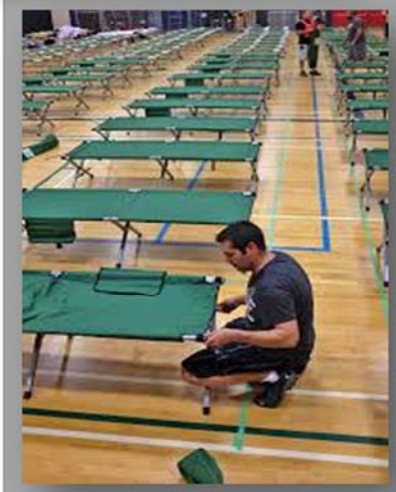
northern health
the northern way of caring

2017 Cariboo Wildfires



July 7 – August 23, 2017

HEMBC Health Emergency Management

Northern Health
After Action Report

Prepared by: Northern Health Emergency Management

Date: January 8, 2018

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1. EVENT OVERVIEW

Event Name	Northern Health Response - 2017 Cariboo Wildfires
Event Date	July 7- August 23, 2017
Event Description *(Type of event)*	Evacuation of Interior Health Authority (Williams Lake and area) to Northern Health Authority (Prince George and Quesnel)
Facilities/Sites/Departments Affected	Prince George: • Gateway Lodge Assisted Living • Gateway Residential Care Facility (Long Term Care) • Jubilee Lodge (Long Term Care) • Simon Fraser Lodge (Complex Care) • Rainbow Lodge & Adult Care Centre (Assisted Living) • Maternal Child Family Place (Acute Care) • University Hospital of Northern BC • ENAT (Complex Care) • Kordyban Lodge (BC Cancer) • Brain Injured Group (Group Home) • Prince George Hospice House • University Northern BC Student Residence (Assisted Living/ Long Term Care) Quesnel: • Dunrovin Park Lodge (Assisted Living/ Residential Care) • GR Baker Memorial Hospital
Code(s) Activated *(if applicable)*	No Codes Activated
Debriefing Partners (Northern Health):	• Northern Health All Staff Survey • Quesnel Emergency Operations Centre (EOC) • Prince George Emergency Operations Centre (EOC) • Communications Department • Staffing Services • Finance Department • Open House (HSBC, Scotia Bank & Brunswick Building Staff) • Primary Care Clinic & Nursing Triage
Report Requested by:	Cathy Ulrich, CEO Northern Health

1.1 Summary of Event

Between April 1 and September 15, 2017 a total of 1255 wildfires and approximately 1,186,853 hectares of fires burnt throughout the Province of BC. In the Northern region of the province, 706 fires and over 900,000 hectares were burnt, with 2017 being the worst year in recorded history in terms of land lost due to wildfires.

On July 7, 2017 a Provincial State of Emergency was declared. The Province saw a total of 101 fire starts on July 7 with another 80 on July 8. The rapid growth of these fires caused the evacuation north of Williams Lake and surrounding areas.

During the declared Provincial State of Emergency, the City of Prince George received approximately 10,000 evacuees from the Cariboo and Chilcotin regions and the northern region of our province saw a total of 78 evacuation orders and 80 evacuation alerts. The City of Prince George opened Emergency Social Services (ESS), reception centre and group lodging at the College of New Caledonia and additional group lodging at the Northern Sports Centre at the University of Northern BC (UNBC). Approximately 65,000 people were displaced provincially, including 48,000 people evacuated on July 17 from the City of Williams Lake and surrounding areas.

Twelve First Nations Communities were evacuated during the Provincial State of Emergency affecting; Tsilhqot'in National Government, Northern Secwepemc te Qqelmucw, Carrier Chilcotin Tribal Council and Sothern Dakelh Nation Alliance and approximately 7,880 community members. Two of these First Nations Communities are located within the Northern Health Authority boundary; Lhoosk'uz Dene (Kluskus Nation) and Nazko First Nation.

The Provincial State of Emergency order was extended four times and lasted until midnight on September 15.

On July 8, 2017 at approximately 00:45 Northern Health (NH) received notification that an evacuation was required for Interior Health Authority (IHA) for Williams Lake and surrounding area. Due to the road closures on Highway 97 South caused by wildfires all patients, assisted living and long term care clients within Williams Lake IHA care would need to be transported north. NH activated three Emergency Operation Centres (EOC) including the Prince George Health Services EOC, Quesnel Health Services EOC and NH Regional EOC. Between July 8 and August 23, Northern Health accepted approximately 254 IHA patients, assisted living and long term care clients with the majority arriving from the Williams Lake and 100 Mile House areas. Northern Health hosted these health care evacuees in various Prince George and Quesnel facilities for a total of 47 days. To meet

the needs of the general population of evacuees, Northern Health set up a Primary Care Clinic and Nursing Triage Unit at the College of New Caledonia (CNC). The Primary Care Clinic included 10 treatment beds, 1 isolation room and 3 exam rooms, accumulating approximately 1,000 patient visits during its operations. All IHA patients, assisted living and long term care clients were successfully repatriated and Prince George Health Services, Quesnel Health Services and NH Regional Emergency Operations Centre (EOC) were demobilized by August 23, 2017.

1.2 Event impacts

Northern Health sites capacity was increased and NH partnered with local organizations to support the additional IHA patients, assisted living and long term care clients. Additional capacity fluctuated through-out the event at the following locations:

Facility	Location	Additional Evacuation Capacity Created	Maximum Evacuation Capacity Accepted
Gateway Lodge Assisted Living and Gateway Residential Care Facility (Long Term Care)	Prince George	100	99
Jubilee Lodge (Long Term Care)	Prince George	9	9
Simon Fraser Lodge (Complex Care)	Prince George	7	7
Rainbow Lodge & Adult Care Centre (Assisted Living)	Prince George	16	16
Maternal Child Family Place (Acute)	Prince George	4	4
University Hospital of Northern BC	Prince George	26	26
ENAT (Complex Care)	Prince George	5	4
Kordyban Lodge (BC Cancer)	Prince George	10	2
Brain Injured Group (Group Care Home)	Prince George	2	0
Prince George Hospice House	Prince George	4	3
University Northern BC Student Residents (Assisted Living/ Long Term Care)	Prince George	80	60
Primary Care Clinic (Treatment Beds)	Prince George	10	
Primary Care Clinic (Exam Rooms)	Prince George	3	
Dunrovin Park Lodge (Assisted Living/ Long Term Care)	Quesnel	8	8
GR Baker Memorial Hospital	Quesnel	16	16

2. AFTER ACTION REVIEW PROCESS

2.1 General Outline of Process

In September 2017, Northern Health Emergency Management began developing an After Action Review Report of this incident from activation through to demobilization. This process included an all-staff survey in collaboration with Quality and Innovation and department meetings took place with; Prince George Health Services EOC, Quesnel Health Services EOC, Staffing Services, Human Resources, Finance, Public Health, Communications, Primary Care Clinic and Health Information Management. Additionally, two Open House sessions were held for NH employees of HSBC, Brunswick and Scotia Bank buildings to provide additional feedback. Overall over 335 staff and physicians participated and provided feedback and recommendations. This feedback is summarized below.

2.2 Summary of Staff Survey Results

The all staff survey was open from October 2 to 20, 2017 and received over 270 staff responses from numerous clinical, administrative and support roles.

The following are summaries of the Northern Health Response to Interior Health Fire Evacuation and Repatriation Events: After Action Review Survey, prepared by Quality and Innovation.

Figure 1. Role at Northern Health during Wildfire Events

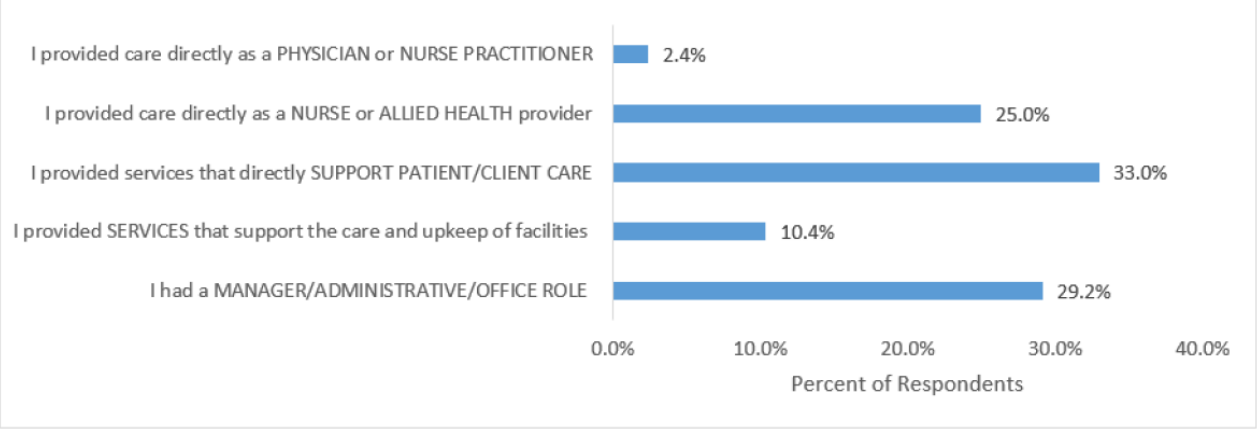


Figure 2: The distribution of staff who responded to the survey were primarily from Prince George and Quesnel. Other responses in Figure 2 refer to those that supported from communities across Northern Health, such as Valemount, Dawson Creek and Terrace.

Figure 2. Distribution of Northern Health Staff Support to Specific Communities

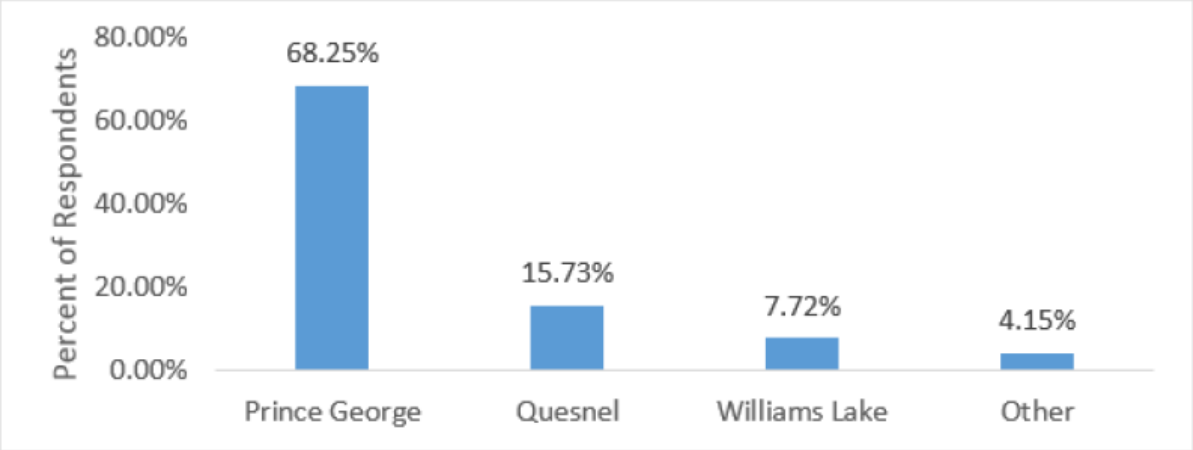


Figure 3: Numerous facilities and programs were supported by staff and physicians. Of those that selected "other", many performed functions such navigational or person liaising support, corporate services or work from home.

Figure 3. Facilities/Programs Supported by Survey Respondents

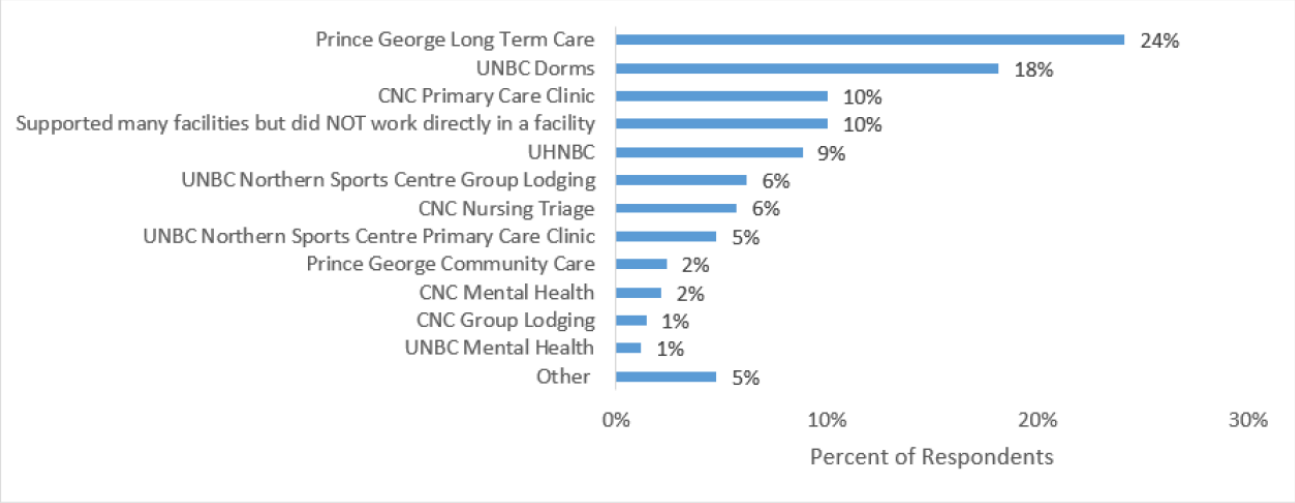


Figure 5: The majority of respondents indicate that their team, the group of people they worked most closely with during the events, were effective in: determining resources required once their scope was clarified; receiving updated information required to do their job; and, understanding their role within their team.

Figure 5. Effectiveness of Team Response

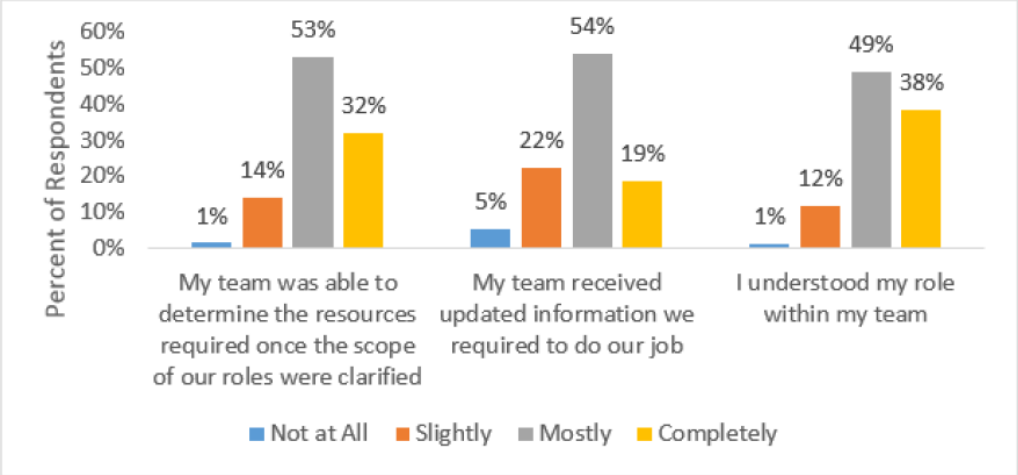
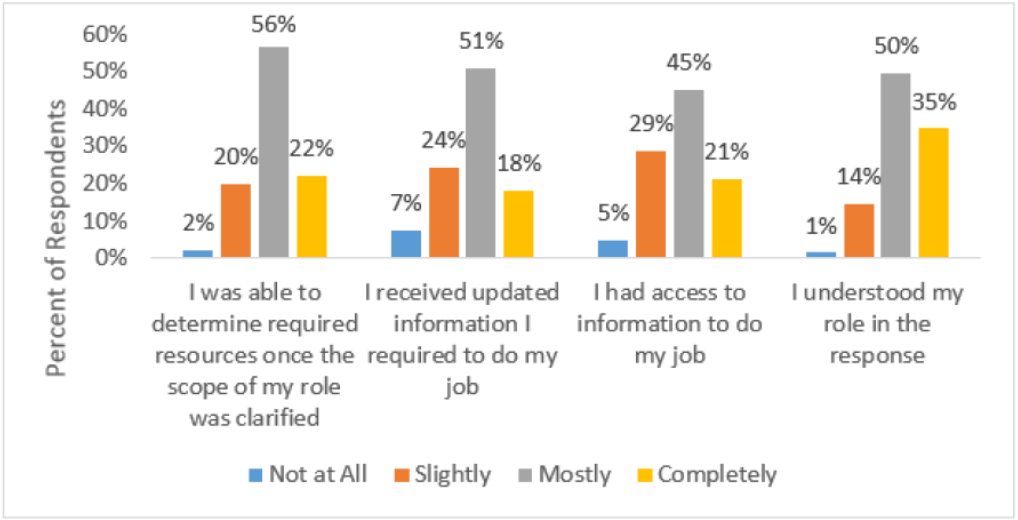


Figure 6: Northern Health's response in supporting staff to perform their roles and duties as assigned during the event was described favorably. The majority felt that Northern Health was able to: determine required resources, provide updated information, provide access to needed information, and provide an understanding of roles.

Figure 6. Effectiveness of Northern Health's Support



2.3 HR / Staffing Services Wildfire Report – Included (Unionized) Employees

In total, NH utilized staff from four BC Health Authorities and two private agencies for a total of 127 unionized staff:

Non-NH Employee Summary

Health Authority	Job Family	Number of Employees
Interior Health	Direct Care (DC) Nurse	28
	Health Care Aide	26
	LPNs	17
	Unclassified	2
	Occupational Therapist	2
	Housekeeping	1
	Social Worker	1
	Physiotherapist	1
	Respiratory Therapist	1
Interior Health Total		**76**
Vancouver Island	Health Care Aide	10
	LPNs	4
	Direct Care (DC) Nurse	4
	Admitting Clerk	1
Vancouver Island Total		**18**
Retirement Concepts	Health Care Aide	13
	LPNs	5
Retirement Concepts Total		**17**
Fraser Health	Health Care Aide	9
	LPNs	1
Fraser Health Total		**10**
Agency	Direct Care (DC) Nurse	3
	LPNs	2
Agency Wildfire Total		**5**
Vancouver Coastal	Health Care Aide	1
Vancouver Coastal Total		**1**
Grand Total		**127**

3. SUCCESSES, GENERAL OBSERVATIONS & SUGGESTIONS IDENTIFIED FROM FEEDBACK

3.1 Successes

Staff Survey

- Teamwork and the dedication of NH staff and physicians to patient care
- Having clear and effective leadership at a local and organizational level
- Communication among staff and team members
- The dedication of staff, physicians and others to providing support
- Responsive resources and willingness to provide and supplement as needed

Prince George Health Services and Quesnel Health Services Emergency Operations Centres (EOC):

- Regional Support:
  - Felt supported by NH to focus on duties of EOC vs. being concerned about 'regular duties' during response
  - Support provided by NH EOC to mobilize and coordinate quickly
- Communication & Collaboration within the EOC team(s):
  - Teams understood each other's roles in the EOC
  - Teams understood each other's roles when working with other EOCs (Quesnel, Prince George, NH) – previous EOC training provided role clarity to support coordination
  - Visually displaying information in EOC – maps, charts, whiteboards, staffing structures etc.
  - Coordination calls with other EOCs and key stakeholders
  - Media relations – local media was respectful and recognized the public wanted to hear the positive stories
- Stability in EOC positions:
  - Consistency allowed staff to become familiar and comfortable in EOC position- role orientation
- EOC was professional and respectful:
  - Welcoming and supportive teams
  - Recognizing fatigue within the team and supporting opportunities for rest
  - Opportunities to break intense environment with humor and relieve stress – when was appropriate

Staffing Services

- Implementing processes to manage baseline staffing with staffing change submissions:
  - Engaged HR advisor to help with staffing model to sort out baseline vs extra
  - Print outs provided of disciplines with hours required. Effective as a baseline guide
  - Put in schedule / timeline for when managers could submit changes to baseline staff

- Designated HR contacts for each site:
    - Designated HR contacts for each site & some located on site
    - Dedicated and consistent staffing clerk for facility sites
- Adding additional staffing resources:
    - Increasing short call team on evenings & weekends
    - Seconding staffing clerks from other departments helped with daytime workload
    - Having on call manager relay between 2 staffing managers

Finance

- One cost centre for event
- At the request of NH, BC Clinical and Support Services (BCCSS) opening up signing authority to avoid delays in item requests

Open House

- Internal Communication Processes:
    - Daily huddles on site
    - Daily communications from 'higher ups'
- Responsiveness and Support:
    - Cooperation of all levels of management to allow staff to be redeployed outside of regular role
    - Clinical staff supporting non-clinical staff to assist and learn new function
    - Seeing our organization pull together and staff willingness to do whatever was required to support the evacuees and each other
    - Collaboration between departments to support the response
- Staffing Services
    - Sign up shift process and shift confirmation for NH corporate offices

Primary Care Clinic & Nursing Triage Unit

- 24/7 Triage, Nursing and Physician services (on site or on call), fully staffed from 08:00-23:00
- Physician engagement and partnership in planning and operationalizing early
- Clinic set up utilizing a community based model - community resources & supports that included; mental health and addiction, counselling, diagnostic imaging, lab, hospice, pharmacy etc.
- Communication boards included information on clinic protocols & community contacts
- Opportunity to live Northern Health Values; integration of primary and community care, level of collaboration within our organization
- Experience and partnership with First Nations Health Authority

3.2 Opportunities for Improvement Identified from Feedback (In no particular order)

Internal Communication Process

- Teleconferences (with IHA) long and at times, chaotic
- Communication gaps between EOCs and frontline – both directions – process changes without communication
- Disconnection between external organizations and information- IHA services available
- Code Orange not communicated
- Physician communication was challenging – hard to maintain specialized communication processes with physicians
- Defined communication strategy and separate mailbox for emergency related communications
- Work more closely with the pharmacy services improve processes for coordinated efforts between staff and physicians

Staffing Resources & Processes

- Not enough staff to support patients, assisted living and residential clients upon arrival, resulting in staff fatigue - some still reporting not fully recovered
- Did not anticipate the level of mental health and substance use clients/ patients that presented and required supports
- Staffing model changes at non-NH sites with expectations short turn-a-rounds – conflicting resource requirements for staff from EOC vs. at site level
- Facebook post for recruitment went viral and due to volume of interest from staff it was difficult to respond and coordinate with staffing services to answer questions and book shifts
- No process to access non-NH staff meant that staffing did not know when non-NH staff could be accessed to staff shifts
- Non-clinical staff felt they could not say no when asked to support patient care – felt uncomfortable and at times unsafe, no say in personal strengths and how to best be utilized to support patient care
- Improve workflow and process, such as sign-in and sign-out processes
- Limited high level orientation provided to staff supporting patient care outside of regular role; patient safety, precautions, witnessing (perceived) clinical distress ex. excluded non-clinical staff feeding and toileting patients with minimal to no orientation– concerns about patient choking on food
- Continuously reorientation of ‘new’ staff to sites; patients, building, processes etc.- lack of overlap at shift change over to pass on information to on coming shift
- NH excluded staff who are not regularly in clinical leadership roles and provided leadership to non-NH sites did not have a clear orientation to the expectation of their role. Example: NH Leadership at UNBC student residents was not familiar with how to contact staffing services about staff booking off and what to do to fill those vacant shifts – out of their regular scope.

Emergency Preparedness

- Initially multiple EOCs were activated; made decisions challenging and confusing as there was overlap in EOC roles
- At times information and decisions were not going through EOC
- Disconnection between sites and EOC
- Ongoing EOC training for all site leadership in forms of exercises and drills, not just theory. Including expansion of EOC training to frontline leaders (Clinical Practice Leads, Team Leads etc.)
- Communication within organization what command and control means – level of urgency for information, data etc.
- Use these learnings to plan for potential future emergencies; develop, document and communicate a coordinated and clearly articulated plan for future events
- Further inclusion of physicians and the Divisions of Family practice in preparedness planning

Infrastructure

- Access to reports and data in EOC was difficult due to delays in activating and authorizing processes required
- Access to NH systems at Non-NH Sites- ex. UNBC student residence internet access & printers
- Manually entering patient daily stats and activity to ensure accuracy of reports
- Access to one charting system for emergency situations
- Documentation is essential. Have up-to-date care plans, assessments and documents available and in preparation for potential future emergencies
- More security at beginning of event. Security of sites for patients/clients and staff. At the beginning of the events evacuees were out of their routines, receiving funding payments resulting in overuse/abuse of substances and fighting

External Communications

- Patients and residents in facility felt disconnected from what was happening at home – this gap was filled by NH staff
- Develop brochures and communications for evacuees to ease the burden on staff

Demobilization

- Returning back to 'normal' work was difficult due to intensity and duration of event
- Increase immediate opportunities for group debriefing
- Operational lead to ensure follow up and thorough demobilization is done. Including; supplies, patient follow up
- Limited recognition by NH as to the scale of the event and no celebration of staff efforts – more formal and public acknowledgement of response
- Increased acknowledgment of the toll this took on many staff and physicians; Recognizing the efforts of everyone, not only those in Prince George

4. RECOMMENDATIONS

4.1 Summary of Recommendations Received from Feedback

Internal Communication Process

1. Consider ongoing wide-reaching emergency messaging system to communicate the EOC activation, structure, incident information, roles, responsibilities and point of contact with all staff. Example: Internal communication software (SnapComms).
2. Consider development of a physician communication tool to enhance the communication pathways during emergent events.
3. Determine Communication pathways and distribution for NH AAR Report for Internal and External Stakeholders

Staffing Resources & Processes

1. Develop a process of early identification within the EOC (planning) for staffing requirements and availability of staffing resources within the sending and receiving facilities.
2. Early establishment of EOC staff schedule for extended deployments, following the concept of stepping back but not away, to provide rest periods but also consistency within the EOC.
3. Develop a multi-health authority agreement to facilitate inter-HA employee usage – include process to expedite issues resolution. Example: Pay enquiry, performance management, staff safety etc.
4. Develop standard HR-related questions and answers (FAQ) for emergency response and immediate review of applicability upon declaration of an emergency. Example: Compensation, expense reimbursement, etc.
5. Set up all policies and procedures for deploying staff, movement of staff, and payment of staff for activation in an emergency with flexibility to collectively agree to adaptations of the policy and procedure dependent on the emergency.
6. Build into contracts of for-profit and non-profit providers expectations regarding contribution during an emergency response event(s).
7. Identify the process of the BC Staff Registry Program for immediate deployment if required in the future.
8. Develop a general site orientation package and provide to staff prior to their first shift.

Emergency Preparedness

1. Develop a standardized format for EOC set up indicating required materials and resources.
2. Develop a NH Facility Evacuation Reference Guide Template in the event of a community wide evacuation.
3. Develop a NH Facility Reference Guide Template for receiving patients from evacuated health care facilities
4. Develop working group with City of PG to determine future ESS location and guideline requirements for Group Lodging - consideration for Public Health, Environmental Health, Primary Care Clinic health facility requirements

5. Develop guideline for future set up of Primary Care Clinic within group lodging location - NH reference guide
6. Expand the EOC training program to include regular exercises and drills for facility administrative, physicians and clinical frontline leadership.
7. Modify NH Regional EOC ICS structure to mirror NH leadership structure. Example: Finance/ Logistics, adding HR/Staffing.
8. Consider a series of regular brief informative concepts of emergency preparedness communicated to all staff via internal communications.
9. Development of an exercise and educational annual training schedule
10. Incorporate interactive mapping software programs for situational awareness during EOC briefings.
11. Consider regular inter HA table top exercises and familiarity of other HA emergency response structures.
12. Incorporate the 5 minute drill concept to engage administrative leadership staff for community wide evacuations.
13. Design a standardized EOC teleconference agenda for purpose of meeting, ground rules and prioritizing order to increase the efficiency of the emergency response teleconference.

Infrastructure

1. Early engagement with Information & Technology Services (ITS) to ensure accessibility for NH staff and non-NH staff to support patient care.
2. Provide temporary access to electronic systems for EOC leadership during large scale events to reduce delays and impacts on getting reports and data
3. A process be established and agreed to in Northern Health, advance of the next emergency response regarding how transportation of equipment will be decided (pre-arranged contracts with appropriate transportation companies) and related policies and procedures.
4. Development of a document regarding resources and 'must have/ things to consider' for setting up a primary care clinic and triage area within an evacuation centre.

External Communications

1. Develop ongoing external partner relationships prior to a crisis to ensure communication pathways and situational awareness.

First Nations Partners

1. Develop ongoing relationships with the First Nations Health Authority to assist in supporting the healthcare needs of First Nations Community evacuees. This would include:
    - Utilizing First Nations Health Authority staff to support community member evacuees during the event.
    - Supporting First Nations Health Authority to make connections within the community they are evacuated to for duration of stay to support healthcare needs.

Demobilization

1. Early debriefing for all staff involved in response to reduce Critical Incident Stress (CIS). The debriefing process should be immediate and is typically no longer than the first 24 hours after the completion of the critical event.
2. After Action Review (AAR) completed post event; following a rest period of one to two weeks and within two months. AAR to include key stakeholder groups within NH's response structure.
3. Following the significant mobilization of NH resources and post incident, consider prompt staff appreciation event and public acknowledgment to celebrate the work and event demobilization.
4. EOC to establish demobilization 'planning team' prior to the completion of the event to guide and support the demobilization.

Public Health

1. Involve Environmental Health Officer in Emergency Response Processes, including activation of group lodging.
2. Public Health Wildfire Working Group to reform for future events and include representation from; Health Protection, Population Health & Preventative Public Health.