

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 Ebola Virus Disease

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

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

NOTE: THERE ARE ADDITIONAL CONSIDERATIONS 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 Ebola Virus Disease 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 Ebola Virus Disease in May 2015

Ebola Virus Disease is a Class 2 Emergency

Copies of the template can be located on the Grampians Region Health Collaborative webpage under Emergency Management:

<http://grhc.org.au/em-main/em-resources>

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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, or special disease event) that threatens a facility, or an external mass casualty incident that will result in large numbers of cases presenting to a health facility, or small numbers of a new or unknown disease disrupting business as usual and using a large volume of physical and human resources to manage.

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
DMS	Director Medical Services
DHHS	Department of Health and Human Services
EM	Emergency Management
EOC	Emergency Operations Centre (EOC)
ESO	Emergency Services Organisation
EVD	Ebola Virus Disease
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

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*.

Source: Victorian Ebola Virus Disease Plan Version 3: May 2015

10. A higher risk exposure is a term that will be used in Victoria to include any of the following:

- percutaneous or mucous membrane exposure to blood or body fluid of an EVD patient;
- direct skin contact with or exposure to blood or body fluids of an EVD patient without appropriate personal protective equipment (PPE);
- processing blood or body fluids of a confirmed EVD patient without appropriate PPE or standard biosafety precautions;
- direct contact with a dead body without appropriate PPE in an EVD-affected area;
- people who had direct contact with bats or primates (alive or dead), or who had consumed ‘bushmeat’ in EVD endemic areas.

11. A lower risk exposure is a term that will be used in Victoria to encompass direct contact without evidence of visible or recalled blood or body fluid contact, and will include any of the following:

- household contact of a confirmed case of EVD;
- other close contact with a confirmed case of EVD in health care facilities or community settings, with ‘close contact’ defined as:
 - i. being in the same room as a patient with active vomiting or diarrhoea or coughing while not wearing appropriate PPE (i.e. as per standard, contact and droplet precautions), or
 - ii. being within the same room as a patient where there is an aerosol generating procedure being undertaken while not wearing appropriate PPE (i.e. standard, contact, droplet and airborne precautions), or
 - iii. having direct brief skin contact (e.g. shaking hands) with an EVD patient while not wearing appropriate PPE in the absence of any recognised body fluid or blood exposure.

12. A casual exposure is a term that will be used in Victoria to cover:

- being in the near vicinity of a case with possible contact with a shared surface without appropriate PPE.

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Adapted by: Grampians Region Infection Control Group November 2015	Review Date: June 2017
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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.

GOVERNANCE

Source: Victorian Ebola Virus Disease Plan Version 3 May 2015

28. If a suspected or confirmed Ebola event has been identified to be an emergency in Victoria, under Victoria's *Emergency Management Act 2013*, that event would be classified as a Class 2 emergency. Under that legislation, Victoria's Emergency Management Commissioner would:
- be responsible for coordinating the activities of agencies with roles or responsibilities in relation to the response to Class 2 emergencies;
 - ensure that control arrangements are in place during a Class 2 emergency;
 - be responsible for consequence management for a major emergency;
 - be responsible for coordinating recovery; and
 - coordinate data collection and impact assessment processes.
29. Victoria's Chief Health Officer (DHHS) is the Incident Controller for EVD preparedness and response in Victoria. The Department of Health & Human Services has a lead responsibility for recovery arrangements.
30. A State Health Incident Management Team (SHIMT) will be formed under both the State Health Emergency Response Plan (SHERP) and Department of Health's Public Health Control Plan.
31. In the event of a confirmed case of EVD, the membership of the SHIMT will be augmented by representatives of any health service that has admitted the case, aiming for a representative of the executive of the health service, a lead for infectious diseases, and a lead for infection control.
32. In the event of a confirmed case of EVD, the CHO will request the Emergency Management Commissioner to convene a State Emergency Management Team (SEMT) meeting, comprising representatives of response and support agencies.
33. Under SHERP, it is expected that a health service where a patient is admitted with confirmed EVD would convene a health service Incident Management Team (IMT). In order to maintain high quality liaison with the State response, DHHS may provide a DHHS Liaison Officer to attend meetings of any health service IMT that is formed in response to a suspected or confirmed case of EVD.
34. The *Victorian Ebola Virus Disease Plan* will be reviewed and exercised annually and debriefs conducted to improve practice and adjust the Plan following relevant incidents, or suspected and confirmed cases.

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Patient and specimen management

Patient transfer and destination health service

Designated adult hospital for suspected and confirmed EVD cases

35. The designated hospital for receiving any adult suspected or confirmed case of EVD is the Royal Melbourne Hospital Victorian Infectious Diseases Service (RMH-VIDS).
36. In the highly unlikely event of multiple suspected or confirmed EVD cases that exceed the normal capacity of RMH-VIDS, an urgent meeting will take place with the DHHS State Health and Medical Commander or delegate to determine case management options.
37. There is a strong preference for all cases of EVD in Victoria to be managed at RMH-VIDS or The Royal Children's Hospital (RCH), and for other services to be scaled back to accommodate this, rather than placing EVD cases across the hospital system in Victoria.
38. A suspected or confirmed case of EVD in a pregnant woman, including a woman in labour, will be directed to RMH-VIDS. RMH-VIDS will activate a request to the Royal Women's Hospital to provide assistance as needed, including obstetric and midwifery expertise, so that all required care can be provided at RMH-VIDS.

Designated paediatric hospital for suspected and confirmed EVD cases

39. A person who is under 16 years of age and who is a suspected or confirmed case of EVD will be admitted to the Royal Children's Hospital (RCH) for assessment and testing, after a discussion between the CHO or delegate and the duty emergency department consultant at RCH.

Framework for assessing need for patient transfer to a designated hospital

40. The most likely places where a suspected case of EVD could present are Melbourne Airport or a hospital emergency department.
41. The likelihood of EVD in a returned traveller without lower or higher exposures from areas with EVD transmission is generally very low, compared to other potential causes of febrile illness.
42. A framework is described below for decision-making on transfer to RMH-VIDS / RCH of a suspected case.
43. The following cases will generally be transferred to RMH-VIDS / RCH as a matter of urgency:
 - a confirmed case;
 - a suspected case with higher risk exposures and a highly consistent clinical picture.

44. The presence of any of the following factors will favour transfer to RMH-VIDS / RCH before confirmation of EVD. These factors will be considered in a discussion between DHHS, RMH-VIDS / RCH and the referring health service:
- Higher likelihood of EVD:
 - i. clinical features highly consistent with EVD in view of an infectious diseases specialist;
 - ii. an agreed higher or lower risk exposure;
 - Criticality of patient allied to need for urgent pathology:
 - i. patient is critical or requires intensive care;
 - ii. urgent need for general pathology;
 - Lower negative predictive value of initial testing to exclude EVD:
 - i. indeterminate result on initial VIDRL testing;
 - Lower capability of health service to handle a suspected case:
 - i. health service does not have appropriate infection prevention and control capability;
 - ii. health service does not have access to infectious diseases expertise.
45. The Chief Health Officer or their delegate will decide on whether transfer will occur, and to where.
46. A case that is to be transferred to RMH-VIDS or RCH after consideration of the above factors will have all testing done at the receiving hospital, including for EVD and routine pathology.
47. A patient who remains at the presenting health service after assessment against this framework will have any clinical specimens collected at that health service for transport to VIDRL for EVD testing ('Test and Hold' strategy), and routine pathology should be avoided until EVD is excluded.

Ambulance transfer arrangements

48. Ambulance Victoria (AV) is equipped to transfer suspected or confirmed cases of EVD in Victoria.
49. AV will use infection prevention and control precautions as recommended for clinical care in this guidance for the transfer of suspected cases. Where there are copious amounts of blood or body fluid, additional PPE could be required as described in the section on infection prevention and control (*see points 84 to 100*).
50. Whenever possible, DHHS will activate a transfer of a suspected case by calling AV directly on an agreed number.
51. A medical practitioner at a sending hospital, or at a primary care setting, should not generally activate a transfer by AV unless the situation is critical, and the practitioner has been unable to contact DHHS for any reason.
52. For a paediatric patient requiring specialised retrieval, RCH will coordinate retrieval through either the Paediatric Emergency Transport Service (PETS) or the Neonate Emergency Transport Service (NETS).

Transfer of accompanying parents or carers with minors

53. If a suspected case is a young child, well parents or carers may request to transfer to the receiving health service with them. This will require a risk assessment regarding the level of suspicion for EVD and potential infectivity of the case. As a general rule:

- If the case only has 'dry' symptoms (such as fever, myalgia or headache), then a single parent or carer at the discretion of DHHS may be permitted to accompany the child during transfer if the parent or carer is wearing appropriate PPE and remains at least 1 metre away from the case if possible, avoiding physical contact;
- If the case has any 'wet' symptoms (i.e. vomiting, diarrhoea or bleeding), then the parent or carer will not be able to transfer with the case and alternative arrangements for travelling to the receiving health service should be arranged.

International repatriation of a confirmed case

54. If there is a need to repatriate a confirmed EVD case back to Victoria from an affected country, the handling and responsibility will rest with the Commonwealth Department of Health, in consultation with the Chief Health Officer.

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>

Grampians Region Department of Health & Human Services

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 the Grampians Regional Office. The GR Regional Emergency Operations Centre (REOC) is activated initially via the REOC 24/7 emergency notification line.

GR REOC activation number	5338 7928
GR REOC site	Cnr. Dana & Armstrong Streets, Ballarat
GR REOC email	grampianshealthcoordinator@grampians.vic.gov.au
DHHS Communicable Disease Melbourne	1300 651 160

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 3 and 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.

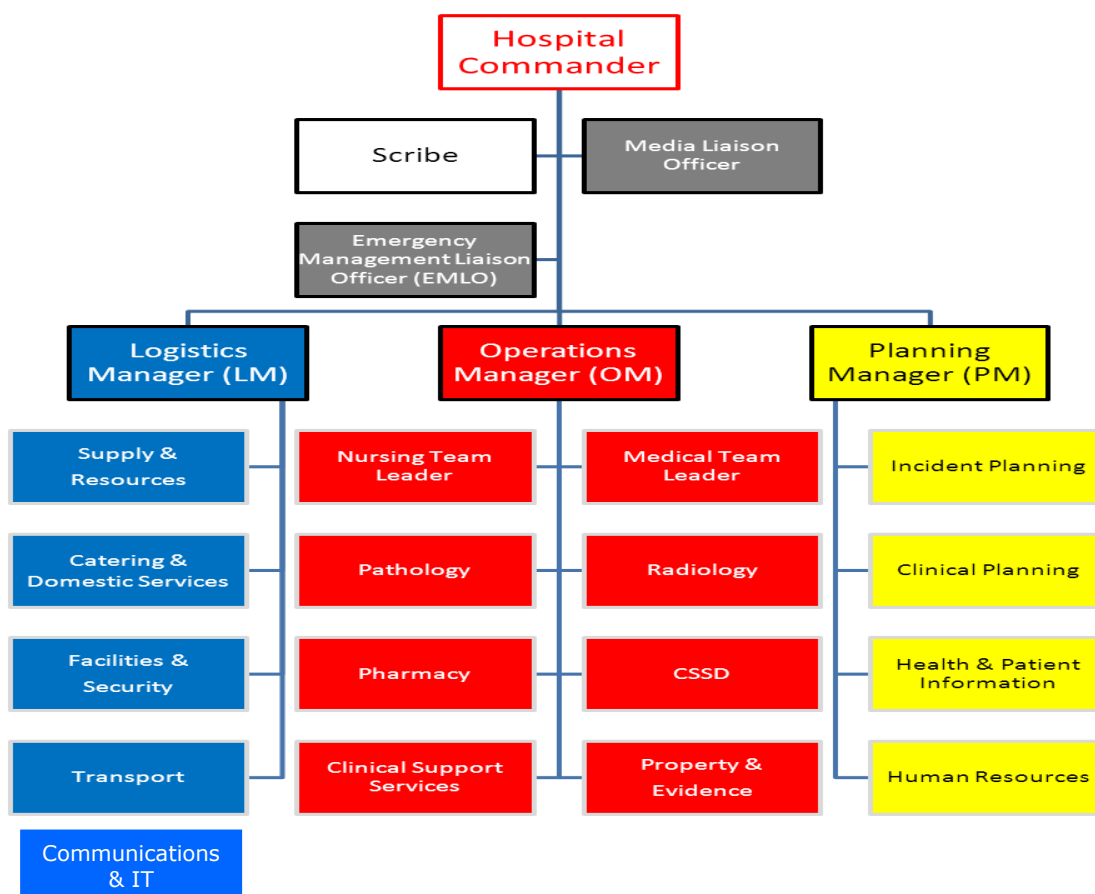
Early isolation of that physical evidence, with a continuity chain linking it to its place in the scene, is the best result for investigators. This can be summarized into the catch-phrase – **“BAG, TAG, SEAL and SECURE”**.

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 Ebola Virus Disease Code Brown Sub Plan and assume role of Hospital Commander (HoC)
- **Immediately liaise with DHHS Communicable Diseases Melbourne 1300 651 160**
- 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 Grampians Regional Office (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 listed 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 ED or urgent care is closed or placed on bypass)
- 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 – Appendix 3) and approve the IAP
- 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

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 as required
- Ensure provision of staff rest periods and relief
- Ensure a list of all staff involved in direct patient care is completed for the designated patient care area. This information must align with the PPE checklist completed at each episode of care by all direct care staff and reviewed each shift
- 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 8 hours including HoIMT members. Two staff (Trained Observer and Healthcare Worker) are required each time staff provide care for a suspected or confirmed Ebola Virus Disease (EVD) patient. Staff required to wear PPE for patient care should not remain in this equipment for more than 30-40 minutes duration at any one time.
- 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 42 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 (Appendix 5)
- 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 HoIC

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 42 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
- 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,
 - Counselling, staff health monitoring and support
 - Infection Control
- 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)
- Consider patient placement, flow and segregation including systems to separate suspected and confirmed EVD cases, patient isolation, family waiting area to limit cross infection. Inform HoIMT & senior staff of decisions
- Determine resources required (eg additional space, clinical staff and protective equipment, waste management requirements and environmental cleaning) Appendix 9
- Notify nearest Radiology, Pathology and Pharmacy services as required
- Consider support services (orderly/security)
- Liaison with Planning and Logistics staff to effect appropriate to affect:
 - Review emergency department/ urgent care patient flow, if unable to separate EVD patients from other patients in this area consider closing or placing this area on bypass
 - Appropriate protective equipment availability (Appendix 13)
 - Waste management requirements (Appendix 15)
 - Environmental cleaning requirements (Appendix 16)
- Advise all Managers to maintain a high level of vigilance for correct use of PPE, completion of PPE checklist and the specimen collection checklists (Appendix 13a and 14)

Ongoing:

- Obtain regular information and updates from operations team members and pass 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
- Consider requesting the cessation of normal activities as indicated
- Carry out the necessary operational strategies outlined in the IAP (Appendix 3)

- Maintain an Incident Log (Appendix 5)
- 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 relevant area. (Liaison with Planning Manager to maintain Emergency Management Structure Diagram)
- Ensure that all staff, patients and their family are observed for signs of stress or fatigue
- 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 42 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 (Appendix 5)
- 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 42 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 (Appendix 5)
- 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 42 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 and track (Appendix 9)
- Call in staff placed on stand by, as required
- Respond to requests for additional equipment and supply needs including PPE (Appendix 13) and clinical waste management containers (Appendix 15)
- 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 42 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 (Appendix 16)
- 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
- Provide support to other areas as required
- Maintain patient services
- Ensure appropriate systems in place to maintain appropriate hygiene and food handlings standards
- Determine strategy for collection and secure storage for increased volumes of clinical waste (Appendix 15)
- 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 42 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
- Remove unauthorised persons from restricted areas
- Maintain hospital access for authorised vehicles only
- Secure patient care areas, ED and triage areas 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

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 42 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 42 for further information that may be related to your role

Communications and IT

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 42 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 all staff on duty trained in the use of PPE for EVD to remain on duty to assist if required
- Obtain a briefing from Operational Manager
- Designate staff member to contact off duty staff trained in the use of PPE for EVD and place them on standby noting their availability
- Prepare to transfer emergency department/ urgent care patients out to acute care wards if necessary. Consult with Medical Team Leader
- Assess current stocks of relevant supplies and prepare list:
 - Medical consumables
 - PPE (Appendix 13)
 - Waste management containers (Appendix 15)
 - Cleaning equipment (Appendix 16)
- Liaise with Infection Control manager regarding infection prevention strategies.
- Familiarise with case definition (Appendix 11)
- Ensure staff are aware of appropriate infection control precautions, including necessity to use a trained observer for putting on and removing PPE (Appendix 13a)

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 medical team leader/ 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 via alternative route.
- 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 if required (Appendix 13 and 13a)
- Ensure checklists (Appendix 13a and 14) are completed by every staff member who provides care to a suspected or confirmed EVD patient, and these are reviewed each shift for potential issues
- Monitor staff for signs of illness, liaise with Infection Control manager to discuss concerns as required
- Keep staff alert to identify and report all hazards/unsafe conditions to the OM
- Ensure awareness of protocols for care of the deceased (Appendix 17)

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 42 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/ Coordinator
- Familiarise with case definition (Appendix 11)
- Liaise with Nurse In-Charge regarding current In-Patient requirements, discharges or transfers
- Undertake assessment of emergency department/ urgent care with the Infection Control Manager/ Coordinator

Activate

- Liaise with **DHHS Communicable Diseases Melbourne 1300 651 160**
- Assess incoming emergency patients in conjunction with nursing staff
- Provide Situation Reports to the Operations Manager and/or Hospital Commander and infection Control manager/ Coordinator
- Access medical support as required

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 42 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 if prior arrangement documented

Activate

- Receive Situation Report from Operations Manager
- Specimens are only taken as directed by **DHHS Communicable Diseases Melbourne 1300 651 160**
- EVD Specimen Collection, Packaging, and Transportation checklist to be used (Appendix 14)
- Provide regular Situation Reports to Operations Manager (Appendix 2)

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 42 for further information that may be related to your role

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 if prior arrangement documented

Activate

- Receive Situation Report from Operations Manager
- Contact Service Provider and activate emergency arrangements
 - Provide Radiology services
- Provide regular Situation Reports to Operations Manager (Appendix 2)

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 42 for further information that may be related to your role

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 such as IV rehydration solutions, malaria treatment, antibiotics as required. Assess current stock supplies across the Health Service
- Preparation of list of requirements
- 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 (Appendix 2)

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 42 for further information that may be related to your role

CSSD

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 42 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
- Liaison with Victoria Police representative may be required. In particular vehicle used to transport patient to hospital may require quarantine until further assessment completed.
- Appropriately bag, tag, record and store evidence in line with Incident Property and Evidentiary Log
- 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 (Appendix 2)

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 42 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 (Appendix 10)
- Contact off duty staff and place them on standby noting their availability. These staff may be required for "business as usual" in acute care wards to replace EVD trained staff deployed to emergency/urgent care.

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 (Appendix 2)

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 42 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 – Appendix 3)
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 42 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 EVD trained staff (Appendix 10)
- If required gather available trained staff 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 42 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

Activate

- Assist in the assignment of available EVD trained 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 (Appendix 2)

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 42 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 (Appendix 8)
- 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 (Appendix 2)

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 42 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 (Appendix 2)

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 42 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 (Appendix 2)

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 42 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.

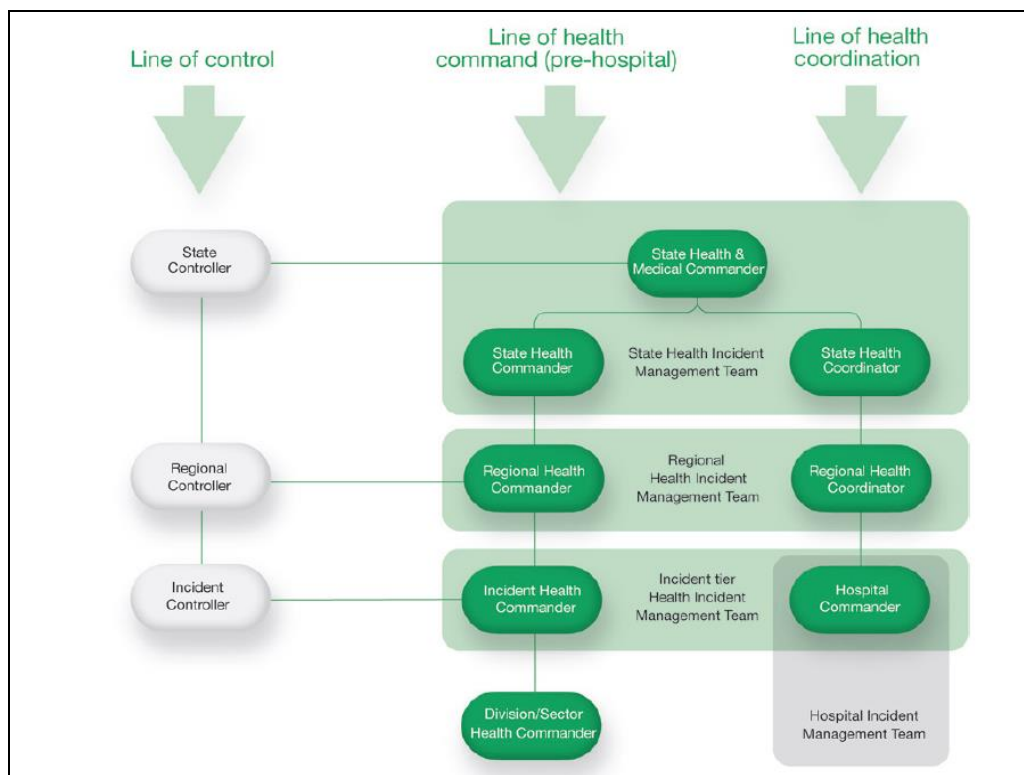
State Health Emergency Response Plan

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:

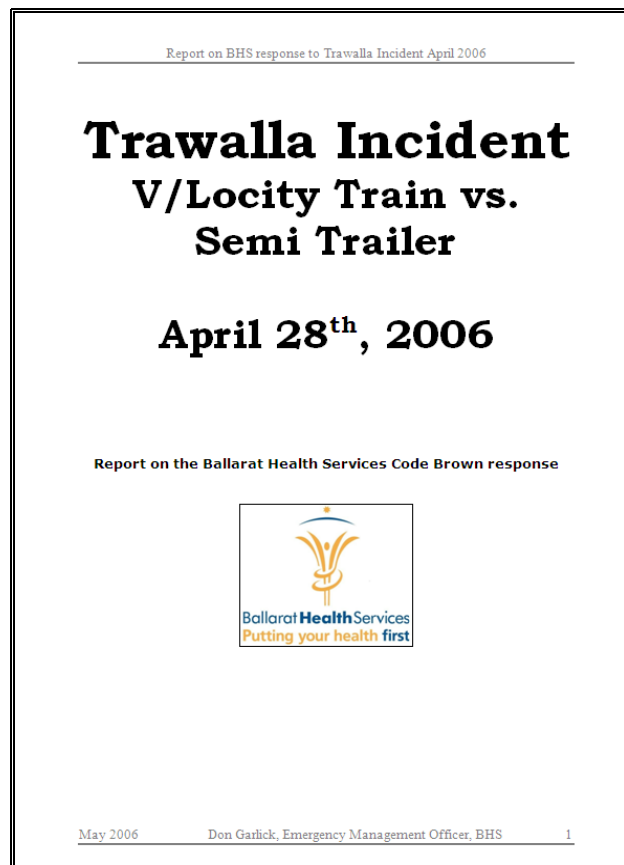
- What happened
- Where it happened
- How it happened (if known)
- How it was reported/alarm raised
- The sequence of events
- Who were involved in the incident
- What went wrong
- Need for changes to procedures or equipment etc
- What went right
- Recommendations

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:	Consequence:
Rare: Could happen but probably never will	1: Insignificant
Unlikely: Could happen	2: Minor
Moderate: Could occur at some stage	3: Moderate
Likely: Will probably occur	4: Major
Almost certain: Could easily happen	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: _____		Likelihood		Consequence		Risk Rating		Status	
Date last Updated: _____		5 Almost Certain		5 Extreme		Consequence		A Addressed	
Prepared by: _____		4 Likely		4 Major		5 Extreme		IP In Progress	
		3 Possible		3 Moderate		4 Extreme		NA Not Addressed	
		2 Unlikely		2 Low		3 High			
		1 Rare		1 Negligible		2 Medium			
						1 Medium			
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
	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	

**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

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 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.

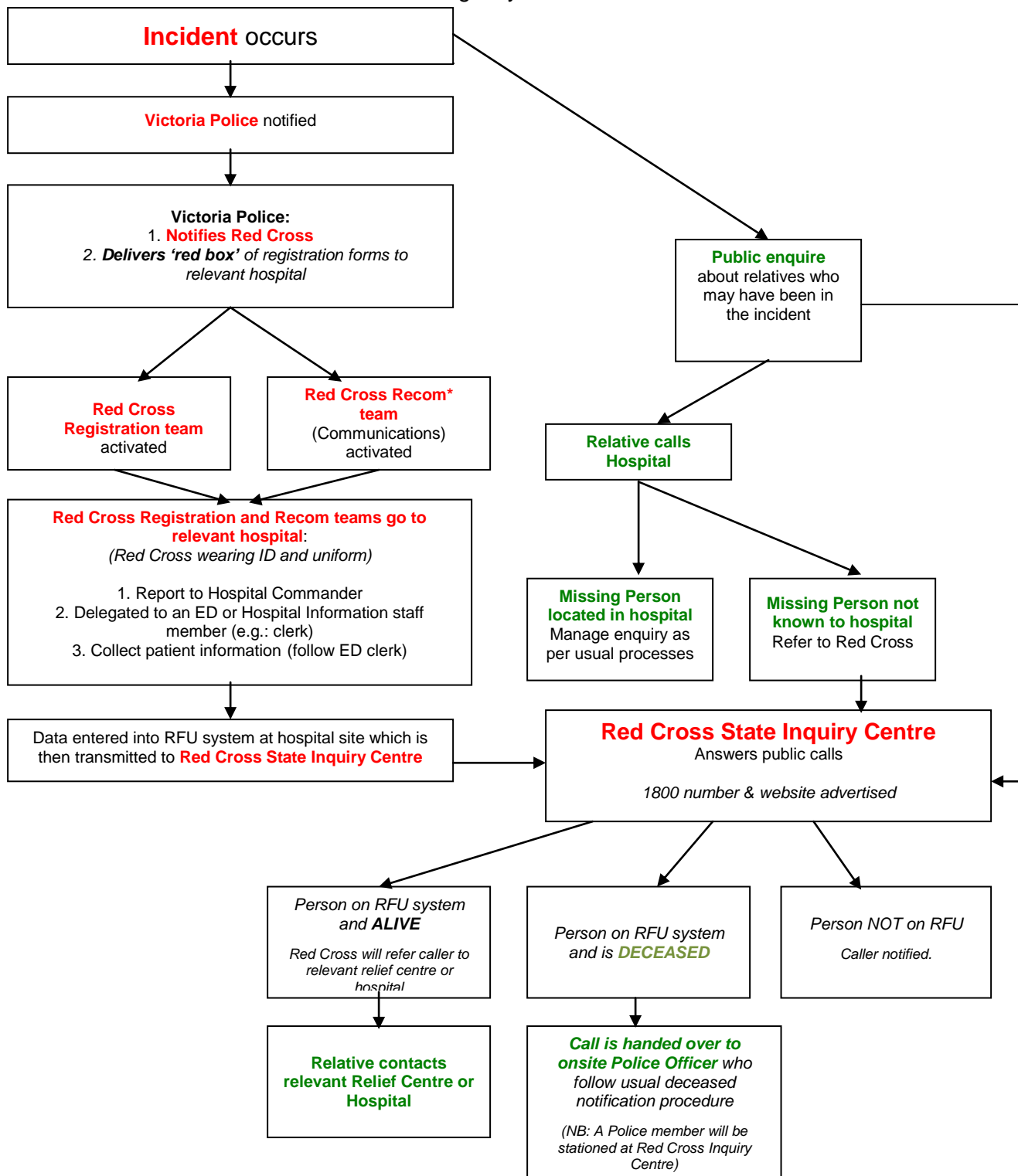
In significant emergencies Red Cross would establishes the State Inquiry Centre (1800 727 077) for all enquiries from the public. The current system for collecting information would require Red Cross staff to attend the individual hospital(s) to obtain the data.

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

[illegible]

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: 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 Pathology on site Radiology on site Pharmacy 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</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 CLINIC	
FAX	

Appendix 11: Case Definition

Source: Victorian Ebola Virus Disease Plan Version 3 May 2015

Case definitions in Victoria

6. Persons under investigation (PUI) for Ebola Virus Disease (EVD), and suspected or confirmed cases of EVD, are subject to quarantine provisions and are considered to have a Group A notifiable condition requiring immediate notification under the *Public Health and Wellbeing Regulations 2009*.
7. A medical practitioner who has reasonable grounds to believe that a patient has, or may have EVD must under law notify DH immediately on **1300 651 160** to enable an assessment by the Chief Health Officer (CHO) or delegate, and to trigger other immediate public health actions.
8. Any other health professional who identifies a PUI or suspected case of EVD must also notify DHHS, unless they are sure a notification has already been made.
9. The determination of an individual as a PUI or suspected or confirmed case of EVD will be made by the CHO or delegate, in consultation with an infectious diseases expert.
10. A **higher risk exposure** is a term that will be used in Victoria to include any of the following:
 - percutaneous or mucous membrane exposure to blood or body fluid of an EVD patient;
 - direct skin contact with or exposure to blood or body fluids of an EVD patient without appropriate personal protective equipment (PPE);
 - processing blood or body fluids of a confirmed EVD patient without appropriate PPE or standard biosafety precautions;
 - direct contact with a dead body without appropriate PPE in an EVD-affected area;
 - people who had direct contact with bats or primates (alive or dead), or who had consumed 'bushmeat' in EVD endemic areas.
11. A **lower risk exposure** is a term that will be used in Victoria to encompass direct contact without evidence of visible or recalled blood or body fluid contact, and will include any of the following:
 - household contact of a confirmed case of EVD;
 - other close contact with a confirmed case of EVD in health care facilities or community settings, with 'close contact' defined as:
 - i. being in the same room as a patient with active vomiting or diarrhoea or coughing while not wearing appropriate PPE (i.e. as per standard, contact and droplet precautions), or
 - ii. being within the same room as a patient where there is an aerosol generating procedure being undertaken while not wearing appropriate PPE (i.e. standard, contact, droplet and airborne precautions), or
 - iii. having direct brief skin contact (e.g. shaking hands) with an EVD patient while not wearing appropriate PPE in the absence of any recognised body fluid or blood exposure.

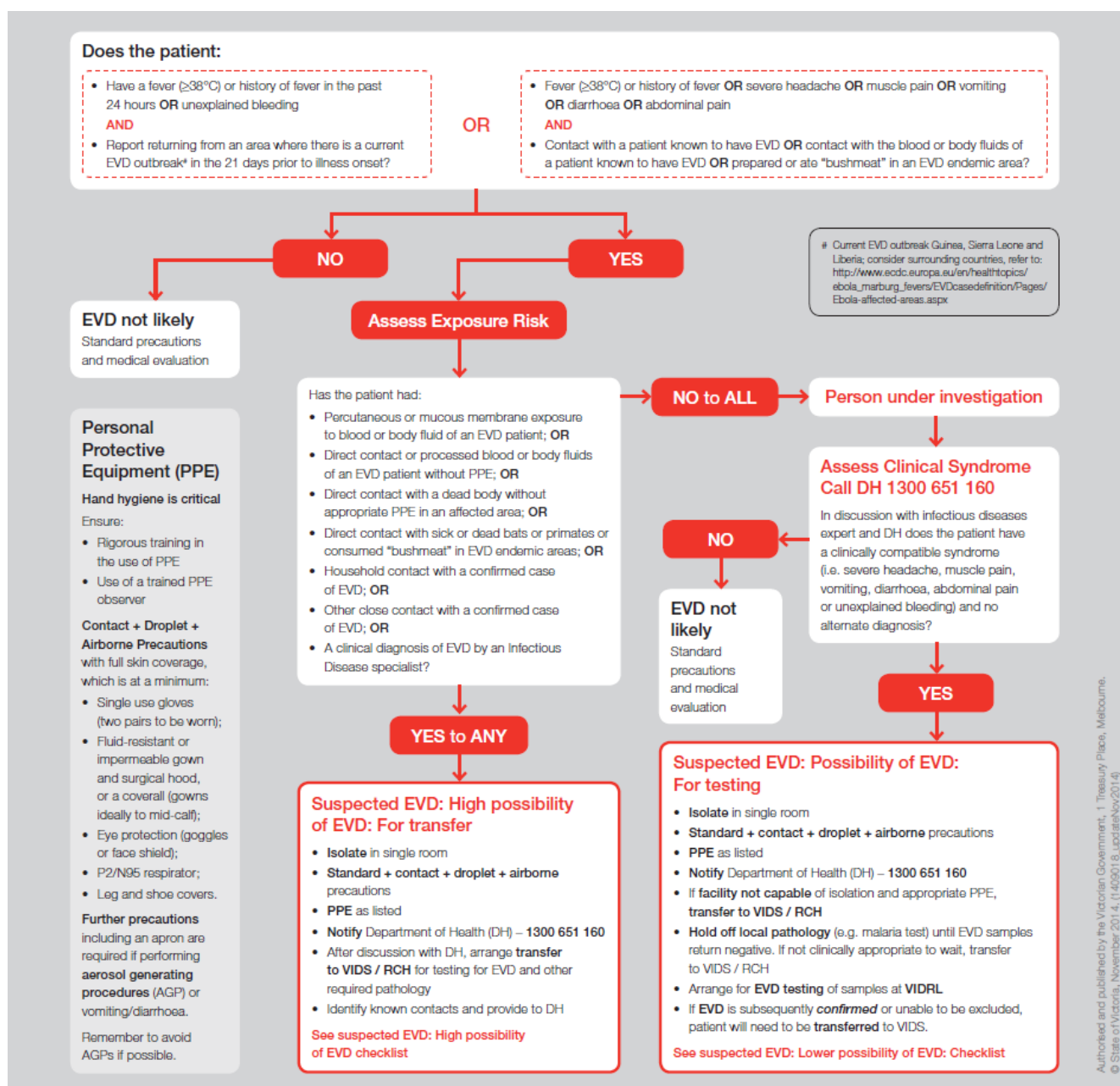
12. A **casual exposure** is a term that will be used in Victoria to cover:
- being in the near vicinity of a case with possible contact with a shared surface without appropriate PPE.
13. **Clinical evidence** means any of the following:
- fever $\geq 38^{\circ}\text{C}$ or history of fever in the last 24 hours **OR**
 - unexplained haemorrhage or bruising **OR**
 - any one of severe headache, muscle pain, vomiting, diarrhoea or abdominal pain **IF** there is agreed evidence of a higher or lower risk exposure.
14. **Limited epidemiological evidence** means:
- residence in, or travel to, an EVD affected area or a casual exposure in the past 21 days or in the 21 days prior to disease onset.
15. **Epidemiological evidence** means:
- a higher risk exposure or a lower risk exposure in the past 21 days or in the 21 days prior to disease onset.
16. **Laboratory suggestive evidence** means at the Victorian Infectious Diseases Reference Laboratory (VIDRL):
- detection of Ebola virus by Polymerase chain reaction (PCR), Enzyme Linked Immunosorbent Assay (ELISA) or electron microscopy **OR**
 - virus isolation **OR**
 - IgG seroconversion or a four-fold or greater rise in titre to Ebola virus **OR**
 - IgM detected against Ebola virus antigen.
17. **Laboratory definitive evidence** means at the Centre for Disease Control (CDC) Special Pathogens Laboratory Atlanta, or National Institute of Virology (NIV) Johannesburg:
- detection of Ebola virus by PCR, ELISA **OR**
 - virus isolation **OR**
 - IgG seroconversion or a four-fold or greater rise in titre to Ebola virus.
18. A **person under investigation (PUI)** is a case with clinical evidence **AND** limited epidemiological evidence only.
- This is a category that is designed to indicate a substantially lower likelihood of EVD and an agreement may be reached not to test such a case for EVD if there is compelling evidence of an alternative diagnosis, and agreement between an infectious diseases expert and the CHO that the alternative diagnosis is the cause of illness.
 - The CHO may determine that testing for EVD is appropriate for a PUI. Once the CHO has determined that a PUI should be tested for EVD, that case will be managed in exactly the same way as a suspected case, and will from that point forward be referred to as a 'suspected case of EVD' until testing is undertaken when there will be a further assessment of the case status of the individual.
19. A **suspected case of EVD** is a case with clinical evidence **AND** epidemiological evidence.
20. A **confirmed case by Victorian Infectious Diseases Reference Laboratory (VIDRL)** of EVD requires laboratory suggestive evidence only [note this is defined as

a 'Probable case' in the CDNA guidelines].

21. A **confirmed case by CDC Atlanta or National Institute of Virology in Johannesburg** of EVD requires laboratory definitive evidence only.
22. A case is considered rejected on the determination of the CHO, and may be based on advice from an infectious diseases physician. In some circumstances, a case could remain a suspected case despite an initial negative PCR on blood if the onset of illness was within 72 hours of the initial test **AND**
 - there is no likely alternative diagnosis **OR**
 - clinical suspicion of EVD is high **OR**
 - the CHO remains concerned that EVD is not excluded.
23. For the rest of this document, a 'confirmed case' refers to a confirmed case at VIDRL or a confirmed case at CDC Atlanta or in Johannesburg.
24. As recommended by CDC Atlanta, brief interactions (such as walking by a person or moving through a hospital where a confirmed case of EVD is admitted) do not constitute contact with a case.

Appendix 12: Triage














Source: <https://www2.health.vic.gov.au/emergencies/emergency-type/infectious-diseases/ebola>



Department of Health



Appendix 13: PPE Requirements

PPE Requirements for Healthcare Workers During the Management of Suspected or Confirmed EVD Patients Equipment List	
Respirator N95/P2 Mask 	Disposable Boots (if used) 
Face Shield 	Boot or Shoe Covers 
Gloves – Nitrile 	Disposable Apron 
Impervious Long Sleeve Gown 	Alcohol Based Hand Rub 
Impervious Surgical Hood 	Disinfect Wipes (Clinell®) 
Disposable/Single Use Scrubs 	Disinfectant Pad (for disinfecting sole of boots or shoes) 
Hair Covers (If used) 	Clinical Waste Container/Bags – Containment System 

Grampians Region Checklist for Putting On and Taking Off PPE for EVD – Equipment List version1: December 2014

Guidance on Personal Protective Equipment (PPE) To Be Used by Healthcare Workers During the Management of Patients with Ebola Virus Disease in Grampians Region Hospitals



Check List

Putting On (Donning) PPE

Removing (Doffing) PPE

Sources:

Victorian Ebola Virus Disease Plan Version 2: 12 November 2014.

CDC Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During the Management of Patients with Ebola Virus Disease In US Hospitals (accessed 15 December 2014)

Check List

Putting On (Donning) PPE

Removing (Doffing) PPE

Important Messages Before Commencing

Checklist

The trained observer will be in the PPE removal area to observe and assist with the putting on and removing of PPE as outlined below. While the observer will not participate in any Ebola patient care activities while conducting observations, the trained observer should wear the same PPE as the patient's healthcare worker according to the same procedures outlined below. This is to ensure that the observer is ready in the event that immediate support is required for the patient's healthcare worker such as a PPE breach or fatigue. If this occurs another observer should be engaged to assist both in removing their PPE.

The trained observer will get ready first, with the patient's healthcare worker assisting using the checklist. The trained observer will then complete the same checklist and assist the patient's healthcare worker to put on and remove PPE.

It is difficult to wear full PPE for any length of time due to fatigue and /or heat exhaustion. Therefore; it is recommended that the trained observer and healthcare worker caring for an EVD patient should be relieved for a break after 30-40 minutes.

To prepare for removal the patients' healthcare worker will verify that the trained observer is available in the PPE removal area before leaving the patient's room and before entering the designated removal area and beginning the PPE removal process.

If the trained observer assists with PPE Removing, then the trained observer should disinfect outer-gloved hands with an Alcohol based Hand Rub (ABHR) immediately after contact with healthcare worker's PPE. If the Trained Observer enters the patient care area for any reason then the checklist is followed and completed for the removal of their PPE. In this instance another trained observer would be required to facilitate the removal process for both healthcare workers.

Putting On (Donning) PPE Check List 14 Steps

This Putting On PPE check list assumes the facility has elected to use N95/ P2 respirators.

One document to be fully completed for the observer and patient's healthcare worker for each episode of care.

Date and Time

.....

Trained Observer Name/Designation

.....

**HealthCare Worker Entering the Patient Room
Name/Designation**

.....

The trained observer is to verify successful compliance with this check list.
There are 14 steps for Putting On PPE.

CHECK LIST		
Observer	Patient's HCW	Putting On (Donning) PPE
<input type="checkbox"/>	<input type="checkbox"/>	Step 1 Engage Trained Observer: The Putting On process is conducted under the guidance and supervision of a trained observer who confirms visually that all PPE is serviceable and has been put on successfully. The trained observer will use a written checklist to confirm each step in Putting On PPE and can assist with ensuring and verifying the integrity of the PPE. No exposed skin or hair of the healthcare worker should be visible at the conclusion of the Putting On process.
<input type="checkbox"/>	<input type="checkbox"/>	Step 2 Remove Personal Clothing and Items: Change into surgical scrubs (or disposable garments) and dedicated disposable or washable (plastic or rubber) footwear in a suitable, clean area. No personal items (e.g. jewellery, watches, cell phones, pagers, pens) should be brought into patient room. Ensure hair is tied back and out of eyes.
<input type="checkbox"/>	<input type="checkbox"/>	Step 3 Inspect PPE Prior to Putting On: Visually inspect the PPE to be worn to ensure it is in serviceable condition, all required PPE and supplies are available, and that the sizes selected are correct for the healthcare worker. The trained observer reviews the Putting On sequence with the healthcare worker before the healthcare worker begins and reads it to the healthcare worker in a step-by-step fashion.
<input type="checkbox"/>	<input type="checkbox"/>	Step 4 Perform Hand Hygiene: Perform hand hygiene with ABHR. When using ABHR, allow hands to dry before moving to next step.
<input type="checkbox"/>	<input type="checkbox"/>	Step 5 Put on Boot or Shoe Covers (only if reusable shoes or boots are used): Sitting down in chair marked clean to ensure safety.
<input type="checkbox"/>	<input type="checkbox"/>	Step 6 Put on Inner Gloves: Put on first pair of gloves.
<input type="checkbox"/>	<input type="checkbox"/>	Step 7 Put on Gown: Put on gown. Ensure gown is large enough to allow unrestricted freedom of movement. Ensure cuffs of inner gloves are tucked under the sleeve of the gown.
<input type="checkbox"/>	<input type="checkbox"/>	Step 8 Put on N95/ P2 Mask: Fit Check <u>Gently inhale.</u> When you breathe in the mask should draw slightly towards the face and collapse. <u>Gently exhale.</u> The mask should fill up with air. It is important at this stage that there is NO air leakage around the edges of the mask.

<input type="checkbox"/>	<input type="checkbox"/>	Step 9 Put on Surgical Hood: Over the N95/ P2 mask, place a surgical hood that covers all of the hair and the ears, and ensure that it extends past the neck to the shoulders. Be certain that hood completely covers the ears and neck. Disposable hair covers may be used to prevent hair from hanging down.
<input type="checkbox"/>	<input type="checkbox"/>	Step 10 Put on Outer Apron (if used): Put on full-body apron to provide additional protection to the front of the body against exposure to body fluids or excrement from the patient.
<input type="checkbox"/>	<input type="checkbox"/>	Step 11 Put on Outer Gloves: Put on second pair of gloves (with extended cuffs). Ensure the cuffs are pulled over the sleeves of the gown.
<input type="checkbox"/>	<input type="checkbox"/>	Step 12 Put on Face Shield: Put on full face shield over the N95 respirator and surgical hood to provide additional protection to the front and sides of the face, including skin and eyes.
<input type="checkbox"/>	<input type="checkbox"/>	Step 13 Verify: After completing the Putting On process, the integrity of the equipment is verified by the trained observer. The healthcare worker should be comfortable and able to extend the arms, bend at the waist and go through a range of motions to ensure there is sufficient range of movement while all areas of the body remain covered. A mirror in the room can be useful for the healthcare worker while Putting On PPE.
<input type="checkbox"/>	<input type="checkbox"/>	Step 14 Decontaminate Outer Gloves: Decontaminate outer-gloved hands with ABHR. That is with gloves on. Allow to dry prior to patient contact.

Removing (Doffing) PPE Check List 25 Steps

One document to be fully completed for the observer (if required) and patient's healthcare worker for each episode of care.

Date and Time

.....

Trained Observer Name/Designation

.....

**HealthCare Worker Entering the Patient Room
Name/Designation**

.....

The trained observer is to verify successful compliance with this check list.

If the trained observer assists with PPE Removing, then the trained observer should disinfect outer-gloved hands with an Alcohol based Hand Rub (ABHR) immediately after contact with healthcare worker's PPE.

If the Trained Observer enters the patient care area for any reason then the checklist is followed and completed for the removal of their PPE. In this instance another trained observer would be required to facilitate the removal process for both healthcare workers.

There are 25 steps in this checklist for Removing PPE.

CHECK LIST		
Observer (only if entered the patient care area)	Patient's HCW	Removing (Doffing) PPE
<input type="checkbox"/>	<input type="checkbox"/>	Step 1 Engage Trained Observer: The Removing process is conducted under the supervision of a trained observer, who reads aloud each step of the procedure and confirms visually that the PPE has been removed properly. Prior to Removing PPE, the trained observer must remind healthcare workers to avoid reflexive actions that may put them at risk, such as touching their face. Post this instruction and repeat it verbally during Removing. Although the trained observer should minimize touching healthcare workers or their PPE during the Removing process, the trained observer may assist with removal of specific components of PPE as outlined below. The trained observer disinfects the outer-gloved hands immediately after handling any healthcare worker PPE.
<input type="checkbox"/>	<input type="checkbox"/>	Step 2 Inspect: Inspect the PPE to assess for visible contamination, cuts, or tears before starting to remove. This includes inspecting boots or shoes. If any PPE is visibly contaminated, then disinfect using an *EPA-registered disinfectant wipe (such as Clinell).
<input type="checkbox"/>	<input type="checkbox"/>	Step 3 Decontaminate Outer Gloves: Decontaminate outer-gloved hands with ABHR. That is with gloves on. Remain in the patient care area.
<input type="checkbox"/>	<input type="checkbox"/>	Step 4 Remove Outer Apron (if used): Remove and discard apron taking care to avoid contaminating gloves by rolling the apron from inside to outside. Remain in the patient care area. Inspect: Following apron removal, inspect the PPE equipment to assess for visible contamination or cuts or tears. If visibly contaminated, then disinfect affected PPE using an *EPA-registered disinfectant wipe (such as Clinell).
<input type="checkbox"/>	<input type="checkbox"/>	Step 5 Decontaminate Outer Gloves: Decontaminate outer-gloved hands with ABHR. That is with gloves on. Remain in the patient care area.

<input type="checkbox"/>	<input type="checkbox"/>	<p>Step 6 Step out of the patient care area onto disinfectant pad (remain on pad until step 18)</p> <p><u>If Boot or Shoe Covers used</u> :Remove covers while sitting down in the chair marked dirty to ensure safety, remove and discard boot or shoe covers into clinical waste. Inspect and if there is any visual contamination of the boot or shoe then disinfect affected PPE using an *EPA-registered disinfectant wipe (such as Clinell). Leave on boots/shoes and remain on the pad until step 18.</p> <p><u>If Boot or Shoe Covers NOT Used</u>: Inspect and if there is any visual contamination of the boot or shoe then disinfect affected PPE using an *EPA-registered disinfectant wipe (such as Clinell). Leave on boots/shoes and remain on pad until step 18.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>Step 7 Decontaminate Outer Gloves: Decontaminate outer-gloved hands with ABHR. That is with gloves on.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>Step 8 Remove Outer Gloves: Remove and discard outer gloves taking care not to contaminate inner gloves during removal process. Discard into clinical waste.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>Step 9 Inspect and Decontaminate Inner Gloves: Inspect the inner gloves' outer surfaces for visible contamination, cuts, or tears. If an inner glove is visibly soiled, cut, or torn, then decontaminate the glove with ABHR. Then remove the inner gloves, perform hand hygiene with ABHR on bare hands, and put on a clean pair of gloves. If no visible contamination, cuts, or tears are identified on the inner gloves, then decontaminate the inner-gloved hands with ABHR.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>Step 10 Remove Face Shield: Remove the full face shield by tilting the head slightly forward, grabbing the rear strap and pulling it over the head, gently allowing the face shield to fall forward and discard. Avoid touching the front surface of the face shield. Discard into clinical waste.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>Step 11 Decontaminate Inner Gloves: Disinfect inner gloves with ABHR.</p>
<input type="checkbox"/>	<input type="checkbox"/>	<p>Step 12 Remove Surgical Hood: Unfasten (if applicable) surgical hood, gently remove, and discard into clinical waste. The trained observer may assist with unfastening hood if required.</p>

<input type="checkbox"/>	<input type="checkbox"/>	Step 13 Decontaminate Inner Gloves: Decontaminate inner gloves with ABHR.
<input type="checkbox"/>	<input type="checkbox"/>	Step 14 Remove Gown: Remove and discard gown into clinical waste. Depending on gown design and location of fasteners, the healthcare worker can either untie fasteners, receive assistance by the trained observer to unfasten to gown, or gently break fasteners. Avoid contact of scrubs or disposable garments with outer surface of gown during removal. Pull gown away from body, rolling inside out and touching only the inside of the gown.
<input type="checkbox"/>	<input type="checkbox"/>	Step 15 Decontaminate and Change Inner Gloves: Decontaminate inner gloves with ABHR. Remove and discard gloves taking care not to contaminate bare hands during removal process. Discard into clinical waste. Perform hand hygiene with ABHR. Put on a new pair of inner gloves.
<input type="checkbox"/>	<input type="checkbox"/>	Step 16 Remove N95/ P2 Mask: Remove the N95/ P2 respirator by tilting the head slightly forward, grasping first the bottom tie or elastic strap, then the top tie or elastic strap, and remove without touching the front of the N95/ P2 respirator. Discard into clinical waste.
<input type="checkbox"/>	<input type="checkbox"/>	Step 17 Decontaminate Inner Gloves: Decontaminate inner gloves with ABHR.
<input type="checkbox"/>	<input type="checkbox"/>	Step 18 Disinfect Boots or Shoes and Remove: Sitting on a new clean surface, second chair marked clean, use an *EPA-registered disinfectant wipe to wipe down every external surface of the boots or shoes. Reusable boots or shoes: Clean one boot or shoe and step this foot off pad onto the clean area, clean second boot or shoe and step this foot off pad onto the clean area. Non-reusable boots or shoes: Step out of boots or shoes, step off the pad onto the clean area, and discard boots or shoes into clinical waste.
<input type="checkbox"/>	<input type="checkbox"/>	Step 19 Decontaminate Inner Gloves: Decontaminate inner-gloves with ABHR.
<input type="checkbox"/>	<input type="checkbox"/>	Step 20 Remove and Discard Inner Gloves: Remove inner gloves taking care not to contaminate inner gloves during removal process. Discard into clinical waste.

<input type="checkbox"/>	<input type="checkbox"/>	Step 21 Perform Hand Hygiene: Perform hand hygiene on bare hands with ABHR.
<input type="checkbox"/>	<input type="checkbox"/>	Step 22 Inspect Body for Contamination: Perform a final inspection of healthcare worker for any indication of contamination of the surgical scrubs or disposable garments. If contamination is identified, immediately inform infection control consultant or occupational safety and health coordinator or their designee before exiting PPE removal area.
<input type="checkbox"/>	<input type="checkbox"/>	Step 23 Exit and Shower: The healthcare worker may leave the area wearing the scrubs. If disposable boots or shoes have been used provide the healthcare worker with footwear for leaving the area. Showers are recommended at each shift's end for healthcare workers performing high risk patient care (e.g., exposed to large quantities of blood, body fluids, or excreta). Showers are also suggested for healthcare workers spending extended periods of time in the room.
<input type="checkbox"/>	<input type="checkbox"/>	Step 24 The observer to hand to this completed form to the designated person for the completion of step 25 Name: _____ Contact Number: _____ _____

<input type="checkbox"/>	<input type="checkbox"/>	<p>Additional Step</p> <p>Step 25 Evaluation/ Medical Assessment:</p> <p>Either the infection control consultant or occupational health safety and health coordinator or their designee on the unit at the time should meet with the healthcare worker to review the patient care activities performed to identify any concerns about care protocols and to record healthcare worker's level of fatigue and/or any issues identified by the healthcare worker.</p> <p><u>Notes:</u></p>
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Guidance on Collection and Transport of Pathology Specimens During the Management of Patients with Ebola Virus Disease in Grampians Region Hospitals



Checklist

Specimen Collection Specimen Packaging Specimen Transportation

Sources:

Victorian Ebola Virus Disease Plan Version 2: 12 November 2014 Victorian Department of Health

Requirements for the Packaging and Transport of Pathology Specimens and Associated Materials (Fourth Edition 2013)
National Pathology Accreditation Advisory Council

National High Security Quarantine Laboratory Guideline for Management of Quarantinable Viral Haemorrhagic Fevers –
website accessed 20/01/2015

Technical Report Series – Laboratory Procedures and Precautions for Samples Collected from Patients with Viral
Haemorrhagic Fevers October 2014 Public Health Laboratory Network

Grampians Region Checklist for Collection and Transport of Pathology Specimens for EVD Version1: May 2015
Page 1 of 11

Important Messages Before Commencing this Checklist

Ebola Virus Disease (EVD)

- Ebola Virus is a Tier 1 Security Sensitive Biological Agent (SSBA)
- Ebola Virus is a Category A substance - an infectious substance that is transported in a form that, when exposure to it occurs, is capable of causing permanent disability, or a life-threatening or fatal disease in otherwise healthy humans
- Patient specimens must be assigned to UN2814 – cause disease in humans

Testing for Ebola in Australia is conducted at the National High Security Quarantine Laboratory (NHSQL) at VIDRL.

National High Security Quarantine Laboratory
Victorian Infectious Diseases Reference Laboratory (VIDRL)
The Doherty Institute
792 Elizabeth Street
Melbourne Vic 3000

Where tests for Ebola virus have been ordered, routine haematology and other tests should be minimised since blood is highly infectious. If other tests are required for the immediate management of the patient, these should only be performed in close collaboration with specialist physicians, laboratory staff and public health authorities at the point of care or in laboratories designated to do this work, guided by jurisdictional viral haemorrhagic fever or laboratory plans wherever possible.

Tests Available	Specimen Type
Detection of haemorrhagic fever viruses (Ebola, Marburg, Lassa, Crimean-Congo, Rift Valley Fever) by nucleic acid.	Acute serum or plasma Throat Swab +/- Urine
Haemorrhagic fever virus serology (Ebola, Marburg, Lassa, Crimean-Congo, Rift Valley Fever viruses).*	Acute serum Convalescent serum

* NB: Serology is only an adjunct to direct detection of VHF viruses.

Checklist

Specimen Collection Specimen Packaging Specimen Transportation

Notes

Telephone contact with the VIDRL on-call microbiologist is essential before any specimen referral.

Contact	Phone number
VIDRL on-call microbiologist	0438 599 437

In case of difficulty back up numbers are:

VIDRL on-call laboratory manager AND	0438 599 439
The Royal Melbourne Hospital Switchboard	03 9342 7000

The person collecting the specimen must be an experienced clinician.

The person collecting the specimen must be accompanied by a trained observer.

The trained observer and the person collecting the specimen MUST put on and take off PPE as per *Guidance on Personal Protective Equipment (PPE) To Be Used by Healthcare Workers During the Management of Patients with Ebola Virus Disease in Grampians Region Hospitals*.

While the observer will not participate in any Ebola patient care activities while conducting observations, the trained observer should wear the same PPE as the patient's healthcare worker collecting the specimens. This is to ensure that the observer is ready in the event that immediate support is required for the patient's healthcare worker such as a PPE breach or fatigue. If this occurs another observer should be engaged to assist both in removing their PPE.

The trained observer will guide the putting on and removing of PPE using the checklist above and will assist with packaging requirements outlined in this checklist to ensure extreme care is taken to avoid exposure to the specimen, and that there are no safety breaches whilst handling specimens and removing PPE.

Specimen Collection Checklist

23 Steps

The trained observer is to verify successful compliance with each step of this check list.
There are 23 steps that must be checked off to ensure the correct procedure is carried out.

Date and Time

.....

Trained Observer Name/Designation

.....

Healthcare Worker Taking Specimen Name/Designation

.....

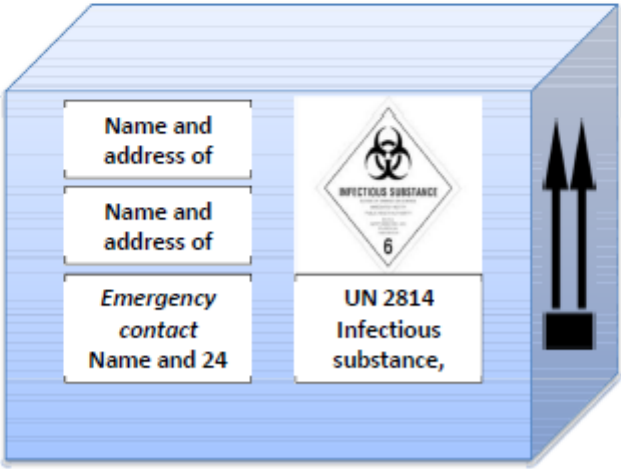
CHECK LIST		
SPECIMEN COLLECTION AND PREPARATION FOR TRANSPORT		
Tick as step completed	CHECKLIST	
<input type="checkbox"/>	Step 1 Notify DHHS and Authorise Testing <input type="checkbox"/> Treating doctor has notified DHHS of suspicion of EVD <input type="checkbox"/> DHHS has authorised EVD testing	1300 651 160
<input type="checkbox"/>	Step 2 Contact VIDRL Contact the medical microbiologist on-call at VIDRL	0438 599 437
<input type="checkbox"/>	Step 3 Courier arranged through DHHS A courier has been arranged to take specimens to VIDRL Name of courier: _____ Time organised for collection: _____ (Remove page 11 from this document and hand the page to courier)	1300 651 160
<input type="checkbox"/>	Step 4 Determine Clinician who will Take Specimen An experience clinician should collect specimens. Take specimen as close as possible to the time determined with the courier for collection as above	
<input type="checkbox"/>	STEP 5 Equipment Preparation <u>Before entering the room</u> assemble all equipment required to collect specimens <ul style="list-style-type: none"> <input type="checkbox"/> Blood sampling tubes (or other specimen containers as appropriate) <input type="checkbox"/> Blood sampling system <input type="checkbox"/> Swab and/or sterile specimen container (if throat and/or urine samples requested by DHHS) <input type="checkbox"/> Disposable Tourniquet <input type="checkbox"/> Skin antiseptic solution <input type="checkbox"/> Gauze pads <input type="checkbox"/> Adhesive tape/bandage <input type="checkbox"/> Pathology forms <input type="checkbox"/> Pen <input type="checkbox"/> Sharps container (all waste disposed of into this container) <input type="checkbox"/> PPE <input type="checkbox"/> Absorbent material (tissue) <p>Blood specimen – approximately 10 ml of unclotted blood, which is covered by either an EDTA or ACD tube.</p> <p>Throat swabs should be placed in plastic screw-cap containers in 1 ml of sterile, viral transport medium (Minimum Essential Medium plus 2% foetal calf serum, penicillin 100 units/ml, streptomycin 100 ug/ml, neomycin 40 ug/ml and amphotericin B 20 ug/ml; available from VIDRL on request) or equivalent transport medium. A dry swab is preferable if no VTM is available.</p> <p>Midstream urine specimens should be collected by clean catch. Five millilitres of urine should be placed into a sterile, leak-proof, plastic screw-cap container</p>	

Grampians Region Checklist for Collection and Transport of Pathology Specimens for EVD Version1: May 2015

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<input type="checkbox"/>	<p>STEP 6 Documentation <u>Before entering the room</u> fill out patient documentation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Label blood collection tube, specimen container, swab <ul style="list-style-type: none"> o Name of patient o Hospital identification o Date and time of collection o Nature of suspected infection o Fill out necessary laboratory request forms
<input type="checkbox"/>	<p>STEP 7 Packaging Preparation <u>Before entering the room</u> assemble material for packaging of specimens</p> <p>Primary packaging – TAKE INTO PATIENT ROOM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood tube, specimen container, swab <input type="checkbox"/> Absorbable material e.g. tissue <input type="checkbox"/> Disinfectant wipes – (5000 ppm available chlorine) <input type="checkbox"/> Biohazard specimen bag <p>Secondary packaging – LEAVE OUTSIDE PATIENT ROOM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Plastic leak-proof packaging container (glass containers must not be used) <input type="checkbox"/> Tape to seal leak-proof container <p>Outer packaging – LEAVE OUTSIDE PATIENT ROOM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Secure box or transport tube <input type="checkbox"/> Infectious risk labels/biohazard labels <input type="checkbox"/> Permanent marker to label outer packaging
<input type="checkbox"/>	<p>STEP 8 Engage the Trained Observer Ensure a trained observer is available to assist with putting on PPE and preparing sample for transport</p>
<input type="checkbox"/>	<p>STEP 9 Put on PPE <u>Before entering the room</u> put on all PPE as per <i>Guidance on Personal Protective Equipment (PPE) To Be Used by Healthcare Workers During the Management of Patients with Ebola Virus Disease in Grampians Region Hospitals</i>. The trained Observer to complete the checklist and assist when necessary.</p>
<input type="checkbox"/>	<p>STEP 10 Enter the Patient Room and Prepare the Equipment Prepare room before commencing taking specimens</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ensure sharps container is ready for use to allow hands free disposal of all equipment used during specimen collection. <input type="checkbox"/> Place all blood collection equipment in a place that is easy to access <input type="checkbox"/> Place biohazard bag, absorbent material (tissues) and disinfectant wipes (5000 ppm available chlorine) within reach and ready for use

<input type="checkbox"/>	STEP 11 Collect Specimen Collect venous blood sample from patient taking <u>extreme care to avoid self-inoculation</u> (10 ml of clotted blood, 5 ml urine, viral medium or dry throat swab) <ul style="list-style-type: none"> <input type="checkbox"/> Needle is not recapped <input type="checkbox"/> Needle is not bent, broken or removed from syringe or otherwise handled <input type="checkbox"/> All blood taking equipment is placed directly into the sharps container <input type="checkbox"/> Care is taken not to contaminate specimen tubes or containers and biohazard bag
<input type="checkbox"/>	STEP 12 Apply Pressure to the Collection Site Give the patient a clean gauze pad to press gently on the collection site to stop bleeding, ask patient not to bend the arm. Do not leave patient until bleeding has stopped <ul style="list-style-type: none"> <input type="checkbox"/> Clean skin and put an adhesive bandage on the site
<input type="checkbox"/>	STEP 13 Check your Environment <ul style="list-style-type: none"> <input type="checkbox"/> Ensure that all blood taking equipment has been placed into the sharps container <input type="checkbox"/> Place all other items contaminated with blood or body fluids into the clinical waste bag
<input type="checkbox"/>	STEP 14 Clean Specimen Container Wipe over the outside of the specimen tube/container with disinfectant (5000 ppm available chlorine)
<input type="checkbox"/>	STEP 15 Ensure Specimen is Protected from Breakage in Packaging Wrap the specimen tube/ container in sufficient absorbent material (tissue) to absorb the entire contents in case of leaks or breaks
<input type="checkbox"/>	STEP 16 Place Specimen into Primary Container <ul style="list-style-type: none"> <input type="checkbox"/> Place specimen container wrapped in absorbent material (tissue) and place into a biohazard bag and seal <input type="checkbox"/> Wipe over the outside of biohazard bag with disinfectant (5000 ppm available chlorine)
<input type="checkbox"/>	STEP 17 Engage the Trained Observer for Placement of Specimen into Secondary Container Ask the trained observer to approach the patient room, <u>without entering</u> <ul style="list-style-type: none"> <input type="checkbox"/> Exit the patient room The specimen MUST be placed into a secondary container at this point with the assistance of the trained observer. <ul style="list-style-type: none"> <input type="checkbox"/> Trained Observer will hold the screw-cap plastic container open for the specimen (in a sealed biohazard bag with absorbent material) to be placed into by the collector <input type="checkbox"/> The Trained Observer to seal the container and tape to secure. <input type="checkbox"/> Place the sealed screw-cap plastic container into another biohazard specimen bag with the request form inserted into the <u>outer pocket</u> of the specimen bag. Under no circumstances should the request form be placed in the same container as the specimen <input type="checkbox"/> Take care not to touch outside of biohazard bag with gloves

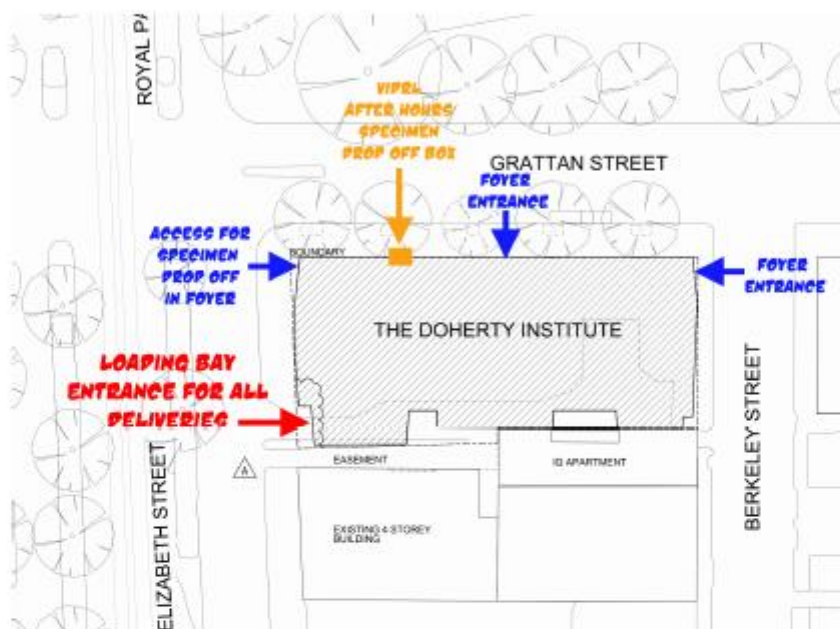
	<input type="checkbox"/> Seal biohazard specimen bag zip lock <input type="checkbox"/> Wipe over the outside of biohazard bag with disinfectant (5000 ppm available chlorine) <input type="checkbox"/> Remove outer gloves and decontaminate inner gloves
<input type="checkbox"/>	STEP 18 Place Specimen into the Outer Packaging Trained observer will place biohazard bag into the rigid outer packaging/canister for transportation
<input type="checkbox"/>	STEP 19 Clean Outer Packaging before Transportation Trained observer will disinfect the outer packaging/canister before preparing packaging for transport to VIDRL <input type="checkbox"/> Take the container and wipe over the outside with disinfectant (5000 ppm available chlorine)
<input type="checkbox"/>	STEP 20 Remove PPE Remove all PPE as per <i>Guidance on Personal Protective Equipment (PPE) To Be Used by Healthcare Workers During the Management of Patients with Ebola Virus Disease in Grampians Region Hospitals</i>
<input type="checkbox"/>	STEP 21 Label Outer Packaging for Transportation Once PPE is safely removed clearly label outer packaging - <ul style="list-style-type: none"> <input type="checkbox"/> Name and address of sender <input type="checkbox"/> Name and address of receiver National High Security Quarantine Laboratory Victorian Infectious Diseases Reference Laboratory The Doherty Institute 792 Elizabeth Street Melbourne Vic 3000 <input type="checkbox"/> Name and 24-hour telephone number of emergency contact <input type="checkbox"/> UN number 2814 <input type="checkbox"/> Infectious substance, affecting humans <input type="checkbox"/> Total volume or weight of the infectious substance, Category A <input type="checkbox"/> Infectious risk/Biohazard label 

<input type="checkbox"/>	<p>Step 22 Notify VIDRL when Specimen Dispatched</p> <p>The courier should have been contacted in step 3 and a time arranged for collection. If the courier has not arrived call to confirm time of arrival. Notify the on-call VIDRL medical microbiologist of the dispatch of the specimen with departure time, courier details and approximate arrival time to VIDRL - 0438 599 437</p> <p><u>Inform the courier of the following:</u></p> <p>Specimen delivery is to the foyer specimen receiving area at the Doherty Institute, accessed from Elizabeth Street where there are two short-term delivery parking spaces. After 5.30pm or on weekends the specimen shipping container should be deposited in the specimen delivery chute located on the Grattan Street frontage, and a VIDRL staff member notified by calling the specimen reception phone number which appears on the chute. If the package is too big call the on call laboratory manager on 0438 599 439.</p> <p>Give a copy of page 10 <u>"COURIER INFORMATION"</u> to the courier</p>
<input type="checkbox"/>	<p>Step 23 The observer to hand this completed form to the designated person</p> <p>Either the infection control consultant or occupational health safety and health coordinator or their designee on the unit at the time should check that all steps have been completed. Retain this form as a record of specimen dispatch.</p>

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COURIER INFORMATION

Specimen delivery is to the foyer specimen receiving area at the Doherty Institute, accessed from Elizabeth Street where there are two short-term delivery parking spaces. After 5.30pm or on weekends the specimen shipping container should be deposited in the specimen delivery chute located on the Grattan Street frontage, and a VIDRL staff member notified by calling the specimen reception phone number which appears on the chute. If the package is too big call the on call laboratory manager on 0438 599 439.



After hours specimen drop off box – Grattan Street



Appendix 15: Waste Management

Source: Victorian Ebola Virus Disease Plan Version 3 May 2015

10. Waste management

10.1 Overview

- In Victoria, the EPAV is the responsible body for the regulation of packaging, transport and disposal of waste. EPAV has created a special waste classification that directs the handling of clinical waste generated in the care of an EVD patient ("Ebola waste").
- Health Purchasing Victoria (HPV) is running a state-wide procurement process on behalf of health services for the transport and removal of Ebola waste, and can be contacted to obtain the details of which waste contractor(s) can be used.
- In Victoria, most health services do not have the capacity to treat Ebola waste on site (e.g. steam sterilisation or incineration) therefore it is highly likely that waste will need to be transported, and if so, must be packaged and transported according to the following requirements.
- Ebola waste should be considered infectious and disposal must adhere to the EPA standards.
- The arrangements below apply for the handling of any waste from a confirmed case of Ebola, or a suspected case who is producing secretions (wet symptoms such as vomiting, diarrhoea or bleeding). In practice, this means that waste generated from the care of a suspected case with secretions should be packaged and stored until Ebola is excluded in the patient, and then the waste can be managed as per normal protocols. Waste generated from suspected cases while they are not producing secretions (dry symptoms only) can be treated using normal waste disposal processes.
- All personnel involved in Ebola waste packaging, transport and disposal must wear PPE appropriate to the clinical setting and relevant patient zone.

10.2 Responsibilities of a waste generator and waster contractor

- A **waste generator** (i.e. a health service or cleaning contractor) should at a minimum undertake the following actions:
 - have a plan for the safe handling of Ebola waste, its transfer into appropriate packaging and secure storage;
 - ensure that the minimum packaging requirements for transport are met;
 - Designated health services (RMH-VIDS/RCH) should:
 - ensure they are issued with the EPAV Ebola waste classification for Ebola waste (2015/165, **Appendix 2B**);
 - ensure agreement with an approved waste contractor in advance that confirms they are satisfied with the packaging requirements and have approval from EPAV for the transport and treatment of the Ebola waste;.
 - Non-designated health services should:
 - have the appropriate Ebola plans in place;
 - should they receive a suspected or confirmed Ebola case, inform DHHS who will obtain the Ebola waste classification for the health service from EPAV (**Appendix 2B**), and facilitate entry into the state-wide Ebola waste contract via HPV.
- A **waste contractor** should at a minimum undertake the following actions:
 - confirm the packaging requirements for Ebola waste with the waste generator;
 - obtain the required permit from the EPAV for vehicles intended for transport of Ebola waste (R100);
 - ensure the destination waste facility is licensed by EPAV for the treatment of Ebola waste;
 - comply with all other regulations required by the EPAV including completion of necessary transport certificates.
- In order to be able to receive waste for treatment, a waste treatment facility must ensure that it meets licensing requirements set by EPAV for the safe incineration of Ebola waste.

10.3 Waste disposal

- Following a risk assessment by the health service concerned, some waste generated in the course of providing care to a suspected case of Ebola could be considered not to be contaminated with Ebola virus, and so could be managed as clinical waste according to normal protocols. The risk assessment centres around whether the patient with suspected EVD is producing secretions (vomiting, diarrhoea, bleeding) or not. The Communicable Diseases Network Australia and Infection Prevention and Control Expert Advisory Group recommend that if a suspected patient is not producing secretions, there is negligible risk that items they have used in the home, community or ambulatory care settings would be contaminated with Ebola virus. These items should be cleaned and reused in the normal way, unless there is another reason to discard them, and waste can be disposed of as normal clinical waste or general rubbish.
- Ebola waste generated in caring for a confirmed case of EVD or a suspected case producing wet symptoms must be packaged and handled according to the following requirements:
 - double bagged and sealed with a knot or other equally effective positive means of closure in biohazard (yellow) bags that are leak proof and tear resistant, or any other clinical waste bags that adhere to relevant Australian standards, i.e. be at least 50µm thick and leak proof;
 - absorbent material should be added to the primary and secondary bag, or the space between them in order to contain any residual liquids. Suitable absorbent materials may include, for example, Sphag sorb, Zeomed, Vernagel or Clinisorb.
 - sharps waste must be placed in a sharps container certified to AS 4031:1992 which must then be placed in an outer bag containing absorbent material before being placed in a secure rigid outer container;
 - the double bagging process should either involve keeping the first clinical waste bags inside the patient room and then placing these bags inside a second clinical waste bag kept outside the patient room or some other process to render the outer bag free from contamination (eg. disinfected with 1,000 ppm chlorine wipes); A “buddy” system must be used for this procedure;
 - bags should not be filled to capacity as this will prevent them from being adequately sealed and no individual bag should weigh more than 10kg;
 - Bags should never be slung over a shoulder or carried in a manner that permits contact the carrier’s body or legs;
 - the double-bagged waste must be placed in a secure rigid outer container that carries labelling consistent with UN2814/ADG Class 6.2 for transport; the outer container should contain absorbent material sufficient to contain any residual liquids. The secure rigid

outer container should not be inverted at any point in the transport process whilst it contains Ebola waste;

- the secure rigid outer container should be of sufficient dimensions to deposit and accommodate waste items likely to be generated in the routine care of the patient, e.g. items of personal protective equipment;
- the outer surface of the secure rigid outer container should be disinfected with virocidal disinfectant, such as 1,000 ppm chlorine wipes;
- the secure rigid outer container must carry outer labelling consistent with UN2814/ADG Class 6.2 for transport and carry the text “In the case of damage or leakage immediately notify Public Health Authority”;
- the Ebola waste should be stored in a safe and secure locked environment to prevent accidental or unauthorised access.

10.4 Waste transport

- Ebola waste must be transported according to the following requirements:
 - the secure rigid outer container should be accompanied by a Transport Certificate setting out the prescribed waste as Hazard Category A waste/ UN Number 2814; this includes the requirement for the waste generator to ensure that the waste transporter is aware of the transportation of Ebola waste;
 - in permitted vehicles compliant with the EPAV special waste classification for Ebola waste (R100).

10.5 Waste treatment

- Ebola waste is to be treated through:
 - incineration in a waste disposal facility licensed by the EPAV in the destruction of Ebola waste (this is the common practice in Victoria), **or**
 - steam sterilisation prior to disposal as normal category B clinical and related waste (UN3291) using a method validated for the treatment of category A pathogens to the satisfaction of existing regulators.

10.6 Handling of bulk items

- Bulk items (i.e. mattresses or items too large to be secured as per the packaging instructions described above) that cannot be cleaned and disinfected and as such require transport and treatment as Ebola waste will require prior discussion with a waste contractor. Such waste should be handled as follows:
 - disinfection of the entire surface of the article should occur (e.g. using strong sodium hypochlorite solution at 5000-10000 ppm);
 - subsequent enclosure in tear and impact resistant plastic sheeting and then sealed closed with tape as to prevent leakage; ends may need to be twisted closed and secured with at least two wraps of tape or two zip-ties to prevent excess fluid from leaking; this surface should again be disinfected;
 - a second layer of the same plastic sheeting should be applied and again sealed and disinfected;
 - finally the item should be wrapped in 6mm polyethylene sheet (HDPE or equivalent material) and sealed with tape as to prevent leakage followed by surface disinfection;
 - some items may need to be broken down in size prior to packaging to ensure it can be safely secured for transport and placed in incinerators at waste treatment facilities;
 - some larger bulk items may need further discussion with the Department of Health & Human Services and EPAV as a suitable method might be agreed that completely disinfects the item at source, rendering it free of Ebola virus and meaning it would no longer be classified as Ebola waste.

10.7 Faeces and urine

General

- Patients with suspected/ confirmed EVD should be isolated in a single room, ideally with ensuite toilet facilities.
- If no ensuite toilet facility is available, a dedicated commode should be provided. Single use bedpans/urinals should be used.
- Toilet waste from patients with EVD can be safely flushed into the sewerage system. As an enveloped virus, Ebola virus is more susceptible to environmental stresses and chemical germicides than most enteric viruses. However, as a precautionary measure, toilet waste should be treated before disposal through the sewage system or as Ebola waste. Suggested regimes are as follows:

If using a standard toilet:

- The patient should be instructed to not flush the toilet.
- Staff should add five bleach tablets (e.g. Chlortabs™ / Chlorclean™) to the toilet bowl (i.e. 5x1000 ppm strength). This is preferred to adding sodium hypochlorite solution to the toilet bowl which increases the risk of splashing/aerosol creation.
- Leave for 30 minutes before flushing.
- Ensure the toilet lid is down and that staff are wearing a P2/N95 respiratory protection device (RPD) in addition to other PPE in case of aerosols when the toilet is flushed.

If using a commode:

- Disposable pans/urinals should be used.
- The contents of the pan/urinal must be solidified with high-absorbency granules or gel.
- Both the pan/urinal and contents should be placed into a biohazard bag as Ebola waste.
- A bedpan/urinal can be used and emptied into a pan sanitiser if available within the ward area.
- The bed pan should be filled with 200 ml of 5000 ppm sodium hypochlorite and left for 30 mins before emptying and being placed in the pan sanitiser. The sanitiser should be run on a hypochlorite cycle.

10.8 Cleaning equipment

- Cleaning equipment such as mop heads and cloths should be disposed of as Ebola waste after each clean.
- All cleaning equipment should be disposed of as Ebola waste during terminal cleaning.

10.9 Furnishings – carpet, curtains etc

- If a porous material such as linen, mattress or carpet is obviously soiled with body fluids or substances it should be discarded as Ebola waste.
- Non-soiled surfaces should be cleaned or laundered as normal using detergent and/or disinfectant.
- Otherwise, plastic covered equipment should be cleaned and disinfected as above.

10.10 Removing waste from the room

- A staff member must be available to assist with double bagging Ebola waste ('Buddy' system) as directed above.

10.11 Storage of waste until collected

- Prior to collection by the contractor, Ebola waste must be stored securely and access restricted to authorised and trained personnel.

Appendix 2B – EPAV Ebola Waste Classification Template

This classification is to be issued directly to designated Ebola treatment hospitals (RMH-VIDS/RCH). Other non-designated hospitals may have the classification issued on an as needed basis by the EPAV should an Ebola patient present for treatment.

Classification

Environment Protection Act 1970

Act No. 8056/1970

Environment Protection (Industrial Waste Resource) Regulations 2009

Prescribed Industrial Waste – Classification by Hazard for Ebola waste

Pursuant to regulation 11(1)(a) of the *Environment Protection (Industrial Waste Resource) Regulations 2009*, the Environment Protection Authority Victoria ("EPA") hereby classifies the industrial waste specified in this classification as Category A prescribed industrial waste.

1. CLASSIFICATION NUMBER

2015/165

2. WASTE TO WHICH THIS CLASSIFICATION APPLIES

- 2.1 This classification applies to the objects and materials, including but not limited to bedding, sanitary napkins, personal protective equipment and any other material that is or, in the opinion of the waste generator, may be contaminated or soiled with body fluids from patients confirmed as having Ebola virus; and
- 2.2 human tissue, anatomical waste and diagnostic specimens arising from patients confirmed as having Ebola virus ("waste").

3. TO WHOM THIS CLASSIFICATION APPLIES

This classification applies to < name of the hospital, address, ACN > ("the waste generator").

4. PERIOD OF VALIDITY

This classification commences on < date/Month/year > and is effective unless it is revoked or varied by the EPA.

5. MANAGEMENT OPTIONS

- 5.1 The waste referred to in Section 2 of this classification must be packaged in accordance with the following conditions before being transported to an EPA licensed premises.

- 5.1.1 Place the waste into the first plastic film bag as per Schedule 1.
- 5.1.2 Close the bag by tying the bag with a knot or other equally effective positive means of closure that will ensure any liquid contents will not leak from the packaging.
- 5.1.3 Place the first plastic bag, with the knot facing upward, into a second plastic film bag.
- 5.1.4 Securely tie the outer bag.
- 5.1.5 Place the second (double bagged) package into outer container as per Schedule 1.
- 5.1.6 Securely close the outer container.
- 5.1.7 Repeat steps 5.1.1 to 5.1.6 as necessary until the outer container is sufficiently full to the extent that the outer container can be safely closed, handled, transported and incinerated in accordance with this classification.
- 5.1.8 Disinfect the exterior surface of the outer container with virocidal disinfectant that is recommended by the Health Department for use as a disinfectant for the Ebola virus.
- 5.1.9 Transfer the outer container to a secure, isolated area with limited access, so that waste can be stored separately from other clinical waste until it can be transported for destruction.
- 5.2 Waste which is not in compliance with Section 5.1 of this classification must not be transferred to a treatment facility.
- 5.3 The waste producer referred to in Section 3 of this classification must ensure, in obtaining transportation for the classified waste, that:
 - 5.3.1 Waste is transported as quickly as practicable directly to a licensed treatment facility for incineration. This means that vehicles are not to pick up other cargo after collecting the waste referred to in Section 2, nor make unnecessary stops, but instead must proceed directly to the treatment facility.
 - 5.3.2 Each vehicle that transports the waste:
 - 5.3.2.1 has an EPA-issued Vehicle Permit to transport *R100 Clinical Waste*; and
 - 5.3.2.2 is fully enclosed, and the driver compartment is separated from the load area; and
 - 5.3.2.3 is fitted with load securing devices and a totally leak-proof load compartment, with seamless floor, which is drainable to a spill collection sump.
 - 5.3.3 the outer container is secured to prevent the container moving while the vehicle is in motion.
 - 5.3.4 the waste transporter provides a specifically prepared Emergency Procedure Guide (EPG) to the driver outlining reporting mechanisms to deal with emergency situations. The EPG must be readily accessible, relevant and easily interpreted.
 - 5.3.5 a copy of this Classification is present at all times in the vehicles transporting the waste.
- 5.4 The waste producer referred to in Section 3 of this classification must ensure, in obtaining destruction of the classified waste, that:
 - 5.4.1 at the waste receiver's premises, the packaged waste is unloaded, loaded, handled, treated and stored in secure bunded areas constructed, sized, operated and maintained in accordance with the EPA Publication No 347 "*Bundling Guidelines*".
 - 5.4.2 the waste containers are stored separately from other waste in a secure, isolated area with limited access.



- 5.4.3 waste that has been managed in accordance with this Classification is incinerated as quickly as practicable at the incineration facility.

6. NOTES

This classification may be amended or revoked by the EPA by way of written notice.

TIMOTHY DAVID FARAGHER

Delegate to the Environment Protection Authority Victoria

Schedule 1 - Packaging requirements

- I. Individual plastic film bags may weigh no more than 10 kg when filled. An outer packaging (rigid container) may contain more than one set of double bagged waste.
- II. Where appropriate, wrap objects with sharp edges to prevent the tearing or puncture of the plastic bags.
- III. All outer containers used for the waste must be of a rigid design with a lid that is able to be secured and prevent spillage of the contents during transport under normal operating conditions.
- IV. All containers and plastic bags must be marked in accordance with Part C of *Environment Protection (Industrial Waste Resource) Regulations 2009*.
- V. The rigid outer layer should display labeling consistent with Australian Dangerous Goods Code 6.2.



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Appendix 16: Environmental Cleaning

Source: Victorian Ebola Virus Disease Plan Version 3 May 2015

1. General

- For **suspected cases of Ebola virus disease (EVD) not producing secretions/wet symptoms** (vomiting, diarrhoea, bleeding), whilst awaiting laboratory results, standard precautions, routine cleaning and disinfection practices including the management of linen and waste should be used. The Infection Prevention and Control Expert Advisory Group (IPCEAG) advises that if a person with suspected EVD is later shown to have EVD, but was in the non-secretory phase, there is negligible risk that items they have used would be contaminated with Ebola virus.
- For a **confirmed case of EVD or in a suspected case of EVD producing secretions**, follow the directions outlined in this Appendix.
- All staff carrying out cleaning and disinfection must be trained in the use of appropriate PPE including at a minimum single use gloves (two pairs to be worn), fluid-resistant or impermeable gown and surgical hood or a coverall, eye protection (e.g. goggles or face shield), leg and shoe covers; and a P2 respirator.
- In Victoria, the responsible body for the regulation of packaging, transport and disposal of waste is the Environment Protection Authority - Victoria (EPAV). EPAV has created a special waste classification (2015/165, see **Appendix 2B**) that directs the handling of clinical waste generated in the care of an EVD patient ("Ebola waste"). This classification is issued directly to individual hospitals and applies to objects or materials that may be contaminated or soiled with body fluids from patients confirmed as having Ebola virus, and human tissue, anatomical waste and diagnostic specimens arising from patients confirmed as having Ebola virus.

2. Disinfectants

- EVD is inactivated by many common hospital-grade disinfectants including agents that are active against other viruses such as norovirus, rotavirus and adenovirus.
- The recommended disinfectant is freshly prepared sodium hypochlorite (bleach - NaOCl) solution using powder sachets or as tablets, granules or gels.
- In some instances the use of tablets is preferred to a solution to reduce the possibility of aerosols (refer to the human waste management in section 10 of this Appendix). Tablets and granules are sold as sodium dichloroisocyanurate (various brands - NaDCC) with different chlorine concentrations – refer to the manufacturer's instructions for achieving appropriate concentrations of solution. The concentrations are expressed as a percentage or parts per million (ppm) of available chlorine.
- Once diluted, chlorine solutions lose potency rapidly, so must be prepared in small volumes on a daily basis as required.
- 0.5% phenolic (with detergent) solution may also be used in a similar way to sodium hypochlorite as above.

3. Routine cleaning

- Routine environmental cleaning should be undertaken using either:
 - a two-step detergent clean (physical clean with two-step detergent followed by a chemical disinfectant), or
 - by using a combined 2-in-1 detergent/disinfectant clean (physical clean using a combined detergent/disinfectant wipe/solution).
- Daily cleaning of all hard, non-porous surfaces such as floors, toilets, counters and high-touch surfaces (e.g. door handles, bed rails and call bells, telephones and tables) should be carried out with a neutral detergent, rinsed and dried.
- Visibly soiled surfaces should be wiped clean with single use cleaning cloths, warm water and detergent until visibly clean, rinsed and dried.
- All cleaned surfaces should then be disinfected with freshly prepared sodium hypochlorite (bleach) solution as described above in a concentration of 1,000 ppm (0.1%) (2-step approach).
- Toilets and surfaces that have been visibly soiled should be disinfected with a higher concentration solution of 5,000ppm (0.5%) solution.

Spot Cleaning

- As above or as per spills management (below).

4. Terminal Cleaning

4.1 Cleaning

- Terminal cleaning should be carried out as above.
- A higher concentration of sodium hypochlorite (5000ppm) should be used.
- All textiles contaminated with body fluids including curtains should be disposed of as Ebola waste.
- If applicable, maintain negative pressure during terminal cleaning and for 30 minutes afterwards before another patient is admitted to the room.

4.2 Fumigation

- As EVD is not airborne fumigation of rooms is not required.

5. Cleaning equipment

- All single use cleaning cloths and the mop head should be disposed of as Ebola waste after each routine clean.
- All cleaning equipment (mop handles, buckets if used) should remain in the room until terminal cleaning has been completed.
- Mop handles should be cleaned after each use.
- Remaining cleaning solution should be disposed of using absorbent granules/gel, which is then disposed of as Ebola waste.
- Cleaning gloves should be disposed of as Ebola waste. Chemical resistant or household type gloves should be used.
- Buckets, if used, should be cleaned and dried and kept inside the room.

6. Spills Management

- Spills of body fluids/substances should be contained.
- Large spills (greater than 10 cm) may require increased PPE such as single use, impermeable leg covers and shoe covers.
- Absorbent sodium hypochlorite granules or gels (5000ppm) should be placed on the spill and the spill covered with paper towel to limit spread of the spill. This should be left for a minimum of 30 minutes before removing and disposing of the absorbed spill and paper towel.
- The area of the spill should be cleaned with warm water and detergent, dried and wiped over with 5000ppm of sodium hypochlorite solution left for 30 minutes, rinsed and dried.

7. Medical Equipment

The use of patient dedicated equipment is recommended where reusable equipment is available.

7.1 Single use

- Single use equipment should be used where available and appropriate, and be disposed of as Ebola waste when no longer required.

7.2 Reusable

- Reusable semi-critical and critical equipment should be cleaned and disinfected in the room as appropriate prior to transport to the reprocessing area.
- Any visible contamination should first be cleaned using single use hospital-grade disinfection wipes (e.g. strong chlorine disinfectant).
- The items should then be cleaned in a two-step process, first with a neutral detergent, and then with a strong sodium hypochlorite solution (i.e. 5000-10,000 ppm available chlorine equivalent to 0.5% to 1%). Manufacturers' instructions should be followed.

- Once in the reprocessing area routine cleaning and disinfection or sterilisation should be undertaken.

8. Crockery and Cutlery

- Single use items should be used where possible.
- Reusable items should be cleaned and disinfected prior to leaving the room and should then be treated routinely.

9. Linen

9.1 Single use

- Where possible, use disposable linen and clothing. Linen includes sheets, pillowcases, blankets, towels and face washers.
- Bed clothing should also be single use where possible and appropriate.

9.2 Reusable

- Where reusable linen is used it should be disposed of as Ebola waste.

9.3 Bedding

- Plastic covered mattresses and pillows (if not already in use) should be used for all suspected, probable and confirmed cases of EVD.
- Single use plastic sheeting should be used where necessary and disposed of as Ebola waste.

Appendix 17: Care of the Deceased

Source: Victorian Ebola Virus Disease Plan Version 3 May 2015

Safe Handling of Human Remains of a Patient with Ebola Virus Disease

These recommendations give guidance on the safe handling of human remains that may contain Ebola virus and are for use by personnel who perform care of the deceased in hospitals and mortuaries. In patients who die with Ebola virus infection, virus can be detected throughout the body. Ebola virus can be transmitted by laceration and puncture with contaminated instruments used during postmortem care, through direct handling of human remains without appropriate personal protective equipment, and through splashes of blood or other body fluids (e.g. urine, saliva, faeces) to unprotected mucosa (e.g. eyes, nose, or mouth) which occur during care of the deceased.

The following are important principles of care in these circumstances:

- Only personnel trained in handling infected human remains, and wearing PPE, should touch, or move, any Ebola-infected remains or suspected Ebola-infected remains;
- Handling of human remains should be kept to a minimum;
- **Autopsies should not be performed on patients who die with Ebola virus disease.** If an autopsy is requested, the DHHS Communicable Disease Prevention and Control section and the Victorian Institute of Forensic Medicine should be consulted.

Definitions for Terms Used in this Appendix

Cremation: The act of reducing human remains to ash by intense heat.

Leakproof bag: A body bag that is puncture-resistant and sealed in a manner so as to contain all contents and prevent leakage of fluids during handling, transport, or shipping.

Roles and responsibilities in the care of the deceased

The completion of a death certificate by a medical practitioner is a vital part of the notification process of a death to the Registrar of Births, Deaths and Marriages and enables an authority to be provided to the funeral director to arrange disposal of the deceased. Completing a death certificate and reporting a death to the Coroner are mutually exclusive exercises. Doctors should be familiar with the criteria for reporting deaths to the Coroner. A death as a result of Ebola virus disease would not ordinarily be reported to a Coroner. If a diagnosis of Ebola virus disease has been made prior to death and there are no other criteria for reporting the death, a death certificate could be completed.

Health services care for the remains of those who have died in their care. Where the cause of death is understood and does not meet the criteria for reportable deaths, a death certificate is completed and the deceased is transferred to a funeral director chosen by the next of kin.

If the death is reported to the Coroner, Victoria Police will assist to investigate the circumstances surrounding the cause of death. Victoria Police attend the place where a reportable death has occurred and work closely with the Victorian Institute of Forensic Medicine.

The Victorian Institute of Forensic Medicine (VIFM) forensic pathologists assist the State Coroner, police and courts to resolve causes of death and how injuries might have occurred. Only those people whose death is reported to the State Coroner are brought to mortuaries like VIFM.

Funeral Directors prepare human remains for interment or cremation. This includes making arrangements with a Cemeteries Trust for disposition of the deceased.

Cemeteries Trusts operate cemeteries and crematoria. DHHS administers the *Cemeteries and Crematoria Act 2003*. As independent entities, trusts are the decision makers in relation to the provision of their services provided these decisions are lawful.

Personal protective equipment for care of the deceased

- **Personal protective equipment (PPE):** Prior to contact with the deceased, postmortem care personnel must wear at a minimum single use gloves (two pairs to be worn), fluid-resistant or impermeable gown and surgical hood or a coverall, eye protection (e.g. goggles or face shield), and leg and shoe covers.
- **Putting on, wearing, removing, and disposing of protective equipment:** PPE should be in place **BEFORE** entering the room, contact with the deceased, worn during the process of collection and placement in body bags, and should be removed immediately after and discarded as regulated medical waste. Use caution when removing PPE as to avoid contaminating the wearer. Hand hygiene (washing your hands thoroughly with soap and water) should be performed immediately following the removal of PPE.

Preparation of the deceased

- **Preparation of the deceased:** All contact with the deceased should be minimized. At the site of death, the deceased should be placed in leak-proof body bag not less than 150 µm thick and zippered closed. Change your gown or gloves after placing the deceased in the bag. Leave any intravenous lines or endotracheal tubes that may be present in place. Avoid washing or cleaning the deceased. The bagged remains should then be placed in another leak-proof plastic body bag not less than 150µm thick and zippered closed before being transported to the morgue.
- **Surface decontamination:** Prior to transport to the mortuary, perform surface decontamination of the outer body bag by first removing visible surface contamination on bag surfaces with recommended disinfectants which can kill a wide range of viruses. An example of an effective disinfectant is sodium hypochlorite (refer to **Appendix 2A**). Follow the product's label instructions. After any visible contamination has been removed, reapply the disinfectant to the entire bag surface and allow to air dry. Following the removal of the body, the patient room should be cleaned and disinfected. Reusable equipment should be cleaned and disinfected according to standard procedures. For more information on environmental infection control, please refer to "[Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus](http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html)" (<http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html>).
- **Individuals driving or riding in a vehicle carrying deceased persons:** PPE is not required for individuals driving or riding in a vehicle carrying deceased persons, provided that drivers or riders will not be handling the body and the body is safely contained in a disinfected body bag as described above.

Mortuary Care

- Do not open the body bags and do not remove remains from the body bags. Bagged remains should be placed directly into a sealed casket.
- Do not perform embalming. The risks of occupational exposure to Ebola virus while embalming outweighs its advantages; therefore, bodies infected with Ebola virus should not be embalmed.
- Mortuary care personnel should wear at a minimum single use gloves (two pairs to be worn), fluid-resistant or impermeable gown and surgical hood or a coverall, eye protection (e.g. goggles or face shield), and leg and shoe covers when handling the bagged remains.
- In the event of leakage of fluids from the body bag, thoroughly clean and decontaminate areas of the environment with recommended disinfectants (refer **Appendix 2A**). Reusable equipment should be cleaned and disinfected according to standard procedures. For more information on environmental infection control, please refer to "[Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus](http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html)" (<http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html>).

Disposition of Remains

- There should be no viewing of the deceased by family members. The body bags and casket should remain sealed.
- Remains should be cremated or buried promptly in a sealed casket.
- Once the bagged body is placed in the sealed casket, no additional cleaning is needed unless leakage has occurred.
- As an additional precaution gloves should be worn when handling the sealed casket.
- No PPE is needed when handling the cremated remains.

The Australian Funeral Directors Association, *Funeral Industry Infection Control Guidelines*, 2008 can be obtained from: <http://afda.org.au/media/member/ICG.pdf>

Transportation of human remains

Transportation of remains that contain Ebola virus should be minimized.

Reported deaths

The Victorian Institute of Forensic Medicine (VIFM) will be alerted if Police who attend a reported death suspect that a deceased person may have Ebola virus disease. If the deceased was reported to have flu like symptoms immediately prior to death and has recently travelled to an affected area in Africa, the VIFM on-call pathologist is to be notified. VIFM will advise Police to secure the scene and await further advice.

The on-call pathologist, in consultation with Director VIFM will make the decision to either treat the deceased as "suspected Ebola" or a normal case. The Director of VIFM will also notify the Chief Health Officer and the State Coroner immediately.

If the decision is made to treat the deceased as "suspected Ebola" the deceased is to remain in situ and the police Disaster Victim Identification/CBR unit will attend to provide advice and assist in the process. A VIFM Forensic Pathologist with appropriate PPE described above will attend the scene and collect a blood sample for testing at VIDRL. Only DHHS can authorise EVD testing and will make the initial contact with VIDRL. The Forensic Pathologist will notify DH by calling **1300 651 160** to obtain authorisation for EVD testing.

If the test is positive, the Police DVI-CBR unit will attend to manage the deceased. A risk assessment will take place in conjunction with the forensic pathologist to determine the level of PPE.

VIFM maintains protocols for:

- Determining appropriate levels of PPE;
- Admission of the deceased;
- Examination of the deceased;
- Sample collection;
- Storage of the deceased;
- Environmental cleaning of examination area;
- Transfer of the deceased to a nominated funeral director;
- Management of communications with families and stakeholders.

As a government facility, VIFM also is sometimes requested to manage bodies when other mortuaries are unable to or not prepared to store or transport the bodies. This situation could occur in cases of Ebola virus disease infection.

Further information

For advice in relation to the care of deceased persons with EVD please contact DHHS Communicable Disease Prevention and Control Unit on **1300 651 160**.

References

Centers for Disease Control and Prevention, Guidance for Safe Handling of Human Remains of Ebola Patients in Hospitals and Mortuaries. Available from: <http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html> Accessed on 09 September 2014

Appendix 18: 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 19: 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.

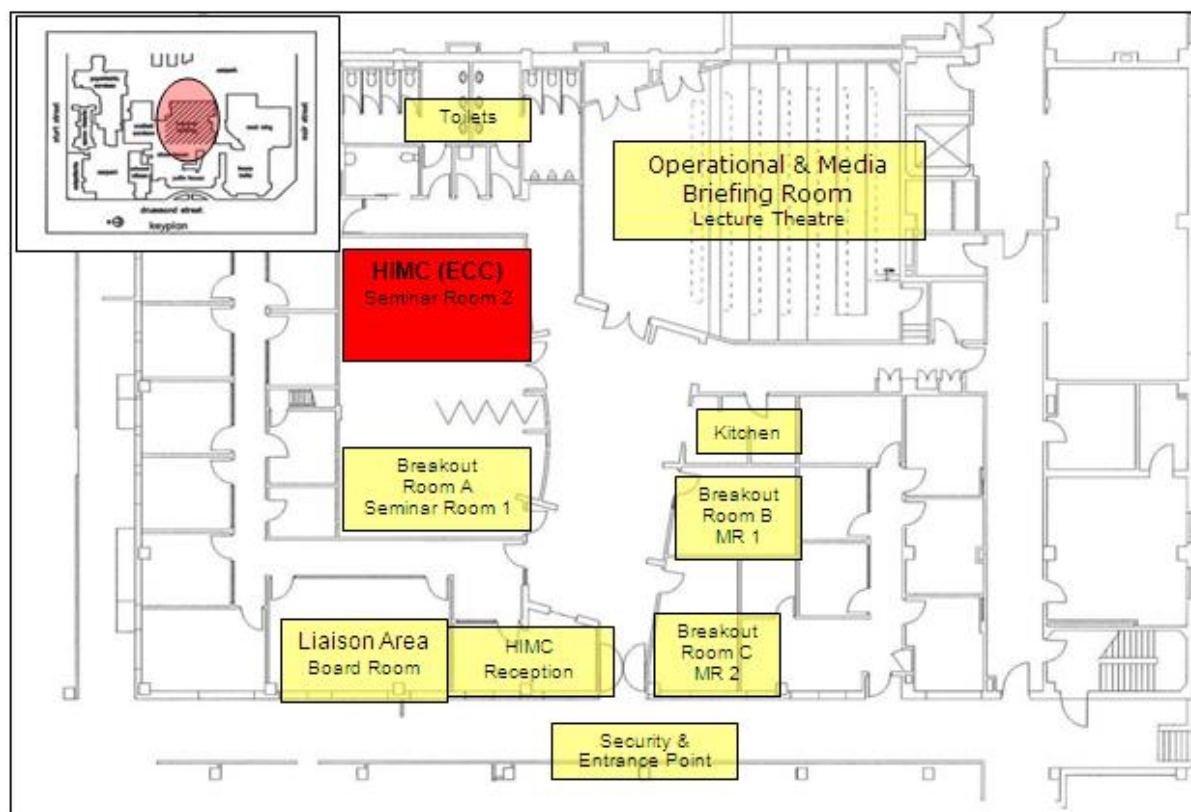
Incident Control System (ICS)	Where emergency response personnel are organised in a non-hierarchical manner, so that units work alongside one another under a coordinator, but are not subject to a vertical chain of command. The ICS method works best where units can easily be assigned different tasks, 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.
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 20: 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 21: 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

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 May 2015	1	Ebola Virus Disease Sub Plan	Sue Atkins Grampians Region Department of Health & Human Services