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SMDHU EBOLA RESPONSE PLAN

simcoe muskoka
DISTRICT HEALTH UNIT

CONTENTS

BACKGROUND

First noted in March 2014, the current outbreak of Ebola in West Africa is the largest outbreak since the disease was first discovered in 1976. Ebola virus disease (EVD) causes an acute but serious illness of hemorrhagic fever which is often fatal. The current average case fatality rate is around 50%[1].

The incubation period is 2 to 21 days but the average is 8 to 10 days and humans are not contagious until symptoms are displayed. Initial symptoms include sudden onset of fever, weakness, muscle pain, headache and sore throat. These symptoms are followed by vomiting, diarrhea, unexplained hemorrhage, and symptoms of impaired kidney and liver function[2].

Researchers identified a two year old in rural Guinea as the index case for the current epidemic. Reports suggest that the family hunted bats that are known to harbor the Ebola virus strain identified which may have been the original source of the infection[3].

Besides animals such as infected fruit bats and primates, Ebola is transmitted by blood or body fluids including but not limited to urine, saliva, sweat, feces, vomit, breast milk, and semen. Objects such as needles and syringes that have been contaminated with virus can also transmit the disease.

GLOSSARY

CD – Communicable Disease

EVD – Ebola virus disease is a severe disease causing hemorrhagic fever in humans and animals.

IMS – Incident Management System

PUI - Person under investigation – definition not yet released by Public Health Ontario (PHO), but working definition is a person who is being investigated medically for EVD.

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[1] WHO Ebola virus disease Fact Sheet http://www.who.int/mediacentre/factsheets/fs103/en/ (Retrieved 31 October 2014)

[2] Ebola (Ebola Virus Disease) Sign and Symptoms http://www.cdc.gov/vhf/ebola/symptoms/index.html (Retrieved 31 October 2014)

[3] Baize, Sylvain; Pannetier, Delphine; Oestereich, Lisa; Rieger, Toni. "Emergence of Zaire Ebola Virus Disease in Guinea — Preliminary Report". *N Engl J Med 2014; 371:1418-1425.* (9 October 2014)

Probable case – as per Ministry of Health and Long-Term Care (revised May 2014). Infectious Diseases Protocol, 2009 – Appendix B: Provincial Case Definitions for Reportable Diseases; Disease: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/hemorrhagic_fevers_cd.pdf

Confirmed case - Ministry of Health and Long-Term Care (revised May 2014). Infectious Diseases Protocol, 2009 – Appendix B: Provincial Case Definitions for Reportable Diseases; Disease: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/hemorrhagic_fevers_cd.pdf

CURRENT SITUATION

As of October 27, 2014, the current outbreak statistics stand at 13703 total cases, with 4920 deaths (World Health Organization, 2014). Widespread transmission of cases continues in Guinea, Liberia, and Sierra Leone. WHO, UN partners, and the international community have scaled up support in these three countries. Localized transmission has occurred in Mali, Nigeria, Senegal, Spain and the United States of America. The outbreaks in Nigeria and Senegal were declared over as of October 20th and October 17th, respectively.

The occurrence of EVD is ever-changing. Mali, a neighbor of Guinea confirmed its first case of Ebola on October 23, 2014 related to exposure in a traveler from Guinea. An initial investigation identified 82 close and unprotected contacts that remain under observation in isolation[4]. Current Ebola outbreak response maps can be obtained from the WHO Global Alert and Response website at http://www.who.int/csr/disease/ebola/maps/en/ .

Two travel related cases have resulted in locally acquired cases occurring in Spain and the United States of America. In both of these situations the index cases originated from West Africa. As of November 5th, no cases have been confirmed in Canada. The province of Ontario has had 11 negative laboratory tests.

SUPPORTING DOCUMENTS

World Health Organization (WHO):

Situation reports: Ebola response roadmap - http://www.who.int/csr/disease/ebola/situation-reports/en/

[4] Ebola Response Roadmap Situation Report http://apps.who.int/iris/bitstream/10665/137376/1/roadmapsitrep_29Oct2014_eng.pdf?ua=1 (retrieved 29 October 2014)

- a series of regular updates that contains review of the epidemiological situation and response monitoring Ebola outbreak response: maps - http://www.who.int/csr/disease/ebola/maps/en/
- regional confirmed and probable case maps

Centers for Disease Control (CDC):

2014 Ebola Outbreak in West Africa - http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/index.html

- Situation overview, outbreak updates, current case counts, and outbreak distribution map. Additional links on side bar to various guidance and best practices documents.

Public Health Agency of Canada (PHAC):

Ebola Virus disease - http://healthycanadians.gc.ca/diseases-conditions-maladies-affections/disease-maladie/ebola/index-eng.php

- Recent notices, news releases, Chief Medical Officer of Health statements
- Pathogen Safety Data Sheet – Infectious substances
- National Case Definition: Ebola Virus Diseases (EVD)

Public Health Ontario:

Ebola virus disease (EVD) page - http://www.publichealthontario.ca/ebola

- Interim Risk Assessment and Evaluation of Returning Travelers
- EVD interim case report form and case management resources for public health units
- EVD interim public health follow-up form
- Testing Information: Ebola Virus Disease (EVD) – Sample collection and submission guide, Ebola Virus Disease (EVD) Guidance Document: Shipping of Suspect EVD Specimens to PHO Laboratories
- Links to CMOH directives from the MOHLTC

**Ensure to regularly check for updated versions as documents are being continually updated.*

CURRENT DIRECTIVES – MINISTRY OF HEALTH AND LONG TERM CARE

As of October 30, 2014, the MOHLTC have updated Directive 1 related to precautions and procedures for Acute Care Settings. Please refer to the link for the full directive.

http://www.health.gov.on.ca/en/public/programs/emu/ebola/docs/evd_directive_1_20141030.pdf

COMMUNICATION PLANNING

Ebola Communications Plan

A comprehensive coordinated communications plan is critical to ensure that the communication needs of the health unit regarding Ebola preparedness are met. The Ebola Communications Plan is intended to provide the health unit guidance, recommendations and to coordinate communication initiatives to ensure accurate and timely communication to both external and internal audiences. The objectives of the plan for external audiences include:

- Ensure consistent messaging to the media, public and partners
- Reassure public of low risk and preparedness of health care system for a person under investigation, a probable case or confirmed case
- Sharing of communications among all health care partners to ensure accurate and consistent messaging
- Direct public to Health Connection as credible source for information

And internally:

- Ensure staff receive timely and current information regarding agency direction and public messaging
- Ensure staff understand deployment/redeployment protocols
- Ensure stakeholders and partners are informed and are using accurate and consistent messaging with their audiences
- Ensure that the Board of Health is informed when a person is under investigation, and when there is a probable or a confirmed case.

Ebola Communications Plan

SMDHU Staff

Information sessions [re: (i) SMDHU Ebola Response Plan and (ii) general Ebola information] will be provided to all staff via office meetings between November 17-21. The SMDHU Staff Ebola Information Session will be facilitated by one member of the Communicable Disease Team and the relevant Branch Office Lead (BOL). The content for the SMDHU Staff Ebola Information Session will include scientific and epidemiological information that is relevant to staff working in various roles and will be similar to information provided at the Royal Victoria Regional Health Centre and or Orillia Soldier's Memorial Hospital "Grand Rounds". Context relevant to SMDHU services will be added to the content (i.e. "what this means to staff providing service in businesses, homes, clinics, offices and community settings"). The SMDHU Staff Ebola Information Session will provide staff with enough knowledge to correctly inform community partners and clients that SMDHU has an Ebola Response Plan and to direct client/community partners to Health Connection for specific information. The SMDHU Staff Ebola Information

Session objective is to increase staff confidence in the SMDHU response to Ebola and develop abilities to direct clients/community partners to relevant resources.

SURVEILLANCE PLANNING

Initial Notification Action Planning

Scenario #1

Notification will likely come from an acute care facility to CD Intake Line or assigned Liaison related to an individual who has failed initial screening at ER Triage. This will trigger the following actions:

a) Notification received during the routine workday:

- Immediate notification of CD Management, CS Director and MOH office
- Once an assessment of the risk is completed with the reporting source, the PUI meets definition as determined by Public Health Ontario
- MOH will notify PHO, CMOH, and the LHINs
- CD Manager will notify PHO and MOHLTC contacts
- MOH will notify Executive Members – consider IMS initiation
- MOH (or CD Management) will notify HP&S Manager to assess and prepare to initiate communications plan
- Consider internal communication to all staff - including potential for redeployment to support communications and investigation
- Utilize Ebola Communications Plan as framework

b) Notification received afterhours:

- CD On-Call will notify on-call MOH/AMOH who will then determine when to initiate the above process.
- Notification to the CMOH/MOHLTC/PHO through the Spills Action Centre as normal for urgent after hours issues (as per PHO guidance for PHU's)
- Recommended Notifications and consider IMS initiation:
    - CS Director or designate
    - CS Director or designate to notify CD Managers for potentially calling in additional staff to assist with phones and current outbreak investigations
    - Additional calls to all Directors as potential for redeployment and enhancement of services is determined
    - Utilize Ebola Communications Plan as framework

Scenario #2

PUI or case resides in another jurisdiction but contacts reside in SMDHU

Follow process above but MOH or AMOH will determine in consultation with CD Management, potential impact to service provision. Communication process will be critical to management of call volume.

EVD Analytic Database

The EVD Analytic Database is based on the Communicable Disease (CD) Intake database currently used by the Data Management Assistant (DMA) in CD to log all incoming laboratory results. The database will be stored on the **I:\\ drive** with access limited only to management and staff responsible for data entry and analysis, and will be password-protected. The majority of the main tables will be linked to the CD intake database including additional tables required for the EVD investigation. When data entry staff are completing the information in the EVD Analytical Database, fields relevant to the CD intake database will automatically be transferred. This will ensure the seamless collection of data for both systems without needing to double-document. Filters will be put in place so data entry staff for the EVD investigation will only be able to see the information relevant for EVD cases and contacts and will not be able to access any other information from the CD intake database.

The database will be comprehensive in the types of information collected and will include:

The classification of the client: case vs. contact;

- If case, whether they meet the person under investigation, probable or confirmed definition
- Demographics
- Lab results
- Priority or high-risk populations (e.g. childcare workers or attendees, health-care workers, immune-compromised, etc.)
- Exposure locations, times and dates
- Isolation
- Interventions (including hospitalizations)
- List of contacts linked to index cases
- Contact follow-up
- Temperature monitoring follow-up progress
- Symptoms

The Population Health Assessment, Surveillance and Evaluation (PHASE) team will be the data steward and responsible for compiling reports and assessing data quality. Reports and queries will be included in the database based on the information the CD Team Management and the MOH office require for routine reporting and to assess data quality.

Once the case and contact management forms have been finalized and approved, the Research Analyst will complete the database design template, along with a project charter and work breakdown structure outlining the scope, steps and timeline of completion. These documents will also be reviewed and approved by PHASE and CD Management before proceeding with the construction of the database. The database will be constructed in a way that it can be reused for other large-scale disease investigations with minor adjustments to the tables specific to the type of disease.

Database Design Document: I:\CD Investigations\2014 Ebola\Reporting\DraftDB\20141023EbolaDatabase_DesignTemplateV1.docx

Emergency Department Syndromic Surveillance (EDSS) System

The EDSS is an automated electronic surveillance system that takes real-time data from triage at participating hospitals' emergency departments. Data is provided for person, place and time of care as well as the chief complaint for the visit. The chief complaint field is used to identify key syndromes that group similar signs and symptoms together.

Routine surveillance of the EDSS is undertaken on a weekly basis. For routine surveillance, Gastroenteritis, Respiratory and Fever/Influenza-like Illness (ILI) emergency department visits should each be investigated to assess and identify any increases in infectious disease syndromes. The system has automated algorithms that process throughout the day to assess for any unusual visit counts. Alerts are generated for the syndrome and health unit in which an unusual event occurs. The Epidemiologist is responsible for investigating these alerts, as outlined in the EDSS Routine Surveillance Protocol.

The EDSS will be used to monitor and assess the impact of a potential case of EVD on hospitals in Simcoe Muskoka upon identification of a Person Under Investigation (PUI). Information from the EDSS will be used to assess the number of visits to our local hospitals as well as syndromes for which individuals are seeking care. This information can also be used by the SMDHU Communicable Disease Surveillance Unit (CDSU) Hospital Liaisons in the provision of guidance to their partner organizations. The EDSS will also be used to assess business continuity at the hospitals should an EVD PUI be identified.

If required, contact PHASE Manager for a copy of the EDSS Routine Surveillance Protocol.

Client Health Record Information System (CHRIS) and CD Phone Line Logs

CHRIS and the CD Phone line logs will be utilized to track the number of Ebola inquiries handled by Health Connection Core and CD teams.

Data Collection Process

Data will be collected using Communicable Disease Case and Contact Follow-up forms to gather demographics, signs and symptoms, travel and exposure information on all persons

under investigation, probable or confirmed cases of EVD. These forms will be completed and provided to the DMA for entry into the EVD Analytic Database and into the Integrated Public Health Information System (iPHIS).

For any cases or contacts that require daily temperature monitoring, this information will be entered directly in the EVD Analytic Database and be complemented with nursing documentation on hardcopy SMDHU Progress Notes. The PHASE team will make an effort to assess if the EVD Analytic Database can align with the Nursing Documentation Standards.

In order to ensure all records are secure and accessible at all times, hardcopy records of any EVD case or contact will be stored in a hanging folder system within the Communicable Disease work area at 15 Sperling Drive. These folders will only be accessed by the CD Program Assistant (PA), DMA and CD Management as needed.

Quality Assurance

A member of the PHASE team will be identified as the lead for Quality Assurance of the data in the EVD Analytic Database. Their role will include assessing the completeness and correctness of the data entered into the database.

Draft Data Collection Forms:

Cases: Public Health Ontario Reporting Form

Contacts: ..\Investigations\2014EVD\Contact Management\2014EVDContactTracingForm.doc

Process Map: I:\CD Investigations\2014 EVD\Protocols\EVD - Data Entry and Process Map.pdf

Reporting Requirements

Reporting on our local situation will highlight the number of cases, by classification and contacts within SMDHU. Contact follow-up and monitoring statistics will be reported on, including details on isolation and other precautionary measures that have been undertaken.

EVD Analytic Database Analysis Outline: I:\CD Investigations\2014 EVD\Reporting\Analytic DB Proposed Analysis Outline.doc

The Analysis Outline will be finalized once reviewed and approved by the Medical Officer of Health (MOH) office and CD Management. The EVD Analytic Database will then be designed to produce these reports quickly and easily. Designated management will be given permissions to access and run these reports as needed.

Daily Reporting

In addition to the reporting functionality that will be available via the EVD Analytic Database, summary reports will be created and disseminated on a daily basis based on the requirements of the IMS structure and as identified in a surveillance clock, should one be created. Reporting to external organizations will be done on an as-needed basis.

Reports will compile information from a variety of data sources that will include, but is not limited to:

- Local Situation through SMDHU Case/Contact EVD Analytic Database

- CHRIS and CD Phone Log Emergency Department Syndromic Surveillance System
- Provincial/national overview
- International situation updates, as provided by WHO
- Social media and email inquiries

Draft Daily Report Template*: I:\CD Investigations\2014 Ebola\Reporting\EbolaReportSummary_Template.docx*

CD RESPONSE

Case Management – PUI and Confirmed cases

Communication will be a critical function for CD response to a PUI or case of Ebola virus disease within our jurisdiction. The CDSU will carry the lead working with our acute care partners in their roles as liaisons. It will be essential that the Communicable Disease Investigations Unit (CDIU) are prepared to be immediately available to support CD phone lines upon receipt of a notification of a PUI. As the investigation develops, further risk assessment based on the potential of confirmation of illness and/or potential secondary cases will drive further deployment to the CD Team.

The investigation tools are under development to support CD staff. Public Health Ontario has released tools to be used in PUI and case investigations.
http://www.publichealthontario.ca/en/eRepository/EVD_case_report_form.pdf

http://www.publichealthontario.ca/en/eRepository/EVD_public_health_followup_form.pdf

Further guidance for returning travelers has been received and summarized in the document Draft SMDHU Response to Returning Travelers.

These forms would create paper files of the investigation at this time and would require further expansion of our records management system to ensure the safe and secure handling of these documents.

It is anticipated that staff would continue to work out of the Barrie and Gravenhurst sites and that these offices would be the centres for any of the CD and monitoring work required.

Contact Management

The required monitoring for symptoms of contacts of cases of EVD is still uncertain. We know from our work in SARS, twice daily calls were made to all contacts. At this time, daily contacting is the recommendation. The other consideration may be the number of contacts we may be required to monitor from out of jurisdiction cases.

We recommend that once a contact is identified, the CD team assigned staff initiate an assessment for exposure risk and current health status. The staff person will also provide

education on EVD disease and on reporting of symptom development (if it occurs) to the health unit. If we move to daily monitoring, it is recommended that a second team of qualified individuals be initiated to complete this work in parallel to the CD Team.

Training (development needed)

It is recognized that staff deployed to assist the CD team will need further training, on expectations for investigation, risk assessment, reporting requirements, protection of others in the home and community, PPE, etc. These tools still need to be developed.

Additional Staff Supports

Triage Charts (under review)

Policy (under development)

Fact Sheet (draft available)

Links to Laboratory information
http://www.publichealthontario.ca/en/BrowseByTopic/InfectiousDiseases/Pages/Viral-Hemorrhagic-Fevers.aspx

Further exploration will occur of the potential utilization of the SMDHU Client Health Record Information System (CHRIS) system.

ACTIVATION OF IMS STRUCTURE

The activation of the agency IMS structure will be determined by the Medical Officer of Health or designate. The decision will be based on a number or criteria which may include the following:

- Significant increase in local perceived risks by the residents of SMDHU resulting in an inability to maintain adequate level of service to our Health Connection lines and media requests/demands for information
- Local surveillance data indicating potential risk of infection to residents of SMDHU (PUI or contacts)
- Local confirmation of a case of Ebola
- Declaration or order by the Chief Medical Officer of Health

Our SMDHU emergency response plan may be found at this link ERP .

HEALTH AND SAFETY CONSIDERATIONS

Staff tasked to conduct work as part of the SMDHU Ebola Response Plan will be utilized to answer questions, assess risk of exposure in returning travelers from the Ebola affected areas and make recommendations for follow-up such as self-monitoring of symptoms. Staff will also

be working with hospitals and health care providers in the community to ensure timely assessment, management and follow-up of returning travelers who become ill.

During routine service delivery and/or redeployment, staff will not engage in any activities that will bring a staff member into direct contact with a PUI, a probable case or confirmed case of Ebola.

INFECTION PREVENTION AND CONTROL STRATEGIES

For All Staff

Routine Practices will be followed when providing services for all clients. At the time of writing this plan, we continue to follow all processes that are currently in place. However, there may be further direction from the CMOH or PHO on more specific screening for EVD.

Clients are currently being screened for symptoms of Acute Respiratory Infections when pre-booking or confirming appointments. Clients will be asked to rebook appointment if they are acutely ill with fever over 38°C, or feeling feverish - having shakes or chills and respiratory symptoms such as a new/worse cough or shortness of breath within the past 24 hours. Link: Screening Algorithm for Acute Respiratory Infection (under review)

Signage of Self Screening for Acute Respiratory Infections will be posted at all entrances to all SMDHU offices instructing clients to self-screen upon arrival at entrance for new/worse cough or shortness of breath and feeling feverish. Appendix B: Signage for Self Screening for Acute Respiratory Infection (ARI)

Staff will encourage all clients to conduct hand hygiene with ABHR and use cough etiquette (cough in sleeve or tissue, wear a mask) prior to receiving services.

Prior to every interaction with a client and/or the client's environment, staff will assess the risk of acquiring a potential infection spread by either the client or the client's environment by conducting a Risk Assessment.

Staff will utilize Environmental Controls (e.g. plexiglass barriers, sharps containers, ABHR) and the appropriate Personal Protective Equipment as determined by a Risk Assessment in consultation with Manager/Supervisor to protect them and the clients they serve.

Hand hygiene will be performed before staff enters into a client's environment; before they come in direct contact with the client; after they have come in direct contact with the client and after they leave the client's environment.

Staff will report to their Manager/Supervisor if they suspect or have acquired a Reportable or Infectious Disease while conducting work for the SMDHU or when they have acquired an Acute Respiratory Infection.

NOTE: Staff will be informed if there are any changes to Routine Practices during redeployment.

REDEPLOYMENT

As an agency, we have created a redeployment plan which is (insert link when available). Redeployment will be led by the Chief Nursing Officer with full consultation with relevant SMDHU management. In planning for the potential EVD PUI or case in SMDHU, the following response specifics are being considered.

Principles of redeployment:

- Leverage competencies of staff that may not be currently utilized (i.e. knowledge or experience from previous roles/work in communicable disease or health connection).
    - This principle reduces the amount of time required for CD/disease knowledge and competency acquisition
    - May reduce risk of errors as staff with no knowledge or experience may have higher error rate in care delivery
    - Reduces time requirement of knowledge experts to educate staff – enables knowledge experts to stay focused on care/work.
- Assign staff to roles most similar in the redeployment to the role they currently fulfill (i.e. PHNs that provide a lot of phone-based service, should be assigned to provide phone-based service).
- Consider elements of the Collective Agreement in redeployment with a goal of avoiding unnecessary grievances.
- Redeploy effectively to ensure fatigue of working staff is not excessive – error rates increase with excessive fatigue.
- If an individual clearly states to a manager that they cannot provide the care safely – consider alternate redeployment – client safety is vital.

Redeployment for Communicable Disease Team

The CD manager has articulated the order of redeployment for direct CD services based on the length of service required (how many days/extended hours/weeks) and the complexity (i.e. # of contacts, # of suspect cases, # of cases). In order, redeployment would occur as:

- Almost all CD staff will be reassigned from non-Ebola work to Ebola CD work (hospital liaison role, Infection Control Coordinator and some TB PHN work would continue)
- Staff (PHNs (7) , PHIs (5) and PAs/DMAs) that have experience in CD that now work in HPS, HLS and FHS will be assigned to CD team and Ebola work
- Staff from SH will be assigned to Ebola work

Redeployment for Health Connection

Health Connection FTE allocation is 4.5 FTE of PHN time (8 individuals including 3 casuals) and 3.0 CSR (RPN) time. On average 3 PHNs and 3 CSRs are scheduled on a daily basis. Most HLS PHNs (approx. 44 FTE/55 individuals) have received orientation and training to Health Connection relative to their redeployment role (includes training in CHRIS and agent phones).

Extension of Health Connection Hours

- Health Connection service should be able to manage the volume of work/calls if Health Connection hours are extended (4:30 – 8:00 pm Monday – Friday) for a short period (i.e. 2 weeks) with utilization of casual nurses assigned to the Health Connection team. The ability to manage extended hours assumes that some Health Connection services (i.e. booking of appointments for clients attending VPD clinics or Sexual Health clinics) is dramatically reduced or eliminated from Health Connection service.

Health Connection Service on Weekends or > than 2 weeks Extended Hours

- If the requirement is that Health Connection provides service on weekends (days or evenings) or beyond 2 weeks, PHNs from HLS will need to be re-assigned from their program to Health Connection.
- Re-assignment should be based on Business Continuity planning principles. Potentially re-assigning nurses from each HLS program so each program can still provide some level of health promotion/community services until requirement for reassignment no longer enables a program to provide their specific service and all PHNs within that program are assigned to Health Connection.
- Re-deployment of non-nurses in HLS programs should align with Business Continuity Principles and assigning work that most closely resembles individual's current role and is useful to agency's response to Ebola.

Redeployment for Surveillance Purposes

Depending on the extent of the outbreak, the majority of the Population Health Assessment, Surveillance and Evaluation (PHASE) team may be redeployed to help manage the surveillance activities. This is dependent on the needs of IMS and whether surveillance and daily reporting is required on weekends and after hours on weekdays.

Vector Directory Number & Messaging

- Incident VDN will need to be activated and programmed by IT and should probably be the first option off the main menu. Could include a library of pre-recorded messages that public provide general information about EVD.
    - call routing will need to be determined so that EVD inquiries can be self-directed to the appropriate staff
        - Worried well inquiries – HC Core team
        - PUI, confirmed cases or HCP – CD
- EVD announcement messages for main menu and incident VDN will need to be developed and recorded

RETURN TO REGULAR DUTIES

Decision to return to "normal" business practices will be based on a number of considerations.

1. Contact volume has returned within normal limits or can be managed with return to regular staffing levels on Health Connection lines.

2. Current situation in SMDHU jurisdiction, no further evidence of transmission or contacts to be monitored, MOH office instructs to return to regular business practices.
3. CMOH declaring the provincial situation over and return to regular business practices.

For the most heavily burdened teams and staff, this may take additional time and supports. If compensating time balances are beyond expectations, it may be prudent to allow higher staffing levels in order for staff to take time off and recover from the demands of the investigation. If there is added stress from the outcomes of investigations, consultation with Human Resources is needed to assist in planning supports for recovery.