based Action Cards.

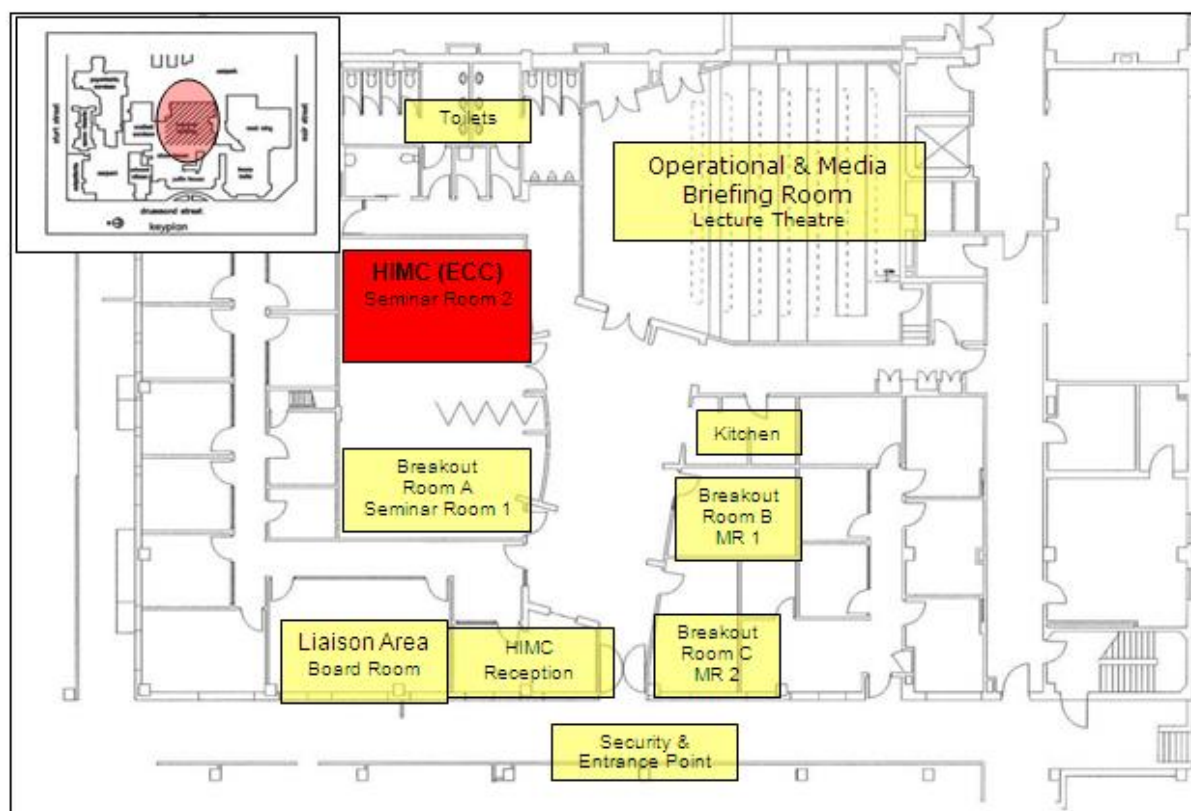
Incident Control System (ICS)	Where emergency response personnel are organised in a non-hierarchical manner, so that units work alongside one another under a coordinator, but are not subject to a vertical chain of command. The ICS method works best where units can easily be assigned different tasks, with minimal overlap, and where communication between units is excellent. Information on the incident and relief efforts is therefore equally shared among emergency workers.
Incident	An event that causes or may cause an interruption to or a reduction in the quality of the service(s) provided and requires a response from one or more agencies.
Lead Agency	An agency nominated through the health sector external emergency plans, Code Brown, to coordinate response activities for a specific emergency in the respective Health Service or Region.
Likelihood	Used as a qualitative description of probability and frequency.
Loss	Any negative consequence, financial or otherwise.
Major Incident	Any event that: <ul style="list-style-type: none"> • Presents a serious threat to the health status of a community. • Results in presentation to a health care provider or more Influenza cases or patients in number, type or degree than they are staffed or equipped to treat at that time • Cannot be dealt with by emergency services or otherwise requires a significant and coordinated response. • Leads to or represents the loss of services which prevent health care facilities from continuing to care for patients/clients.
Management	Implementing the policy determined by the governing body and coordinating the day to day service activities, which achieve the purpose and goals of the organization.
Mass Influenza cases	An influx of patients requiring assessment, treatment and care that is beyond the normal capacity of the organization to manage.
Monitor	To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify change.
National Registration and Inquiry System (NRIS)	A computer and manual system used to register evacuated and injured persons in order to inform their location to family and friends who may be seeking their whereabouts.
Organisation	A company, firm, enterprise or association, or other legal entity or part thereof, whether incorporated or not, public or private, that has its own function(s) and administration.
Plan	A formal record of agreed management roles, responsibilities, strategies, systems and arrangements.
Preparedness	Involves both <i>arrangements</i> and <i>measures</i> . <i>Arrangements</i> to ensure that, should an emergency occur, all those resources and services which are needed to cope with the effects can be sufficiently mobilized and deployed. <i>Measures</i> to ensure that, should an emergency occur, communities, resources and services are capable of coping with the effects
Public Health Liaison Officer	A liaison officer appointed the Health Incident Management Team when the DHS Public Health Branch is the control agency.
Recovery	The coordinated efforts and processes to effect the immediate, medium and long term care following a disaster.
Risk	The likelihood of an adverse event or outcome.
Risk acceptance	An informed decision to accept the likelihood and the consequences of a particular risk.
Risk analysis	A systematic use of available information to determine how often specified event may occur and the magnitude of their likely consequences.
Risk assessment	The overall process of risk analysis and risk evaluation.
Risk Identification	The process of determining what can happen, why and how.
Risk Management	A systematic application of management policies, procedures, practices to the tasks of identifying, analyzing, evaluating, treating and monitoring risk.
Risk reduction	A selective application of appropriate techniques and management principles to reduce either the likelihood of an occurrence or its consequences, or both.
Review	A formal process of updating, amending or re-planning based on evaluation outcomes.
Regional Health Coordinator	Role that provides support and coordination to the regional health system. Is a senior member of the GR Department of Health

RIEMS	Request Information Emergency Management System – an electronic communication data base system.
Risk Management	The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects. It is a process involving the systemic application of management policies, procedures and practices to the tasks of establishing the context and identifying, analysing, evaluating, treating, monitoring and communicating risk.
Rural Region	Victoria has five Rural Regional Offices as an outreach of the central Department of Health.
Service partners	Other health sector personnel and may include but not be limited to, Private Hospitals, Community Health Centres, Local Govt., General Practitioners etc.
SITREP	A situation report – provided during an incident at predetermined intervals.
Stand-by “Code Brown Stand-by”	The period, normally following an alert, when deployment of resources is imminent. Personnel are ready to respond immediately.
Activation “Code Brown Activation”	The agency is on full readiness response to the incident and has all processes and systems activated.
Stand-down “Code Brown Stand-down”	The phase when an agency’s response is no longer required, and services are wound back. Site teams are returned to base, and additional staff released from duty.
Support	The control or lead agency may need assistance from support agencies. Support agencies are either from within the same Health Service or are designated as a partner with a clear role delineated in the Code Brown plan.
Surge capacity	Surge capacity is the ability to respond/manage an unexpected increase in patient volume that would severely challenge the normal operating capacity of the Health Service/hospital.
Surge capability	Surge capability is how to address unusual or very specialized medical needs. Examples of this could be mass serious burns, SARS or infectious diseases pandemic.
Triage	The process, by which Influenza cases are sorted, prioritized and distributed, according to their need for first aid, resuscitation, emergency transportation and appropriate care.
Trigger Point	When the situation threatens to overwhelm the available resources in the area.
Victorian Medical Assistance Teams (VMAT)	<p>Reports to Field Emergency Medical Officer (FEMO)</p> <p>FEMO will recommend the scale of VMAT response required based on clinical requirements</p> <p>Nominated health services will supply a team of up to six medical and nursing personnel with PPE and clinical equipment</p> <p>VMAT may provide specialist clinical care to complex trauma patients</p> <p>VMAT may provide extended duration care to mass Influenza cases at an incident</p>

Appendix 14: Location Maps

YOUR HEALTH FACILITY Code Brown Plan should contain the following location maps:

1. YOUR HEALTH FACILITY site plan with key areas located
2. Plans that demonstrate casualty flow through YOUR HEALTH FACILITY
3. Alternate care facilities that may be used in an evacuation or to manage a casualty surge



An example of a HoIMC location map.

Appendix 15: Contact Information for Surrounding Hospitals/Health Agencies

YOUR HEALTH FACILITY Code Brown Plan may contain a list of contacts, travel distance and times for other hospitals/health facilities located near you. *The following is an example only.*

HEALTH SERVICE	CONTACT NAME	PHONE NUMBER	APPOX DISTANCE FROM CHARLTON	APPROX TRAVEL TIME
Bendigo Health Care Group	Emergency Co-ordinator 7.00am – 11.00pm After Hours: Supervisor	5454 7633 5454 8109	107kms	1 hour 12 mins
Ballarat Health Services	Ask for Patient Flow Co-ordinator If any problems ask for Admitting Officer, Emergency Department	5320 4000	174kms	2 hours 16mins
Rural Northwest Health Warracknabeal	Nurse In Charge	5396 1200 (61200)	101kms	1 hour 18mins
Rural Northwest Health Hopetoun	Nurse In Charge	5083 2000 (32000)	142kms	1 hour 45mins
Wimmera Health Care Group	Switchboard – clearly state that it is emergency call (code brown)	5381 9111	1131kms	1 hour 45mins
Stawell Regional Health	Emergency Co-ordinator	5358 8555	117kms	1 hour 30mins
East Grampians Health Service: Ararat	Nursing Supervisor In Charge	BH: 5352 9320 AH: 5352 9420	135kms	1 hours 45mins
Inglewood and District Health Service	Nurse In Charge	5431 7027	62kms	45mins
Maryborough and District Health Service: Maryborough	Director of Nursing Nurse In Charge	BH: 5461 0333 AH: 5461 0333	124kms	1 hour 27mins
Maryborough and District Health Service: Dunolly	Nurse In Charge	5468 2900	95kms	1 hour 10mins
Boort	Director of Nursing	5455 2100	47kms	36mins
Kerang	Emergency Co-ordinator	5450 9200	99kms	1 hour 16mins
Swan Hill	Executive Officer Clinical Services	5033 9300	126kms	1 hour 33mins

Appendix 16: Pandemic Influenza Direct Care Staff Record Sheet

STAFF RECORD FOR DIRECT CARE STAFF DURING PANDEMIC INFLUENZA

Access to database: Infection Control, Planning Manager

Personal ID (or addressograph label)

Name
DOB
T/N.
Address

--

Direct care capabilities

Staff category	
Co-morbidities which preclude care of Pandemic Influenza patients	
Seasonal Influenza immunisation last 12 months	
Pneumococcal immunisation (if 65 or over) last 4 years	
Certified in Respiratory PPE last 12 month	
Certified in Respiratory Isolation last 12 months	
Assessed as eligible to nurse Pandemic Influenza patients	YES / NO
Signature	Date

Pandemic Influenza Patients Nursed

Patient Name	Date commenced	Date completed	Pt. Tamiflu commenced	Staff member Tamiflu commenced	Staff member Tamiflu completed

Staff member pre and post-shift daily temperature records (Appendix 17)

Record any temperatures over 37.9°C here and date. Notify Staff Monitoring and Support Officer promptly

Occupational exposure
(Record any unprotected occupational exposure)

(Record any unprotected occupational exposure)				
Date	Patient	Circumstance	Staff Tamiflu commenced	Staff Tamiflu completed

Contracted Pandemic Influenza

Date	Tamiflu commenced	Recovered	
			Immunologically able to nurse AI patients after recovery

Leave record

[illegible]

Post-traumatic counselling

Post-traumatic Counseling		
Date offered / accepted / rejected	Commenced	Completed

Dependents at home

Dependents at home	
Name	Age
Care level	
Name	Age
Care level	
Name	Age
Care level	
Arrangement made for dependent care and date	
Would prefer not to go home if nursing Pandemic Influenza patients:	
Accommodation arrangements made (detail and for dates specified)	

Appendix 17: Pandemic Influenza Fever and Symptom Log

Sample Fever & Symptom Log – Daily

Name: _____ Date of Birth: _____

Since you may have had an exposure to _____, you need to monitor your temperature twice a day and symptoms for _____ days after your last exposure. The exact dates are _____. You have been provided this chart and a mask.

The attached chart is to record your temperature daily and any symptoms, should they occur. If you develop a fever greater than _____ or any symptoms:

- You will be referred for medical examination
- You may be asked to wear a mask over your face

You will be contacted daily to monitor your temperature and symptoms. If you have any questions, please contact _____ at _____.

You may wish to enter your health care provider's name and telephone below for easy reference should you become ill.

Health Care Provider: _____

Telephone Number: _____

Sample Fever & Symptom Log – Daily

You will be asked daily if you have experienced the following symptoms in the last 24 hours. Indicate "Y" for Yes and "N" for No

Date	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_
Medications taken today*	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
If yes, list:										
Muscle Aches	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Malaise**	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Headache	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Diarrhea	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Cough	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Shortness of Breath	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Sore Throat	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Morning Temperature										
Evening Temperature										
Other Symptoms/Comments										

*List "medications taken today." Be sure to include aspirin,

***"Malaise" is described as general feeling of being unwell, tired, fatigued, low appetite, &/or lack of energy

Appendix 18: Home Isolation Assessment Tool

Home Isolation Assessment Tool

Person Conducting Assessment:		Date of Assessment:
Patient Name	DOB:	Case ID #
Home Address:		E-mail:
Phone: home	Cell:	Other:
Case Classification	Language	Interpreter Needed? <input type="checkbox"/>

Section A. Minimum Requirements for Home Isolation

	Y	N
1. Is the patient able to understand and adhere to the following infection control measures?		
a. Hand washing?	<input type="checkbox"/>	<input type="checkbox"/>
b. Use of mask and gloves?	<input type="checkbox"/>	<input type="checkbox"/>
c. Method to take temperature and read thermometer?	<input type="checkbox"/>	<input type="checkbox"/>
d. Proper handling of soiled laundry & contaminated wastes?	<input type="checkbox"/>	<input type="checkbox"/>
e. Proper laundering of clothes?	<input type="checkbox"/>	<input type="checkbox"/>
f. Cleaning of environment?	<input type="checkbox"/>	<input type="checkbox"/>
g. Proper cleaning of dishes?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient's home have the following features?		
a. Telephone?	<input type="checkbox"/>	<input type="checkbox"/>
b. Electricity?	<input type="checkbox"/>	<input type="checkbox"/>
c. Potable water (including hot water)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Heat?	<input type="checkbox"/>	<input type="checkbox"/>
e. Separate bedroom for use by infected patient only?	<input type="checkbox"/>	<input type="checkbox"/>
f. In a multiple family dwelling, is there separate air handling?	<input type="checkbox"/>	<input type="checkbox"/>
g. Accessible bathroom with sink and commode?	<input type="checkbox"/>	<input type="checkbox"/>
h. Waste and sewage disposal (septic tank, community sewage line)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the patient have a means for washing clothes (i.e., washer in home or another individual to take laundry to an outside facility)?	<input type="checkbox"/>	<input type="checkbox"/>

4. Is there a person (inside or outside the home) or service that will supply the patient with needed supplies and services such as grocery delivery, banking, medications and other personal supplies? Name of person or service ☐ ☐
5. Does the patient have household members who are unable to independently care for them (e.g., children, disabled)? ☐ ☐
6. If the answer to #5 is yes is there someone, other than the patient, who is available to provide care for those individuals? ☐ ☐
7. Does the patient require a caregiver while in home isolation? ☐ ☐
8. If the answer to #7 is YES, is the available caregiver someone who does not have high risk complications (e.g., chronic heart or lung conditions, diabetes, immunosuppressed)? ☐ ☐
9. Caregiver contact information: Phone home: _____ Cell _____
 Pager _____ E-mail _____

Section B. Other Needs to Consider: (evaluate and respond to these factors on a case-by-case basis)

- | | Y | N |
|--|--------------------------|--------------------------|
| 1. Does the patient have a 2-day supply of the following items? | | |
| a. Dishwashing soap? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Plastic garbage bags? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Laundry soap? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Household disinfectants for cleaning? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient have access to mental health support & social resources | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the patient have social diversions (e.g., TV, radio, reading materials?) to occupy them while isolated at home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the caregiver and other household members been given isolation information and has it been reviewed by these individuals? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the patient received educational material on disease process and isolation? | <input type="checkbox"/> | <input type="checkbox"/> |

Section C. Household Contacts:

The number of household members remaining in the home during isolation should be limited to those needed for support of the patient whenever possible. If household members cannot be relocated, the suitability of the home environment for isolating patients depends on several factors, and should be made on a case-by-case basis. Those persons remaining in the home should limit patient contact and be able to follow infection control precautions. Persons with compromised immune systems and persons who require/cannot avoid close contact with the infected patient are at higher risk of acquiring infection. Some persons (i.e., those with diabetes or chronic heart or lung conditions) are at higher risk of complications if they develop infection.

Name/relationship	Age (yrs)	Will contact remain in same home as patient?	Is contact immunosuppressed, have DM, heart or lung condition?	Special needs/comments
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

Section D. Final Steps

Check when provided/done

- 1.) Home infection control starter kit (7 day supply of thermometers, gloves, masks, alcohol-based hand gel, soap for washing, facial tissues) ☐
2. Voluntary isolation order/letter given ☐

Section E. Public Health Assessment and Recommendation

☐ Home Isolation Name and relationship of caregiver _____ ☐ NA

☐ Isolation in an alternative facility

Name of Facility _____ phone # _____

Reasons for not recommending home isolation

Disposition:

☐ Patient agrees to adhere to isolation recommendation ☐ Patient refuses to adhere

Date of next follow-up assessment:

(Adapted from Seattle & King County)

Appendix 19: Establishing a Flu Clinic and Triage Forms

Guidelines for establishing a fever clinic during a Human Influenza Pandemic.

Accessed 19 May 2015

<http://www.public.health.wa.gov.au/cproot/186/2/feverclinic.pdf>

Objective: Operation of a Flu Clinic will allow effective triage, processing and treatment of large numbers of presenting cases who will be assessed into categories:

- those requiring hospital care
- those requiring intermediate care (motel or other communal facility)
- those with low grade infections, or contacts of infected persons requiring home care or quarantine

Flu Clinic Situation and Hours of Operation

The Flu Clinic will be situated at:

Hours of operation will be advertised to the community

Requirements for the Flu Clinic

Separate entrance – flow through – exit
Adequate ventilation in each room
Signage to separated “worried well” from affected persons
Reasonable space to allow social distancing
Mask and hand rub for all persons attending on arrival
Facilities for delivery of supplies, and collection of waste
Access for patient transport
Phone and computer facilities
Catering facilities and supplies
Ablution and cleaning facilities
Storage for supplies, and secure storage for medications
Reception and consulting rooms

Control and Management

The Flu Clinic will be managed by a Flu Clinic Manager who reports to the Agency Operations Manager

Human Resources

Medical Officer
Triage Nurses
Receptionists/ Ward Clerks
Nurses Cleaners
All on antivirals, and maintaining Staff Records and BD temperatures on themselves

Patient Supplies

In addition to the equipment requirements listed below, the Flu Clinic will require supplies of antiviral medications, antibiotics, and Pandemic Vaccine (when available), all kept under **secure** conditions. Supplies for Patients under the Home Care Monitoring Program include:

- Copy of Home Self Care Guidelines
- Copy of Home Monitoring Record
- Clinical thermometer
- Hospital phone number to contact the Home Monitoring Service
- Municipality(MECC) phone number to obtain home food support, if required
- Antivirals/antibiotics, when prescribed

EQUIPMENT REQUIREMENTS

<p> Auriscope Aqium Gel, Isowipes Bandages Barouches, Pillows, Linen, Tea Towels, Bath Towels, Face Cloths, Infectious Linen Bags & Trolleys Blood bottles, Swabs Blue Sheets Bottled water for mixing Paediatric medications Chairs for Patients Defibrillator Easi IV (adsyte fix) Fax machine Flu Specific Procedure Manual Oximeters Oxyviva Pans Rubbish bins Saline and water ampoules for injection mix Screens & privacy – portable Sharps Container, Swabs, B O Persist plus Splints – Arm Spyhgmomanometers Stethoscope Suction Tubing Syringes, trays, Cannula vial access Tables/Desks Tape Thermometer Torches Tourniquets Trolleys Urinals Vomit Bowls - disposable </p>	<p> Giving sets Gloves Glucometre Gowns Individual Tissues & Paper Bag Infectious bins Information Brochures IV Solutions Locked Cupboard for storage of equipment Masks: Pocket, High Filter and Ordinary for visitors/patients Medical Records (blank) Needles, adsytes, Interlink, Leur lock O₂ Masks, Vent masks, O₂ Tubing band-aids Combine dressing Dressing towel Eye pad Gauze IV additive labels Packs Rubbish bins and bags Scissors Solution Specimen bags for IMVS Water proof drape Wooden spatulas Script pads A&E forms Medication chart Referrals IMVS forms Clipboards Pens Paper Mobile Phone x 2 </p>
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Appendix 20: Antivirals

Antivirals

Control of an influenza outbreak is not possible simply by treating ill cases as they occur. In the absence of an effective vaccine, chemoprophylaxis with antiviral agents is essential if virus transmission between individuals is to be interrupted, and the outbreak curtailed and controlled. It is probably impossible for any government to stockpile sufficient antiviral medications to treat the whole population. Therefore the priorities for chemoprophylaxis will be determined by National Guidelines. These priorities will target such population sub-groups as:

- The most vulnerable age groups, e.g.: young children, immunocompromised person, including the aged
- The most vulnerable age groups for which the particular influenza virus has a predilection, e.g.: the young-adult age group in the 1918-19 Spanish Flu Pandemic
- The most at-risk occupations because of close contact with infected persons, e.g.: health care workers

Range of Antiviral Medications

The two most modern antiviral agents are Oseltamivir (Tamiflu), and Zanamivir (Relenza). These agents have the demonstrated benefit of developing less resistance over time, than earlier antivirals.

Oseltamivir has been shown to be effective in the treatment and prevention of epidemic influenza in adults, adolescents and children > 1 year. Oseltamivir is indicated for the prophylaxis of influenza in adults >13 years

Antivirals for Treatment

Treatment must be commenced within 48 hours from onset of symptoms

Oseltamivir: Adults and adolescents: 75 mg twice daily orally for 5 days
Adults with decreased renal function: 75 mg once daily for 5 days
Children 1-12 years: dose calculated on body weight

Zanamivir: Administered by inhaler. Requires cooperative patient >5 years
Children over 7 years and adults: 2 inhalations (10mg total) twice daily for 5 days

Antivirals for Prophylaxis

Prophylaxis must be commenced with 48 hours of contact with infected person

Oseltamivir: Adolescents and adults: 75 mg once daily for at least 7 weeks (safety data allows administration for up to 8 weeks) (unpublished data available on administration up to 12 weeks)
Protection only lasts while medication course is being administered

Appendix 21: Immunisation

Candidate pandemic vaccines

Candidate pandemic vaccines are based on a viral strain that is thought to have 'pandemic potential' – avian-origin H5, H7 and H9 viruses, and swine-origin H3N2 variant viruses are all presently considered strains of pandemic potential, against which vaccine seed strains have been developed. The virus strain from which these types of vaccines are made is unlikely to be an exact match to the strain that eventually causes the pandemic. If these vaccines are used they may reduce the severity of illness in those who become infected, or prevent infection in some people, but not to the extent of a customised pandemic vaccine. They may also 'prime' the immune system – potentially shortening the amount of time it takes to mount an immune response to the customised vaccine, and possibly decreasing the number of doses of customised vaccine that are required.

Customised pandemic vaccine

Customised pandemic vaccine is a specific vaccine against the pandemic virus based on the actual pandemic viral strain. As such, production of this vaccine can only begin once the actual virus has emerged. It is likely that customised pandemic vaccines will provide a significant level of protection against both infection and the development of severe illness. The exact level of protection and particular effectiveness of the vaccine in different groups (for example, the elderly, children and people with severe medical conditions) will not be known until the pandemic has begun and rapid studies are performed. The public's perceived risk-benefit profile for vaccination is likely to be dynamic, becoming less favourable over the course of a pandemic response. For this reason, clear communication throughout the pandemic response is critical to ensure good uptake of the customised vaccine.

Pandemic vaccination program

In response to a pandemic and on the availability of a suitable vaccine, the Australian Government will introduce a vaccination program in order to minimise the amount of influenza virus circulating in the community.

At the time of such a program, guidelines will be developed to provide useful information, forms, guidelines and tips to be used to implement such a program. One such example is the Panvax® H1N1 vaccine – Guidelines for administration – December 2009.

The purpose of such guidelines would be to assist immunisation providers in a range of settings to meet their professional responsibilities and community expectations for a quality program and safe service delivery.

Victoria has a wide range of immunisation providers, who may play an active role in the delivery of a pandemic vaccination program, be it mass vaccination or any other means Victorian health management plan for pandemic influenza 46 deemed suitable at the time

Principles of a pandemic vaccination program

The following areas will need to be detailed once a pandemic virus emerges:

- priority groups
- immunisation providers
- vaccine presentation and distribution
- cold chain storage
- valid consent
- pre-vaccination screening
- preparation of vaccine
- administration of vaccine
- immediate post-vaccination care
- recording and documentation
- adverse events following immunisation
- recognition and management of anaphylaxis
- reporting adverse events
- forms o vaccine order form o consent form o information sheet o anaphylaxis observation record

Key actions by stage

Preparedness

- Encourage and deliver the National Immunisation Program (including seasonal influenza and pneumococcal program).
- Promote seasonal influenza vaccination to the community including workplaces.
- Educate vaccination service providers about influenza immunisation.
- Deliver vaccination services as appropriate.
- Report adverse events following immunisation to SAEFVIC (Surveillance of Adverse Events Following Vaccination in the Community) via www.safevic.org.au

Standby

Pandemic vaccination program

- Provide input into development of a pandemic-specific immunisation program.
- Receive and manage the distribution of vaccination equipment.
- Prepare to deliver a pandemic immunisation program.

Initial/targeted action

- Coordinate a pandemic immunisation program (if/when vaccine is available).

Standdown

- • Return to preparedness activities

Appendix 22: Care of the Deceased

Care of the deceased

Infection prevention and control

Infection prevention and control policies and procedures used in the funeral industry are no different from those used in healthcare settings. Standard precautions should be taken when caring for deceased pandemic influenza cases. Standard precautions are detailed in the AFDA's Funeral industry infection control guideline (2008 edition) and include:

- individual measures such as hand hygiene, respiratory hygiene, cough etiquette and immunisation
- appropriate personal protective equipment (PPE)

Autopsy

If a patient dies during the infectious period, the lungs may still contain viable virus. There is less risk to employees from aerosols (airborne or droplet transmission) from the lungs of the deceased than from the living.

Standard and transmission-based precautions should be undertaken. The transmission-based precautions are contact and droplet precautions plus eye protection and airborne precautions for aerosol-generating procedures (Australian Government Department of Health 2014).

Mortuary care

Mortuary or funeral home staff should be informed that the deceased had pandemic influenza and that standard precautions are all that is required in the event of exposure to the body. Embalming and the hygienic preparation of the deceased (cleaning, tidying of hair, and shaving) may be conducted as routine.

Funerals

There is potential for the virus to be transmitted among those attending funerals. This risk is related to the gathering of people in an enclosed space, not to any risk placed by the body of the deceased.

However, because of the potential adverse psychological impact, it is not anticipated that funerals will be banned. To minimise transmission, however, the department may place restrictions on the type and size of the gathering, if the disease has a high clinical severity rate and moderate to high transmissibility, at certain stages in the progress of a pandemic (Australian Government Department of Health 2014).

Key actions by stage

Preparedness

- The Department of Health will liaise with VIFM, AFDA and CCAV to ensure preparedness for an influenza pandemic regarding mass fatality planning.
- Organisations should develop business continuity plans that consider an influenza pandemic.
- Promote influenza prevention activities such as:
 - seasonal influenza immunisation of staff
 - good hygiene, which includes hand hygiene and respiratory/cough etiquette
 - staying away from school, childcare, work or public gatherings if symptomatic to minimise the risk of infecting others
 - seeking medical advice if symptoms continue or get worse.

Standby

- Continue activities outlined for preparedness.
- Activate business continuity plans.

Initial/targeted response

As per standby.

Standdown

- Return to normal business.
- Review actions taken and update plans.
- Return to influenza prevention and control activities outlined for preparedness.

Grampians Region Health Emergency Management Network Code Brown Template Revisions

Date	Version	Details	Author Title
2006	1	Original Template developed based on the <i>Department of Human Services - Code Brown Framework Project</i>	Don Garlick Ballarat Health Services Tom Niederle Grampians Region Department of Human Services
2008	2	Template revised as Health Services <i>Group C and Small Rural Health Services – Grampians Region, Victoria</i>) modelled on the East Wimmera Health Services Code Brown Plan	Tom Niederle Grampians Region Department of Human Services Pat Standen Grampians Region Department of Human Services
April 2014	3	Major review and revision.	Don Garlick Ballarat Health Services Paul Burton Ambulance Victoria Janet Feeny Stawell Regional Health
Addition Sub Plan November 2015	1	Health Management Plan for Pandemic Influenza	Sue Atkins Grampians Region Department of Health & Human Services
Update Sub Plan July 2019	2	Health Management Plan for Pandemic Influenza Minor revision	Sue Atkins Grampians Region Department of Health & Human Services