Annex J

Guidelines for Non-Traditional Sites and Workers

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Note:

- This annex may not contain up-to-date information on the antiviral strategy. Refer to the Preparedness section of the Plan and Annex E for this information.
- See Background section of the Plan for information on the latest pandemic phase terminology.
- This annex may be out-of-date with respect to other planning activities and policy decisions.
- This annex is expected to be updated in 2007.

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Introduction

In influenza pandemics over 50% of persons may be infected and the majority of illnesses and deaths will tend to occur over a period of six to eight weeks in any one location. Epidemiologic data from influenza epidemics and past pandemics show that 15% to 35% of the population could become clinically ill. Consequently, even a low frequency of complications result in marked increases in rates of hospitalizations. An estimate of the health and economic impact of a pandemic in Canada has been performed using a model developed by Meltzer and colleagues, CDC, Atlanta (<http://www.cdc.gov/ncidod/eid/vol5no5/meltzer.htm>). Based on this model it is estimated that between 2.1 and 5.0 million people would require outpatient care, between 34 thousand and 138 thousand people would require hospitalization and between 11 thousand and 58 thousand people would die in Canada during an influenza pandemic.

Due to the large number of patients who would require medical services during an influenza pandemic, communities and health care organizations must have guidelines in place that will address what will be done if health care organizations are overwhelmed. The use of non-traditional sites (NT sites) for the provision of medical care and the need for additional human resources, including volunteers and other health care or non-health care workers, must be considered as a strong possibility and planned for accordingly. Legislative, management and professional authorities will have to be clearly defined at the local level.

This document is divided into two main sections. The first section provides guidelines regarding the utilization and administration of NT sites, and the preparedness and operational activities that should take place with respect to NT sites during the interpandemic, pandemic and post-pandemic periods. The second section focuses on the need for and identification of additional human resources as part of pandemic planning, and also identifies activities by each pandemic period.

1.1 Definition of a Non-Traditional Site

The following is a definition of a non-traditional site (NT site) for the purposes of planning for an influenza pandemic.

A non-traditional site is a site that is:

a) currently not an established health care site, or

b) is an established health care site that usually offers a different type or level of care.

The functions of a non-traditional site will vary depending on the needs of the community but will focus on monitoring, care and support of influenza patients during an influenza pandemic.

1.2 Potential Roles of Non-Traditional Sites

The role of any NT site will depend on the needs of the community and the resources available. It is expected that NT sites will be used during a pandemic for three main purposes:

- the care of patients who are not critically ill when hospitals are overloaded,
- as domiciliary care for individuals unable to care for themselves at home, and
- as a "step-down" unit for the care of stable patients that have been transferred from acute care hospitals.

Where possible care at non-traditional sites should be limited to supportive care or palliation for influenza patients. Critical care would likely not be possible within these sites and should remain in the acute care setting. Persons with immunosuppressive illness or communicable diseases other than influenza (e.g. tuberculosis) should not be admitted to these sites.

In communities with a high proportion of elderly or high risk persons, the role of the NT site may need to be expanded to include the provision of health care services specifically related to dealing with the exacerbation of co-morbidities (e.g. chronic heart or lung disease, diabetes) in these groups.

Depending on the impact of the pandemic and the health care resources available in the community, NT sites may serve several functions. They may be set-up as triage centres, mobile health units, acute care or sub-acute care providers, clinics, or emergency residential facilities for those that cannot care for themselves at home or for cases that usually live with a high-risk individual.

1.3 Administrative Options for Non-Traditional Sites

NT sites may be established as a "satellite site" of an acute care facility or other health care facility, or as a "free-standing site". The "satellite site" model is advantageous since it does not require establishment of a separate administrative structure. Specifically, linkage with an existing acute care facility or other health care facility would facilitate the following:

- prompt implementation of an administrative structure,
- ordering, tracking and maintenance of equipment and supplies,

- implementation of record keeping and patient tracking systems,
- implementation/establishment of nursing protocols and patient care guidelines,
- sharing of expertise and human resources between sites,
- access to services such as sterilization, laboratory services, pharmacy services, laundry, food services,
- referrals between the site and the affiliated health care facility, and
- extension of liability, workers compensation and other insurance programs to the satellite site.

The satellite site is the recommended administrative option, however, where it is not possible to set-up a "satellite site" the establishment of "free-standing sites" will be necessary. Planning for the administration of "free-standing sites", including how the issues listed above will be dealt with at the site, will need to be completed during the inter-pandemic period. It is recommended that pandemic planning be incorporated into the existing emergency response plan.

Triage, transfer and transport agreements between the NT site and the affiliated health care facility or referral hospital need to be established.

Regardless of the administrative structure of the site, an individual or team needs to be designated to oversee the care provided in each NT site. This person/team should monitor patient flow, maintain a log of patient activity including patient outcome, and monitor availability of supplies. Delegation of these responsibilities to ensure ongoing and consistent administration of the site needs to be planned for in advance.

1.4 Insurance Issues

In planning for the establishment of NT sites during a pandemic it is important that insurance needs are considered and that provisions for appropriate insurance are made. Do not assume that the insurance covering the site for its usual use will extend to cover its use as an emergency medical site. Specifically, fire/damage/theft insurance and site liability insurance will be required for NT sites.

1.5 National Emergency Stockpile System

The National Emergency Stockpile System (NESS) was primarily developed for use in crises such as natural disasters, earthquakes, or other emergencies in which there is a sudden need for supplies and equipment to deal with a large number of people with varying medical needs. The program involves the purchase, packaging, shipping and storing of supplies and equipment organized into "kits" designed to meet specific emergency medical needs. The components of the "kits" are packaged and stored in warehouses across Canada to facilitate timely distribution. The NESS should not be confused with emergency stockpiles that may exist within each province or territory.

In the event of a pandemic, specific kits or units from the stockpile could potentially be used to facilitate reception, intake, triage and provision of medical and social services at a NT site. The following is a brief description of the types of kits/units available through the NESS.

- *Emergency Hospital* - capable of providing support to the existing health care system by the provision of acute and short term medical care for up to 200 patients. Also has the adaptability to support social services functions (i.e., evacuation centres, reception areas, shelters, etc).
- *Advanced Treatment Centre* - capable of providing early medical and limited surgical procedures in a 'field' or operational environment; also used to support the movement of patients to

other health care facilities. Can also support the movement of evacuees and the operations of shelters, evacuation centres, reception areas, etc.

- *Casualty Collecting Unit* - capable of providing immediate first aid care and movement of patients to other health care facilities. Also can support the movement of evacuees and the operations of evacuation centres, shelters, reception areas, etc.
- *Reception Centre Kit* - provides supplies, and registration and inquiry materials for the set-up and operation of reception functions for evacuation centres/shelters.
- *Mobile Feeding Unit* - provides an emergency feeding capability in a 'field' environment, or where normal food services are not available (equipment and supplies, not food).
- *Trauma Kit* - consists of first aid, intubation equipment, IV solutions and medical components to support first line response, patient triage and stabilization. Is useful in a patient staging facility (mini clinics, advanced treatment centres, etc.).
- *Mini Clinic* - intended to supplement existing medical care facilities in a disaster situation that overwhelms their system (e.g. a hospital emergency room). It would be located adjacent to these facilities to triage and treat the less seriously injured, so that the main facility remains clear to accept and treat the seriously injured.

The equipment supplied is older but well maintained. New equipment is being added to certain units and others are being reconfigured to be more effective. Transportation of these materials is dependent upon commercial or military vehicles and requires access by road or, for some items, an airport that will accept a Hercules aircraft.

In the event of a local emergency that overwhelms available municipal resources, the protocol for accessing the NESS program is that the municipality contacts the provincial/territorial emergency management authorities. Release of equipment or supplies must then be coordinated through the Provincial/Territorial Health, or Social Services Director. In certain cases the distribution of drugs is handled directly by provincial Chief Medical Officers of Health.

The NESS equipment and supplies are owned by the Office of Emergency Services, Health Canada and are made available to the provinces/territories on a loan basis. The province/territory administers this Federal program under guidelines established by the Office of Emergency Services and through 'Memoranda of Agreement' between the Minister of Health, Health Canada and the Provincial/Territorial Health and Social Services Minister(s). In a national emergency or large-scale disaster, the authority for the release and use of the stockpile equipment remains with the Director of Emergency Services, Health Canada. To obtain an Emergency Hospital or other unit, a Provincial Emergency Services Director must apply to the Director, Centre for Emergency Preparedness and Response, Health Canada.

For more information on the National Emergency Stockpile System contact your provincial/territorial Emergency Services Directors

1.6 NT Site Planning During the Interpandemic Period

The following activities should take place during the interpandemic period. Further detail is provided below the list.

- Review emergency preparedness legislation
- Identify triggers for implementation
- Plan for the triage process
- Assess locations for potential NT sites
- Planning for critical equipment and supplies

1.6.1 Review Emergency Preparedness Legislation

Emergency preparedness legislation makes many provisions for management of a crisis including: obtaining and accessing materials and other resources, implementation of crisis plans and a crisis management structure. Pandemic planning should be integrated with the emergency plans of the jurisdictions in order to make best use of existing plans and resources.

Important note: Regional pandemic plans should not assume that a national or provincial emergency will be "declared", as this is unlikely to occur during a pandemic. Provincial and Territorial planners should assess issues such as workers compensation and liability insurance, maintaining and supporting workers and other aspects of the plan without, such a declaration.

The national support framework is not contingent upon declaration of a national emergency. The resource management and non-traditional sites working groups recommend all provincial and territorial planners review both federal and provincial/territorial emergency legislation to determine how to integrate plans within the framework of emergency legislation.

For example it is important to identify what provisions of legislation are particularly applicable to obtaining use of property and materials in a crisis. These provisions would include but likely not be limited to:

- the ability and responsibility of authorities to requisition property for use as NT sites,
- access to transportation, materials, administrative staff and other resources, and
- compensation for requisitioned property.

1.6.2 Identify Triggers for Implementation

Existing legislation and emergency plans at the government and institutional level already identify criteria that would trigger the implementation of specific plans. The Canadian Pandemic Influenza Plan and the pandemic phases will also describe general points of action.

In co-ordination with existing legislation and plans, provincial/territorial, regional and local authorities and institutions should identify key criteria and methodologies that would trigger the phased implementation of plans regarding NT sites in their jurisdiction. Local authorities, most likely the local medical officer of health, together with the local pandemic response team, will decide when to initiate the pandemic influenza plan for their jurisdiction, including recommendations regarding the establishment of NT sites.

Since it is likely that the pandemic will not start in Canada, the first trigger for the consideration of establishment of NT sites may be reports of the severity and epidemiology of the pandemic from other countries. This will likely be the first indicator of what to expect when the pandemic reaches Canada in terms of demand on traditional health care services.

In each locality it will be important for the local pandemic response team to be monitoring the availability of resources in their local acute care facilities and projections regarding when capacity may be exceeded (especially if there will be "free-standing sites"). Therefore potential triggers include:

- The proportion of emergency room visits attributable to influenza.
- The proportion of influenza cases requiring hospitalisation.
- The capacity of the hospital to accommodate influenza cases.
- The proportion of cases who normally live with high-risk individuals or who have no support at home and cannot care for themselves.

Other triggers may include reports from sentinel physician or walk-in clinics that they cannot accommodate all of the patients requesting appointments for influenza-like-illness (ILI). Ambulance re-routing to other acute care setting due to full emergency rooms may serve as another trigger

for further implementation of plans for NT sites. These triggers should be established during the interpandemic period.

1.6.3 Plan for the Triage Process

> *Definition of Triage:*
>
> A process whereby a group of casualties or patients is sorted according to the seriousness of their illness or injuries, so that treatment priorities can be allocated between them. In emergency situations it is designed to maximize the number of survivors.

In order to reduce demand on hospital emergency departments and potentially on family physicians and walk-in clinics, it may be necessary to perform triage at NT sites during the pandemic. The use of such a system will require a significant public awareness campaign since ill people will tend to seek services at their usual health care providers.

The Clinical Care Guidelines and Tools (Annex G) provide recommendations on the assessment and management of influenza and non-influenza patients during a pandemic, including algorithms on the triage of adults and children based on their clinical presentation and risk factors or co-morbidities. The guidelines on initial assessment and management assist healthcare staff, as well as volunteers with minimal expertise, to rapidly evaluate the needs of each individual and to sort patients efficiently in a crisis situation (i.e., to decide when patients can be treated as outpatients, or if they need to be redirected or admitted to a hospital). In larger communities, patients who required further assessment by a physician, X-rays and laboratory tests (secondary assessment) would likely be transferred to an acute care facility. Some NT triage centres, however, may have the facilities to perform secondary assessment and treatment without moving the patients.

Designation of NT sites as triage centres specifically for ILI has the added advantage of potentially reducing the exposure of other patients to influenza, consistent application of current recommendations through the use of patient care protocols and control over the number and type of other services, such as laboratory testing and chest x-rays, that are being ordered.

Non-traditional triage sites may be established at public health clinics/units, specifically identified walk-in clinics or triage centres adjacent to or associated with acute care institutions.

Triage sites will need to be organized to provide streamlined and efficient service. The following table is provided for planning purposes and suggest how a site might be organized.

Zone	Service	Training Required
Registration zone	Register in-coming patients	Trained non-medical workers
Waiting zone	Awaiting primary assessment	Medical professionals with trained non-medical workers
Primary assessment zone	Vital signs Chest auscultation & assessment	Trained non-medical Medical professional (physician or nurse)
Secondary assessment zone	On-site lab tests Secondary assessment	Trained non-medical workers Physician
Advanced first aid & transfer zone	Service to patients who arrive in distress includes oxygen, suction, etc. while they await transfer to emergency department	Advanced first aid
Education zone	Education resources and advice	Trained non-medical workers
Discharge zone	Follow up or transfer	

The Infection Control and Occupational Health Guidelines (Annex F) lists some guidelines for the set up of triage and preliminary treatment sites including:

- If possible, separate those with ILI and those without ILI by: minimizing time spent in waiting rooms; providing separate entrance/waiting areas for patients with lLI; placing patients with ILI directly into a single room; separate patients as quickly as possible by placing ILI patients in an area of the waiting room separated from non ILI patients by at least one metre.
- Remove magazines and toys from the waiting rooms.
- Clean equipment and environmental surfaces in examination/treatment rooms potentially contaminated by coughing patients as frequently as possible, preferably after each patient.

1.6.4 Assess Locations for Potential NT Sites

It is recommended that a multidisciplinary team approach be used to assess potential NT sites in a jurisdiction, to ensure suitability of a potential site. Ideally the assessment team should include:

- emergency personnel/police/fire,
- health care personnel, and
- engineering/maintenance/public works staff.

This team should conduct a community-wide space and site inventory to determine the location and availability of potential sites for NT hospitals and vacant land for possible mobile hospital installations. This assessment should be repeated at regular intervals during the interpandemic period to ensure that identified sites remain suitable. Potential locations for NT sites include, but are not limited to:

- schools
- hotels
- community halls
- banquet facilities
- arenas
- churches
- closed hospitals or hospital wards
- day care centres

For each location the feasibility of its use as a NT site should be determined based on the information below and the intended use of the facility.

Since a site at which inpatient care will be provided will have the most stringent and demanding requirements, it might be reasonable to assess each location for this type of service provision. Locations that are not found to be suitable for provision of inpatient care may be considered for another purpose such as triage or provision of education/counselling services.

Characteristics and Services Required for an Inpatient Care Setting

Each building under consideration should meet the National Building Code standards for its currently designated building type.

Once the building code standards have been assessed, the following issues need to be considered:

- Adequacy of external facilities:
  - public accessibility (including public transport, parking, directions) off-loading, traffic control, assistants for elderly, etc.

- Adequacy of internal space:
  - washrooms and sinks: number m/f; amenities, function
  - kitchen: refrigeration, dishes, dishwashing capability, food preparation areas etc.
  - secure space for administration/patient records
  - space for reception, waiting, patient care, patient/family education, counselling/support, and any other services defined by the planning process
  - secure storage capacity for pharmacy and other supplies
  - mortuary space
- Adequacy of critical support systems required for the site to provide patient care:
  - ventilation system (adequate air flow, air conditioning)
  - physical plant/ building engineering
  - electricity - power for lighting, sterilizers, refrigeration, food services.
  - natural gas supply – e.g., for heating or electricity or cooking
  - water supply
  - sanitation (including number of toilets, showers or washing facilities)
- Arrangements to provide essential support services required for the provision of in-patient care:
  - security
  - communications capability
  - maintenance
  - laundry
  - environmental/cleaning services
  - sterilization services – Sterilization of equipment should be provided by trained and experienced personnel using certified equipment. Appropriate arrangements for sterilization services, e.g., with a hospital, may be required
  - pharmaceutical services
  - medical waste disposal/storage
  - mortuary/funeral services
  - food services
  - facilities for staff lodging and feeding

Infection Control

When planning for a NT site it is important to establish whether the site will focus only on the care of influenza patients or whether other types of patients will be receiving services at these sites. Infection control issues will be greater if transmission of influenza to other patients is a possibility.

All patient beds should be separated by at least one metre; as is the norm for patients with any medical condition. If non-influenza patients will be seen at these sites separate waiting areas should be considered for potential influenza patients. For NT sites focussed on influenza, there appears to be no infection control basis for segregating people at various stages of illness. In either situation health care workers and visitors to the site will need to be educated regarding appropriate infection control practices.

Infection prevention and control issues are addressed in detail in Annex F of the Plan.

Security and Safety

The safety of buildings will be based on National Building Code and CSA standards. "Security" includes security of access, security of medications, and the security of patients. Security issues must be considered in choosing sites as well as when planning for staffing needs.

Upgrade Facilities

Some facilities may need to be upgraded, in order to be used as a medical site. Local authorities may wish to upgrade designated facilities in order to ensure they are adequate. Upgrades such as improving power supplies and upgrading washing facilities may be considered as an investment in emergency preparedness and part of overall emergency planning for the community.

As it is much less expensive to build in facilities at the time of construction then to add them later, emergency planners and pandemic co-coordinators may work with local authorities, school boards, etc. to add facilities to buildings that are under construction. .

1.6.5 Planning for Critical Equipment and Supplies

During the interpandemic period planners should identify critical equipment and supplies necessary for the establishment and operation of NT sites. Sources of supplies need to be identified; expected needs during an influenza pandemic and ability to meet those needs should be discussed with all possible suppliers. Potential access to the NESS should also be addressed.

A pandemic will likely result in shortages of medications, medical supplies and potentially operational supplies. Since multiple jurisdictions including other countries will potentially be affected by these shortages, the response plan should not rely heavily on outside assistance in terms of the provision of supplies and equipment. Some of the issues directly affecting Canadian supplies will be:

- *Interrupted transportation lines*—Canadian supplies travel long distances by truck train and aircraft. Supplies are often obtained from the U.S. and other nations. Difficulties at border crossings may substantially affect supply lines. In addition, a loss of up to 30% of workers, drivers, and other transportation staff may affect the production and delivery of supplies.
- *Lack of inventory* — In an effort to reduce costs, most health regions have moved to "just-in-time" inventory systems that keep minimal supplies on hand. Consideration should be given to the purchase of products made in Canada to avoid potential supply problems due to border crossing restrictions implemented at the time of the pandemic.
- *Embargoes* — The majority of medical supplies are not produced in Canada. Health Canada has made major efforts to establish a domestic infrastructure for the manufacturing of influenza vaccine and has encouraged in-Canada manufacture of some antibiotics. However in many cases supplies are provided by only one or two manufacturers worldwide or the essential ingredients or components come from a single source. In past pandemics and health crises other nations have banned the export of critical vaccines, medications and supplies.

Recommendations for the use of vaccine and antivirals during a limited supply situation are provided in other annexes.

Transportation and Supply Logistics

Transportation planning for NT sites should include consideration of the types of supplies and products (e.g., dangerous goods such as oxygen, biomedical waste, equipment for sterilization)

that will need to be transported to and from NT sites, who will provide these services (i.e., will volunteers need to be trained) and whether the site has appropriate delivery access. The size and types of vehicles and other mechanisms of transport have been identified for each "kit" that is available through the NESS.

Stockpiling

Provinces/territories and local health authorities may wish to review the possibility of rotating stockpiles of critical supplies for NT sites within their own jurisdictions. Jurisdictions may specifically wish to keep some older equipment such as beds, which need little maintenance and have no specific "shelf life". Appropriate assessment should be made of the maintenance and training required to ensure the safety and effectiveness of older equipment, training needed by staff to use unfamiliar equipment, etc.

After such a critical assessment, institutions and health authorities may consider maintaining certain critical pieces of older equipment such as ventilators.

The stockpiling of antiviral drugs will be discussed at the national level, however, the need to and feasibility of stockpiling critical medications for the management of patients with influenza and secondary pneumonia, should be addressed at the P/T and local levels. In addition, provinces and territories will have to discuss with local pandemic planners the need to stock larger quantities of medications and equipment to manage persons with co-morbidities, e.g. chronic cardiac and respiratory disease, diabetes, renal failure, that may be exacerbated by influenza infection. The Clinical Care Guidelines (Annex G) provide guidance on antibiotics for the treatment of secondary pneumonia. The antibiotics currently stockpiled at the national level will be reviewed to determine whether these can be utilized in a pandemic, in addition to, further discussions on the need for additional national stockpiles.

Equipment and Supplies

The issue of equipment and supplies has been addressed in other annexes. The Resource Management annex provides information on supplies and equipment issues for acute care facilities that can be extrapolated to identify needs for NT sites. In addition, the treatment protocols in the Clinical Care Guidelines (Annex G) can be used to plan for medical supply and equipment needs. The Infection Control annex will address the use of masks and gowns and other supplies in various settings.

The services offered by each NT site will obviously dictate equipment and supply needs. For example, it is unlikely that NT Sites will be able to provide the expertise and resources required to support intubated patients, however, equipment may be needed to support patients requiring ventilation while they are transported to another facility. Isolated communities may wish to review the possibilities for hand ventilators (Ambubags) for short-term assistance and other equipment that does not require the same expertise or support as for ventilated patients.

The following is a preliminary list of medical equipment and supplies needed to provide medical care in each site.

- beds, bedding
- lights
- intravenous equipment (e.g., needles, intravenous catheters, fluid and tubing, syringes, tape, tourniquet)
- sterilizers
- sphygmomanometer, stethoscopes, thermometers

- miscellaneous supplies (e.g., antiseptics, dressings, bandages, steristrips, gloves, alcohol based hand sanitizers, alcohol sponges, gauze sponges, arm boards, pulse oximeter, extra batteries for equipment needs, flashlights, scissors, tongue blades, portable lamps)
- emergency drugs (e.g., epinephrine, diazepam, salbutamol)
- airway supplies (e.g., bag-valve-mask, oxygen masks, oxygen tubing, oxygen tank, spacer device for aerosolized medication, motor-driven nebulizers, oral airways, suction machines and catheters)
- patient identification tools
- privacy screens
- communications (telephone, fax, cell, radio or alternatives for isolated communities)
- computers and Internet access

Supplies will need to be carefully managed. An example of a supply management form is provided in Appendix A.

Local Production

During a crisis some items, which are usually ordered from centralized sources, may be produced locally. Procurement specialists may wish to review which supplies could be obtained or produced locally if prior arrangements are made. Possible suppliers and suppliers of alternative products should be contacted to explore this possibility.

1.7 NT Site Planning During the Pandemic Period

The following activities, with respect to NT sites, should occur during the pandemic, when there are indications that NT sites will be needed, based on local resource availability and utilization, and projections of disease impact:

- Re-evaluate plans based on WHO and Health Canada epidemiological projections.
- Appoint site administrators/managers or teams
- Implement plans to prepare the site(s)
- Co-ordinate procurement of supplies

1.7.1 Re-evaluate Plans Based on WHO and Health Canada Epidemiological Projections

Based on expected attack rates and the demographic of the groups most affected, local planners may re-evaluate what sites and services may be required. For example, if it appears pregnant women will be seriously affected by influenza as they were in 1918, moving deliveries to birthing centres may not be appropriate.

1.7.2 Appoint Site Administrators/Managers or Teams

Each NT site will require a site administrator/manager or a team of managers to locate the site, set up, manage adaptations, schedule staff, oversee movement of supplies, maintenance etc. and continue to operate the site. Depending on the size of the NT site, what services are offered and the community, this may require on-site management 24 hours a day 7 days a week for the duration of the epidemic wave. The nature of the task and the fact that any one may fall ill or be incapacitated requires that all such managers should have alternative people to whom to delegate authority.

1.7.3 Implement Plans to Prepare the Site(s)

The Centre for Emergency Response and Preparedness (CEPR), Health Canada, has developed outlines for the planning and operation of Emergency Reception Centres and Shelters available through CEPR or the Provincial/Territorial Emergency Services Directors.

- Contact those currently responsible for the site (school board, civic authorities for community centres, etc.)
- Conduct a "walk through" of the site to determine any problems or needed emergency upgrades.
- Ensure heat/light/power/water/telephone is operational.
- Ensure adequate furniture and position.
- Remove any obstructions, tripping hazards, impediments to flow, etc.
- Affix or erect any necessary directional signs, including route to washrooms if unclear.
- Identify various rooms/areas for specific functions (e.g., rest, food service, etc.)
- Ensure adequate hand hygiene stations are available.
- Document and report any:
  - deficiencies in facilities;
  - failure of heat/light/power/water/telephones.
- Arrange to move out and store any equipment that will not be needed (e.g. desks, chairs).
- Clean and disinfect the site.
- Contact any required transportation providers.
- Notify pre-determined media for public direction.
- Determine staff support - electrician/plumber/public health inspector/public health nurse/ occupational health and safety personnel.
- Determine municipal support.
- Address financial implications to municipality. Ideally, using previously established accounts.
- Notify garbage removal contractor if required.
- Notify recycling removal contractor if size or duration indicates.
- Notify staff, volunteer agencies, and specialty personnel (see Human Resource Section).

1.7.4 Coordinate Procurement of Supplies

- Contact stationery, office, and support equipment providers; arrange transportation if required.
- Contact identified food suppliers (may be a pre-alert to provide lead time).
- Notify any required food transporters (vehicles).
- Arrange for dishes/eating utensils if not present at identified food serving locations.
- Order additional medical supplies.
- Establish alternate transportation/distribution arrangements if required.
- Establish local production of supplies where possible.
- Evaluate the need to access supplies from the NESS and request if necessary.

1.8 NT Site Planning During the Post-Pandemic Period

The possibility of subsequent waves of the pandemic, and the resources that would be required during those waves, should be considered before decommissioning NT sites.

Activities at NT sites during the post-pandemic period will focus on the discharging or re-locating of patients, storage of medical records and the decommissioning of the NT site(s). Each site should be assessed for damage or necessary alterations to return it to its previous use. Supplies should be redistributed, stored or returned to stockpiles. Insurers will also need to be notified of the date the site was decommissioned in order to discontinue the coverage.

2.1 Introduction

During an influenza pandemic there will be an increased need for people with health care training to deal with the increased demands on the health care system. This may involve the re-locating of health care workers to different settings, including NT sites or to different locations within the same traditional site to provide services that differ from their usual responsibilities. In addition, non-health care workers may need to be hired/contracted to provide supplementary services essential to the establishment and operation of NT sites or the expanded role of current health care sites. Volunteers will also be a potentially vital source of human resources to facilitate the management of health care services during a pandemic.

During an influenza pandemic the shortage of trained medical staff will be one of many barriers to the provision of adequate care. A significant proportion of the workforce may be unable to attend work for a period of time due to illness in themselves or family members. Communities and health care organizations will need to have specific guidelines in place to address what will be done if the health care system is overwhelmed and NT sites must be established or current service sites expanded. Human resource management in the acute care setting during a pandemic is addressed in the Resource Management Guidelines for Health Care Facilities During an Influenza Pandemic, Annex H of the Plan. This section of the document will, therefore, focus on human resource issues outside of the traditional acute care settings.

2.2 Human Resource Planning During the Interpandemic Period

Planning during the interpandemic period for the optimal use of human resources at NT sites and other health care sites involves several steps. The following list of steps/activities is provided to assist with this part of the planning process, details are provided in the following sections.

- Appoint a human resource management team.
- Identification of human resource needs and a database to be used for staff and scheduling.
- Review emergency preparedness legislation.
- Recruitment of health care professionals.
- Plan for salaries or payments to staff not currently employed by the health care system.
- Identify and recruit volunteers.
- Provide training.
- Establish immunization recommendations.
- Supporting health care workers in NT sites.
- Insurance/licensing.

2.2.1 Appoint a Human Resource Management Team

The work involved in identifying current health care workers who could be re-located to NT sites; recruiting additional health care workers, non-medical workers and volunteers; and managing the training, assignment and support of these workers, should be initiated during the interpandemic period.

Establishment of a team or subcommittee that could take on these responsibilities in each jurisdiction is an important first step. A combination of professionals with expertise in human resource issues, pandemic planning, health care administration, and volunteer organizations would be desirable for this planning team/subcommittee.

2.2.2 Identify Human Resource Needs

One approach to identifying the human resource needs for NT and other health care sites is to consider each potential type of site and the services that would be provided at each. From this exercise the number and type of health care workers and non-health care workers that would be required per site could be estimated.

The following is a list of where additional or new human resources will be needed during a pandemic (excluding acute care facilities).

- Triage Sites – community triage sites: at clinics, non-traditional sites, attached to an existing hospital
- Non-Traditional Sites – including emergency care centres, emergency hospitals, support hotels, nursing stations, etc.
- Vaccination Clinics – mobile clinics, clinics in acute care sites, etc.
- Home Care/Community Care – to reduce the pressure on other health care programs
- Long Term Care Facilities
- Telephone Information Services, 24-hour health lines
- Other – doctors' offices, specialty health services (cancer or cardiac treatment centres), etc.

In order to make best use of the skills of various health care workers a pandemic will likely require that health care workers be reallocated from their usual roles and settings. For example, trained, health care professionals, will be required to supervise volunteers and other staff in clinics and non-traditional sites.

Shortages of physicians and nurses will require extensive use of other health care professionals, trained non-medical workers and trained volunteers. Each jurisdictions needs to conduct an inventory of health care personnel and potential volunteers and determine sources from which additional staff could be acquired, assuming that hospitals are using much, if not all, available staff for their own needs. The following list is for reference, and may be adapted and altered to meet various needs.

Health Care Workers (HCWs)

Within facilities, consideration should be given to reassigning medical and nursing personnel with administrative, research and educational assignments to clinical duties.

Alternate sources of HCWs would include, but are not limited to:

- retired physicians/nurses (need to be assurance that work during a pandemic would not affect their pension plans)
- physicians/nurses currently not working in clinical health care (i.e., working in education, administration, research, private industry)
- medical and nursing students
- registered nursing assistants
- patient care assistants
- emergency medical technicians

- veterinarians
- pharmacists
- therapists (respiratory/occupational/physio)
- technicians (laboratory, radiography)
- pharmacists, therapists, technicians in training
- health care aides

Personal Care Services

Personal care services involve those people that provide health care and support services in the home. It is recognized that these organizations already function near capacity and may have limited ability to expand during a pandemic. These services include, but are not limited to:

- VON
- Home Health Agencies

Categories of Workers

In a pandemic, in addition to current health care workers, health care tasks may have to be undertaken by personnel who would not normally perform these tasks. For the purposes of assigning tasks, training, support, insurance and other issues human resource planners and managers must be aware of the following types of workers:

- paid health care professionals
- paid health care workers who are not licensed professionals
- paid non-health care/non-medical staff (support, maintenance, etc.)
- volunteer health care professionals
- volunteers trained in medical tasks, but who are not licensed professionals.
- volunteers not trained in medical tasks, but can provide other essential services to health care sites– e.g. electricians, who help set up the NT site.

For each site the essential functions and the skills required to complete each task should be identified and documented. It will be necessary to establish medical and nursing directives for each NT site (triage, influenza hospital, nursing station, community clinic or support hotel) and to access existing directives for sites that may need to be expanded during a pandemic.

The next step is to list the type of workers/volunteers who already have the skills to carry out these tasks. (In existing institutions these roles are already defined, however they will need to be developed and adapted for use in the non-traditional sites.) Any gaps in required skill sets should be addressed during this planning exercise. It may be necessary to investigate the local availability and access to other types of service providers in this type of emergency situation (e.g., mortuary services).

Checklist of Functions and Personnel at Non-Traditional Sites

This is a checklist of functions that may be required at a non-traditional site. It is an example of how the exercise described above might be documented. Depending on size, number of patients and function of the site, many tasks may be carried out by the same individual. Consider that these functions may be required 24 /7. Some services may be provided by a central hospital or community.

FUNCTIONS	SKILL SETS/PERSONNEL
A. Administration	
Site administration/management	Management/administration
Co-ordination of patient care – staff scheduling and support, assessing service demands and supply	Medical training/knowledge (e.g. in-charge nurse), leadership and coordination skills
Medical management	Physician or nurse with physician backup
On-site training and orientation of staff, volunteer and family members	Knowledge of basic patient care, patient triage, infection control, occupational health and safety
Spokesperson	Medical management. If no medical spokesperson refer to hospital or site administrator
Receptionist	Communication/language skills, public relations
Health records management	Clerical skills (including computer skills), confidentiality agreement
Information technology resource	Knowledge of IT systems and problem solving skills
B. Patient Care	
Medical triage	Medical training/nurse, ideally with ER training
Admissions/discharge	Medical training/nurse, ideally with experience in discharge planning
Patient care - medical	Instructed in nursing care: rehydration, feeding, ambulation, bathing, vital signs monitor, give meds
Physiotherapy	Trained in chest phyiotherapy and mobilization
Respiratory care	Trained in oxygen delivery, patient monitoring, equipment monitoring (oximeters) and inventory
Pharmacy services	Pharmacist at hospital or in community
Discharge planning	(Refer to community care, self care)
C. Infection Control	
Sterilization of equipment	Trained in sterilization and infection control
Housekeeping	Basic infection control knowledge
D. Food Services	**Hospital or community based?**
Patient nutrition/therapeutic diets	Dietician at hospital or in community (home care, meals on wheels)
Food preparation - workers' meals	Basic food safety training
E. Social Services	
Social service/community care	Counselling, accessing community resources/ Liaison Social Worker
Psychology/pastoral care/grief counselling	Social workers, religious leaders, psychologists, local service clubs/support groups
Care for children/family members of workers	Training or experience in child care, care for elderly, home care/criminal records check
F. Morgue	
Transportation of corpses	Driver's license
Preparation and storage of corpses (see Annex on Mass Fatalities)	Body bagging, shelving corpses

FUNCTIONS	SKILL SETS/PERSONNEL
G. Transportation	
Patients, staff	Class 4 license
Dangerous goods (e.g. oxygen), medical waste	Appropriate licenses and liability insurance
Supplies, lab tests	Drivers license, criminal records check
H. Services	
Laboratory testing	Laboratory services at hospital or in community
Maintenance	plumbing, electrical, etc.
Laundry	local laundry business
Communication services and equipment support – phone, cells, cable, computer support	Local businesses
I. Security (Staff ID will be necessary)	
Public order and personal safety	Crowd control, traffic control
Protection of site – fire safety, theft	Trained in building safety and security

Training for health care workers, volunteers, family members may be carried out at the time of a pandemic.

2.2.3 Review Emergency Legislation

Emergency legislation makes many provisions for the management of workers during a crisis. This includes the recruitment of professional and other paid staff as well as volunteers, managing human resources and protection of people who volunteer. Pandemic planning should be integrated with the emergency plans of the jurisdictions as much as possible, in order to make best use of existing plans and resources. Remember, it is unlikely that an Emergency will be "declared". Therefore human resource planning should be based on existing plans without a declaration.

The following provisions of legislation are particularly applicable to human resource issues including:

- authority regarding licensing and scope of practice issues, and the ability of government to make unilateral changes during a crisis;
- safety and protection of workers, (one of the primary responsibilities);
- fair compensation;
- insurance, both site insurance, workers compensation and other forms of insurance;
- training;
- provision of clothing and equipment;
- protection of the jobs of workers who take leave to assist during the crisis.

Compelling Workers

Under emergency legislation provinces/territories may have the authority to designate "Essential Services" and workers and have the ability to compel people's time or property with due compensation as a last resort.

This issue has been raised both because of the existing shortage of health care workers and concerns that health care workers and others may refuse to work during a pandemic due to changed job responsibilities, fear of infection, family responsibilities or other reasons. However, the extreme difficulty of enacting or enforcing such legislation has been noted and jurisdictions

are strongly encouraged to review all other methods of obtaining essential human resources, in advance of a pandemic.

2.2.4 Recruitment of Health Care Professionals

While actual recruitment of health care professionals for the purpose of service provision will not be necessary until the pandemic arrives, it is important to establish an ongoing dialogue with these professionals in the interpandemic period. Communication must take place to inform health care professionals about influenza, influenza pandemic plans and their roles within those plans. It will be important to convey the potential impact of the pandemic on health care service provision and specifically the need for additional human resource and NT sites. Issues regarding licensing and scope of practice expansion during a crisis should be discussed with the goal of addressing any concerns during the interpandemic period rather that at the time of the pandemic. In addition, any potential impediments for recruited/volunteer health worker being able to return to their own workplace following the provision of services in the NT site, will need to be addressed in advance. Education regarding the identification and treatment of influenza and immunization programs should also be ongoing during the interpandemic period.

In order to be able to call on health care professionals, for the purpose of pandemic training or the implementation of the pandemic response, planners should review the logistical and legal issues around developing databases of HCWs who have the training and skills needed during a pandemic. This may be achieved by arranging with the appropriate licensing bodies or associations for the establishment and maintenance of databases of members for use during a crisis. There may be legal requirements that individuals agree to keep their names on a list of professionals available for work in a crisis.

2.2.5 Plan for Salaries or Payments to Staff Not Currently Employed by the Health Care System

Decisions around payment and expenditures will be based on current arrangements and labour agreements in each province, territory or local jurisdictions. Planning must be based on these contractual arrangements or assessment of current local salaries for similar work.

2.2.6 Identify and Recruit Volunteers

Definition of Pandemic Volunteer

The following is a definition of a volunteer for the purposes of pandemic planning and response.

> *A volunteer is a person registered with a government agency or government designated agency, who carries out unpaid activities, occasionally or regularly, to help support Canada to prepare for and respond to an influenza pandemic. A volunteer is one who offers his/her service of his/her own free will, without promise of financial gain, and without economic or political pressure or coercion.*

A volunteer may be a health care or other professional, or any other person who offers their services freely. Notwithstanding that while a volunteer may not expect financial gain, or remuneration for their time, the agency or government may provide supports such as: insurance protection, family support and job security to facilitate the recruitment of needed volunteers.

Interpandemic Tasks in Volunteer Management

There are several tasks/activities that should take place during the interpandemic period to optimise the use of volunteers in the pandemic response. These include:

a. Communicate with the public and with volunteer organizations.

b. Develop and maintain databases of volunteer organizations.

c. Develop Job descriptions and skill lists for volunteer positions in conjunction with volunteer agencies. (See Checklist of Functions and Personnel)

d. Develop recruitment, screening procedures.

e. Develop training procedures.

f. Monitor and track qualifications.

g. Prepare to manage volunteers.

The time between the WHO declaration of an influenza pandemic, the first wave and analysis of the severity of the pandemic will be very short. There will be a need to recruit, screen, train and deploy volunteers as quickly as possible. Therefore procedures need to be in place in order to best place volunteers in as short a time as possible.

a. Communicate with volunteer agencies

Existing volunteer agencies will be the primary source of trained, screened volunteers in most jurisdictions. Developing ongoing communications and planning procedures with these agencies will be essential to the planning effort.

Potential sources of volunteers include, but are not limited to:

- Red Cross
- St. John Ambulance
- Salvation Army
- Volunteer Fire Departments
- Mennonite Disaster Services
- Adventist Disaster Relief Association (ADRA)
- Scouts, Sea/Army/Air Cadets, Guides
- Big Brothers
- Big Sisters
- Community Service Agencies
- Christian Reformed World Relief Committee - Disaster Response Services

Each jurisdiction needs to liaise with non-governmental organizations within their district to determine the approximate number of volunteers who would be available during a pandemic.

During the interpandemic period, recruitment of volunteers, both those with health care skills and those without should take place primarily through existing agencies. These agencies already have recruitment, screening, training programs and management programs in place. It is important that health authorities and emergency planners establish communication with existing agencies to communicate community needs during a pandemic, in order that agencies may recruit and maintain a core group of volunteers with appropriate training. They may wish to add certain types of training to standard training programs in order to address issues regarding pandemic influenza. Specifically, volunteers should be aware that unlike other emergencies such as earthquakes or floods, the duration of the “emergency” will be longer for an influenza pandemic and more than one pandemic wave will likely occur. Since people view

the risk of disease differently than the risk of injury, and will be concerned about bringing this disease home to their families, it is important that these issues are addressed during training sessions.

b. Develop and maintain databases of volunteers

Because maintaining up-to-date databases of volunteers is time consuming, difficult and expensive, health authorities will likely have to depend on existing volunteer agencies. Such agencies should be encouraged, where possible, to track trained and screened (those that had interviews, reference checks and criminal records checks) volunteers and track records of certificates or diplomas and maintain methods of communication. Health authorities may wish to encourage these agencies to keep their databases current, and to expand the information on their volunteers' skill sets or experiences, to include skill sets that would be required in a pandemic.

c. Develop job descriptions and skill lists for volunteers

Develop a list of jobs, job descriptions and skills based on the needs of the region or community and working in conjunction with volunteer agencies. (See Checklist of Functions and Personnel). This list can be used to determine which training programs are necessary and how best to recruit, train and assign volunteers in the interpandemic and pandemic periods.

d. Develop volunteer recruitment, and screening procedures

Develop procedures that can be implemented quickly once a pandemic is declared. (See Pandemic Period – Recruitment, Screening and Deployment.)

e. Monitor and track qualifications and certification

Plan for methods to ensure health care workers, including volunteers are trained and certified for the tasks they are undertaking.

- Review the logistical and legal issues around developing databases of HCW's who have the training and skills to be deployed during a pandemic.
- Arrange with appropriate agencies to maintain databases of members for use during a crisis. There may be legal requirements that individuals agree to keep their names on a list of those available for work in a crisis.
- Plan for a "Quick Check" method of confirming certification or qualification.
- If a volunteer is trained at an NT site during a pandemic, plan for ways to test and record the level of skills.

f. Prepare to manage volunteers

During a major crisis many people come forward who wish to volunteer. In some cases managing the numbers of people who come forward to volunteer is a major logistical effort in itself.

During the interpandemic period:

- Review emergency plans for managing an influx of volunteers.
- Plan for a volunteer co-ordinator or team – identify agencies, positions or individuals – to take responsibility for directing the process of accepting, screening, training and placing volunteers.
- Ensure resource information is available to the volunteer co-coordinator/team.
- Plan for a location for volunteer recruitment/management that is separate from existing hospitals or clinics to reduce congestion and security issues.

2.2.7 Provide Training

Both health care professionals and other workers will need training for dealing with pandemic influenza. Professionals may need training or refresher courses in tasks they don't normally perform, including supervision and management. Due to the limited number of health care professionals that will be available in the community, volunteers and other non-medically trained staff will likely be needed to perform direct patient care.

i) Train the Trainer

Health authorities and existing volunteer agencies, may establish programs to "train the trainers," to maintain resources to call on during a pandemic. Plan for where and how training programs will be delivered, ideally during the interpandemic period, but also during the pandemic.

ii) Train for Self-Care

All health care workers should be trained in self-care as it pertains to pandemic influenza treatment and symptom control and the ability to communicate the principles of self-care to others. As professionals will likely be required for the provision of medical services, teaching self-care skills may become part of the volunteers' role.

A number of jurisdictions are currently developing "Self-Care" modules designed to improve the quality of home care. (See the Clinical Care annex for more information). Jurisdictions are encouraged to share such resources and to develop other health information services for the public, e.g. 24-hour telephone health information services. Ensure that all those training in self-care are using consistent, accurate and up-to-date information.

Plan for methods to educate health care workers and the public in Self-Care. While some education will be done in advance, much of the education of patients and their families will take place in clinics, NT Sites, vaccination clinics during a pandemic.

iii) Train Health Care Professionals

A number of training programs exist which can be adapted for pandemic influenza. Health care professionals may need training for reassignment and training for supervision.

The time for training once a pandemic is underway will be extremely short; therefore training should be incorporated into existing programs now. By incorporating the skills needed during a pandemic into existing training, we reduce costs, improve efficiency and enhance readiness.

Training may include medical training essential to working in a pandemic situation including:

- Infection control procedures
- Use of respirators and care of patients on respirators
- Worker and volunteer supervision
- Working with grieving families

Develop a plan for training/retraining health care workers who have not been working in health care (retirees, etc.) at the time of a pandemic. (See Resource Management Guidelines in Acute Care Settings [Annex H] for lists of Health Care Professionals.)

iv) Train Volunteers

During the interpandemic period, volunteer training may be left as much as possible to existing agencies. In areas without well-developed volunteer systems and agencies, planners may wish to review the need for developing, maintaining and funding core groups of volunteers trained for medical emergencies such as pandemic, and trained trainers.

All volunteers should be trained for

- Self-care and
- Infection prevention and control (routine or universal precautions).

Based on the Checklist of Functions for your jurisdiction, volunteers working in direct patient care may also be trained in:

- Basic personal care (bed baths, bed pans)
- Observation of condition (temp, pulse, resp, etc.)
- Case definition, identify the illness
- Giving medications (pills, eye and ear drops, liquids)
- Oxygen administration
- Pressure ulcer prevention – skin care
- Ambulation, mobilization

Volunteers will also be needed who are trained in the following:

- Cleaning in health care facilities
- Records management
- Food preparation (food safety courses)
- Workplace Hazardous Materials Information Systems (WHMIS) protocols
- Security staff trained in working with grief stricken people.

Review the Checklist of Functions for the training required in your jurisdiction. As far as possible, existing agencies should be encouraged to maintain skills in these tasks during the inter-pandemic period.

v) Training Resources and Programs

Curricula for the above listed skills are available through existing agencies.

Training programs include, but are not limited to:

- on-line courses, including an Infection Prevention on-line course for infection control issues at www.igc.org/avsc/ip/index.html
- Association for Practitioners in Infection Control and Epidemiology training manual "Influenza Prevention: A Community and Healthcare Worker Education Program" < http://www.apic.org/resc/>
- St. John Ambulance Brigade. Brigade Training System. 1997
- St. John Ambulance Brigade. Handbook on the Administration of Oxygen. 1993. ISBN 0-919434-77-0
- The Canadian Red Cross Society. Yes You Can Prevent Disease Transmission. 1998
- Nursing colleges training programs (i.e. the basic care programs for health care aides)
- CHICA, APIC and the Infection Control Association in the UK have a "tool kit" with detailed forms and templates that could be used at the NT site, 2002. [reference: "Infection Control Toolkit" - Strategies for Pandemics and Disasters, can be ordered through the Community and Hospital Infection Control Association (CHICA-Canada), Phone: 204-897-5990 or toll free 866-999-7111; Email : chicacda@mb.sympatico.ca]

2.2.8 Establish Immunization Recommendations

While no vaccine for the pandemic strain of influenza will likely be available in advance of the arrival of the pandemic in Canada, health care workers should be up-to-date with the other recommended immunizations. Because immunizations require varying amounts of time and some require more than one dose for a person to develop immunity, it will likely be impossible to

provide all of these once a pandemic is declared, or to provide them within an appropriate time frame given the lack of supplies and human resources.

Where possible volunteers already working with existing agencies or recruited in the interpandemic period should be encouraged or required to be up-to-date with respect to the recommended immunization schedule. In addition, depending on type of work they will be doing during the pandemic, it may be appropriate to recommend that volunteers receive the same immunizations that are recommended for health care workers (e.g., hepatitis B vaccine). Volunteer recruiters should also ask for immunization records, where possible, to facilitate identification of individuals who are not up-to-date with respect to the current recommended schedule.

2.2.9 Supporting Workers in NT Sites

Plans to extend support programs for health care workers (including trainees, volunteers and retirees) to all workers at NT sites should also be included in overall plan for the management of human resources. Support should include: provision of food and drink, grief counseling, support for families and job protection.

2.2.10 Insurance/Licensing

In addition to addressing any liability / insurance issues in relation to health care professionals and other non-professional health care workers, these issues must also be addressed for retired/trainee health care professionals and volunteers performing patient care and other non-medical tasks.

There are a number of insurance issues which present major concerns, especially the insurance required for workers at NT sites including volunteers. The Non-Traditional Sites and Workers subgroup has noted that issues around personal liability and workers compensation (including compensation for acquired illness) may present a powerful barrier and disincentive to the recruitment of health care workers, especially volunteers, during a crisis. A recommendation has been put forth, that these issues be addressed on a national basis, and be reviewed by provincial/territorial planners to determine the legislative, administrative, licensing and other options within each province and territory.

The scale of a pandemic may require significant changes to scopes of practice of professionals, and delegation of tasks to non-professional staff and volunteers. These raise many issues regarding insurance and licensing which must be reviewed with respect to existing insurance, licensing practices, cross jurisdictional licensing, labour agreements and Emergency Legislation. The types of insurance which must be reviewed include:

- Malpractice and personal liability
- Transfer of licensing between jurisdictions
- Workers compensation
- Accidental death and dismemberment.
- Directors and officers liability (depending on the administrative authority)

Malpractice/Liability Insurance of Workers and Volunteers

Review liability protection/malpractice insurance coverage to see how it will extend to cover workers in Non-Traditional Sites, professionals, those taking on tasks not usually part of their scope of practice and volunteers.

Transfer of Licensing Between Jurisdictions

Each province/territory must review with its professional licensing bodies (medical colleges, nurses associations) how pandemic workers with varying qualifications, or licensed in other jurisdictions, may deliver some services. Professional licensing bodies may be asked to liaise and extend privileges to out of province professionals, or foreign trained professionals based on their standing in another jurisdiction.

Workers' Compensation

Each province/territory must make appropriate arrangements with their workers' compensation board if pandemic volunteers are to be covered by workers' compensation. A Memorandum of Understanding (MOU) between the Office of Critical Infrastructure Protection and Emergency Preparedness (OCIPEP) Canada and the provinces/territories asserts that registered volunteers or persons compelled for emergency service work are protected by workers' compensation during emergency response, as long as they are registered. Some volunteer agencies have a liability policy for their volunteers. In some circumstances, volunteers who register with designated agencies may be covered by workers' compensation under Emergency Preparedness Legislation. However, there are a number of issues to be resolved with workers' compensation Boards at the provincial level:

- Definition of Health Care Workers for this purpose
- Definition of volunteers for this purpose
- Does the policy require a declaration of Emergency and at what level of government or would the insurance come into effect once the Minister of Health declares a pandemic?
- Compensation is usually based on loss of income, however, in some cases volunteers may be retired, homemakers, or self-employed. Would compensation cover costs of the person's other responsibilities, such as family care?
- Would compensation be available if volunteers became ill rather than injured?

Accidental Death and Dismemberment

Usually a subset of workers' compensation. Ensure that this insurance is available.

Directors and Officers liability

If the health care site or service is a part of an existing institution, hospital, or health authority, determine whether existing insurance can be extended to those managing sites or services elsewhere or obtain this insurance elsewhere.

2.3 Human Resource Planning During the Pandemic Period

Once a pandemic is declared there will be a massive effort required to implement the programs and activities developed during the interpandemic period to manage the human resource issues. Activities will include:

- Activation of the Human Resource Management Team
- Implement Volunteer Management Team
- Provide Human Resource Management Team with lists and job descriptions of personnel required.
- Contact supporting organizations to request additional personnel with special skills, e.g. translation services, churches/counselling services.

2.3.1 Contact Health Care Professionals

By the time a pandemic is declared most existing health care institutions and agencies will be aware that the WHO and Health Canada have been monitoring a growing situation. Communications with professionals is vital at this stage as professionals will be required to take on additional or changed responsibilities and may be reassigned to other sites or activities.

2.3.2 Volunteer Recruiting, Screening, Training, Deployment

a. Communicate with volunteer agencies

Communicating with the volunteer agencies to co-ordinate the activities of voluntary efforts will be one of the first tasks of the Volunteer Management Team.

b. Call for volunteers

In emergencies often volunteers come forward. This potentially large and commendable response needs to be channelled so that those with needed skills can be placed where they are needed most and their skills can be optimized. However, not all volunteers will have the skills, ability or stability required for the jobs they want to do. Therefore, any calls for volunteers should identify the needed skill sets to streamline the recruitment process.

Volunteer recruitment and screening needs to be considered, including:

- position descriptions
- advertising the need for volunteers
- screening criteria
- volunteer application forms
- interview
- reference checks
- criminal record check.

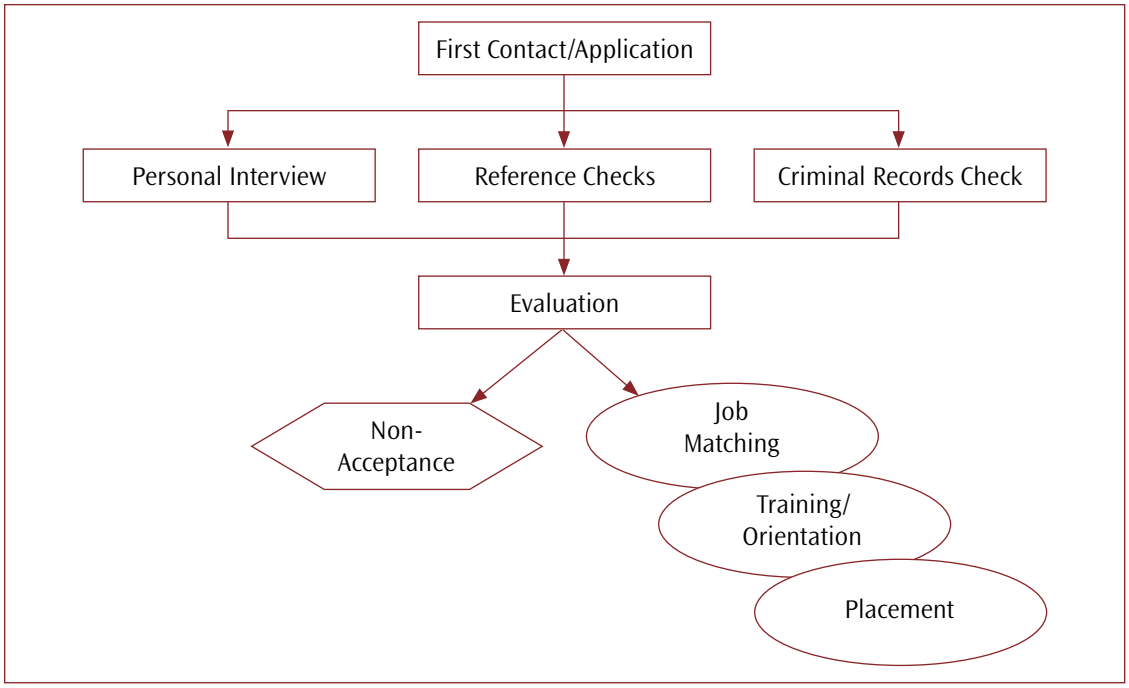
Useful resources include, but are not limited to:

- The Canadian Red Cross Society. National Volunteer Policy Manual
- The Canadian Red Cross Society. The 30-Minute Quick-Response Guide. 1995.
- The Canadian Red Cross Society. Disaster Response Team: Participant Attachments. 1996.
- St. John Ambulance Brigade. Screening Brigade Volunteers. 2000.

c. Volunteer screening

Volunteers in a pandemic may be placed in positions of significant trust and authority, with vulnerable people. Volunteer positions will vary in nature, in the type of training, skills and abilities required, in the setting and in the level of risk to the volunteer. Volunteer screening must take all of these issues into consideration and provide for interviews, review of qualifications and appropriate assignment. In addition, it is important to ensure that volunteers do not have a personal history, which indicates they are incompatible with the safety and well being of vulnerable people.

Screening processes must review the stability of the individuals and may include criminal record checks. Information on procedures used by the Red Cross, and St. John Ambulance is available through their offices.



The most important part of volunteer recruitment and assignment is the interview process. Reference checks are also a good screening tool. A criminal records check is usually required by law for volunteers who work with vulnerable people. However, during the pandemic, police services may not have the resources due to illness and/or have other high priority duties to provide this service. Therefore more emphasis may need to be placed on conducting a good interview and reference check process. It will be important to use trained volunteer recruiters, preferably identified and trained during the interpandemic period.

- Check existing emergency plans, regional or municipal plans for information on recruiting and screening volunteers
- Partner with existing agencies, where possible.
- Review Red Cross, St. John Ambulance and other resource documents

Due Diligence: The volunteer recruitment process should include a briefing meeting on risks and infection control (routine or universal precautions), and should require the individual to sign an agreement acknowledging they have been informed of the risks and protections, prior to being assigned to a placement.

2.3.3 Training During the Pandemic

Training programs developed or planned during the interpandemic period should be "geared up". These will include those programs listed in the interpandemic section of this document.

Training for Families/Caregivers

Family members of patients may stay at the site to help care for a patient or may be asked to take a patient home. In either case, the family member will need some training, especially in the areas of re-hydration, infection control, observation and assessment, and self-care. In addition, families may require counselling to help them support those who are ill or to cope with fear and grief.

Training for Support Tasks

In addition to training for patient care there are needs for training for intake, housekeeping, maintenance and other tasks. There are standards set for training of all workers related to health care, including housekeeping and maintenance staff. In many cases staff associations set these standards.

It is important to note that during a crisis it will not be possible to demand the same level of training for volunteers, which would normally be required of staff. Thus, it will be important to consider what are the minimum standards and basic information that must be communicated on certain issues.

2.3.4 Supporting Workers in NT Sites

Support provided to Workers at Non-Traditional Sites may include:

- Emotional support/grief counselling (aimed at permitting workers to continue to work and reduce loss of staff due to grief or traumatic stress).
- Family care (for children, seniors, sick family members who do not require hospitalization). This poses some questions around infection control if gathering children or others together for group care.
- Job protection for workers who move from other jobs during pandemic.
- Job protection for spouses who do family care to allow workers to work in health care.

2.3.5 Communicate Changes to Licensing and Insurance Provisions

Inform site managers and coordinators, as well as health care professionals in all sites and health care programs of changes in licensing and insurance and what it will mean for flexibility in staff deployment and additional staffing.

2.4 Human Resource Planning During the Post-Pandemic Period

Activities during this period will focus on the demobilization of staff and volunteers. Assessment of insurance claims or claims for assistance will also occur during this period.