

Chapter 2 Planning Approach

2.0 INTRODUCTION

The Niagara Region Public Health Department (NRPHD) recognizes that this first version of the plan is simply a starting point and that ongoing input from stakeholder sectors is needed. The plan will be continuously revised and updated as new information becomes available.

NRPHD initiated pandemic influenza planning in 2000, and reconvened in June 2005. In order to effectively plan for an emergency response, NRPHD sought input from key stakeholders in the health, emergency planning, social service, volunteer, community, and business sectors. This approach has facilitated the development of working relationships and partnerships which are essential for an emergency response in the Niagara Region.

An ethical framework for local decision-making and references to relevant legislative authority are also presented in Chapter 2.

2.0.1 PURPOSE AND SCOPE

The Niagara Region Influenza Pandemic Plan (NRIPP) is to be utilized as a guide for responding to, and recovering from, a pandemic influenza emergency at a local level. The NRIPP has been designed for use by Regional, Municipal, and community stakeholders for various planning purposes.

Examples include the following:

- Health sector, including:
 - Board of Health.
 - Niagara Health System.
 - Community and physicians.
 - Pharmacists.
- Community health sector, laboratories.
- Mortuary professionals.
- Homeless service providers.
- Community service providers.
- Business sector.

- Faith-based organizations and agencies.
- Educational institutions (public, separate and private).
- Day nurseries.
- Non-government, volunteer community service providers.
- Public safety and correctional services.

NRPHD is the lead agency for the Region of Niagara influenza pandemic planning preparedness and response. Although local planning must be based on the federal and provincial plans, local contingency plans are required for surveillance, vaccines and antivirals administration and distribution, public health measures, health services, emergency response, and communications.

At the beginning of the planning period, the Niagara Region Influenza Pandemic Steering Committee and subsequent work groups identified specific goals and planning assumptions for each of the six sub-committees (see section 2.2). The plan will be updated continually and revised as new information, directions, or recommendations are made available. Planning gaps and next steps for all levels of government are identified throughout the plan.

Version 1 of this plan has been placed on the NRPHD web page (www.regional.niagara.on.ca/pandemic) and will be updated regularly as new information becomes available (updates will be indicated by version number). NRPHD will continue to develop and improve the plan in collaboration with other governments and local stakeholders. The release of this first version marks an important step in moving forward.

2.0.2 GOALS OF PANDEMIC PLANNING

The following goals were based on the Canadian Pandemic Influenza Plan (CPIP) and the Ontario Health Plan for an Influenza Pandemic (OHP/IP):

1. Minimize serious illness and overall deaths through appropriate management of Niagara's health care system, and
2. Minimize societal disruption in Niagara as a result of an influenza pandemic.

2.0.3 OBJECTIVES

The following objectives were developed for the Niagara Region Influenza Pandemic Plan (NRIPP) and the planning approach:

1. Co-ordinate the Region of Niagara's response to pandemic influenza.

2. Define and recommend preparedness activities that should be undertaken before a pandemic occurs that will enhance the effectiveness of a pandemic response.
3. Make recommendations on interventions that should be implemented as components of an effective pandemic influenza response.
4. Develop a plan that can be adapted for other public health emergencies (e.g. smallpox).
5. Develop community linkages and effective working partnerships with key stakeholders that will improve the Region's preparedness for any public health emergency.
6. Work collaboratively with the provincial and federal levels in pandemic influenza planning and clarify roles, responsibilities and actions.
7. Support provincial and federal planning initiatives by being represented on planning work groups and steering committees.

2.0.4 IMPLICATIONS AND ASSUMPTIONS

Although there is alignment with the planning assumptions of the Federal and Provincial plans, the NRIPP has adapted the following general assumptions:

- The Niagara Region Influenza Pandemic Plan will be an evolving document. Niagara Region Public Health Department will continue to revise and build the Plan as local, provincial, and federal planning proceeds.
- Influenza pandemic simultaneously will affect the Region of Niagara and the Province of Ontario and other jurisdictions. Therefore, mutual aid will not be feasible.
- Influenza pandemic will be caused by a new or novel subtype of influenza A virus; therefore, the following is assumed:
 - Niagara Region likely will have very little lead time between when the World Health Organization (WHO) declares pandemic phase 6 and when the novel influenza pandemic strain is identified in Niagara.¹
 - The impact of illness upon the residents of Niagara will be significant.
 - There will be a cumulative attack rate of 15 - 35% during the first wave.
 - There will be multiple waves of influenza pandemic activity.
 - More severe illness and mortality than the usual seasonal influenza is likely in all population groups.

¹ Pandemic Phase 6 means increased and sustained transmission in the general population.

- The specific pandemic epidemiology (incidence, distribution, and control of disease in the population) will not be known until the pandemic virus emerges.
- Children and otherwise healthy adults may be at greater risk because elderly adults may have some residual immunity from exposure to a similar virus earlier in their lives if the pandemic is caused by a recycled influenza strain.
- The psychological impact on the public likely will be significant.
- Social gatherings may need to be curtailed or cancelled to prevent further spread of the infection.
- Supply chains of resources from every sector likely will be disrupted.
- The Region of Niagara will implement the Incident Management System in pandemic alert phase 5.

2.1 STEERING COMMITTEE MEMBERSHIP

The Niagara Region Influenza Pandemic Steering Committee consists of the Health Management Team of the NRPHD:

- Commissioner of Public Health Department/Medical Officer of Health.
- Associate Medical Officers of Health.
- Associate Commissioner of the Public Health Department.
- Director of Clinical Services Division.
- Director of Chronic Disease Prevention Division.
- Director of Population Health Division.
- Director of Health Protection and Promotion Division.
- Epidemiologist.
- Community Development Manager.

2.1.1 GOAL OF THE STEERING COMMITTEE

- Provide expertise and direction for the development of an influenza pandemic plan for the Region of Niagara.

2.1.2 OBJECTIVES OF THE STEERING COMMITTEE

1. Provide expert advice and liaise with work groups to ensure readiness for an influenza pandemic.
2. Ensure that a plan is created and kept up to date through liaison with those necessary to carry out the overall plan.
3. Liaise with appropriate external agencies (neighbouring health units, and cross-border, provincial, and federal governments) to co-ordinate activities.
4. Detail the decision-making process for various functions for each influenza pandemic phase.

2.2 SUB-COMMITTEES

Six sub-committees were formed with multiple stakeholder representatives to support planning for surveillance, vaccine and antiviral medications, public health measures, health services, emergency response, and communications. Each subcommittee developed planning goals at the outset of the process. Some of the goals have been achieved, while others will require development in the next steps of the planning process.

2.2.1 SURVEILLANCE SUB-COMMITTEE

Surveillance is the continuous and systematic process of collecting, analyzing, interpreting, and disseminating descriptive information to monitor public health and to ensure timely interventions to reduce morbidity and mortality.

2.2.1.1 Planning Objectives

1. Detect the pandemic strain early in Niagara Region.
2. Track the occurrence, severity, and progression of the pandemic, based on the World Health Organization (WHO) pandemic phases.
3. Monitor influenza-like illness (ILI) activity in order to do the following:
 - a) Detect unusual events (new strains, including epizootic strains, antigenic drift/shift, unusual outcomes/syndromes, unusual severity, unusual distribution).
 - b) Compare new strains with vaccine composition and recommendations.
 - c) Estimate the impact of ILI in terms of attack rate, out-patient visits, hospitalizations, and case fatality rate.

- d) Describe the affected population(s) in order to identify high-risk groups, modes of transmission, and risk and protective factors.
4. Share surveillance information with responders to help identify disease, guide prevention, control, and research; and evaluate treatment, prophylaxis, and education.

2.2.2 VACCINE/ANTIVIRAL SUB-COMMITTEE

Vaccines are the primary means to prevent disease and death from influenza during an epidemic or pandemic. Antivirals are effective for both influenza treatment and prophylaxis and may provide an adjunctive management strategy during a pandemic – particularly during the period when vaccine is not available.

2.2.2.1 Planning Objectives

1. Develop a mass immunization clinic plan – clinic sites, resources required.
2. Identify locations to store immunization supplies.
3. Develop a strategy for antiviral distribution.
4. Identify the numbers of essential service workers.
5. Develop a plan for staff immunization, education/training for delivery of immunization services, and related activities.
6. Develop a stakeholder communication plan for distribution of antivirals/vaccines (e.g. physicians/hospitals/pharmacies/clinics/workplaces, etc.).

2.2.3 PUBLIC HEALTH MEASURES SUB-COMMITTEE

Public health measures are non-medical interventions, such as contact tracing, closing of schools and limiting of public gatherings, travel restriction, and screening of people entering the country, used to reduce the spread of disease. The type of public health measures used and their timing depend on the epidemiology of the virus (e.g. pathogenicity, modes of transmission, incubation period, attack rate in different age groups, period of communicability, and susceptibility to antivirals).

2.2.3.1 Planning Objectives

1. Implement federal and provincial directives regionally to reduce spread of disease across Niagara.

2. Prepare and disseminate culturally appropriate resources and information to the residents of Niagara regarding self-care activities, treatment, prevention, and impact on local activities.
3. Provide support and guidance to health care workers in all Niagara settings towards a clear co-ordinated response.
4. Provide consultation services, education, and advice to other organizations, institutions, and businesses across Niagara, in response to the impact of implemented measures.
5. Identify the supports available to Niagara's vulnerable and high-risk groups towards meeting their physical, financial, and cultural needs.

2.2.4 HEALTH SERVICES SUB-COMMITTEE

The demand for influenza-related services will increase significantly, and health care settings will have to reduce or curtail other services in order to meet the population's health needs.

Health services include laboratory services, public health services, community-based agencies (e.g. physician services, home care, long-term care homes, pharmacies), emergency services, and hospital or acute care services.

2.2.4.1 Planning Objectives

1. Assure the development and implementation of appropriate health and safety precautions across the health services sector, especially the consistent and appropriate use of personal protective equipment (PPE), and establish mechanisms to assure timely distribution of equipment and supplies necessary for these purposes.
2. Establish mechanisms to assure that febrile respiratory illness (FRI) screening and response are consistently carried out across the health services sector.
3. Develop communication plans and processes such that health services sector members are kept up to date regarding epidemiology of evolving pandemic, system status and stresses, health human resources capacity, etc.
4. Develop clinical diagnosis and treatment guidelines and protocols consistent with those of the federal and provincial pandemic plans.
5. Establish systems to distribute and monitor the usage of antiviral medications (both treatment and prophylactic uses), antibiotics, and influenza vaccines across the health services sector.

6. Assure that health care services and programs across the health services sector are prioritized, such that there is a consistent and appropriate reduction and/or cancellation of non-essential programs in the face of community-wide pandemic activity.
7. Develop human resources plans, especially skills-based surge capacity, to address expected reductions in staff willing/able to work across the health services sector.
8. Develop and designate isolation facilities, especially hospital and long-term care facility options, for the care of seriously ill influenza patients.
9. Designate and plan for alternate care facilities outside of the existing hospital and long-term care facilities if needed, as a result of community burden-of-illness that exceeds present health care system capacity.
10. Assure appropriate co-ordination and use of regional laboratory capacity. Assure the development and implementation of appropriate health and safety precautions across the health services sector, especially the consistent and appropriate use of PPE, and establish mechanisms to assure timely distribution of equipment and supplies necessary for these purposes.

2.2.5 EMERGENCY RESPONSE SUB-COMMITTEE

Emergency response is the broad range of activities required to respond to any emergency. It includes measures to prepare for emergencies, such as developing and testing plans and establishing communication systems. It also includes the services provided by emergency responders, such as police and firefighters, and by workers who provide necessary community services, such as utility and telecommunications workers, and social service providers.

2.2.5.1 Planning Objectives

1. Establish a collaborative structure to facilitate effective communications and co-ordination of service delivery between emergency response personnel and the Public Health Department.
2. Identify and establish structural and functional linkages between emergency services and the Public Health Department Emergency Response Plan.
3. Identify and establish the composition of Influenza Pandemic Emergency Response Planning Working Groups including other pandemic functionaries, external stakeholders and agencies.
4. Provide leadership and directional guidance in order to facilitate emergency response planning activities (i.e. the identification of essential services, roles and responsibilities, including the development and implementation of processes and procedures by Pandemic Phase).

2.2.6 COMMUNICATIONS SUB-COMMITTEE

Effective internal and external communications provide the backbone for a co-ordinated response to an influenza pandemic. A wide range of groups at all levels will need to share accurate, timely, and consistent information about what is known about the pandemic strain, and the risks to public health, as well as advice on how to manage those risks at each stage of pandemic.

During a pandemic, media attention will be intense, and information demands will continue over several months. Sustaining public and workplace confidence over that time will be a challenge. Credible spokespeople will be required locally and within workplaces.

2.2.6.1 Planning Objectives

1. Ensure that the Niagara Region, with Ministry of Health and Long-Term Care support, is prepared to respond to community communication needs (i.e. general public, health care sector, and service providers).
2. Provide consistent, co-ordinated, effective, and ongoing public and provider communications regarding the pandemic plan and in the event of a pandemic outbreak.
3. Identify the communication activities that should occur during each phase of the pandemic.
4. Ensure that health care providers have access to transparent, accessible, accurate, real time information that will help them respond to challenges during each phase of the pandemic.
5. Develop a plan to meet sustained intense media demands during the course of the influenza pandemic, and ensure that the materials and means to meet those demands are established, available, and identified.
6. Encourage and assist the steering committee with effective collaboration and communication across pandemic planning sub-committees.

2.3 ETHICAL FRAMEWORK FOR INFLUENZA PANDEMIC PLANNING, RESPONSE, AND RECOVERY²

All levels of government will have to make difficult decisions based on an ethical framework. Ethical considerations include honesty and transparency, with clear reasons provided for decisions related to the allocation or prioritization of scarce resources, e.g. access to vaccine

² Adapted from: Gibson, J. et al. Ethics in a Pandemic Influenza Crisis. Framework for Decision Making. Joint Centre for Bioethics. University of Toronto 2005.

and antiviral medications. An ethical framework ensures stakeholder involvement in the decision-making process, with accurate communication.

The following outlines how the Niagara Region Influenza Pandemic Plan has adopted the Ethical Framework for Decision-Making as outlined in the Ontario Health Plan for an Influenza Pandemic.

2.3.1 Decision-Making Principles

Open and transparent - The process by which decisions are made must be open to scrutiny and the basis should be explained. The influenza pandemic plan for the Region of Niagara was developed by the Niagara Region Influenza Pandemic Steering Committee and the following sub-committees:

- Surveillance.
- Vaccine and Antivirals.
- Public Health Measures.
- Health Services.
- Emergency Response.
- Communications.

Community stakeholder participation was an important component throughout the entire planning process. Further outreach/consultation with stakeholders is an ongoing process, especially as updated versions of the federal and provincial plans become available.

Value-driven reasons based on evidence and principle will be made by people who are credible and accountable. The NRIPP is closely aligned with the direction provided by the federal and provincial influenza pandemic plans.

Planning decisions made were based on input from the following:

- Steering Committee members.
- Work group members.
- Other sector-specific stakeholders.
- Infectious disease/infection control experts.
- Current literature.

- Medical Officer of Health and Associate Medical Officers of Health.

Inclusive – Decisions should be made explicitly with stakeholder views in mind and stakeholders should have opportunities to be engaged in the decision-making process. NRIPP has adopted a key stakeholder model for the development of a comprehensive approach to planning, response, and recovery from influenza pandemic. Input from stakeholders in the health, emergency planning, non-government volunteer, community, and both public and private business sectors was provided and will continue with further local planning.

Responsive – Decisions should be revisited and revised as new information emerges and stakeholders should have opportunities to voice any concerns they have about the decisions (i.e. dispute and complaint mechanism). NRIPP will continue to be developed, enhanced, and revised as new information emerges from the federal and provincial plans. Opportunities for input will continue through larger reference groups, focus groups for sector-specific consultations, etc.

Accountable – Mechanisms will be developed to ensure accountability and sustained ethical decision-making throughout the pandemic.

Niagara's response to an influenza pandemic will be based on the following core ethical values as outlined in the OHPIP:

2.3.2 CORE ETHICAL VALUES

Individual Liberty – This may be restricted in order to protect the public from serious harm. Restrictions to individual liberty will:

- Be proportional to the risk of public harm.
- Be necessary and relevant to protecting the public good.
- Employ the least restrictive means necessary to achieve public health goals.
- Be applied without discrimination.

Protection of the Public from Harm – Public measures may be implemented to protect the public from harm.

Protective measures will include the following:

- Assessing the benefits of protecting the public from harm against the loss of liberty of some individuals (e.g. isolation).
- Ensuring that all stakeholders are aware of the medical and moral reasons for the measures, the benefits of compliance, and the consequences of failure to comply.

- Establishing mechanisms to review decisions as the situation changes and to address stakeholder concerns and complaints.

Proportionality – Restrictions on individual liberty and measures taken should not exceed the minimum required to address the level of risk or community needs.

Niagara will do the following:

- Use the least restrictive or coercive measure possible when limiting or restricting liberties or entitlements.
- Use more coercive measures only in circumstances where less restrictive means have failed to achieve appropriate public health ends.

Privacy – Individuals have a right to privacy, including the privacy of their health information.

Niagara will do the following:

- Determine whether the good intended is significant enough to justify the potential harm of suspending privacy rights (e.g. potential stigmatization of individuals and communities).
- Require private information only if there are no less intrusive means to protect health.
- Limit any disclosure to only that information required to achieve legitimate public health goals.
- Take steps to prevent stigmatization (e.g. public education to correct misperceptions about disease transmission).

Equity – All patients have an equal claim to receive the health care they need, and health care institutions are obligated to ensure sufficient supply of health services and materials. During a pandemic, tough decisions may have to be made about who will receive antiviral medication and vaccinations, and which health services will be temporarily suspended.

Niagara will do the following:

- Strive to preserve as much equity as possible between the needs of influenza patients and patients who need urgent treatment for other diseases.
- Establish fair decision-making processes/criteria.
- Identify diversity and respect and, wherever possible, ethno-cultural faith practice.

Duty to Provide Care – Health care workers have an ethical duty to provide care and respond to suffering. During a pandemic, demands for care may overwhelm health care workers and their institutions and create challenges related to resources, practice, liability, and workplace

safety. Health care workers may have to weigh their duty to provide care against competing obligations (i.e. to their own health, family and friends). When providers cannot provide appropriate care because of constraints caused by the pandemic, they may be faced with moral dilemmas. To support providers in their efforts to discharge their duty to provide care, Ontario and/or Niagara will:

- Work collaboratively with stakeholders, regulatory colleges, and labour associations to establish practice guidelines.
- Work collaboratively with stakeholders, including labour associations, to establish fair dispute resolution processes.
- Strive to ensure that the appropriate supports are in place (e.g. resources, supplies, equipment).
- Develop a mechanism for provider complaints and claims for work exemptions.

Reciprocity – Society has an ethical responsibility to support those who face a disproportionate burden in protecting the public good. During a pandemic, the greatest burden will fall on public health practitioners, other health care workers, patients, and their families. Health care workers will be asked to take on expanded duties. Decision-makers will take steps to ease the burdens of health care workers, patients, and patients' families. They may be exposed to greater risk in the workplace, suffer physical and emotional stress, and be isolated from peers and family. Individuals who are isolated may experience significant social, economic, and emotional burdens.

Trust – Trust is an essential part of the relationship between government and citizens, between health care workers and patients, between organizations and their staff, between the public and health care workers, and among organizations within a health system. During a pandemic, some people may perceive measures to protect the public from harm (e.g. limiting access to certain health services) as a betrayal of trust. In order to maintain trust during a pandemic, decision-makers will take steps to build trust with stakeholders before the pandemic occurs (i.e. engage stakeholders early) and ensure that decisions-making processes are ethical and transparent.

Solidarity – An influenza pandemic will require solidarity among community, health care institutions, public health units, and government. Solidarity requires good communication and open collaboration within and between these stakeholders to share information and to co-ordinate health care delivery.

Stewardship – In our society, both institutions and individuals will be entrusted with governance over scarce resources, such as vaccines, ventilators, hospital beds, and even health workers. Those entrusted with governance should be guided by the notion of stewardship, which includes protecting and developing one's resources, and being accountable for public well-being. To ensure good stewardship of scarce resources, decision-makers will consider both the benefit to the public good and equity (i.e. fair distribution of both benefits and burdens).

2.4 LEGAL/LEGISLATIVE FRAMEWORK

Actions taken during an emergency response must be guided by the legal/legislative framework. If interventions such as quarantine or isolation are used during a pandemic emergency, they can pose an unusual burden on members of society and social distancing for disease containment such as school closures or limiting of large public gatherings. Consideration must also be given to how best to address individuals unwilling or unable to be effectively quarantined or isolated. This would include those in homeless shelters, rooming houses, school residences, and correctional facilities. Legal authority must be considered in every component of pandemic planning. It is anticipated that the following statutes will play a role and provide legal authority to respond to influenza pandemic at the local level:

- Health Promotion and Protection Act R.S.O. 1990 c. H. 7 (HPPA).
- Emergency Management and Civil Protection Act R.S. O. 1990, c. E. 9.
- Personal Health Information Protection Act, 2004 S.O. 2004, c. 3 Sched. A (PHIPA).
- Quarantine Act R.S.C. 1985, c. Q-1.
- Coroners Act R.S.O. 1990 c. C.37.
- Occupational Health and Safety Act R.S.O. 1990 c.O.1.
- Niagara Region Emergency Management Plan 2006 Schedule A to By-Law 33-2004.
- The Ambulance Act.

2.4.1 HEALTH PROMOTION AND PROTECTION ACT

In Ontario, the Health Protection and Promotion Act requires Boards of Health to provide or ensure provision of a minimum level of public health programs and services in specified areas such as the control of infectious and reportable diseases, health promotion, health protection, and disease prevention. Mandatory Health Programs and Services Guidelines published by the Ministry of Health and Long-Term Care, set out minimum standards that must be met by Boards of Health delivering these public health programs and services. Regulations published under the authority to the HPPA assist to control the spread of communicable and reportable diseases. Regulation 569, Reports, establishes the parameters within which those who are required to report communicable and reportable diseases to the Medical Officer of Health must operate. The Report regulation specifies the information that must be reported for diseases listed in the regulation, and under certain conditions, such additional information that the Medical Officer of Health may require. A Medical Officer of Health is authorized under section 22 of the HPPA to issue an order under prescribed conditions to control communicable diseases. The content of these orders could include an order requiring an individual or identified group to isolate himself/herself or themselves, to place himself/herself or themselves under the care and treatment of a physician (if the disease is a virulent disease, as defined in

the HPPA), or to submit to an examination by a physician. A Medical Officer of Health may also, under certain conditions, seek a court order under section 35 of the HPPA to isolate an individual in a hospital or other facility for a period of up to four months.

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/900569_e.htm

2.4.2 EMERGENCY MANAGEMENT AND CIVIL PROTECTION ACT

On June 20, 2006, Bill 56 received Royal Assent, becoming the new **Emergency Management and Civil Protection Act**. The Act amends the definition of emergency to include danger caused by disease or health risk.

The new definition of “emergency” means a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property, and that is caused by the forces of nature, a disease or other health risk, an accident or an act, whether intentional or otherwise. The Emergency Management Act establishes the requirements for emergency management programs and emergency plans in the Province of Ontario. The Act specifies what must be included in emergency management programs and emergency plans. The emergency plan is the legal authority as empowered by Niagara Regional By-law 33-2004.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90e09_e.htm

2.4.3 PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004 (PHIPA)

PHIPA regulates the collection, use, and disclosure of personal health information by health information custodians (a defined term in the Act) and includes physicians, hospitals, long-term care facilities, Medical Officers of Health, and the Ministry of Health and Long-Term Care. The Act also establishes rules for individuals and organizations receiving personal information from health information custodians. Consent is generally required to collect, use, and disclose personal health information; however, the Act specifies certain circumstances when it is not required. For example, the Act permits disclosure of personal health information to the Chief Medical Officer of Health or the Medical Officer of Health without the consent of the individual to whom the information relates where the disclosure is for a purpose of the Health Protection and Promotion Act. Disclosure of personal health information without consent is also permitted for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/04p03_e.htm

2.4.4 QUARANTINE ACT

The purpose of the federal Quarantine Act is to prevent the introduction and spread of communicable diseases in Canada. It is applicable to persons and conveyances arriving in, or in the process of departing from, Canada. It includes a number of measures to prevent the spread of dangerous, infectious and contagious diseases including the authority to screen, examine, and detain arriving and departing individuals, conveyances, and their goods and

cargo, which may be a public health risk to Canadians and those beyond Canadian borders. Bill C-12, the new Quarantine Act, received Royal Assent on May 12, 2005. The new Act came into force December 2006. The new legislation updates and expands the existing legislation to include contemporary public health measures including referral to public health authorities, detention, treatment, and disinfestation. It also includes measures for collecting and disclosing personal information if it is necessary to prevent the spread of a communicable disease.

<http://laws.justice.gc.ca/en/Q-1/index.html>

2.4.5 CORONERS ACT

When a person dies while a resident in specified facilities, including a resident in a home for the aged or a nursing home, a psychiatric facility, or an institution under the Mental Hospitals Act, the Coroners Act requires the person in charge of the hospital, facility, or institution to immediately give notice of the death to the Coroner. Further, if any person believes that a person has died under circumstances that may require investigation, that person must immediately notify a coroner or police officer of the facts and circumstances relating to the death. The Coroner must investigate the circumstances of the death and determine whether to hold an inquest.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90c37_e.htm

2.4.6 OCCUPATIONAL HEALTH AND SAFETY ACT

The Occupational Health and Safety Act is enforced by the Ministry of Labour. The Act imposes a general duty on employers to take all reasonable precautions to protect the health and safety of workers. The duties of workers are, generally, to work safely in accordance with the Act and regulations.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90o01_e.htm

2.4.7 OTHER LEGISLATIVE REFERENCES

Ambulance Act, 1990.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90a19_e.htm

Public Hospitals Act, 1990.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90p40_e.htm

Private Hospitals Act, 1990.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90p24_e.htm

Nursing Homes Act, 1990.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90n07_e.htm

Charitable Institutions Act, 1990.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90c09_e.htm

Homes for the Aged and Rest Homes Act, 1990.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90h13_e.htm

Health Facilities Special Orders Act, 1990.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90h05_e.htm

Long-Term Care Act, 1994.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/94l26_e.htm

Community Care Access Corporations Act, 2001.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/01c33_e.htm

Regulated Health Professions Act, 1991 (RHPA).

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/91r18_e.htm

Medicine Act, 1991.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/91m30_e.htm

Nursing Act, 1991.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/91n32_e.htm

Medical Laboratory Technology Act, 1991.

http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/91m28_e.htm

Health Care and Residential Facilities Regulation

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/930067_e.htm