The Role of Public Health Nurses Supporting Reception Centres and Emergency Shelter Sites

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Contents

1. Abbreviations

CRC	Canadian Red Cross
CRNM	College of Registered Nurses of Manitoba
EMO	Emergency Management Organization
ESS	Emergency Social Services
MOH	Medical Officer of Health
NIHB	Non-Insured Health Benefits
OTC	Over-the-Counter Medication
PH	Public Health
PHN	Public Health Nurse
STBBI	Sexually Transmitted and Blood Borne Infections
RHA	Regional Health Authority

2. Purpose

To provide guidance for the role, responsibilities, and expectations for Public Health Nurses (PHNs) assigned to support displaced populations from evacuated communities at a reception centre or emergency shelter site.

3. Scope

This guideline applies to all PHNs employed by the Regional Health Authorities (RHAs) who are assigned to support displaced populations from evacuated communities at a reception centre or emergency shelter site.

For the purposes of this document, reception centres refer to common spaces where displaced people are triaged, registered, and supported by emergency management teams (e.g., Emergency Social Services (ESS), Canadian Red Cross (CRC)) and where regional health support has been requested and PHNs are deployed to provide direct service [1]. Emergency shelter sites refer to the locations where safe temporary lodging has been arranged for displaced populations from evacuated communities [2]. Depending on circumstances and site selection, this may include commercial accommodations (e.g., hotels, boarding homes) or congregate public facilities that have been adapted for accommodation purposes (e.g., schools, community centres, arenas) [2]. Hereinafter, these settings will be referred to collectively as shelter sites but are inclusive of both types of accommodations as described above. In some cases, reception centres and emergency shelter sites may be situated at the same location.

The roles and activities outlined in this document are intended as guiding expectations and recommendations based on best practices for PHNs and do not supersede:

- The legislated scope of practice for Registered Nurses within *The Regulated Health Professions Act,* S.M. 2009, c. 15 [3]
- The regulations within the *College of Registered Nurses of Manitoba (CRNM) General Regulation,* CCSM 2017, c. R117 [4]
- The CRNM Practice Expectations for Registered Nurses [5]
- Documented policies and operating procedures from RHAs and institutions.

4. Definitions

Reception Centre: A public site or facility (e.g., community centre), where after an emergency or a disaster, people are evacuated to and where their immediate basic ESS needs are either met or arranged [1]. Past experiences have shown that displaced populations may arrive with injuries or illnesses, may be experiencing trauma or distress, and may not have necessary medications or equipment. At reception centres, first aid, mental health services, addictions support, public health services, and other health supports are often provided in addition to basic ESS, transportation, sanitation, and recreation [1].

Emergency Shelter Site: Temporary and safe accommodations for displaced populations from evacuated communities that have been arranged through ESS emergency lodging services [1,2]. These may include commercial accommodations (e.g., hotels, boarding homes) or congregate public lodging facilities [1,2]. Congregate lodging facilities are buildings not usually used for living purposes, such as schools or community centres, that have been adapted into communal dormitory-type accommodations to support a large number of evacuated individuals [2].

Emergency Social Services: Services provided on a short-term basis to preserve the emotional and physical well-being of evacuees in emergency situations [6]. ESS includes six pillars: reception, registration and inquiry services, lodging, food, clothing, and specialized or personal services, such as medical and mental health support [1,6]. ESS are the responsibility of the municipalities and local authorities but may be provided in partnership with the province [6]. Local authorities can request Provincial ESS assistance through Manitoba Emergency Measures Organization. Provincial ESS are often coordinated by Manitoba Government's Department of Families; these team members collaborate with others (including PHNs) on site [6].

Emergencies or Disasters: Emergencies refer to present or imminent events concerning persons or property that require prompt coordination and response to protect the health, safety, and welfare of people (e.g., power outages) [7]. Disasters refer to hazardous events which originate within the geophysical or biological environment, or by human action, whether malicious or unintentional (e.g., wildfires or floods) [7].

Holistic Care: PHNs approach client care and population assessment with the understanding of health as a state of complete mental, physical, spiritual, emotional, and social well-being [8,9].

Creative Engagement: Involves PHNs developing creative ways and utilizing inventive strategies to address possible barriers and establish and maintain trusting and effective relationships with displaced populations [9,10].

5. Background

Evacuations may be required in response to climate-related, human-caused, or technological emergencies or disasters. In Manitoba, emergencies and disasters, such as wildfires, have caused large-scale evacuations across the province, disproportionately impacting First Nations and remote communities [11].

PHNs support the core functions of public health in Manitoba, including health promotion, health protection, disease and injury prevention, health surveillance, population health assessment, as well as emergency preparedness and response [12]. PHNs routinely respond to the impacts of emergencies or disasters, such as evacuations, that may threaten the health, welfare, and continuity of care for populations across the province. In these situations, PHNs apply a population-wide, health equity approach, informed by their strong community knowledge and relationships. When supporting displaced populations, PHNs adapt their roles within these core functions as needed, while remaining within their professional authority, scope of practice, knowledge, and competencies [13,14,15].

The guiding expectations for PHNs outlined in this guideline integrate and build on a variety of local and national documents. These include Standards [9,16], Competencies [17], and Roles and Activities [18] for public health nursing practice developed by provincial and national bodies, as well as the general core competencies of public health developed by the National Collaborating Centres for Public Health [18]. This guideline also incorporates key regional resources that were developed and provided by the RHA public health teams [19].

PHN response activities may evolve as population needs change throughout an evacuation event. For this reason, this guideline is organized along a continuum of public health response, including preparation and activation, immediate, intermediate, and long-term stages. The components in these stages are intended to be flexible, not necessarily limited to specific timeframes, and guided by PHN judgment and evolving individual and community needs. Surge events, such as a communicable disease outbreak, may require PHNs to adjust to changing demands and priorities. Some activities are core PHN practices and remain relevant throughout the response, such as monitoring and advocating for continuity of health services, providing emotional support, and strengthening relationships.

6. Guidelines

6.1. Preparation and Activation

Emergency preparedness is a core function of public health and a key competency for PHNs [12,18]. In the preparation phase, PHNs familiarize themselves with their regional Incident Command systems or structures, and access points for regional and provincial policies, guidance documents, and operational resources. For information and updates on local hazards, types of evacuations, ESS coordination, and emergency response in Manitoba, is available through the Province of Manitoba Emergency Management Organization [20]. Where applicable, PHNs also complete regional orientation or training relevant to emergency response. In the event of an evacuation where PHN presence is requested, PHNs receive direction from their designated supervisor and/or management team.

If a reception centre or emergency shelter site is activated, assigned PHNs:

- **Retrieve necessary applicable materials** (emergency medical supplies, work cellphone and laptop, station signage, PH office contact information, and documentation and health information storage supplies).
- **Report to the designated reception centre/shelter site** where services are being provided and connect with the site leader or manager present.
- **Review reporting structures for reception centre/shelter site** and regional public health team involved in response, including processes for reporting on-site medical emergencies, incidents, near misses, and observations or recommendations.
- **Review site emergency initiation protocols and procedures** to be prepared if a code blue, medical emergency procedure, or other urgent health event occurs.
    - All medical emergencies that occur in supported reception centres and shelter sites require activation of an emergency response plan and emergency medical services (EMS), 911, code blue, or site emergency protocol initiation.
- **Establish a Public Health Nursing area or station**, identify a safe and secure place for private health conversations, set-up equipment, and display signage, hours, resources, and contact information as applicable.
- **Seek out site relevant regional or provincial policies, guidance documents, and operational resources** (e.g., Shared Health - Health Services and Resource Guide for Health Providers Working with Wildfire Evacuees).

See **Appendix A –** Example List of Medical Supplies for PHN Emergency Response.
Note that if the local Public Health Office keeps an emergency kit (e.g. Go-Bag or Disaster Cart), it is checked and restocked annually at minimum when not in use and daily when supplies are being used, or in accordance with regional policy.

See **Appendix B –** Example List of Documentation Supplies for PHN Emergency Response.

6.2. Immediate Response

The duration of the immediate response stage may vary depending on whether displaced populations are passing through a community or region or being temporarily received there. For the purposes of this guideline, the immediate stage refers to the period from the initial reception of displaced populations into the host community through approximately the first 5-7 days following their arrival.

Based on community needs and direction from emergency management and public health leadership, activities during this stage may include PHN presence at reception centres and/or team-based outreach to emergency shelter sites (e.g., hotel settings). Wherever possible, PHNs are encouraged to review information provided by the evacuated communities regarding the anticipated health needs of the incoming populations to support informed and timely response efforts.

6.2.1. Population Health Assessment and Triage

Emergencies, disasters, and evacuations can result in injury, illness, and the exacerbation of comorbidities [21,22,23,24,25]. For example, smoke exposure from wildfires can cause exacerbations of asthma, bronchitis, and chronic lung disease [21,22,23]. Psychological health may also be a significant area of need when people who have experienced an emergency or disaster arrive to reception centres or shelter sites [21,26,27]. In addition to addressing the ongoing health needs of displaced populations, PHNs may also assess, educate, and support affected individuals considering these unique risks and applying a view of holistic care [8,9].

PHNs carry out and respond to population health assessment and triage needs by:

- **Proactively assessing and gathering information** on the health needs of the population to plan response.
- **Identifying priority or structurally disadvantaged groups** that may need additional, emergent, or public health support (e.g., pregnant individuals, infants, families with young children, older adults, those with communicable or chronic illnesses, people who do not have their life saving medications, those with disabilities or mobility issues, those who are experiencing acute mental health issues, those with substance use or addictions needs).
- **Immediately investigating reported communicable illness** to confirm diagnosis and ensuring adequate treatment and/or isolation (e.g., active Tuberculosis cases).
- **Providing emotional support, reassurance, and a calming presence** for those experiencing stress, anxiety, grief, or difficulty coping, while applying trauma and violence informed approaches and considering cultural safety.

- **Referring individuals to on-site mental health responders** for further intervention and community mental health services for crisis or continued support as needed.
- **Activating the appropriate emergency response** for all medical emergencies occurring at reception centres or emergency shelter sites (e.g., EMS/911, Code Blue, or site-specific emergency protocol initiation).

Consistent with their roles in population health assessment and triage, and health system navigation, PHNs support individuals in obtaining access to appropriate first aid, primary care, wound care, and other appropriate services and work in collaboration with on-site or nearby primary care professionals, designated first-aid responders (e.g., St. John's Ambulance) and emergency service providers. PHNs may provide basic first aid (e.g., bandaging minor cuts or scrapes) within PHN scope of practice to support immediate client safety. In these circumstances, PHNs apply professional judgment and assessment skills to take appropriate action while coordinating further access to appropriate care. PHNs are expected to administer and document first aid in accordance with regional policies, standards, and established protocols.

6.2.2. Health System and Prescription Navigation

PHNs support the urgent needs of displaced populations by connecting them to local health resources and making referrals as appropriate [29,30]. This may include:

- **Assisting and arranging timely transfer** for those who require immediate access to off-site primary, urgent, or emergency care (e.g., physical, mental health, or specialized services). Activate emergency response and call emergency services (911) as needed.
- **Coordinating transportation and support through appropriate processes** (e.g., ESS or CRC) for all clients requiring off-site services, ensuring needs such as mobility supports or childcare are considered.
- **Assisting individuals who arrive without medications, medical equipment, or documentation** to access prescribers, pharmacists, health cards, and other necessary services (e.g., Non-Insured Health Benefits (NIHB)).
    - Health Card information can be retrieved via the Client Registry, which can access a client's demographics, and any information such as PHIN. Individuals may contact the Manitoba Health, Seniors and Long-term Care Insured Benefits Branch at https://www.gov.mb.ca/health/mhsip/contact-info.html
- **Providing urgent health teaching and education** within PHN scope.

Consistent with their role in health system navigation, PHNs support individuals in accessing required prescriptions and non-prescription drugs (herein referred to as over-the-counter [OTC] medications) through prescribers, ESS, primary care services, and nearby pharmacies or retail providers. If access is an issue, PHNs work with partners to identify processes for OTC medication availability.

In situations where PHNs are required to provide an OTC medication (*Reserved Act 9* in the *College of Registered Nurses of Manitoba (CRNM) General Regulation*, CCSM 2017, c. R117 [4]), they apply professional judgement, assessment skills, knowledge of contraindications, and take appropriate action while coordinating access to appropriate services.

6.2.3. Relationship-Building

PHNs engage and support displaced populations using strength-based, trauma and violence informed approaches to develop trusting therapeutic relationships [10]. This may include having an intentional and informal presence at reception centres and emergency shelters sites to build rapport, develop trust, and proactively identify needs. This creative engagement approach – sometimes referred to as "*loitering with intent*" – involves PHNs remaining visibly present and approachable, creating natural opportunities to connect with displaced populations and learn about their home community. Conversation starters may include:

- *Who are the natural leaders in the community? Who might need more support?*
- *What are some of things that contribute to this community's wellness, hope, belonging, meaning, and purpose? What may be possible and needed in this new space?*
- *Are there community events or ceremonies that were planned that had to be stopped because of the evacuation?*
- *Are there community members or leaders who have been providing updates?*

PHNs practice relationship-building by [9,18]:

- **Using creative engagement** to initiate and maintain contact, address barriers and continue public health assessment and intervention with displaced populations.
- **Fostering and maintaining therapeutic and trusting relationships** with the displaced populations based on mutual respect.
- **Promoting maximum participation and self-determination** of displaced individuals, families, and community members in their health and decision-making.

6.2.4. Collaboration and Advocacy

PHNs collaborate, coordinate, and build effective coalitions with other responders, agencies, and leaders from displaced communities to address emerging issues and ensure the provision of comprehensive services [9,31]. PHNs also act as advocates for displaced individuals, families, and communities based on identified needs and to promote and protect health and well-being [9,32]. This includes:

- **Supporting site coordination**, including clarifying site-specific processes and articulating the PHN role to other responding agencies and departments.

- **Working collaboratively with ESS and regional programs,** including primary care, home care, and mental health and addictions services to ensure client needs are met.
- **Communicating observations and recommendations** to emergency management and regional leadership to support the general wellness of the population and operations at the site.
- **Communicating with authorities, partner agencies, and community leaders**, when appropriate, to gather pertinent information to inform response efforts.
- **Advocating for culturally appropriate and relevant supports** and arranging interpreters through community leaders or other channels as needed.
- **Advocating for individuals and communities facing barriers** and supporting access to supportive services (e.g., individuals with special nutritional requirements, disability considerations, or security/safety concerns).

6.3. Intermediate Response

Following the initial immediate response and typically within the first few weeks after an evacuation (though timelines may vary), displaced communities may continue to have population and public health needs that require ongoing support. In this stage, PHNs continue to assess, triage, and respond to new and ongoing population health needs while building client awareness of available local services and supporting client capacity for independence. PHNs act as point of contact to connect displaced populations to specialized care and community resources. This lessens the burden for displaced populations having to navigate complex support-service systems when they are experiencing uncertainty and distress [27].

6.3.1. Continuity of Care and Further Outreach

Populations who have been displaced due to evacuations may experience disruptions and barriers to ongoing care and specialized health services [22,29,30,33,34].

PHNs support continuity of care and further outreach for population well-being by:

- **Assisting individuals to maintain access to essential health services**, including scheduled medical appointments, specialized care, and diagnostic testing that may be disrupted by the evacuation. PHNs play a role in supporting the identification of affected individuals and their locations, and in facilitating support for individuals who may face challenges traveling or making alternative arrangements for these health services (e.g., connecting evacuees receiving cancer care with Cancer Navigation Services).
- **Applying targeted outreach strategies** to identify populations and individuals whose health needs are unmet or who require ongoing, intensive support (e.g., working with communities to identify all pregnant people and infants under 12 months old so they can receive public health maternal/child services, appropriate care, and follow-up).

- **Coordinating and connecting individuals with ongoing specialized services** as required such as diabetes management, home care, harm reduction, wound or foot care, mental health support, prenatal care, or dental care.

Depending on the circumstances, populations may remain displaced in a host community for several weeks or even months. Public health services are adjusted over time as the situation stabilizes (see section 6.4 Long Term Response).

6.3.2. Resource Navigation

PHNs often have strong knowledge and relationships with community supports and act as the "*community connector*" to link displaced populations with local resources [18].

PHNs provide community resource navigation by:

- **Connecting displaced individuals with appropriate and culturally relevant resources** (e.g., recreation programs for families with young children, women's resource centres, Friendship Centers).
- **Using existing relationships to advocate** for on-site supports when appropriate.
- **Maintaining current resource guides** with local services, hours, and contact information for PHN reference, as well as for distribution and display at reception centres and emergency shelter sites (e.g., advocacy and social supports, crisis services, cultural services, government benefits and legal supports, health and access centres, and family or older adult programs).

6.3.3. Communication and Health Education

PHNs are highly skilled at interpreting and conveying health information to community audiences, including displaced populations, and providing health education [18,32]. This includes:

- **Sharing relevant information and appropriate situational updates** (e.g., equipment and supply support process with NIHB, resources for health card access, CRC support available for family reunification).
- **Offering health education and distributing resources on relevant and priority topics** (e.g., instructions for formula preparation and bottle cleaning, monitoring for complications from smoke exposure, on-site workshops to advertise supports available for older adults).

6.3.4. Harm Reduction and Substance Use Services Support

Harm reduction is an evidence-informed public health approach to substance use that reduces harm to individuals, families, and the broader community [33,36].

PHNs support access to harm reduction and substance use services for displaced populations with an understanding of community context by [33]:

- **Providing health education and communication on harm reduction and substance use services and supporting connection or referral to care** where appropriate (e.g., addictions medicine/Rapid Access to Addictions Medicine clinics, drug checking, drug alerts, extended hour access to safer supply programs).
    - Information about harm reduction may be found at https://www.gov.mb.ca/health/publichealth/harm-reduction.html#programs
    - Locations for harm reduction supplies and services may be found at https://streetconnections.ca/locations
    - Locations for take home naloxone distribution may be found at https://www.manitoba.ca/health/publichealth/naloxone-finder.html
- **Providing access to harm reduction and safer sex supplies** at congregate sites including:
    - safer sex supplies (e.g., condoms, lubricant, dental dams)
    - safer injecting supplies (needles/syringes, steri-cup/cookers, sterile water, filters, alcohol swabs, tourniquets, ascorbic acid, sharps containers). *Note that safer smoking supplies (safer crack and safer meth use devices) are not required supplies at congregate sites. Client may be referred to sites that distribute these supplies.*
    - take home naloxone kits
        - Be aware of distribution criteria https://www.gov.mb.ca/health/publichealth/docs/Take-Home-Naloxone-Distribution-Site-Requirements.pdf
        - Training posters are available for download at https://www.gov.mb.ca/health/publichealth/docs/how-respond-opioid-toxicity.pdf
- **Collecting data** on the number of individual encounters and total number of sterile needles distributed. Collection of personal health information or identifiers is not required during supply distribution encounters.
    - For further details and guidance on the distribution of harm reduction supplies, please see the Manitoba Population and Public Health Standard - Harm Reduction: Supply Distribution and Community Engagement [36].
- **Supporting continuity of care** for individuals who were receiving substance use services in home community (e.g., Opioid Agonist Treatment, residential treatment), by ensuring connection with local programs as appropriate and available.

If an individual appears to be experiencing apparent opioid toxicity in a reception centre or congregate sheltering site (not a private hotel room), appropriately trained individuals administer naloxone and provide cardiopulmonary resuscitation (CPR) as required. PHNs working in reception centres or evacuation sites are not required to be trained in opioid toxicity response. Where PHNs have received appropriate training, they may administer naloxone as outlined in the FORTHCOMING Manitoba Health, Seniors and Long-Term Care Public Health guideline titled *Interim Response to Apparent Opioid*

Toxicity by PHNs Working in Reception Centres of Emergency Shelter Sites [37]. Application of this practice and training is determined at the RHA level.

6.3.5. Communicable Disease Control

PHNs work with public health team members, including Communicable Disease Coordinators and Medical Officers of Health (MOHs) to apply principles of epidemiology and knowledge of the disease process to prevent and control the spread of communicable disease in displaced populations [1,15,35].

PHNs contribute to communicable disease control by:

- **Providing health education and resources** on immunizations, communicable diseases, and infection prevention and control.
- **Supporting case and contact investigations** for reportable communicable diseases which includes providing interventions and follow-up as outlined in the communicable disease protocols (e.g., contact tracing, chemoprophylaxis, immunoprophylaxis, isolation/segregation to prevent further exposures)
    - Communicable disease management protocols may be found at: https://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html
- **Reviewing immunization records and administering vaccines** as required. Refer to RHA immunization resources and to the Manitoba Immunization Program Manual for resources such as vaccine eligibility, immunization schedules, consent forms, fact sheets, vaccine storage and handling.
- **Providing guidance for non-reportable communicable diseases** (e.g., lice, some gastrointestinal illnesses).
- **Assisting with response plans for outbreaks** (as directed by regional CD Coordinator and/or MOH) and collaborating with the facility management and other partners (e.g., public health inspectors, infection prevention and control).
- **Facilitating required specimen collection(s)**, as directed by the regional CD Coordinator or MOH for communicable disease detection.

If providing point-of-care STBBI testing on-site, for guidance and standards please see Manitoba Population and Public Health Guideline - Non-Traditional STBBI Testing by Regional Public Health Teams [38]

For articulation on the scope of practice and care guidance for PHNs administering medications for the treatment of uncomplicated gonorrhea, chlamydia, and syphilis, as authorized under *Reserved Act 9* in the *College of Registered Nurses of Manitoba (CRNM) General Regulation*, CCSM 2017, c. R117 [4], please see Manitoba Population and Public Health Guideline - Treatment for Uncomplicated Gonorrhea, Chlamydia, and Syphilis by Public Health Nurses [39]

6.4. Long-Term Response

Depending on the circumstances of the evacuation, populations may remain displaced in a host community for several weeks or even months. During this stage, in alignment with RHA guidance and PH leadership, PHNs:

- **Continue to recognize and respond to the unique needs displaced populations may have** (e.g., impacts due to prolonged separation from home community social and cultural support systems) [21,23,34,40].
- **May shift toward providing PH services similar to those offered to local populations** within PHN portfolio in their designated area.
- **May participate in a debrief and evaluation** of the services that were provided once displaced populations return to home community, identifying strengths, challenges, and opportunities for improvement.

6.5. Documentation and Reporting

Documentation is a key communication tool for care coordination and continuity throughout the immediate, intermediate, and long-term stages of evacuation response [41].

PHNs practice effective documentation and reporting by:

- **Documenting significant encounters** with clients, such as health assessment, education, or medication administration using regionally designated documentation and referral forms (e.g., when a referral is made to other programs).
- **Documenting in the patient health record when health services are provided,** in accordance with regional documentation policies, procedures, and established documentation systems, ensuring accuracy, timeliness, and clarity.
- **Ensuring secure, locked storage and appropriate transfer of health information**, whether to the local public health office or to other appropriate location/contact (e.g., Public Health Managers), in accordance with the *Personal Health Information Act,* CCSM 1997, c. P33.5 [42] and in accordance with regional policies and procedures.
- **Submitting Incident Reports and communicating incidents, observations or recommendations** to the appropriate contact, following site- and region-specific processes (e.g., RL).

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Appendix A – Example List of Medical Supplies for PHN Emergency Response

This example list was developed utilizing resources from the RHA public health teams. The suggested supplies and amounts vary depending on the scale of evacuation.

Item Description	Suggested Amount
BP cuffs (various sizes) and stethoscope (adult)	1-2 of each
Digital thermometer (with probe covers box)	1-2
Extra batteries for thermometer	2
Gloves (nitrile/non-latex), medium size	1 box
Procedure (Surgical) masks	1-2 boxes
Hand sanitizer	2-4 (depending on size)
Blue pads/Incontinence pads	4-5
Accel wipes	1-2 large packs
Towelettes/Handi-wipes	25 packages
Resuscitation mask with barrier (1-way valve)	1
Kleenex	1 box
Garbage bags	12
Sharps container	1
Instant cold packs (chemical type)	4
Pregnancy Tests	1-2 boxes
Basic First Aid Supplies	
Alcohol swabs	1-2 boxes
Tongue depressors (Junior and Senior)	25 of each
Pen light	1
Applicator sticks (cotton tip)	50
Band-aids (3/4 x 3”)	2 boxes
2 x 2 and 4 x 4 sterile gauze	2 boxes of each
Bandage (conforming gauze sterile 2” and 4”)	2 packs of each
Bandage (conforming gauze 4”)	2 packs
Soft cloth, adhesive wound dressings	2 packs
Telfa, non-adhesive wound dressing (2 x 2 and 4 x 4)	2 boxes of each
Tensor bandages (2” and 4”)	2-6 of each
Steri-strips	1-2 boxes
Normal saline bottle	2 bottles
Normal saline flush syringes	10
Slings (medium size)	2-6
Tape (medical, paper, 1”)	1 box
Tape (surgical, clear, non-latex)	1 box
Sterile scissors	2-5 pairs
Medical/bandage scissors (recommended 14cm)	1 pair
Sterile tweezers	2 pairs
Safety pins (assorted sizes)	5-10

Appendix B – Example List of Documentation Supplies for PHN Emergency Response

This example list was developed utilizing resources from the RHA public health teams. The suggested supplies and amounts may vary in applicability depending on the scale of evacuation and response. The suggested documentation and referral forms will also vary depending on region and may include local resource guides and information (e.g. city maps), referral forms (e.g. prenatal or home care services), mental health support resources, health or ESS assessment forms, single issue documentation or progress notes, and contact lists for clients requiring follow-up.

Item Description	Suggested Amount
Clipboards	2
Scotch tape dispenser	1 dispenser
Scotch tape rolls	12 rolls
Ruler	1
Stapler and stapler removal	1 of each
Staples	1 box
Highlighters (various colours)	1 box of 12 for each colour
Pencils	1 box of 12
Pens (blue or black, fine tip)	1 box of 12 for each colour
Permanent marker (Sharpie, black, chisel-tip)	1 box of 12
Binder clips (1/2” and ¼” capacity)	1 box of each
Calculator	1
Push pins	1 box of 100
Envelopes	1 pack of 25
Scissors	1
Post It Notes	1 pack of 12
Note pads	1 pack of 5
File folders	5-10
Health documentation forms (e.g. single issue, progress notes, emergency response documentation)	5 of each
WorkStation Supplies	
Computer, printer, fax machine	
Telephone	
Internet Access, access to E-chart, PHIMS, and EMR	(if applicable for e-charting)
Downtime procedure manual	(if applicable for e-charting)

Appendix C – Harm Reduction Supplies and Estimated Proportions

The harm reduction supplies included in this list are based on the Manitoba Population and Public Health Standard - Harm Reduction: Supply Distribution and Community Engagement [36]. For further details and guidance on the distribution of harm reduction supplies, please see this standard [36].

The estimated proportion of supplies needed is based on data that supports that 1% of the population served in Manitoba injects drugs and 3% are at risk for opioid-related harms. These numbers listed below are estimates of the supplies that will be required based on the evacuee population of 1000 people.

Item	Estimated Proportion (per 1000 people)
Needles/Syringes • Sterile insulin or tuberculin syringe/needle combination) • One piece non-detachable (generally 1.0 mL syringe) • Include a range of options in needle length and gauge • Non-safety engineered needles are the standard for supply distribution and community preference	200
Steri-cup/Cookers	200
Filters • Sterile filters are recommended • Wheel type filters may also be offered by regions based on local need and available budget • Aim to make filters available at a 1:1 ratio per needle	200
Alcohol Swabs • Active ingredient 70% isopropyl alcohol • Aim to make alcohol swabs available at a 1:1 ratio per needle	200
Water for Injection • 2-3 mL sterile water ampoules are recommended for people who inject drugs who are unhoused, inject outdoors, or who do not have access to running water • For people with access to running water (e.g., staying in a hotel), tap water boiled for 10 minutes and cooled is also suitable for injection	200
Tourniquets Distribute thin, pliable, easy-to-release, non-latex tourniquets with non-porous surfaces	200

	Approx 1 per person who injects drugs per day Based on client request, no specific limits
Ascorbic Acid • Optional for regions to make available based on demand and/or regional use of drugs for injection that require acidification (crack, brown heroin)	30
Sharps Container	Aim to make as many sharps containers available as would contain all needles distributed by the program
Take home naloxone kits	30