Metro North Hospital and Health Service

# COVID-19 Response Plan – Control phase

## Thirty-fifth Edition 12 April 2022





Metro North Hospital and Health Service

Queensland Government

**Version control**

| Version | Date released |
|---|---|
| 1 | 17 March 2020 |
| 2 | 27 March 2020 |
| 3 | 3 April 2020 |
| 4 | 9 April 2020 |
| 5 | 17 April 2020 |
| 6 | 24 April 2020 |
| 7 | 1 May 2020 |
| 8 | 15 May 2020 |
| 9 | 29 May 2020 |
| 10 | 12 June 2020 |
| 11 | 10 July 2020 |
| 12 | 31 July 2020 |

| Version | Date released |
|---|---|
| 13 | 21 August 2020 |
| 14 | 24 August 2020 |
| 15 | 4 September 2020 |
| 16 | 25 September 2020 |
| 17 | 23 October 2020 |
| 18 | 21 December 2020 |
| 19 | 8 January 2021 |
| 20 | 5 March 2021 |
| 21 | 25 March 2021 |
| 22 | 1 April 2021 |
| 23 | 30 April 2021 |
| 24 | 31 May 2021 |

| Version | Date released |
|---|---|
| 25 | 29 June 2021 |
| 26 | 2 August 2021 |
| 27 | 3 August 2021 |
| 28 | 24 September 2021 |
| 29 | 26 October 2021 |
| 30 | 9 December 2021 |
| 31 | 21 December 2021 |
| 32 | 18 January 2022 |
| 33 | 3 February 2022 |
| 34 | 28 February 2022 |
| 35 | 12 April 2022 |
| | |

Published by the State of Queensland (Metro North Hospital and Health Service), April 2022



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## Abbreviations

| | |
|---|---|
| **AEFI** | Adverse Events Following Immunisation |
| **AHPCC** | Australian Health Protection Principle Committee |
| **BAU** | Business as Usual |
| **CE** | Chief Executive, Metro North Hospital and Health Service |
| **CHO** | Chief Health Officer |
| **CISS** | Community, Indigenous and Sub-acute Services |
| **DDC** | District Disaster Coordination (Queensland Police Service) |
| **DDMG** | District Disaster Management Group |
| **EMP** | Emergency Management Plan |
| **EOC** | Emergency Operations Centre |
| **ERP** | Emergency Response Plan |
| **GP** | General Practitioners |
| **HC** | Hospital Commander |
| **HEOC** | Metro North Hospital and Health Service Emergency Operations Centre |
| **HIU** | Health Improvement Unit |
| **HIC** | Health Incident Controller |
| **HLO** | Health Liaison Officer |
| **IAP** | Incident Action Plan |
| **ICT** | Information and Communication Technology |
| **ICU** | Intensive Care Unit |
| **ILI** | Influenza-like Illness |
| **IMS** | Incident Management System |
| **IMT** | Incident Management Team |
| **LDMG** | Local Disaster Management Group |
| **MN – EMC** | Metro North Emergency Management Committee |
| **MN – EMP** | Metro North Hospital and Health Service Emergency Management Plan |
| **MN - EMU** | Metro North Emergency Management Unit |
| **MN – ERP** | Metro North Hospital and Health Service Emergency Response Plan |
| **MN – IMT** | Metro North Hospital and Health Service Incident Management Team |
| **MN** | Metro North |
| **MNHHS** | Metro North Hospital and Health Service |
| **MNPHU** | Metro North Public Health Unit |
| **MOU** | Memorandum of Understanding |
| **NDIS** | National Disability Insurance Scheme |
| **NDRRA** | Natural Disaster Relief and Recovery Arrangements |
| **NMS** | National Medical Stockpile |
| **PACH** | Patient Access and Coordination Hub |
| **PCR** | Polymerase chain reaction |
| **PPE** | Personal Protective Equipment |
| **QAS** | Queensland Ambulance Service |
| **QDMA** | Queensland Disaster Management Arrangements |
| **QHIMS** | Queensland Health Incident Management System |
| **RACF** | Residential Aged Care Facilities |
| **RBWH** | Royal Brisbane and Women's Hospital |
| **SET** | Senior Executive Team (Metro North Hospital and Health Service) |
| **SHECC** | State Health Emergency Coordination Centre |
| **SITREP** | Situation Report |
| **SMEAC** | Situation, Mission, Execution, Administration, Communication |
| **TPCH** | The Prince Charles Hospital |

# 1 Introduction

## 1.1 Situation

In December 2019, China reported cases of viral pneumonia caused by a previously unknown pathogen that emerged in Wuhan, China. The pathogen was identified as a novel (new) coronavirus (recently named *severe acute respiratory syndrome coronavirus 2* (SARS-CoV-2)), which is closely related genetically to the virus that caused the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS). SAR-CoV-2 causes the illness now known as Coronavirus disease (COVID-19).

Tests to detect COVID-19 in Queensland include the Polymerase Chain Reaction (PCR), carried out at testing clinics and the Rapid Antigen Test (RAT), performed at home or used in health facilities as a screening tool. Individuals no longer need a PCR test to confirm a positive RAT. Individuals are required to report positive RAT using an online registration form.

Vaccines approved for use in Australia by the Therapeutic Goods Australia currently include Vaxzevria (Astra Zeneca), Comirnaty (Pfizer), Spikevax or Takeda (Moderna) and COVID-19 Vaccine Janssen (Janssen). Vaccines are available to persons aged 5 years and older.

Treatments that have been provisionally approved by the TGA for use in Australia include regdanvimab (REGKIRONA), tocilizumab (ACTEMRA), casirivimab + imdevimab (RONAPREVE), Sotrovimab (XEVUDY), and remdesivir (VEKLURY). The TGA has also approved a number of treatments under a provisional registration (effective for six months) for promising treatments as a means of expediting promising new treatments with preliminary clinical data. Clinical guidelines may recommend the 'off-label' use of some medicines already included in the Australian Register of Therapeutic Goods (ARTG) for example dexamethasone.

## 1.2 Purpose

The purpose of this pandemic response plan (Metro North COVID-19 Response Plan), is to ensure continuity of health services and manage the number of cases in the community. All measures are consistent with the National Plan to transition Australia's National COVID-19 Response where priority is given to vaccination consolidation phase activities which seek to minimise serious illness, hospitalisations and fatalities as a result of COVID-19. Given the rapid rate of change, this will remain a living document which will be updated as decisions are made throughout the pandemic. The strategic objectives for the Metro North response are:

- the safety of staff by minimising risk to staff responding to COVID-19 through appropriate training, personal protective equipment (PPE) and infection control practices
- the safety of community by minimising the transmission of COVID-19 within the Metro North community and within healthcare settings through proactive identification and targeted testing, effective infection control activities, and community messaging
- ensuring Metro North maintains critical services continuity
- maximise the health outcomes of peoples with COVID-19.

## 1.3 Authority

The World Health Organisation (WHO) declared that outbreak of COVID-19 a Public Health Emergency of International Concern on 30 January 2020.

Nationally, the Biosecurity Act 2015 and the National Health Security Act 2007 authorises activities to prevent the introduction and spread of diseases in Australia and the exchange of public health surveillance information (including personal information) between state and territory government, the Australian Government and the WHO.

The Queensland Department of Health declared a public health event of state significance under the Public Health Act 2005 on 22 February 2020. The issue of Public Health Agreements are issued by designated Emergency Officers (Environmental Health Officers) under this act. The issuance of a Detention Order by an Emergency Officer (Medical) (Public Health Physicians) is also under this Act. During a public health emergency, the Chief Health Officer (CHO) can issue Public Health Directions to assist in containing, or responding to, the spread of COVID-19 within the community. The latest directions are available in Section 2.1.

The COVID-19 response within Metro North is authorised by the Health Incident Controller (HIC) under the Metro North Emergency Management Plan.

The Metro North Public Health Unit function is critical to containing and responding to the COVID-19 outbreak with expertise drawn from public health and infection control nurses, epidemiologists, doctors, environmental and public health officers. The Metro North Public Health Unit follows the advice and recommendations (with local adaptation) contained within the Communicable Diseases Network Australia (CDNA) National Guidelines for Public Health Units: Coronavirus Disease 2019 (COVID-19) which provides nationally consistent advice and guidance to public health units in responding to the COVID-19 outbreak. Current functions of the Metro North Public Health Unit include:

- Provide information and guidance to general practitioners and the public regarding testing and isolation requirements
- Management of contacts – active contract tracing towards high-risk settings and high-risk close contacts only
- Notification of only major outbreak venues or super-spreader events.
- Undertake compliance and monitoring of Chief Health Officer directions to persons and businesses/industry

## 1.4 Scope

Metro North has entered the control phase (refer to Figure 1 below) of the pandemic. This Plan describes the actions that Metro North is undertaking to 'live with COVID-19' in the community. A vaccine is widely available and vaccination rates are high in Queensland. The Plan's activities are in alignment with the National Plan to transition Australia's National COVID-19 Response.

This Plan is supported by detailed subplans for Directorates, clinical streams and corporate functions and builds upon previous iterations of the Metro North COVID-19 Response Plan.

# 2 Pandemic phases

Australian pandemic phases are based on the WHO phases but are designed to describe the situation in Australia and to guide Australia's response. Thus, the Australian and the WHO phase may not always be the same. The Australian phases describes whether the virus is overseas (OS) or in Australia (AUS). Different response strategies may be used simultaneously in different parts of Australia, due to variations in the local stage of a pandemic. Having an Australian system means that actions can be taken in Australia before a change of phase is declared by the WHO.

**Figure 1 Pandemic phases and description, Australia**

| Phase | Description |
|---|---|
| ALERT<br>OS3 | A novel virus with pandemic potential causes severe disease in humans who have had contact with infected animals. There is no effective transmission between humans.<br>Novel virus has not arrived in Australia. |
| DELAY<br>OS4/OS5/OS6 | Novel virus has not arrived in Australia.<br>OS4<br>Small cluster of cases in one country overseas.<br>OS5<br>Large cluster(s) of cases in only one or two countries overseas.<br>OS6<br>Large cluster(s) of cases in more than two countries overseas. |
| CONTAIN<br>AUS 6a - January 2020 | Pandemic virus has arrived in Australia causing small number of cases and/or small number of clusters. |
| SUSTAIN<br>AUS 6b – 25 March 2020<br>(Metro North) | Pandemic virus is established in Australia and spreading in the community. |
| CONTROL AUS 6c –<br>September 2021 | Customised pandemic vaccine widely available and is beginning to bring the pandemic under control. |
| RECOVER AUS 6d | Pandemic controlled in Australia but further waves may occur if the virus drifts and/or is re-imported into Australia. |

Note 2008 Australian Phases version used over 2019

## 2.1 National and State policy decisions

During a public health emergency, the CHO can issue Public Health Directions to assist in containing, or to respond to, the spread of COVID-19 within the community. The latest Queensland CHO Directions include are listed below (December 2021 onwards). Refer to the Chief Health Officer public health directions site for a full list of public health directions.

- Requirements for Workers at Government Nominated Accommodation Direction
- Disability Accommodation Services Direction
- Home Quarantine for Household Members of an Overseas Traveller Direction
- Hospital Entry Direction
- Mandatory Face Masks Direction
- Quarantine for International Arrivals Direction
- Residential Aged Care Direction
- Use of Technology to Support Home Quarantine Direction
- Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction
- COVID-19 Hotspots and Border Zone Declaration
- Border Restrictions Direction
- Quarantine and COVID-19 Testing for International Air Crew Direction
- Public Health Face Mask Requirements Direction
- Quarantine for International Arrivals Direction
- Public Health and Social Measures linked to vaccination status Direction
- Point of Care Rapid Antigen Tests for COVID-19 for Queensland Public Hospitals Direction
- Management of Close Contacts Direction
- Management of Secondary Contacts Direction
- Queensland Travel Declaration Direction
- Workers in a healthcare setting (COVID-19 Vaccination Requirements Direction
- COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction

# 3 Overview of Metro North and infrastructure

Metro North has a local population of over one million people (1,046,494 - 2019 preliminary estimated resident population), in an area stretching from the Brisbane River to north of Kilcoy. Clinical services are provided at The Royal Brisbane and Women's (RBWH), The Prince Charles Hospital (TPCH) Redcliffe Hospital, Surgical Treatment and Rehabilitation Service (STARS), Caboolture Hospitals, Kilcoy Hospital and at the Woodford Correctional Facility. Mental health, oral health, Indigenous health, subacute services, medical imaging and patient services are provided across many sites including hospitals, community health centres, residential and extended care facilities, and mobile service teams. Metro North has a dedicated Public Health Unit.

There are 341 general practices in the Metro North region[1]. Over one quarter of general practices (26.1 per cent or 89 practices) are located in the Brisbane Inner City sub region, followed by the Brisbane North sub region, with 19.6 per cent (67 practices).

There is a total of 7,113 residential aged care places in the region, representing 73 residential aged care places per 1000 people in the region[2].

There are 23 private hospitals in Metro North, 7 hospitals with general overnight beds, 14 with day surgery facilities and 3 mental health facilities.

| Hospitals with overnight beds | Day surgery facilities | | Mental Health facilities |
|---|---|---|---|
| Brisbane Private Hospital | Chermside Day Hospital | Pacific Day Surgery Centre | New Farm Clinic |
| Caboolture Private Hospital | Eye-Tech Day Surgeries | Queensland Eye Hospital | Pine Rivers Private Hospital |
| Peninsula Private Hospital | Marie Stopes Australia Bowen Hills Day | Rivercity Private Hospital | Toowong Private Hospital |
| St Andrew's War Memorial Hospital | Surgery | Samford Road Day Hospital | |
| St Vincent's Private Hospital Northside | Montserrat Day Hospitals (Indooroopilly) | Spring Hill Clinic | |
| The Wesley Hospital | Moreton Day Hospital | Spring Hill Specialist Day Hospital | |
| North West Private Hospital | North Lakes Day Hospital | Westside Private Hospital | |

## 3.1 Infrastructure

This section provides an overview of the baseline infrastructure across Metro North relevant to the pandemic response.

| Public Hospitals | Total beds | ED treatment spaces | ICU beds | Isolation rooms | Mortuary |
|---|---|---|---|---|---|
| **Public** | **2,126** | **155** | **68** | **423** | **61 Adult** |
| RBWH | 834 | 47 | 36 | 67 | 19 adult, 17 baby |
| TPCH | 569 | 56 | 18 | 142 | 18 |
| Redcliffe | 289 | 27 | 9 | 34 | 15 |
| Caboolture | 231 | 25 | 8 | 38 | 9 |
| Kilcoy | 21 | 0 | 0 | 4 | 0 |
| STARS | 182 | NA | NA | 135 | 0 |

*bed alternatives excluded

[1] Brisbane North PHN, 2019
[2] Department of Health, 2016

As demand on the health service fluctuates, Metro North may establish contractual arrangements with a number of private facilities in the region to be transfer and refer patients to these facilities to increase access to public beds for COVID-19 positive patients.

# 4 Community and Stakeholder engagement

Metro North will continue to communicate and engage with a broad range of key stakeholders during the control phase response.

# 5 Roles and responsibilities

Metro North will lead the implementation of response requirements at a HHS level, in alignment with the National Plan to transition Australia's National COVID-19 Response, and Queensland's COVID-19 Vaccine Plan to Unite Families.

# 6 Control phase responses

The control phase will continue to require a statewide approach to managing any outbreaks. Since the pandemic began, there have been a number of variants of COVID-19 and our response needs to be agile enough to respond to these known variants as well as any future variants. As the largest provider of public healthcare in the State, Metro North will support Central West HHS and Norfolk Island in their COVID-19 response and management. As numbers of COVID-19 positive people increase it is anticipated that a number of Metro North staff will either be positive or furloughed and this may impact our response. In addition, Metro North may be required to support other HHS either with access to beds, workforce or other services, including virtual services. All Metro North facilities will treat COVID-19 positive patients.

## 6.1 Metro North Response

The Metro North response plan outlines a tiered response, spanning from Tier 0 to Tier 5 (see below) which is in alignment with the Department of Health's COVID-19 response. Triggers are determined for each phase however they may vary for each facility depending on their baseline capacity and capability. Baseline and surge capacity is outlined in Appendix 2 and 3. Each Directorate has a local COVID-19 Response Plan which aligns with the Metro North directions below. Where a Directorate identifies the need to activate a change to service provision (such as provision of subacute services at one site) consultation and collaboration should occur with the Metro North executive and other facilities that may be impacted by the decision.

Transitioning to another Tier will require the prior approval of the Metro North Chief Executive, who in turn will brief the Metro North Board and Department of Health representative.

PPE risk will continue to be monitored separately to the tiered response, as per the sustain phase. For example, there may be lower community transmission placing the HHS in Tier 1, however due to the number of close contacts of the person who is positive for COVID-19 there may be a moderate risk of transmission. Further information on the implications for PPE use based on risk assessment is available in section 6.1.8.7

### 6.1.1 Tier 0: Prevent local transmission

| Governance | Personnel | Fever Clinic | ICU |
|---|---|---|---|
| ▪ IMT active<br>▪ EOC – stood up<br>▪ Report PPE daily, weekly PPE stocktake<br>▪ Medication stocktake at each site weekly<br>▪ MN Response – Strategic Planning Group<br>▪ SHECC twice weekly reporting | Staff<br>▪ wipe down personal ipads/phones; wipe down hard surfaces<br>▪ establish weekly communication with staff – vidcasts, emails, as appropriates<br>Visitors<br>▪ do not attend if unwell, as per CHO direction<br>Volunteers<br>▪ do not attend if unwell, complete volunteer checklist, risk assess roles, engaged as appropriate<br>Consumer representation<br>▪ complete Consumer COVID checklist, risk assess roles | Adjacent or external to ED, community-based – adjust capacity based on demand<br>**ED**<br>▪ Identify locations in ED for patients with ILI symptoms. | ▪ Maintain as is<br>**COVID-19 positive patients**<br>▪ Single rooms, isolate suspected/confirmed COVID-19 patients or those in quarantine<br>▪ Virtual Ward – as required<br>▪ Minimise movement of inpatients with confirmed or suspected COVID-19 within wards or across the hospital, use portable x-rays and ultrasounds where able.<br>▪ All blood collection and ancillary services managed within the ward<br>▪ Low intensity COVID-19 ward |
| **Meetings** | **Training** | **Service Operations** | **Facility** |
| ▪ Adhere to social distancing<br>▪ Virtual meetings where able<br>Activate Metro North meetings –<br>▪ MN COVID-19 IMT – twice weekly<br>▪ MN Response – Strategic Planning Group – twice weekly<br>▪ MN EOC Logistics Team<br>▪ MN PPE Usage update<br>▪ MN PPE Clinical advisory group – determine frequency as appropriate | ▪ No restrictions – social distancing to be observed<br>▪ PPE training for all staff<br>▪ Assess PAPR protocols, cleaning and training | ▪ Implement hypervigilant screening/ testing<br>▪ All non-urgent review appointments to be done virtually.<br>▪ Consider patients wearing masks for OPD clinics where social distancing is not possible<br>▪ Increase procedural and outpatient clinic activity to address any demand issues – maximise category 1 and 2, focus on category 3 waiting longer than 240 days and current long waits.<br>▪ Utilise flexible theatre templates<br>▪ Outsource activity where appropriate | ▪ Signage at entrances alerting patients, visitors and staff not to enter a health service if unwell<br>▪ Entrances/Exits – separate staff entrances, sanitising stations at all entrances<br>▪ Fast track all patients with fever >37.5 to ED Triage or Fever Clinic<br>▪ Security – maintain<br>▪ Cleaning - frequent touch point cleaning<br>▪ Pharmacy – maintain 6 months supply of pharmacy stocks (based on usual supply) |
| **Meetings** | **Training** | **Service Operations** | **Facility** |

| | | | |
|---|---|---|---|
| | | ▪ Outpatients supplied with one month of medication.<br>▪ Outreach services to continue | ▪ Consider allocation of CT scanner for suspected or confirmed COVID-19 patients<br>▪ Food, linen and waste services – use PPE in accordance with Queensland Health and Metro North guidance |

### 6.1.2 Tier 1: Limited community transmission

*Note: additional measures to those below may be implemented for periods of time at the discretion of the CHO or the Metro North executive if deemed necessary.

<table>
<tr><th>Governance</th><th>Personnel</th><th>Fever Clinic</th><th>ICU</th></tr>
<tr>
<td rowspan="2">▪ PPE stocktake - if stocktake variance exceeds 5% (of prior day's closing balance) for three consecutive weeks, change to daily stocktake</td>
<td rowspan="2">Staff<br>▪ All staff must be vaccinated<br>▪ PPE wearing as per PPE risk level<br>▪ All staff to be fit tested for at least 2 masks<br>▪ minimise staff movement across wards and facilities<br>▪ develop staff teams and minimise contact between teams<br>▪ consider roles that can work remotely<br>▪ discourage congregation in tearooms and other shared spaces<br>▪ enact staff management plans<br>▪ activate COVID-19 HR hotline – hours as demand indicates<br>▪ Increase capability in casual pools<br>▪ Develop and maintain a COVID response extranet page<br>▪ daily communication with all staff<br>Volunteers and consumers - engage in low risk roles, onsite arrangements as per visitor directions unless individual has had first vaccination at least 10 days ago and consent to be on site<br>Visitors – as per CHO Direction</td>
<td>▪ Increase and/or reallocate<br>▪ Investigate locations to move fever clinics away from ED</td>
<td>▪ Children requiring ICU treatment will be transferred via QAS to QCH<br>▪ Investigate locations to provide high flow oxygen outside of ICU footprint</td>
</tr>
<tr>
<th>ED</th>
<th>COVID-19 positive person</th>
</tr>
<tr>
<td></td>
<td>▪ Relocate ED patient cohorts to alternate location outside ED as required e.g. fast track to OPD, to allow space for influenza like illness patients to be separated<br>▪ Increase and/or reallocate staff<br>▪ Utilise Virtual ED</td>
<td>▪ Assess need for Designated COVID-19 wards<br>▪ GP pathway for COVID-19 positive patients implemented as appropriate<br>▪ Virtual Ward capacity increased<br>▪ Low intensity COVID-19 ward<br>▪ Increase and/or reallocate staff<br>▪ Minimise inter-hospital transfers of suspected or confirmed COVID-19 patients unless higher level care is indicated<br>▪ Identify locations for mass infusions for delivery of monoclonal antibodies</td>
</tr>
</table>

| | | | |
|---|---|---|---|
| | Students – as per CHO Direction | | |
| **Meetings** | **Training** | **Service Operations** | **Facility Protection** |
| ▪ Discretionary suspension of non-essential meetings where they impact on clinicians' time to respond to COVID-19<br>▪ Activate Directorate IMT and related meetings – determine frequency as appropriate<br>Increase frequency of<br>▪ MN IMT – based on need<br>▪ MN Response – Strategic Planning – based on need | ▪ Discretionary suspension of non-essential training where they impact on clinicians' time to respond to COVID-19<br>▪ Adhere to social distancing<br>▪ Essential training to be delivered virtually where able<br>▪ Continue PPE training<br>▪ Continue PAPR training<br>▪ Continue OVP training<br>▪ Continue infection control training<br>▪ Commence ICU upskilling<br>▪ Commence identification of nursing staff to assist in specialist units such as dialysis and SCN/NICU | ▪ Patients to wear level 1 surgical masks for OPD clinics<br>▪ Maintain activity and critical referrals in from other HHSs<br>▪ Increase virtual care<br>▪ Increase HITH capacity including virtual capability<br>▪ Increase use virtual models for outreach services where able<br>▪ Identify locations outside of the outpatient clinic to provide virtual clinics<br>▪ Outbreak management – reallocation of staff to other sites.<br>▪ Reallocate staff to frontline roles as demand dictates<br>▪ Prepare processes to enable suspension of Category 3 and 6 surgery, medical and non-emergency dental procedural activity when advised to deploy these staff to COVID -related care including extra COVID inpatient wards, virtual ward, fever clinics etc . **NOTE**: suspension of activity not to occur without authorisation from the Chief Executive.<br>▪ Prepare processes to enable suspension of accepting Category 3 OPD referrals when advised to deploy these staff to COVID -related care including extra COVID inpatient wards, virtual ward, fever clinics etc . **NOTE**: suspension of activity not to occur without authorisation from the Chief Executive.<br>▪ Specialty services (such as renal dialysis and NICU/SCN to document alternate models of care in case of workforce shortages) | ▪ Security – review model, measure need for enhanced traffic management, evaluate need for security present at building entrances<br>▪ Reduce hospital access points<br>▪ Concierge at key entrances |

### 6.1.3 Tier 2: Moderate community transmission

*Note: additional measures to those below may be implemented for periods of time at the discretion of the CHO or the Metro North executive if deemed necessary.

<table>
<tr><th>Governance</th><th>Personnel</th><th>Fever Clinic</th><th>ICU</th></tr>
<tr>
<td>As per Tier 1 plus:<ul><li>IMT weekly</li><li>Report PPE daily, twice weekly PPE stocktake – if stocktake variance exceeds 5% (of prior day's closing balance) for three consecutive weeks, change to daily stocktake</li><li>SHECC daily reporting</li><li>Communicate to external stakeholder as required</li></ul></td>
<td>As per Tier 1 plus:<br>Staff<ul><li>all staff PPE wearing as per PPE Risk matrix</li><li>Maintain a register of nurses in the HHS with critical care experience and progress upskilling program</li><li>Maintain an expedited fast-tracked credentialling process for priority positions</li><li>Continue to re-allocate staff to frontline as demand dictates</li><li>Continue to recruit and deploy casual staff to frontline services</li><li>Weekly all staff vidcast</li><li>Regular directorate staff forums or equivalent</li></ul>Vaccinated consumers and volunteers engaged onsite as appropriate<br>Visitors – as per CHO Direction<br>Students onsite must be up to date with COVID-19 vaccinations</td>
<td>As per Tier 1<br>ED<br>As per Tier 1 plus:<ul><li>Continue to review ED footprint and zoning</li><li>Virtual ED – increase capacity as demand requires</li></ul></td>
<td>As per Tier 1 plus:<ul><li>Expand ICU footprint and into adjacent alternative areas as required</li></ul>COVID-19 positive person<br>As per Tier 1 plus:<ul><li>Continue Virtual Ward</li><li>Redcliffe, Caboolture, TPCH and RBWH continue to care for COVID-19 positive patients in designated areas</li><li>STARS, COH and Mental Health refer new COVID-19 positive patients to acute facilities</li><li>HITH – increase in capability including virtual capability</li></ul></td>
</tr>
<tr><th>Meetings</th><th>Training</th><th>Service Operations</th><th>Facility Protection</th></tr>
<tr>
<td><ul><li>Adhere to social distancing</li></ul></td>
<td>As per Tier 1 plus:<ul><li>Adhere to social distancing</li><li>Consider venue and delivery model for training sessions</li><li>Assess service delivery impacts for non-essential training.</li></ul></td>
<td>Outpatients<ul><li>Virtual appointments where appropriate</li><li>All OPD patients must wear masks in waiting rooms</li><li>Outsource activity as able</li><li>Repurpose OPD areas as appropriate</li></ul></td>
<td>As per Tier 1 plus:<ul><li>Concierge and signage at entrances, alerting patients, visitors and staff not to enter a health service if unwell</li><li>Concierge at ED Triage</li></ul></td>
</tr>
</table>

| | | | |
|---|---|---|---|
| | | Surgery/procedures<br>▪ Category 1,2 and long wait elective surgery and category 4 and 5 procedures<br>▪ Optimise use of STARS for planned care<br>Dental<br>▪ Inpatients wear level 1 surgical masks<br>▪ Maintain activity and critical referrals in from other HHSs. | ▪ Cleaning – frequent touch point cleaning teams enhanced<br>▪ QR posters available at all access points<br>▪ Continue static fit testing stations<br>▪ Increase PPE stockholding to 40 days at medium risk |

### 6.1.4 Tier 3, 4 and 5: Significant community transmission

The following assumes at least Tier 2 response.

| | Governance | Personnel | Facility Protection | Fever Clinic | ICU | Service Operations | Meetings | Training |
|---|---|---|---|---|---|---|---|---|
| Tier 3 | As per Tier 2 | As per Tier 2 plus:<br>▪ Activate EOI portal for registered non practising clinicians to support response<br>▪ Redirect clinical staff where appropriate to support COVID activities<br>▪ Support staff to return to work if appropriate eg, maternity leave<br>▪ Develop a register of staff working in non-frontline areas who may be redeployed to assist with frontline | As per Tier 2 plus<br>▪ Cleaning – engage contract cleaning service to meet demand. Initiate HHS-wide cleaning rapid response team<br>▪ Security – engage additional security and traffic control providers to meet demand | As per Tier 2<br>**ED**<br>As per Tier 2 | ▪ Expand into PACU and OT (as long as air flow can be separated from the remainder of the hospital)<br>**COVID-19 positive person**<br>As per Tier 2 plus<br>▪ Multiple designated wards or floors where airflow is separate to the remainder of the facility | ▪ Utilise campus wide clinical area (partner organisations)<br>▪ Convert non-clinical areas to clinical<br>▪ Implement alternate models of care based on staffing availability<br>▪ Reduction of planned care to deploy these staff to COVID - related care including | As per Tier 2 | No face to face training, essential training delivered virtually |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | roles e.g. concierge<br>▪ Collaborate with Department of Health on surge workforce and/or panel providers to assist where possible e.g. vaccination programs<br>▪ Increase graduate nurse intake where possible<br>▪ Twice weekly all staff vidcast<br>▪ Regular directorate staff forums or equivalent | | | | extra COVID inpatient wards, virtual ward, fever clinics etc<br>▪ Utilise STARS for planned care | | |
| | Governance | Personnel | Facility Protection | Fever Clinic | ICU | Service Operations | Meetings | Training |
| Tier 4 | As per Tier 3 plus<br>▪ EOC – stood up<br>▪ MN Response – Strategic Planning Group<br>▪ Enact contract with private hospitals (when required)<br>▪ Twice weekly all staff vidcasts | As per Tier 3 plus<br>▪ Minimise staff movement within wards and across facilities<br>▪ Staff where able take breaks outdoors<br>▪ Develop staff teams and minimise contact between teams<br>▪ Working from home arrangements where safe and productive<br>▪ Discourage congregation in tearooms and other shared spaces | As per Tier 3 plus:<br>▪ Increase cleaning services where appropriate to meet demand, if required. Initiate HHS-wide cleaning rapid response team.<br>▪ Engage additional security where required<br>▪ Traffic control – increase resources to meet demand | As per Tier 3 plus<br>▪ Investigate locations to move fever clinics away from hospital sites as required<br>**ED**<br>▪ Expansion of ED spaces to other locations as required e.g. into SSU and relocate SSU to accommodate all patients maintaining | ▪ Expand ICU into medical wards with patient cohorting models if high ICU demand<br>▪ Increase virtual ED capacity<br>**COVID-19 positive person**<br>▪ COVID-19 Virtual Ward – increased capacity<br>▪ Increase COVID-19 ward capability at each facility with | ▪ Emergency and category 1 surgery and category 4 endoscopy planned activity only - to deploy staff to COVID-related care and to manage with furloughed staff<br>▪ Category 1 specialists outpatient appointments only<br>▪ Utilise private hospitals for surge capability | As per Tier 3 plus<br>▪ Frequency of meetings reviewed<br>▪ Virtual essential meetings only | As per Tier 3 plus:<br>▪ At the elbow education support in clinical areas to support junior staff |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | ▪ Daily communication with all staff by HIC<br>▪ All staff PPE wearing as per PPE risk matrix<br>▪ Donning and Doffing audits weekly<br>▪ Consider recruitment of non-clinical staff to assist with clinical load where appropriate<br>▪ Direct people to return to work to support COVID activities<br>▪ Student vaccinated and fit tests, supporting or participating in clinical activities (such as Oral Health Centre).<br>▪ Vaccinated volunteers or consumers engaged onsite<br>▪ Fit testing of all new staff<br>▪ Daily incident controller messages<br>▪ Twice weekly vidcast<br>▪ Regular directorate staff forums or equivalent | ▪ Ensure concierge services are in place<br>▪ Follow Visitor restriction guidelines | separation of patients<br>▪ Increase and/or reallocate staff<br>▪ Virtual ED – increase capacity as demand requires | an emergency department<br>▪ Increase and/or reallocate staff<br>▪ HITH – increase in capability including virtual capability<br>▪ Daily report on HITH referrals and HITH occupancy<br>▪ Utilise overcensus bed areas | ▪ Utilise other facilities such as residential and other health care facilities for patients still requiring medical care e.g. Brighton<br>▪ Ensure COVID Care at Home pathway is active | | |
| | Governance | Personnel | Facility Protection | Fever Clinic | ICU | Service Operations | Meetings | Training |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Tier 5 | As per Tier 4 | As per Tier 4 | As per Tier 4 | As per Tier 4 | As per Tier 4 | As per Tier 4 plus | As per Tier 4 | As per Tier 4 |
| | | | | ED | COVID-19 positive person | | | |
| | | | | As per Tier 4 | As per Tier 4 | | | |

### 6.1.5 Contact tracing and management

The Metro North Public Health Unit is responsible for undertaking contact tracing and management activities through authorised public health nurses and environmental health officers. These officers have the associated function of serving the legal notices by the Emergency Officer (General) appointed under the Public Health Act. The aim of contact tracing is to interrupt transmission of COVID-19 through identification and quarantining of people in contact with infectious cases. Given the rapid spread of COVID-19, there have been changes to contact tracing activities in Queensland. The Metro North Public Health Unit follow the advice and recommendations contained in the CDNA National Guidelines for Public Health Units: Coronavirus Disease 2019 (COVID-19). This guideline outlines Australia's national minimum standard for surveillance, laboratory testing, case management and contact management for COVID-19. The Metro North Public Health Unit may adapt this guidance based on local epidemiological context.

### 6.1.6 Airport management

Metro North is responsible for supporting health screening activities at the Brisbane Airport. Border Force will check vaccination status and screen travellers as they arrive and refer any requiring further assessment to the health workers who will undertake further assessment. If people meet the criteria, they will be referred to an Environmental Health Officer who will issue a notice to isolate, or if the person is symptomatic send them to a fever clinic via ambulance transfer. The Public Health Physician is available for further consultation as needed. All international inbound passengers and cabin crew will be screened to determine if they are required to quarantine and directed accordingly.

### 6.1.7 Isolation hotels

Metro North also has capacity in a number of isolation hotels, for people who are COVID-19 positive and unable to isolate at their usual residence.

### 6.1.8 Clinical management for suspected or confirmed COVID-19 positive patient

Rationalisation of patient contact to essential activities is paramount. Maximal use of phone/skype/video interactions should be used if physical examination is not required.

The clinical spectrum of infection with COVID-19 ranges from mild disease with non-specific signs and symptoms of acute respiratory illness, to severe pneumonia with respiratory failure and septic shock. Deterioration, when it occurs is often rapid, leaving little time for discussions around appropriate levels of care.

The below outlines inpatient care principles:

- For patients on the "critical care pathway" every attempt should be made to make this transition, should it be required, as smooth and predictable as possible.
  - Develop appropriate resuscitation plans.

  - Detect and manage deterioration early, preferably in daylight hours.
  - Avoid Medical Emergency Team (MET) calls, emergency intubation and resuscitation by obtaining early ICU review.
- For patients on the conservative pathway.
  - Ensure adherence to the Advance Health Directive (AHD) and avoid MET calls.
  - Proactive, supportive discussions with patients and families should include prognostic information, the potential for reversibility of symptoms and the potential burden of non-beneficial interventions. It will help to understand the patient's values and preferences regarding life-sustaining interventions.
  - In such discussions avoid assumptions based on chronological age or incomplete understanding of health status. Careful consideration must be given to co-morbidities, underlying frailty, quality of life and anticipated lifespan when determining appropriate management.
  - Involve palliative care clinicians to help identify, triage and support patients in need of specialist palliative care management. This may include triaging patients who may benefit from transfer to a palliative care unit, transfer home (with palliative or home support if indicated), to another hospital or to an alternative care facility.
  - Involve GP's, community services and outreach services as required.
  - Accelerate uptake of advance care planning among older at-risk populations in hospital, community settings and residential aged care facilities (RACF) so that advance care plans stipulate circumstances where hospitalisation or aggressive life-support interventions in hospital would constitute forms of futile and inhumane care and unnecessary use of hospital beds.
- For patients who are residents in an RACF
  - Patients with confirmed or suspected COVID-19 who live in a RACF should be managed on a conservative pathway (see above). Every effort should be made by hospital outreach services (RADAR) and public health units to support RACF staff to provide isolation and care in the residents' "home".
  - The *Preparing and Responding – COVID-19 in Residential Aged Care Facilities* will be used to support RACFs to prepare and respond to COVID-19.

#### 6.1.8.1 Reception

Patients can present at a number of locations including fever clinics and community assessment clinics in Metro North.

- onsite fever clinics
- offsite fever clinics
- general practice
- emergency department
- home.

Metro North has a number of fever clinics with additional locations established as required. At significant community transmission there will be a move to shift fever clinics away from Emergency Departments. Private pathology laboratories conducting COVID-19 testing include **QML Pathology** and **Sullivan Nicolaides Pathology** and **4Cyte Pathology**.

Information for children requiring testing can be found here

#### 6.1.8.2 Clinical Guidelines

Queensland Health have developed a range of clinical guidelines to support clinicians providing care for patients with COVID-19. The clinical guidelines cover pre-elective and emergency surgery COVID-19 testing, COVID-19 assessment, treatment and management, COVID-19 therapies, maternity and neonatal and paediatric care and advice, and service guidance and guidelines.

#### 6.1.8.3 Diagnostics for Reception

Patients presenting to the Fever Clinics will be assessed for testing in accordance with current CDNA guidelines with local adaptations.
Nucleic acid testing using reverse transcription polymerase chain reaction (RT-PCR) or transcription-mediated amplification (TMA) is the gold standard for diagnosing acute symptomatic SARS-CoV-2 infection. For advice refer to PHLN guidance on laboratory testing for SARS-CoV-2 (the virus that causes COVID-19)**.**

Alternative testing methods, including rapid antigen testing (RAT) for SARS-CoV-2, may be used in specific contexts and settings where pre-test probability is high. RATs are considered an important tool to enable hospitals to effectively manage the COVID-19 response. For advice refer to the Point of Care Rapid Antigen Tests for COVID-19 for Queensland Public Hospitals Direction. RT-PCR remains the preferred test for COVID-19 diagnosis but need not be used in the first instance where Rapid Antigen Tests can be used by an authorised tester for screening purposes permitted under the Direction. Metro North has published instructions on undertaking the Panbio COVID-19 rapid antigen self-testing available here.

Testing should occur on persons that display no symptoms (asymptomatic) and symptomatic individuals and testing depends on display of symptoms and people who have had a higher risk of exposure (e.g. international arrivals and close contacts). There are testing requirements for individuals following a possible vaccine related adverse event. Information is available here.

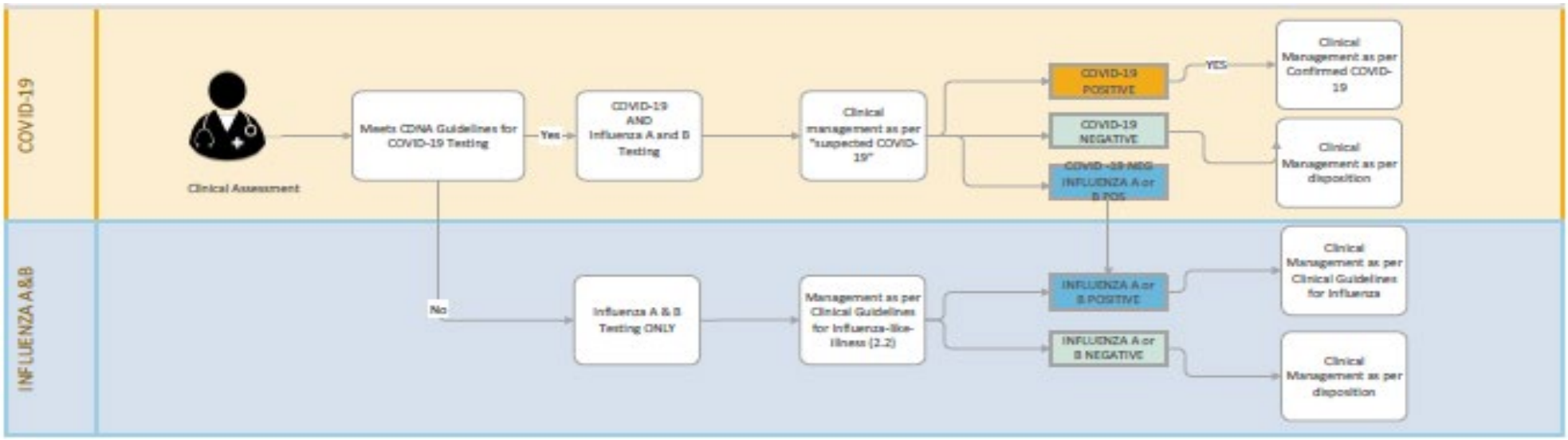
Those who meet current criteria will be tested (either RAT for screening purposes or RT-PCR). For RT-PCR, patients will be swabbed at back of both the nose and the throat. The swab will be referred to the laboratory for testing labelled NCV-PCR. All patients who meet criteria and are subsequently tested are defined as “suspect cases” and should return home to self-isolation. It is important that clinicians in Fever Clinics ensure that this is viable prior to discharge. Alternate accommodation can be arranged via the local HEOC. Discharged patients must be informed that test results may take 48 hours or longer and should be given literature describing their responsibilities as well as pathways to seek help while in isolation.

COVID-19 is a notifiable disease. Following testing of the specimen, patients who are positive will be notified to both Metro North Public Health and also to the Metro North “Virtual Ward.” The patient will be contacted by both services – Public Health to serve an Enforceable “Public Health Order” to self-isolate and initiate contact tracing and the Virtual Ward to ensure ongoing care and early identification of deterioration.

Metro North Public Health Unit will prioritise the case investigation process of confirmed cases when significant community transmission is reached e.g. at risk groups and settings of care.

Patients who test negative for COVID-19 will be notified of this by text message. It is important to note that patients must continue in isolation if they fulfil the criteria laid down by the Australian Government such as recent return from overseas.

**Figure 2: Workflow for patients presenting with influenza like illness**




#### 6.1.8.4 Patient disposition

MET calls and emergency resuscitation carry a very high risk of staff contamination and infection. For this reason, every attempt should be made to eliminate this process from management.

Minimising emergency resuscitation will entail:

- development of an Advanced Health Plan (AHP) for every patient on admission
- clarity of information within wards on every AHP available to staff 24/7
- early recognition of deterioration
- early placement in a single isolation room
- early consultation with ICU.

For patients with comorbidities, escalating or intensive care management of COVID-19 may necessitate communication on care decisions. This may include which therapies should be continued and which therapies should be paused or discontinued. Proactive, supportive discussions with patients and families should include prognostic information, the potential for reversibility of symptoms and the potential burden of non-beneficial interventions. It will help to understand the patient's values and preferences regarding life-sustaining interventions. Palliative care clinicians should be involved to help identify, triage and support patients in need of specialist palliative care management.

#### 6.1.8.5 Baseline for admission

Patients with significant clinical symptoms requiring inpatient care should be admitted under full isolation precautions pending testing for both COVID-19 and a full respiratory screen.

A decision to admit will depend on the clinical presentation. The decision to manage via the Metro North "Virtual Ward" will be made in accordance with the symptoms, social and medical factors as outlined in the COVID-19 models of care requirements and made on a case-by-case basis, considering:

- The patient's ability to engage in home monitoring
- the ability for safe isolation at home
- the risk of transmission in the patient's home environment.

#### 6.1.8.6 Virtual Care in Metro North

Metro North has developed and continues to mature a suite of virtual services to provide care to COVID-19 positive patients. This is constantly under review and is consistent with the state-wide planning.

The COVID-19 model of care in Queensland stratifies patient treatment according to an assessment of an individual's COVID-19 symptoms, social and medical factors. Patients could be treated at home with contact via GP or other contracted healthcare provider, through the Metro North Virtual Ward or receive treatment at a Metro North hospital. A high level description of the models are available via the following links COVID-well Care at Home model, COVID of concern model, COVID Care in Hospital. A description of the Metro North models are described below.

**Metro North COVID-19 Virtual Ward** provides ongoing monitoring and support services that ensure COVID-19 positive patients have access to health care professionals for the duration of their isolation 24/7. This service has an established deteriorating patient pathway that supports transfer to traditional HiTH or an acute care environment if required.

**Metro North Virtual ED** provides acute clinical consultation and peer support to clinician referred patients via telehealth platforms through which the patients being referred are aligned to care in the right setting, first time. Pathways currently in place include all GPs in Metro North, Queensland Ambulance Service officers responding to patients in Metro North, Community and Oral Health programs (Residential Transition Care Program, Community Transition Care Program, Residential Aged Care - Cooinda and Gannet, Post-Acute Care Service (PACS), Halwyn Centre) and Metro North Health Emergency Operation Centre (HEOC) for guests in Hotel Quarantine requesting medical review when other sources including GP telehealth is unavailable/not appropriate. .

There is also a residential aged care facility outbreak response plan that is able to access and/or escalate to Virtual Ward, Virtual ED and Inpatient services as required

#### 6.1.8.7 PPE for staff

Queensland Health has multiple resources for clinicians regarding COVID-19 PPE and infection control information. For the latest information, refer to the Department of Health webpage which provides overarching Queensland Health guidance, PPE escalation guidance, respiratory protection equipment, safe use of PPE.

PPE use and escalation across healthcare settings, community health settings and in-home care, residential aged care and disability accommodation and correctional services will be determined based on assessment of risk of community transmission of COVID-19. It is the discretion of the Metro North Chief Executive Officer to follow PPE protocols except where a Directive requires use of PPE.

Appendix 5 contains the overview of PPE requirements for the above settings at the three risk levels.

It is expected staff will comply with standard precautions, including hand hygiene (5 Moments) for all patients with respiratory infections. In addition:

- patients and staff should observe cough etiquette and respiratory hygiene
- comply with transmission-based precautions for patients with suspected or confirmed COVID-19:
    - contact and airborne precautions for aerosol generating procedures
- if patient transfer outside the room is essential, the patient should wear a surgical mask during transfer and follow respiratory hygiene and cough etiquette.

For most inpatient contacts between healthcare staff and patients the following PPE is safe and appropriate and should be put on before entering the patient's room. For hospitalised patients requiring frequent attendance by medical and nursing staff, a P2/N95 mask should be considered for prolonged or very close contact.

**Airborne** Contact and Standard Precautions for aerosol-generating procedures (for example, taking respiratory specimens, suctioning, intubation, nebulisers), patients with significant respiratory illness, or prolonged exposure (i.e. > 15 minutes face-to-face contact or in same room for > 2 hours).

- negative pressure room where possible
- P2 / N95 mask
- long sleeve impermeable gown
- gloves
- protective eyewear / face shield.

#### 6.1.8.8 Diagnostics for patients admitted to hospital

All patients admitted with suspected COVID-19 should have nasopharyngeal and oropharyngeal (throat) swabs performed (unless this has already been performed prior to the admission) by staff trained to properly perform these procedures in order to maximise the sensitivity of real-time PCR (RT-PCR) testing that is currently the diagnostic test of choice. RT-PCR testing has a turnaround time of 4 to 6 hours but can be significantly delayed by overload within the laboratory.

Presentations with COVID-19 are often indistinguishable from other respiratory viruses so additional testing with a full "respiratory panel "is often appropriate.

In patients with very recent onset of symptoms, RT-PCR tests may take up to 6 days to become positive, and hence the sensitivity of the initial test may be no more than 70%. Repeat testing at 24 and 48 hours is reasonable in patients with risk factors and/or suggestive clinical features and/or non-response to effective antibiotics in cases of atypical pneumonia where other pathogens have been excluded.

In patients who already have lower respiratory tract infection and have a productive cough, after they have rinsed their mouth with water, a deep cough sputum sample should also be expectorated directly into a sterile container.

A serology specimen should be collected during the acute phase of the illness (preferably within the first 7 days of symptom onset), stored, and when serology testing becomes available, tested in parallel with convalescent sera collected 3 or more weeks after acute infection.

Viral cultures and serological tests have no utility in acute diagnosis and should not be requested.

#### 6.1.8.9 Clearances

Refer to the latest Coronavirus Disease 2019 (COVID-19) CDNA National guidelines for public health units for the latest information on the minimum standards for clearances.

### 6.1.9 Digital resources

The following digital resources are available:

- Syndromic activity board – COVID-19
- COVID-19 dashboard – provides the following data elements:
    - total ILI presentation as proportion of total presentations
    - ILI presentation via ED per discharge disposition
    - SSU admitted, D/C or Transferred
    - ILI presentations by Geographic distribution
    - age group distribution.
- COVID-19 intranet site https://metronorth.health.qld.gov.au/extranet/coronavirus
- Alerts in Patient Flow Manager and Wardview for COVID-19 positive patients
- Incoming Passenger app – supports screening and registration of people at any Brisbane airport.
- DcoVA –enables statewide registration of patients with COVID-19, and support management of patients under Public Health Orders (PHOs). It has a direct feed from AUSLAB for COVID-19 results and there is further potential for natural language processing of medical imaging results.
- PHU new COVID-19 positive patient track and trace solution.
- COVID-19 testing clinic process application.
- COVID-19 Care at Home virtual care triage, automated questionnaire monitoring and virtual care stream medical record.
- WAT- workforce attendance tracker.  This allows real time reporting of staff absences.

- Virtual care digital resources - https://qheps.health.qld.gov.au/metronorth/digital-metro-north/virtual-care

### 6.1.10 Resource management

#### 6.1.10.1 PPE stockpiles and clinical consumables

Each Directorate will manage PPE stockpiles and clinical consumables to determine and ensure appropriate stock levels are available to support BAU as well as expected surge. The provision of PPE most focus foremost on staff but is also required for patients and visitors in certain circumstances. PPE appropriate for COVID-19 includes:

- disposable gloves
- long sleeve gowns
- goggles
- surgical/N95 masks and
- alcohol hand gel.

PPE is available and placed at the entrances/triage desks within all publicly accessible areas – particularly in ICU, Emergency Departments and wards being used to accommodate COVID-19 patients.

Clinical consumables notable for management of COVID-19 include flocked swabs for viral polymerase chain reaction.

### 6.1.11 Operational support

**Environmental cleaning of patient care areas:**

1. Cleaners should observe contact precautions signage
2. Environmental cleaning and disinfection of infection control areas will occur in line with current Queensland Health and Metro North Guidelines
3. Frequently touched surfaces such as doorknobs, bedrails, tabletops, light switches, patient handsets in clinical areas and patient room should be cleaned daily
4. Frequently touched surfaces such as doorknobs, bedrails, tabletops, light switches, patient handsets in non-clinical areas will be cleaned more frequently
5. Perform terminal cleaning of all surfaces (as above plus floor, ceiling, walls, blinds) after a patient is discharged
6. A combined cleaning and disinfection procedure should be used; this is either
    a. 2-step - detergent clean, followed by disinfectant; or
    b. 2-in-1 step - using a product that has both cleaning and disinfectant properties.
7. Any hospital-grade, TGA-listed disinfectant that is commonly used against norovirus is suitable, if used according to manufacturer's instructions.

## 6.2 Patient and Family Engagement

Metro North is committed to patient, family and carer partnerships in care. During times of visitor restrictions to hospital and health facilities, Metro North Directorates will aim to phone families/carers daily with patients consent to provide progress reports. These phone consults will include nursing and/or medical officers. Additionally, Directorates will facilitate video visiting where possible.

There are conditions that visitors must meet before visiting a Metro North facility which are outlined here.

## 6.3 COVID-19 Vaccination

Queensland has reached over 90 percent of eligible persons fully vaccinated and continues to vaccinate persons between 5 and 11 years. All Metro North Staff must be vaccinated in accordance with Health Employment Directive 12/21:Employee COVID-19 vaccination requirements (the Directive) and Employee COVID-19 vaccination requirements HR Policy B70 (the HR Policy). Exemptions will be initially considered at a facility level before escalating to a Metro North committee for a decision.

Information on vaccination clinics in Metro North and elsewhere is available here

## 6.4 Human resources

The health, safety and wellbeing of all healthcare workers is a priority for Metro North. A staff management portfolio has been established which will manage and monitor the reallocation of staff, ensuring allocation to priority areas and matching of skillsets as required. Directorates staff management team/coordinator will manage staff within their Directorates and access Metro North team as required. See Appendix 4 – Metro North Pandemic (COVID-19) Surge Workforce Response Plan.

#### 6.4.1.1 Maintaining workforce coverage

**Work permissions and restrictions**

Metro North is classified as an employer in a critical industry. Metro North has a number of critical essential roles it needs to undertake to manage the expected surge in cases. Metro North has established a critical worker list. Critical workers (including close contact) can leave quarantine to carry out that role if they have no COVID-19 symptoms and are fully vaccinated. Refer to the Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction (No. 3) for guidance.

The Australian Government Department of Health has released the *Work Permissions and Restrictions Framework for Workers in Health Care Settings*. This framework supports safe decision making when determining whether to place work permissions/restrictions, independent of quarantine, on a worker after a COVID-19 exposure in a health care setting in the context of an outbreak and community transmission of COVID-19.

**Maintaining service delivery**

In line with the tiered response, Metro North has a range of strategies to maximise the workforce during the pandemic including:

- new rostering models
- recruiting retired or semi-retired clinicians

- reassigning healthcare workers out of their usual work area
- utilising healthcare students as assistants
- reviewing scope of practice
- increasing casual pools and temporary staff
- increasing hours of part time staff on voluntary basis
- active leave management including absenteeism and fatigue
- accelerated recruitment processes.

#### 6.4.1.2 Managing ill workers

As COVID-19 becomes more prevalent in Metro North, people who have COVID-19 will visit businesses and workplaces. Overall, the health response will continue to encourage anyone with symptoms to get tested, isolate and test COVID-19 cases, quarantine and test close contacts of diagnosed COVID-19 cases and publish notification of major outbreak venues or super-spreader events.

##### Leave and returning to work

Ill or quarantined workforce will be managed in line with Department of Health Human Resources policies.

Staff deemed critical workers, will be able to return to work if certain conditions are met. For example, if they are a close contact who is required to perform a critically essential role, as listed by Metro North in a Critical Worker List, they can leave quarantine to carry out critically essential work if they have no COVID-19 symptoms and are fully vaccinated. In this context, fully vaccinated means that you have received the prescribed number of doses, including a booster dose where eligible, of a COVID-19 vaccine approved for use in Australia by the TGA.

##### Flexible workforce arrangements

Human Resources has developed an information page (factsheets, checklists, posters etc) for employees with information on leave entitlements, flexible workforce arrangements, vaccine exemption forms, relocation guidance and other information available here.

##### Quarantine

A close contact who is a critically essential worker can leave quarantine to go to their workplace provided the worker and their employer meet the requirements for critically essential workers.

##### Close contact testing and quarantine duration

When a person becomes aware that they are a close contact, they have to get tested as soon as possible only if they have COVID-19 symptoms. All close contacts still must get tested on Day 6 of their quarantine period and if they develop COVID-19 symptoms. A close contact's quarantine period is defined as:

- starting when they are informed or become aware they are a close contact of a diagnosed person
- ending after 7 days from the date the diagnosed person took the initial test that returned a positive result (provided the close contact has no symptoms and a test on Day 6 of their quarantine returns a negative result).

If a close contact gets a positive rapid antigen test (RAT) they must:

- report their positive RAT result to Queensland Health
- isolate and follow the first steps if you have COVID-19

PCR tests are not required to confirm a positive rapid antigen test (RAT)

A Rapid Antigen Test (RAT) can be used for all testing requirements as a close contact whether or not the person has COVID-19 symptoms. Conversely, a PCR test is a valid COVID-19 test instead if they cannot get a RAT kit.

Metro North HHS staff impacted by isolation / quarantine must be registered with the Metro North Emergency Operations Centre via EOC-MetroNorth@health.qld.gov.au.

#### 6.4.1.3 Staff wellbeing strategy

The Metro North Wellbeing Strategy – COVID-19 covers the emotional, financial, physical and social domains of wellbeing. The aims of the strategy are to ensure staff feel supported and have their wellbeing considered, link to existing resources and provide access to new initiatives tailored to COVID-19. Whilst many of the initiatives will be offered on an ongoing basis, a number of them will be activated as required throughout the pandemic.

Profession focussed support and initiatives are outlined in the Metro North Wellbeing Strategy as well as professional association support include Medical Professional Association Support, Nursing Professional Association Support, Allied Health Professional Association Support.

Metro North's Employee Assistance Service (EAS) provider Benestar is offering expanded support as part of the Staff Wellbeing Strategy.

#### 6.4.1.4 Industrial relations

Engagement with the various unions will occur as required throughout the control phase of the pandemic.

#### 6.4.1.5 Workplace health and safety

Workplace health and safety precautions are being taken in line with the Chief Health Officers' advice. Public Health surveillance, rapid response teams and case investigation will be available. A range of COVID-19 specific health and safety checklists and factsheets have been developed on local induction, workplace injuries (for employees and line managers), QSuper, Workcover and related to management of uniform/clothing for staff working with patients suspected or positive for COVID-19.

#### 6.4.1.6 Fatigue Management

Management of fatigue across Metro North occurs in accordance with the Metro North Fatigue Risk Management Procedure and the Department of Health Fatigue Risk Management Policy I1 (QH-POL-171). A summary document has been developed which outlines the general management of fatigue. Specific guidelines relating to fatigue risk management for Medical and Nursing and Midwifery professional streams has also been developed.

## 6.5 Aboriginal and Torres Strait Islander people

All Aboriginal and/or Torres Strait Islander peoples are considered part of a vulnerable group and at greater risk of COVID-19. Aboriginal and/or Torres Strait Islanders should be encouraged to get vaccinated as the best form of protection against COVID-19.

Health professionals should keep the following points in mind when assessing and treating any patients who may have COVID-19.

- Need to actively identify Indigenous person of Aboriginal and/or Torres Strait Islander origin.
- The high prevalence of chronic disease in Aboriginal and/or Torres Strait Islander populations that may predispose to severe outcomes.
- The social circumstances and needs of patients that are identified as Aboriginal and/or Torres Strait Islander origin.
- The possibility that the patient may be residing with a person who is vulnerable, for example, due to the presence of chronic disease(s).
- Would the patient benefit from support by the Indigenous Hospital Liaison Officer?
- Is the information provided in a culturally appropriate manner, so that the patient, contacts and community understand the information by using culturally specific posters, brochures and pamphlets?

Resources to support Metro North to address the COVID-19 needs of Aboriginal and/or Torres Strait Islander Queenslanders are available online at https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/information-for/first-nations. and Aboriginal and Torres Strait Islander resources – Extranet (health.qld.gov.au) and Australian Government Aboriginal and Torres Strait Islander Advisory Group on COVID-19 communiques.

Challenges to infection control in Aboriginal and/or Torres Strait Islander communities are acknowledged. As such, isolating cases from those who are more vulnerable to severe outcomes and recommending keeping a distance of one metre from others may be a more manageable approach to preventing spread of disease.

- The voluntary home isolation of patients with infection is strongly recommended to reduce transmission but consideration must be given to who else is at home.
- Other measures such as patients using masks can be considered depending on the vulnerability of contacts and living circumstances.
- Information about hand hygiene (hand washing and drying) and cough etiquette should be promoted to patients, contacts and community and are explained in a culturally appropriate manner.

There are a suite of culturally specific resources for COVID-19 available to ensure patients have access to culturally appropriate and translated COVID-19 information.

## 6.6 Vulnerable groups

Communities and individuals identified as being vulnerable, and in which mortality and morbidity is expected to be higher, include people with complex and chronic disease, culturally and linguistically diverse people, older persons and persons in residential aged care.

### 6.6.1 People with Mental illness

The Chief Psychiatrist has made a temporary amendment to the Mental Health Act during this time. Details of the amendment can be found https://qheps.health.qld.gov.au/mentalhealth/mha/mha/mha2016-covid-19 (available internal to QH only).

The Queensland Government through the Department of Housing and Public works also made additional resources available to support COVID-19 responses in housing and homelessness.

### 6.6.2 People with disabilities

Resources for people with disabilities and information for disability support workers and carers are available here. In addition, the National Disability Insurance Scheme have also developed resources for information and support.

### 6.6.3 Residential aged care residents

The Australian Government Department of Health has up to date information and advice on COVID-19 for aged care providers, aged care workers and people who receive residential or home care available here.

The COVID-19 Outbreak Management: Preparing and responding – Guidance for Residential Aged Care Facilities in Queensland has been developed to provide information on how to manage an outbreak in an RACF, including staffing considerations, communication, cleaning and medication management.

Residential aged care facilities have increased advanced care planning and pandemic planning with Metro North virtual services with the aim of increasing support to RACFs and reduce physical outreach.

## 6.7 Financial management

Cost identification and capture processes are to be included in COVID-19 incident response cost centres for Directorates (typically one for screening and indirect costs and one for direct costs of patient care. There are ad-hoc additional cost centres for specific purposes.
Costs will be collected by directorates (including supporting documentation) and claimed by Metro North via Department of Health. Funding (to offset actual expense) will be accrued at end of month by Health Funding and Data Insights team. This will be allocated to directorate level against incident cost centres.
All COVID-19 cost centres set in a central node, but each directorate has a sub-folder in this node for the cost centres under their control.

Selected staff have been issued with emergency corporate credit cards to be used for identified Emergency Events.

The financial delegation matrix in S/4 has been updated to ensure that online orders against emergency event cost centres will workflow to appropriate delegates. Additional financial delegates have been identified at each facility.

### 6.7.1 Medicare ineligible patients

All patients are to receive the required testing and treatment irrespective if they are Medicare eligible or ineligible. The provision of commonwealth funding under the National Partnership Agreement with the States will be at 50 per cent of the costs to provide testing, housing or treatment of all patients.

### 6.7.2 Activity capture

| Case type | Definition |
|---|---|
| Suspected COVID-19 | Individuals are suspected to have COVID-19 if they have one of the criteria described below:<br><br>• acute respiratory illness (that is, fever and at least one sign or symptom of respiratory disease, for example, cough or shortness of breath) AND no other aetiology that fully explains the clinical presentation AND a history of travel to or residence in a country, area or territory that has reported local transmission of COVID-19 during the 14 days prior to symptom onset.<br><br>OR<br><br>• any acute respiratory illness AND has been in contact with a confirmed or probable case of COVID-19 during the 14 days prior to the onset of symptoms.<br><br>OR<br><br>• severe acute respiratory infection (that is, fever and at least one sign or symptom of respiratory disease, for example, cough or shortness of breath) AND who requires hospitalisation AND who has no other aetiology that fully explains the clinical presentation. |

| | |
|---|---|
| A suspected case of COVID-19, as defined above, will then either receive a confirmed or probable diagnosis of COVID 19 or COVID-19 will be ruled out: | |
| Laboratory confirmed COVID-19 | An individual with a laboratory confirmation of infection with COVID 19, irrespective of clinical signs and symptoms. |
| Clinical diagnosed or probable COVID-19 | An individual who is suspected of having COVID-19 but laboratory testing for COVID-19 is inconclusive or not available but in whom a clinical determination of COVID-19 has been made. |
| Ruled out COVID-19 | An individual suspected of having COVID-19 but COVID-19 has subsequently been excluded on laboratory testing and in whom a clinical diagnosis of COVID-19 has not been made. |

Data source: The definitions are based on those developed by the World Health Organization for global surveillance.

## COVID activity

COVID Activity can be accessed in the COVID Dashboard in DSS.

The following link outlines how the data is captured in DSS for COVID identified patients - Dept of Health Short Publication (1 column) template

## Outpatients Tier 2 clinic cancellation codes

Two new cancellation codes have been created in the HBCIS APP Module to accurately reflect reasons for appointment cancellations relating to COVID-19.

These codes are:

| Cancellation Code | Description | Start Date |
|---|---|---|
| 31 | Pub Health Alert Pt Initiated | 05 MAR 2020 |
| 32 | Pub Health Alert Hosp Initiated | 05 MAR 2020 |

## 6.8 Private Hospitals

As at January 2022, the Queensland Department of Health has signed an agreement with private hospital providers in Queensland to support the COVID-19 response. Metro North has an additional 757 inpatient and 21 ICU beds from the private sector to support the delivery of essential health services.

## 6.9 Influenza

Influenza is a viral respiratory disease of global public health importance. The propensity for influenza A viruses to mutate, and change the dynamics of an influenza season, is central to this importance. The seasonal pattern is one of outbreaks or epidemics in the winter months in temperate regions of the world; while in tropical areas, influenza activity may increase at any time of year. The disease varies in severity and may be mild to moderate in some people, but very severe in others. Infection in the very young, the elderly, pregnant women and those with underlying medical conditions, can lead to severe complications, pneumonia, and death.

In Queensland, the influenza season occurs annually in southern and central areas typically between May and October. An influenza surge can generally be identified and tracked; analysis of recent data suggests that influenza has a rapid rise in cases (e.g. a tripling of admissions over a six-week period) but takes longer to dissipate (roughly taking 8-10 weeks to subside). Within Metro North, over the last five years, an influenza surge has begun in last week of June / early July, peaked in the third week of August and settled by early October.

Criteria for movement through phases of the Metro North influenza plan activation and the associated actions for Metro North Emergency Management Committee and facilities will occur in context of this Plan.

### 6.9.1 Placement of patients with influenza

For patients with ILI who are not COVID-19 positive but are pending results for influenza or who are confirmed positive for influenza, the following placement preference applies:

- Single room with unshared ensuite
- Single room with shared ensuite
- Cohort ILI in designated ward with >/= 1 metre distance and curtains closed
- Four bed bay in a ward for cohorting – as designated by facility/service line Executive.

**Guidance for cohorting patients with ILI**
In the first instance, patients with ILI are to be managed with droplet and standard precautions, in single rooms with a private ensuite. If no single rooms are available, the following conditions are to be met before symptomatic patients can be cohorted:

- minimum distance of 1 metre between patients
- curtains are to be pulled to create a physical barrier
- enhances decontamination of equipment and environment
- surgical mask and alcohol-based hand rub is be available at point of care.

Due to the dynamic nature of ED, the following risk mitigations strategies are to be considered:

- all ILI patients presenting to ED are to wear surgical masks if their clinical condition allow - ideally this is provided at point of triage, but should be provided whenever the ILI is first recognised
- if the patient requires admission, the patients access to an inpatient bed is not to be delayed waiting result – the patient is to be isolated/cohorted based on their ILI.

### 6.9.2 Influenza Vaccination program

#### 6.9.2.1 Staff influenza vaccination

Under workplace health and safety legislation Metro North has a duty of care and responsibility to control and minimise risks related to the transmission of infectious diseases. Minimising the incidence of vaccine preventable diseases through staff vaccination programs is designed to reduce the incidence of serious illness and avoidable deaths in staff, patients and other users of Metro North HHS services. There is evidence that a vaccinated healthcare worker has a decreased risk of transmitting influenza to their patients and reduces absenteeism.

Influenza vaccination is an expectation of all Metro North employees. Immunisations will be available for staff members from the directorate workforce vaccination and screening service, or they may choose to be immunised by their own general practitioner or at their local pharmacy and provide evidence of this vaccination.

Metro North conducts a workforce vaccination campaign annually. A multi-platform communication strategy is used including QHEPS intranet site - https://qheps.health.qld.gov.au/metronorth/flu ), posters, email advisories, newsletter messages, e-bulletins and social media that links to WHO and Queensland Health vaccination material.

#### 6.9.2.2 Community influenza vaccination

A broad Influenza Awareness Campaign for targeted community and other stakeholders will occur annually, in the context of the current COVID-19 pandemic. The campaign includes a Flu Briefing for media, in partnership with QAS, PHN and GPs. The key focus is to encourage the community to uptake vaccination available within the community.

#### 6.9.2.3 Inpatient / outpatient influenza vaccination

To further mitigate the likelihood / severity of influenza in at-risk groups, and thereby reducing the impact on the hospital system, Metro North opportunistically offers inpatient/outpatient vaccinations from May until August each year. Outpatients recommended for vaccinations will be referred either the outpatient to their General Practitioner or community pharmacy as appropriate.

## 6.10 Recovery strategies

As Metro North moves into the control phase of the pandemic, we will evaluate:

- the effectiveness of new models of care and whether they should continue
- the impact of COVID-19 on access to services including any services with extended wait times as a result
- the impact of COVID-19 on the health of the population.

# 7 Recover

The Recovery Phase is characterised by the pandemic being under control in Australia however further waves may occur if the virus drifts and/or is reimported into Australia. During this phase there is ongoing evaluation of the response, revision of plans and activation of recovery strategies. National Cabinet agreed to a plan to transition Australia's National COVID-19 Response from its current pre vaccination settings, focussing on continued suppression of community transmission, to post vaccination settings focussed on prevention of serious illness, hospitalisation and fatality, and the public health management of other infectious diseases. Metro North activities will align with the National Plan to transition Australia's National COVID-19 Response where actions will focus on managing COVID-19 consistent with public health management of other infectious diseases. The measures may include:

- Open international borders
- Quarantine for high-risk inbound travel
- Minimise cases in the community without ongoing restrictions or lockdowns
- Live with COVID-19: management consistent with influenza or other infectious diseases;
- Boosters as necessary
- Allow uncapped inbound arrivals for all vaccinated persons, without quarantine;
- Allow uncapped arrivals of non-vaccinated travellers subject to pre-flight and on arrival testing.

Metro North will work with other government agencies to consider whether the community require additional services to enable full psychological, social, economic, environmental and physical recovery from the effects of the COVID-19 outbreak. At-risk groups may need additional support.

Analysis of available data to evaluate the epidemiological, clinical and virological characteristics of the pandemic will be undertaken and ongoing surveillance measures will be considered and incorporated. Newly developed policies and procedures will be reviewed to determine their ongoing applicability and be updated accordingly.

# Appendix 1 Infrastructure at Tier level

| Metro North | Fever Clinic capacity | ED Spaces | ICU Beds | Isolation Room | Rooms^ |
|---|---|---|---|---|---|
| **Tier 1** | 925 | 206 | 87 | 438 | 143 |
| **Tier 2** | Not applicable | 252 | 116 | | 189 |
| **Tier 3,4 and 5** | 2,070 | 319 + private sector capacity and field hospital capacity if required | Tier 3 165<br>Tier 4 212 + private providers<br>Tier 5 is Tier 4 + field hospitals | | 545 + over census, private hospital and field hospital if required |

***^Capacity for COVID-19 positive patients – Tier 1 and 2 is at designated COVID hospitals only, Tier 3, 4 and 5 includes all Metro North facilities***

| *Metro North Health COVID Ward Surge Plan- 18 January 2022* | | | | | | |
|---|---|---|---|---|---|---|
| ***Hospital / Facility*** | ***Tier 1*** | ***Tier 2*** | ***Tier 3*** | ***Tier 4*** | ***Tier 5*** | ***Room Configuration*** |
| **RBWH** | | | | | | |
| RBWH acute beds | 16 (Wattlebrae) + 12(6AS) +14 (6AN) | 16 (Watt) + 26 (6AS/6AN) | 16 (Watt)+ 28 (6AS) + 28 (6AN) | 72 (Watt/6AS/6AN) + 30 (8BS) + 30 (8BN) | 132 + 30 (8AS) + 30 (8AN) | 6AS 12 rooms can accommodate a maximum of 26 persons. In the process of moving to resp acute ward. |
| RBWH ICU | 4 | 4+12 | 20 | 20 | 36 | 4 negative pressure and 32 general ICU beds with ventilators. |
| **RBWH Total** | 46 | 58 | 92 | 152 | 228 | |
| **TPCH** | | | | | | |
| TPCH acute | 14 (ACC) | 14 (ACC)+ 25 (1G) | 39 (ACC/1G) + 30 (1F) +8 (1E) | 77 (ACC/1G/1F/1E) + 2 (paeds) | 79 | Can accommodate more paeds in the ward. |
| TPCH- ICU | 2 | 2+7 | 9+3 | 18 | 27 | 5 negative pressure and 22 general ICU beds with ventilators. |
| **TPCH Total** | 16 | 48 | 89 | 97 | 106 | |
| **Redcliffe** | | | | | | |
| Redcliffe beds | 0 | 0 | 24 | 24 + 16 (pall care ward) + 30 (6W) | 70 | |
| Redcliffe - ICU | 0 | 0 | 10 | 10 | 10 | |
| **Redcliffe Total** | 0 | 0 | 34 | 80 | 80 | |
| **Caboolture** | | | | | | |
| Caboolture Beds | 0 | 0 | 6 (GLAD) + 28 (3B) | 34 (GLAD/3B) + 7 (4A) + 12 (4A) +5 (3A) + 6 (2A)<br>4 (Maternity) + 7(Paeds) | 75 | |
| Caboolture ICU | 0 | 0 | 2 | 4 | 4 | |
| **Caboolture Total** | 0 | 0 | 36 | 79 | 79 | |
| **Metro North Total ICU Capacity** | **6** | **25** | **44** | **52** | **77** | |
| **Metro North Bed Capacity** | **56** | **81** | **207** | **356** | **416** | |
| **Metro North Overall Total** | **62** | **106** | **251** | **408** | **493** | |

# Appendix 2 Definition of essential meeting

An essential meeting or workshop:

1. directly relates to essential functions of Metro North HHS
2. directly relates to priority initiatives of the HHS, for instance, Value Oriented Systems initiatives
3. will result in decisions or actions that are critical to patient care, the HHS achieving performance targets, or the COVID-19 response
4. will result in decision or actions that will mitigate risks related to the HHSs legislative, industrial and financial obligations
5. directly supports the wellbeing of staff.

Additionally:

- The meeting or workshop will not prevent staff providing support to the COVID-19 response, who, if the meeting or workshop did not proceed, could be reallocated to the COVID-19 response. This includes the time spent planning for the meeting or workshop.
- The meeting or workshop can be delivered in a way that is compliant with the Chief Health Officers Directions.
- If the meeting or workshop is conducted in an offsite venue they must have a COVIDSafe Plan.

# Appendix 3 PPE Response guide

Table 1. *Community health services and in-home care settings*: Recommended PPE escalation according to risk of unexpected COVID-19 infections in clients or workers, including contractors and volunteers (in addition to standard precautions +/- transmission-based precautions if indicated for another reason).

| | Community level risk → | Low risk | | Moderate risk | | High risk | |
|---|---|---|---|---|---|---|---|
| | Client category ↓ | Staff who work only in a single community facility/home[1] | Staff who work across multiple community facilities/homes[1] | Staff who work only in a single community facility/homes[1] | Staff who work across multiple community facilities/homes[1] | Staff who work only in a single community facility/homes[1] | Staff who work across multiple community facilities/homes[1] |
| STAFF[6] | No clinical evidence of COVID-19 AND no epidemiological evidence[2] | nil additional | Surgical mask | Surgical mask[5]<br>Protective eyewear[3] (within 1.5m) | Surgical mask[5]<br>Protective eyewear[3]<br>Gown or apron[4] | Surgical mask[5]<br>Protective eyewear[3] (within 1.5m) | Surgical mask[5]<br>Protective eyewear[3]<br>Gown or apron[4] |
| | Staff doing activities other than direct client care | nil additional | Surgical mask | Surgical mask | | Surgical mask | |
| | Clinical evidence of COVID-19 WITHOUT epidemiological evidence[2] of COVID-19 | Surgical mask[5]<br>Protective eyewear[3]<br>Gown<br>Gloves | | P2/N95 respirator<br>Protective eyewear[3]<br>Gown<br>Gloves | | P2/N95 respirator<br>Protective eyewear[3]<br>Gown<br>Gloves | |
| | Confirmed COVID-19 OR<br>Suspected COVID-19 (clinical evidence WITH epidemiological evidence[2] of COVID-19) OR<br>Those subject to quarantine or other public health requirements | P2/N95 respirator<br>Protective eyewear[3]<br>Gown<br>Gloves | | P2/N95 respirator<br>Protective eyewear[3]<br>Gown<br>Gloves | | P2/N95 respirator<br>Protective eyewear[3]<br>Gown<br>Gloves | |
| PPE for clients with clinical or epidemiological evidence of COVID-19 OR in quarantine OR suspected OR confirmed COVID-19 cases | | Clients to wear surgical mask where tolerated (excluding children under 12) | | Clients to wear surgical mask where tolerated (excluding children under 12) | | Clients to wear surgical mask where tolerated (excluding children under 12) | |
| Support persons or other household members during healthcare interaction for non-COVID-19 clients | | nil additional | | Surgical mask | | Surgical mask | |

Table 1 footnotes

[1]Includes all non-hospital paediatric health services (incl. multiple home visits and facilities). Further guidance regarding paediatric health service PPE requirements is available at: https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/covid-19-extranet/ppe-requirements-HVP.pdf.

[2] Epidemiological evidence includes, in the last 14 days: close contact with a confirmed case of COVID-19; international travel with the exception of green zone countries; workers supporting designated COVID-19 quarantine and isolation services; international border staff; international air and maritime crew; people who have been in a setting where there is a COVID-19 case e.g. in close contact category at a QH exposure location, in casual contact category at a QH exposure location pending a negative COVID-19 test result, QH interstate exposure venues; people who have been in areas with recent local transmission of SARS-Cov-2 e.g. QH hotspots. (Risk-assess health, aged and residential care workers)

[3]Protective eyewear is defined as a face-shield, goggles, or dedicated safety glasses – note that prescription glasses alone are not considered adequate eye protection.

[4]Alternatively where applicable change clothes at the end of the interaction, refer to: https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/covid-19-extranet/ppe-requirements-HVP.pdf.

[5]In these situations a P2/N95 respirator should be worn for Aerosol generating procedures (AGP), aerosol generating behaviours (AGB) and upon entering a room within 30 min of an AGP. AGP, AGB and other factors increasing the risk of transmission are outlined in Appendix 7 of the *Queensland Health infection prevention and control guidelines for the management of COVID-19 in healthcare settings*.

[6]Healthcare staff who reside in an area that is designated a different risk level to the healthcare facility they work are to comply with their workplace facility risk PPE requirements.

Table 2. *Healthcare delivery in correctional services:* Recommended PPE escalation according to risk of unexpected COVID-19 infections in clients or workers (in addition to standard precautions +/- transmission-based precautions if indicated for another reason)

| | Community level risk → / Client category ↓ | Low risk<br>As advised by Queensland Health | Moderate risk<br>As advised by Queensland Health, or Restricted Correctional Centre[2] - Stage 2 or 3 | High risk<br>As advised by Queensland Health, or Restricted Correctional Centre[2] - Stage 4 |
|---|---|---|---|---|
| STAFF[1] | No clinical evidence of COVID-19<br>AND no epidemiological evidence[6] | nil additional | Surgical mask[3]<br>Protective eyewear | Surgical mask[3]<br>Protective eyewear |
| | Clinical evidence of COVID-19<br>WITHOUT epidemiological evidence[6] of COVID-19 | Surgical mask[3]<br>Protective eyewear<br>Gown<br>Gloves | P2/N95 respirator[4]<br>Protective eyewear<br>Gown<br>Gloves | P2/N95 respirator[4]<br>Protective eyewear<br>Gown<br>Gloves |
| | Staff doing activities other than direct client care | Not appliable | Surgical mask | Surgical mask |
| | Confirmed COVID-19 cases OR<br>Suspected COVID-19 (clinical evidence WITH epidemiological evidence[6] of COVID-19) OR<br>Those subject to quarantine or other public health requirements | P2/N95 respirator[4]<br>Protective eyewear<br>Gown<br>Gloves | P2/N95 respirator[4]<br>Protective eyewear<br>Gown<br>Gloves | P2/N95 respirator[4]<br>Protective eyewear<br>Gown<br>Gloves |
| PPE for clients with suspected or confirmed COVID-19 (excluding children under 12) | | Client to wear surgical mask where tolerated when outside of single room | Client to wear surgical mask where tolerated when outside of single room | Client to wear surgical mask where tolerated when outside of single room |
| PPE for visitors[3] | | nil additional | Personal and/or professional visitors (excluding health staff) are likely to be prohibited<br>Surgical mask | Personal and professional visitors (excluding health staff) are likely to be prohibited<br>Surgical mask |

Table 2 footnotes

[1]Healthcare staff who reside in an area that is designated a different risk level to the correctional facility they work are to comply with their workplace facility risk PPE requirements.

[2]A restricted correctional centre refers to a correctional centre in stage 2, 3 or 4 as determined by the Commissioner of Queensland Corrective Services following consultation with Queensland Health.

[3]Please refer to applicable Determination by the Commissioner of Queensland Corrective Services.

[4]Fit testing of P2/N95 respirators is required of staff on at least a 12-monthly basis.

[5]In these situations a P2/N95 respirator should be worn for Aerosol generating procedures (AGP), aerosol generating behaviours (AGB) and upon entering a room within 30 min of an AGP. AGP, AGB and other factors increasing the risk of transmission are outlined in Appendix 7 of the *Queensland Health infection prevention and control guidelines for the management of COVID-19 in healthcare settings*.

Note: Staff who are likely to have contact with COVID-19 cases must be fully vaccinated in accordance with Public Health Direction/s where these apply.

[6]Epidemiological evidence includes, in the last 14 days: close contact with a confirmed case of COVID-19; international travel with the exception of green zone countries; workers supporting designated COVID-19 quarantine and isolation services; international border staff; international air and maritime crew; people who have been in a setting where there is a COVID-19 case e.g. in close contact category at a QH exposure location, in casual contact category at a QH exposure location pending a negative COVID-19 test result, QH interstate exposure venues; people who have been in areas with recent local transmission of SARS-Cov-2 e.g. QH hotspots. (Risk-assess health, aged and residential care workers)

Table 3. *Healthcare settings*: Recommended PPE escalation according to risk of unexpected COVID-19 infections in patients or workers (in addition to standard precautions +/- transmission-based precautions if indicated for another reason)

| | Community level risk → <br> Client category ↓ | Low risk | Moderate Risk <br> As advised by Queensland Health, and Restricted Hospital[4] | High Risk <br> As advised by Queensland Health |
|---|---|---|---|---|
| STAFF[1] | NO clinical or epidemiological evidence[2] of COVID-19 | Standard precautions | Surgical mask[5] <br> Protective eyewear | Surgical mask[5] <br> Protective eyewear |
| | Clinical evidence of COVID-19 <br> WITHOUT epidemiological evidence[2] of COVID-19 | Surgical mask[5] <br> Protective eyewear <br> Gown <br> Gloves | P2/N95 respirator <br> Protective eyewear <br> Gown <br> Gloves | P2/N95 respirator <br> Protective eyewear <br> Gown <br> Gloves |
| | Confirmed COVID-19 OR <br> Suspected COVID-19 (clinical evidence WITH epidemiological evidence[2] of COVID-19) OR <br> Those subject to quarantine or other public health requirements | P2/N95 respirator[6] <br> Protective eyewear <br> Gown <br> Gloves | P2/N95 respirator[6] <br> Protective eyewear <br> Gown <br> Gloves | P2/N95 respirator[6] <br> Protective eyewear <br> Gown <br> Gloves |
| | Staff during activities other than direct patient care | Not Applicable | Surgical mask unless working alone in their own office[3] | Surgical mask unless working alone in their own office[3] |
| PPE for patient use - clinical evidence of COVID-19 OR in quarantine OR suspected OR confirmed COVID-19 cases (excluding children under 12) | | Surgical mask <br> where tolerated, unless inpatient in own bed | Surgical mask <br> where tolerated, unless inpatient in own bed | Surgical mask <br> where tolerated, unless inpatient in own bed |
| PPE for patient use - non-COVID-19 (excluding children under 12) | | Nil | Surgical mask <br> where tolerated, unless inpatient in own bed | Surgical mask <br> where tolerated, unless inpatient in own bed |
| PPE for visitors | | Nil | Surgical mask OR <br> Own mask if adequate[3] | Surgical mask OR <br> Own mask if adequate[3] |

## Table 3 footnotes

[1]Healthcare staff who reside in an area that is designated a different risk level to the healthcare facility they work are to comply with their workplace facility risk PPE requirements.

[2]Epidemiological evidence includes, in the last 14 days: close contact with a confirmed case of COVID-19; international travel with the exception of green zone countries; workers supporting designated COVID-19 quarantine and isolation services; international border staff; international air and maritime crew; people who have been in a setting where there is a COVID-19 case e.g. in close contact category at a QH exposure location, in casual contact category at a QH exposure location pending a negative COVID-19 test result, QH interstate exposure venues; people who have been in areas with recent local transmission of SARS-Cov-2 e.g. QH hotspots. (Risk-assess health, aged and residential care workers)

[3]And in accordance with current Public Health Directions

[4]Restricted Hospital as per Chief Health Officer Public Health Directions.

[5]In these situations a P2/N95 respirator should be worn for Aerosol generating procedures (AGP), aerosol generating behaviours (AGB) and upon entering a room within 30 min of an AGP. AGP, AGB and other factors increasing the risk of transmission are outlined in Appendix 7 of the *Queensland Health infection prevention and control guidelines for the management of COVID-19 in healthcare settings*.

[6] Powered Air Purifying Respirators (PAPRs) may be used in certain circumstances as an alternative to P2/N95 respirators. The decision to use these devices is made at a local level following a risk-based assessment.

# Appendix 4 Metro North Health Pandemic (COVID-19) Surge Workforce Response Plan

This appendix provides a summary of the surge workforce response for Metro North Health. The Metro North COVID-19 Response Plan has outlines actions required at each Tier including workforce responses.

| | Tier 0 | Tier 1 | Tier 2<br>As Tier 1 plus | Tier 3<br>As Tier 2 plus | Tier 4<br>As Tier 3 Plus |
|---|---|---|---|---|---|
| **Planned responses** | Business as usual | ▪ enact staff management plans<br>▪ activate COVID-19 HR hotline – hours as demand indicates<br>▪ Refresh/ activate Outbreak management as required<br>▪ Reallocate staff to frontline roles as demand dictates<br>▪ Increase capability in casual pools<br>▪ Prepare processes to enable suspension of non-urgent planned care when advised to deploy these staff to COVID -related care including extra COVID inpatient wards, virtual ward, fever clinics etc<br>▪ Increase virtual care<br>▪ Increase HITH capacity including virtual capability<br>▪ Increase use virtual models for outreach services where able<br>▪ Identify locations outside of the outpatient clinic to provide virtual clinics<br>▪ Discretionary suspension of non-essential training where they impact on clinicians' time to respond to COVID-19<br>▪ Essential training to be delivered virtually where able | ▪ Continue to re-allocate staff to frontline as demand dictates<br>▪ Continue to recruit and deploy casual staff to frontline services<br>▪ Develop an expedited fast tracked credentialling process for priority positions<br>▪ Develop a register of nurses in the HHS with critical care experience and progress upskilling program<br>▪ All virtual outpatient appointments unless not clinically appropriate<br>▪ Increase virtual ED capacity as demand requires<br>▪ Outsource activity as able<br>▪ Only urgent elective surgery and procedures to deploy these staff to COVID -related care including extra COVID inpatient wards, virtual ward, fever clinics etc<br>▪ Increased scope of services to private sector<br>▪ Suspension of non-essential training<br>▪ Orientation for new starters online | ▪ Activate EOI portal for registered non practising clinicians to support response<br>▪ Redirect clinical staff where appropriate to support COVID activities<br>▪ Support staff to return to work if interested e.g. maternity leave<br>▪ Implement alternate models of care based on staffing availability<br>▪ Develop a register of staff working in non-frontline areas who may be redeployed to assist with frontline roles e.g. concierge<br>▪ Collaborate with Department of Health on surge workforce and/or panel providers to assist where possible e.g. vaccination programs<br>▪ Increase graduate nurse intake where possible<br>▪ Reduction of planned care to deploy these staff to COVID -related care including extra COVID inpatient wards, virtual ward, fever clinics etc<br>▪ No face to face training, essential training delivered virtually | ▪ Consider recruitment of non-clinical staff to assist with clinical load where appropriate<br>▪ Emergency and category 1 and 4 planned activity only – to deploy staff to COVID-related care and to manage with furloughed staff<br>▪ Utilise private hospitals for surge capability<br>▪ At the elbow education support in clinical areas to support junior staff |

| | | | | | |
|---|---|---|---|---|---|
| **Workforce engagement and communication** | | ▪ Develop and maintain a COVID response extranet page<br>▪ Twice weekly incident controller broadcast messages | ▪ Daily incident controller messages<br>▪ Weekly all staff vidcast<br>▪ Regular directorate staff forums or equivalent | ▪ Daily incident controller incident messages<br>▪ Twice weekly vidcast<br>▪ Regular Directorate staff forums or equivalent | ▪ Daily incident controller incident messages<br>▪ Twice weekly vidcast<br>▪ Regular Directorate staff forums or equivalent |
| **Staff wellbeing programs** | Business as usual employee assistance programs | ▪ BAU | ▪ Publishing COVID-19 supports (including useful websites, tips for coping and mental health wellbeing telephone support) on the Metro North Health extranet | ▪ Benestar fact sheets and resources including a factsheet on COVID-19: Achieving Wellness | ▪ COVID staff psychology support including staff psychology open door sessions for facility staff<br>▪ COVID-19 HR hotline |
| **Planned Workforce strategy meetings** | | ▪ Twice weekly Metro North IMT meetings comprising clinical directorates, clinical streams, professional leads, business units and external partners (QAS, Brisbane North PHN and consumers) convened based on need | ▪ IMT daily | ▪ IMT daily<br>▪ Three times weekly workforce planning meeting with professional leads | ▪ IMT daily<br>▪ Continue monthly strategic workforce committee meeting convened by ED, HR with all professional leads, COO, Strategy and Planning representatives and workforce planning representatives<br>▪ Three times weekly workforce planning meeting with professional leads |