Mental Health Directorate COVID-19 Response Plan

October 2021

Aligned with v.28 Metro North HHS COVID-19 Response Plan – Control Phase – September 2021

Metro North Health | Queensland Government

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An electronic version of this document is available at

https://metronorth.health.qld.gov.au/extranet/coronavirus

Version control

Version	Date released
1	21 April 2020
2	16 September 2020
3	12 October 2021
4	

Contents

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
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 20003 outbreak of Severe Acute Respiratory Syndrome (SARS). SAR-CoV-2 causes the illness now known as Coronavirus disease (COVID-19). Currently, there is no specific treatment, vaccine or antiviral against new virus. However, in light of recent developments, there is scientific evidence to support Remdesivir in shortening the time to recovery in adult patients hospitalised with COIVD-19 and evidence of lower respiratory tract infection (NEJM) and Dexamethasone in lowering 28 day mortality amongst those receiving ventilation or oxygen alone compared with standard of care (NEJM)

1.2 Purpose

The purpose of this pandemic response plan (Metro North COVID-19 Response Plan), is to ensure continuity of health services and minimise the community impact within Metro North Health (Metro North) of COVID-19 and, specifically, the Mental Health Directive (referred to as Metro North Mental Health). Given the rapid rate that the situation is changing, this will remain a live document updated as decisions are made throughout the pandemic.

The strategic objectives for Metro North in 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 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 World Health Organisation (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.

The Chief Health Officer (CHO) directed all health services to:

- Provide health staff to screen and conduct clinical assessment of passengers identified by Australian Border Force including the transfer of symptomatic persons to emergency departments for testing / treatment and/or supporting access to government provided accommodation where travellers are identified as not being able to isolate in the same location for 14 days
- Via Public Health Units:

- Facilitate the issuing of quarantine notices to international travellers and relevant interstate travellers at points of entry
- Provide information and guidance to general practitioners and the public regarding testing and isolation requirements
- Support the clinical management of persons who are in isolation
- Provide support to quarantined guests in government facilitated accommodation and provide required health checks
- Undertake case and contact management finding for confirmed COVID-19 cases and their close contacts compliance
- Undertake compliance and monitoring of Chief Health Officer directions to persons and businesses/industry

- Plan for new or expanded models of care (such as telehealth, virtual medicine, hospital in the home and treatment of people with chronic conditions at home)1.

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

1.4 Scope

This Control Phase response plan covers the Metro North health sector response to COVID-19 with a vaccine widely available, to ensure the continued delivery of critical clinical services to existing patients and the Metro North community.

This plan is supported by detailed subplans for Directorates, clinical streams and corporate functions and is subsequent to the Metro North COVID-19 Response Plan – Sustain Phase.

2 Pandemic phases

Phase	Description
ALERT 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. Novel virus has not arrived in Australia.
DELAY OS4/OS5/OS6	Novel virus has not arrived in Australia. OS4 Small cluster of cases in one country overseas. OS5 Large cluster(s) of cases in only one or two countries overseas. OS6 Large cluster(s) of cases in more than two countries overseas.
CONTAIN AUS 6a - **January 2020**	Pandemic virus has arrived in Australia causing small number of cases and/or small number of clusters.
SUSTAIN AUS 6b – 25 March 2020 (Metro North HHS)	Pandemic virus is established in Australia and spreading in the community.

[1] 25 February 2020

Phase	Description
CONTROL AUS 6c – 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

Queensland CHO Directions

- Aged Care Direction
- Border Restrictions Direction
- COVID-19 Testing and Vaccination Requirements (Contact by Health Workers with Cases) Direction
- Declared Hotspots direction
- Designated COVID-19 Hospital Network Direction
- Disability Accommodation Services Direction
- Hospital Visitors Direction
- Interstate Areas of Concern (Vulnerable Facilities) Direction
- Interstate Exposure Venues Direction
- Management of Close Contact Direction
- Management of Secondary Contacts Direction
- Mandatory Face Masks Direction
- Movement and Gathering Direction
- Point of Care Serology Tests Direction
- Prescribing, Dispensing or Supply of Hydroxychloroquine Direction
- Protecting Public Officials and Workers (Spitting, Coughing and Sneezing)
- Quarantine and COVID-19 Testing for Air Crew Direction
- Quarantine for International Arrivals Direction
- Queensland COVID-19 Restricted Areas
- Queensland Health Residential Aged Care Facilities (COVID-19 Vaccination) Direction
- Queensland Travel Declaration Direction
- Requirements for Quarantine Facility Workers Direction
- Restricting Cruise Ships from Entering Queensland Waters Directions
- Restrictions for Locked Down Areas (South-East Queensland) Direction
- Restriction on Businesses, Activities and Undertakings Direction
- School and Early Childhood Service Exclusion Direction
- Seasonal Workers Health Management Plans Direction
- Self-isolation for Diagnosed Cases of COVID-19 Direction

3 Overview of Metro North HHS, the Mental Health Directorate 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[2]. 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[3].

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

Metro North Mental Health provides mental health and alcohol and other drug services that support people who have severe and complex needs or are in crisis. The service supports the recovery of people with mental illness through the provision of recovery focused services and consumer and carer services in collaboration with primary and private health providers and Non-Government partners.

Care is delivered to people of all ages in the community, in the hospital and in specialist residential settings. The services for people experiencing mental illness include a range of specialist assessment, treatment, rehabilitation and recovery services that also consist of emergency, consultation liaison, forensic, substance use disorders, eating disorders, community mental health and inner-city homeless services.

Acute mental health inpatient services are provided at RBWH, TPCH and the Caboolture Hospital.

For people experiencing substance use disorders, Metro North Mental Health provides access to evidence-based treatments including opioid maintenance, substance withdrawal management, and counselling. For people experiencing substance misuse issues, there are a range of harm minimisation and brief intervention services. Statewide inpatient detoxification services are provided at RBWH.

3.1 Infrastructure

Facility	Unit type	Room Type	Oxygen
Caboolture	2 Acute wards	30 Single Rooms with ensuite	No
		10 double rooms with ensuite	No

Facility	Unit type	Room Type	Oxygen
		7 single rooms in Psychiatric Intensive Care Unit – 3 with shared bathroom – 4 with ensuite	No
	1 Short Stay ward	8 bed ward, one shared ensuite	No
TPCH	2 Acute wards	34 single rooms with ensuite	No
		5 double rooms with shared ensuite	No
		6 single rooms in Psychiatric Intensive Care Unit with shared bathroom	No

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

RBWH	3 Acute wards	12 single rooms shared ensuite	1 room (MHH)
		9 double rooms shared ensuite	No
		9 x four bedded rooms with shared shower	No
		9 single rooms in High Dependency Unit shared bathroom	Yes
	Adolescent ward	single rooms	Yes
		double rooms	No
	Hospital Drug and Alcohol Service	2 single rooms	No
		5 x four bedded rooms with shared bathroom	No

Note: there are also 2 x 20 bed Secure Mental Health Rehabilitation Units (SMHRUs). 20 beds at TPCH and 20 beds at Caboolture Hospital (9 beds are allocated to the Sunshine Coast HHS). These facilities are not suitable for COVID-19 requirements.

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.

Metro North Mental Health has a range of local partners and stakeholders who they will work with in deliver on this response plan and continue to provide high level healthcare to the local community. These partners and stakeholders include:

- Mental Health Alcohol and Other Drugs Branch
- Queensland Government Correctional Services
- Queensland Police Service
- Primary Health Network
- General Practitioners
- Community Pharmacies
- Red Cross
- Public Health
- Queensland Ambulance Service
- Private Hospitals
- Non-government / NGO home care services
- Residential Aged Care Facilities
- Supported and Hostel Accommodation

5 Roles Responsibilities

During the control phase, Metro North will continue to lead the implementation of response requirements at a HHS level, as outlined in the sustain phase plan.

6 Control phase responses

The control phase will continue to require a statewide approach to managing any outbreaks. Based on modelling the Delta variant, the Department of Health has modelled the below bed requirements and triggers for each tier response.

Current tiered response

Scenario	System Tier	COVID bed occupancy triggers	COVID ICU beds	Workforce	Triggers
Current Status	1	Up to 100 admitted in designated COVID facility. All admitted up to 50 cases then unwell only	6 pts or <3% of current capacity	TBD	Sporadic cases in community or small infrequent clusters (may involve high risk settings) **Low** community transmission risk Tier one not in complex setting or high volume contacts involved, with some emerging under tier two.
	2	Between 100 and 200 admitted within designated facilities. Unwell admitted only	145 pts or <40% of physical capacity	TBD	Sporadic cases in community or small infrequent clusters (may involve high risk settings) **Low-Medium** community transmission risk Tier one not in complex setting or high volume contacts involved, with some emerging under tier two.
Acute Surge	3	Between 200 and 1234 admission or < 14% of state-wide public bed capacity	353 pts or < 60% of expanded capacity	TBD	Large or increasing clusters and outbreaks with identified chains of transmission involving high risk settings **Medium** community transmission risk
	4	Between 1234 and 2698 admissions or up 31% of state-wide public bed capacity	700 pts or <85% of maximum capacity (physical, expanded and private)	TBD	Multiple unlinked cases with unknown source **Medium-High to High** community transmission risk
	5	Over 2698 admission or up 31% or state-wide public bed capacity	>700 pts	TBD	Expanding clusters and outbreaks with no epidemiological links **Very High** community transmission risk

6.1 Metro North Response

The Metro North control phase response plan builds on the approach outlined in the sustain phase plan for each Tier as well as the Department of Health tiers, with specific additional considerations or requirements for the control phase. During the control phase there will continue to be a tiered response, spanning from Tier 0 to Tier 5. 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.

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 0.

The Metro North Mental Health response is guided by the Metro North response and specifics are outlined in the Tiers below.

6.1.1Tier 0: Response: Prevent local transmission

Governance and Logistics (including PPE)	Personnel	Fever Clinic	ICU

▪ Participate MNHHS EOC as required
▪ MNMH IMT stood up - COVID-19 planning included in MNMH Executive committee meetings
▪ Complete BIA reports for MNHHS EOC as required
▪ Director Governance and Quality Management is MNMH EOC Duty Manager
▪ Signage with QR Check In code available and any restrictions in place in line with CHO direction at all entry points
▪ Sanitizing stations at all entrances
▪ Frequent touch point cleaning
▪ Identify PPE stock levels for usual care (non-COVID wards) and for set up of COVID wards
▪ PPE stock centralized and monitored at each MH facility
▪ PPE stockholding to 28 days
▪ Maintain levels of PPE for community – clinics and home and offsite visits
▪ Weekly PPE meeting
▪ Access to medication supply and pharmacy support monitored at each MH facility
▪ *Mental Health Act 2016* requirements, including temporary changes, as per Chief Psychiatrist directions
▪ Liaison with Community Oral
	▪ **All staff must be vaccinated.**
	▪ **Staff to get fit tested.**
	▪ PPE as per CHO directions and DOH guideline – risk matrix
	▪ At any tier – if "moderate risk" PPE required - **additional considerations for staff who are home visiting/off site/custodial settings** – MNHHS requires full PPE due to entering environments that cannot be controlled.
	▪ Line managers to identify staff who may be at higher risk (vulnerable staff), who may have vulnerable family
	▪ members/carer responsibilities. Personnel register to be maintained for higher Tier activation.
	▪ Line managers to ensure they have up to date contact details of their staff
	▪ Active recruitment of all clinical disciplines
	▪ Leave provisions to support testing and/or quarantine requirements for staff available on MNHHS COVID-19 extranet
	▪ Visitors - do not attend if unwell, as per CHO direction
	▪ Volunteers - do not attend if unwell, complete volunteer checklist, risk assess roles, engaged as appropriate
		N/A
		ED/Acute Assessment
		▪ Communication pathways established with MNHHS EOC to alert MNMH of the need to review a person in ED, the community or home/hotel quarantine who may require psychosocial support and/or mental health assessment
		▪ MH COVID Advisors with RBWH and TPCH Acute Care Teams provide consultation and liaison for individuals experiencing mental health issues in hotel quarantine
		▪ Guided by facility and/or ED COVID-19 plans/subplans.
			N/A
			Hospital inpatient response – MH response – Confirmed, Suspected, Quarantine COVID-19
			▪ Confirmed COVID-19 – to be managed in designated COVID wards (RBWH and TPCH only) – i.e. non-MH wards.
			▪ MH CNC located within RBWH COVID ward (Wattlebrae)
			▪ Additional MH staff can be provided for specialling/case by case as required/directed by MNHHS. All requests for this to be activated must go via Operations Directors
			▪ Single rooms identified within MH inpatient units, for isolation requirements if required/directed by MNHHS. All requests for this to be activated must go via Operations Directors
			▪ If single rooms are activated,
			  ▪ ideally, single room/own bathroom
			  ▪ staff to use aerosolising precautions
			  ▪ staff who are caring for COVID-19 consumers should not look after non-

Health re shared Community Health Centre locations and between co-located services at Biala City Community Service as required regarding planning and responses required.	▪ Consumer representation - complete Consumer COVID checklist, risk assess roles ▪ Student placements – do not attend if unwell, as per CHO direction. ▪ NGO/support services BAU ▪ Maintain list of medical officers who can prescribe opiates to support ADS clients if required ▪ Clinical Directors to prepare for separation of inpatient and community for higher Tier activation (Tier 2) ▪ Staff who have been required to work in COVID suspected/confirmed areas/wards will need to work in 'blocks' of rostering and undergo surveillance testing to meet infection control/designated hospital requirements. Ongoing recruitment to support demands of staff who will be required to work in these wards		COVID-19 consumers in the same ward ▪ If single rooms are activated, or other MH inpatient areas are required to be isolated e.g. HDU/PICU – this may impact on access/patient flow for non-COVID acute requirements ▪ Where Virtual Wards are operating at hospital facilities, usually for the COVID well patients in their homes/hotel quarantine, MNMH may be asked to provide consultation/liaison/advice
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Meetings	Training	Service Operations	Clinical Considerations
▪ physical distancing, taking into consideration square meterage as required ▪ Virtual meetings where able	▪ BAU - physical distancing ▪ COVID-19 PPE online training to be completed by all clinical staff as priority and non-clinical staff as a requisite ▪ MNMH Fit Testers trained for ongoing requirements. ▪ MNMH exploring option to purchase dedicated fit testing equipment. ▪ Education around PPE, hand hygiene and fitting masks ▪ OVP and BLS essential training at all Tier levels	▪ Screening questions for all consumers/clients, visitors (including support persons) prior to clinic appointments, home visits, attendance for ECT ▪ All staff, consumers/clients and visitors to check in with app ▪ Visitor restrictions in line with CHO directions ▪ Volunteer and consumer/carer representatives attend as per "personnel" and as per COVID-19 Safe checklist/plan.	▪ BAU with consideration to alternative service delivery options case by case as indicated by screening outcomes ▪ Vaccination of consumers/clients a key priority. - Ensure extended treatment/community/residential consumers are offered vaccination (i.e. SMHRUs, CCUs, SUSDs). - Inpatient consumers – pathways for accessing vaccination clinics

		▪ Identification of teams/roles that can move to flexible working conditions in higher Tier activation ▪ Ensure cleaning schedules are maintained in all areas ▪ Consider consumers/clients wearing masks at clinics/ECT where physical distancing is not possible Staff responsibilities ongoing <u>at all Tiers</u>: ▪ do not attend work if unwell/get tested ▪ wipe down personal ipads/phones ▪ wipe down hard surfaces, shared spaces ▪ wipe down vehicles after use ▪ minimise numbers in shared spaces such as tea rooms, meeting rooms, elevators	or in partnership with MH pharmacists - Discussed/supported with consumers who are receiving community care - High vulnerability groups – e.g. HHOT, Indigenous, Older ▪ All clinical teams to have considered which patient groups/individual patients may be considered most vulnerable for priority continuity of clinical services at higher Tier levels. Including: - MHA 2016 - Depot medication - Opioid replacement - ECT, including those in RACFs - Homeless/at risk homeless - Forensic settings - Aboriginal and Torres Strait Islander peoples - Vulnerable groups such as older persons, eating disorders, young people, perinatal ▪ MHRT will advise if they are attending face to face or virtual ▪ Admission of consumers to commence on Clozapine to have the required monitoring BAU ▪ Olanzapine Depot – BAU - new consumers can be started on the depot and have their injection at the clinics ▪ Pharmacy – hospital pharmacy to maintain 6 months' supply of pharmacy stocks (based on usual supply) ▪ Home visiting and off-site visits BAU

			▪ Videoconference/teleconference should be utilised at any point if screening indicates risk or if community transmission/HHS advice changes ▪ Planned detoxification, new AOD client commencement activities BAU ▪ Group programs/day programs BAU taking into account physical distancing, room size etc ▪ Consideration of the impact of previous community restrictions and/or higher activation on consumers/clients who may have experienced reduced service delivery, isolation and exacerbation of their mental health/AOD condition

Facility – MH inpatient/community residential	**Facility – MH community (includes Consultation Liaison Psychiatry, MHCALL)**	**Facility – Alcohol and Drug – community (includes AOD Consultation Liaison)**	**Facility – Statewide (QFMHS, QHVSS, MH Clinical Cluster, MH Clinical Collaborative, Insight, Dovetail, Adis)**
▪ BAU ▪ Visiting and leave BAU ▪ Visitor restrictions may be introduced at varying times in line with CHO and/or MNHHS direction ▪ Risk assessment of leave provisions based on rates of community transmission ▪ When restrictions are in place, virtual care options to support contact with family/friends ▪ Inpatients who are suspected/quarantine who require testing and who are not complying with mask wearing and/or isolation: – Staff to use aerosolizing precautions	▪ BAU ▪ Screening questions prior to and day of attendance at outpatient clinics/home visit ▪ Where a consumer/client reports respiratory symptoms, the appointment should be postponed if possible and rescheduled as a virtual appointment ▪ The consumer/client is to be encouraged to attend their nearest Fever Clinic to be tested for COVID- 19 ▪ If appointment cannot be avoided, the staff should visit the consumer to prevent to the consumer having further contact with members of the community. Staff should wear full PPE	▪ BAU ▪ Screening questions prior to, and day of, attendance at outpatient clinics ▪ Where a consumer/client reports respiratory symptoms, the appointment should be postponed if possible and rescheduled as a virtual appointment ▪ The consumer/client is to be encouraged to attend their nearest Fever Clinic to be tested for COVID- 19	▪ BAU ▪ Screening questions prior to any in person activities

– Can escalate discussion with relevant MH Executive, Infectious Diseases and Facility Executive as relevant – Can consider rapid testing on case by case as relevant ▪ Education of consumers regarding physical distancing, hand hygiene, mask wearing ▪ Investigate requirements for a designated MH COVID ward that may be required in higher tier activation: - Infrastructure - Infection Control, incl PPE - Staffing, training - Options for re-location/re-allocation of beds that may be used for this ward - Model of service, clinical pathways, escalation pathways ▪ Identify options for additional beds that could be opened to support increased demand generally			

6.1.2 Tier 1 response: 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.

During Tier 1, only designated COVID-19 facilities will accept patients with COVID-19.

Governance and Logistics	Personnel	Fever Clinic	ICU
▪ Participate MNHHS EOC as required ▪ MNMH IMT active - COVID-19 planning included in MNMH Executive committee	▪ **All staff must be vaccinated**	N/A	▪ N/A

meetings and dedicated IMT meetings as required ▪ Complete BIA reports for MNHHS EOC as required ▪ Consider planning for additional PPE supplies to ensure adequate supplies for inpatient and community staff (clinics and home/off site visiting) ▪ Continue with PPE stock centralized and monitored at each MH facility ▪ Weekly/twice weekly PPE meeting as required ▪ Increase PPE stockholding to 40 days at medium risk ▪ Access to medication supply and pharmacy support monitored at each MH facility ▪ Ensure MNMH have dedicated/trained fit testers ▪ Identify locations for static fit testing stations or mobile testing ▪ Ensure e-health availability/accessibility ▪ *Mental Health Act 2016* requirements, including temporary changes, as per Chief Psychiatrist directions	▪ **All staff to be fit tested for at least 2 masks** ▪ PPE as per CHO directions and DOH guideline – risk matrix ▪ At any tier – if "moderate risk" PPE required - **additional considerations for staff who are home visiting/off site/custodial settings** – MNHHS requires full PPE due to entering environments that cannot be controlled. ▪ Regular COVID-19 specific communication with all staff – this can include MNHHS and MNMH communiques ▪ Line managers to be aware of staff who may be at higher risk (vulnerable staff), who may have vulnerable family members/carer responsibilities ▪ Where feasible, minimise staff movement across wards and facilities ▪ However, MNHHS staff, including statewide staff, should move between catchments/sites/teams as per continuity of clinical care – ensuring they are using screening questions prior to attending, and all other precautions/relevant PPE. ▪ Plan for the development of staff teams and the minimisation of contact between teams for higher Tier activation ▪ Consider roles that can work remotely ▪ Discourage congregation in tearooms and other shared spaces ▪ Identify roles which could move to flexible work arrangements in higher Tier activation	**ED/Acute Assessment** As per Tier 0 ▪ For patients requiring admission to MH units, who exhibit respiratory symptoms, to be swabbed prior to transfer to MH. Patient will be nursed as per aerosolizing precautions until negative result. ▪ Guided by facility and/or ED COVID-19 plans/subplans.	**Hospital inpatient response – MH response – Confirmed, Suspected, Quarantine COVID-19** ▪ As per Tier 1 ▪ Minimise inter-hospital transfers of suspected or confirmed COVID-19 patients unless higher level care is indicated

	▪ Explore what tasks could be completed by non-nursing staff if required in higher Tier activation e.g. visual observations ▪ Identify staff: – on secondment who could be pulled back in higher Tier activation – with physical health recency of practice ▪ Student placements as per CHO Direction. Consider which students: – can be deployed from non-frontline positions to clinical positions – who are able/want to do additional work ▪ Identify what training/upskilling of staff may be required for students/staff deployed to different roles in higher Tier activation ▪ Assess personnel needs and review contracts for temporary staff as required, consider extensions ▪ Monitor staff well-being ▪ Monitor staff sick leave/carers leave ▪ Volunteers and consumer representatives - engage in low risk roles, onsite arrangements as per visitor directions unless individual has had first vaccination at least 10 days ago and consents to be on site ▪ Visitors – as per CHO Direction ▪ NGO/support services are considered essential services and are to continue during times of visitor restrictions		

	▪ Communication with NGO/support services about changes in restrictions, group programs, vaccination requirements and any other requirements as relevant ▪ Recruitment – BAU – but consideration of any visitor restrictions and possible need to move to virtual interviews		
Meetings	**Education and Training**	**Service Operations**	**Clinical Considerations**
▪ Review essential and non-essential meetings – revise as feasible ▪ Virtual meetings where feasible Continue with usual schedule of priority clinical meetings e.g. Assessment and Risk Management Committee (ARMC) – by virtual means as feasible	▪ BAU - physical distancing ▪ May require discretionary suspension of non-essential training where they impact on clinicians' time to respond to COVID-19 ▪ PPE training for all staff ▪ OVP and BLS essential training ▪ Education around hand hygiene (online to be available) and mask wearing ▪ Service areas to review training that is essential and non-essential in readiness for activation at Tier 2.	▪ Concierge, check in app screening questions for consumers/clients attending clinics, visitors and staff ▪ Volunteers and consumer/carer representatives to cease attending in person – by virtual means as feasible ▪ Communicate with NGO/support services regarding restrictions, changes and impact on service delivery ▪ Consumers/clients to wear masks in clinics/waiting areas where social distancing not possible	▪ BAU with consideration to alternative service delivery options case by case as indicated by screening outcomes ▪ Risk assessment of clinical needs vs COVID-19 precautions/risk factors that will inform e.g. priority need to continue with home/offsite visits ▪ Vaccination of consumers/clients a key priority. ▪ PPE practices for managing aggressive/behaviorally disturbed patients Admissions with respiratory symptoms to be swabbed prior to admission. Consumer

		▪ Identification of options for combining community teams/accommodation as staffing levels reduce in higher Tier activation ▪ Re-activate exploration with private MH facilities regarding partnership opportunities to access additional inpatient services, in collaboration with MNHHS Planning ▪ Reallocate staff to frontline roles as demand dictates	to be isolated (COVID-19 bed) awaiting test results, aerosolising precautions ▪ Identify how MH consumers who refuse to abide by quarantine requirements will be managed on the inpatient wards if they are admitted under the Public Health Act – if not under the Mental Health Act. If refusing medication, it cannot be given, nor can seclusion occur as not under a Treatment Authority ▪ Identification and planning for vulnerable/high risk groups including, but not limited to, consumers/clients who require/may be: – MHA 2016 – Depot medication – Opioid replacement – ECT, including those in RACFs – Homeless/at risk homeless – Forensic settings – Aboriginal and Torres Strait Islander people – Vulnerable groups such as older persons, eating disorders, young people, perinatal ▪ Identify supports for consumers who may be quarantined/hospitalized; ensure staff aware of support services available – Red Cross can support with food etc

			– How we can support medication – Management of pets if taken into hospital ▪ Ensure that alerts and allergies of all consumers/clients are up to date in relevant clinical records for access via The Viewer. ▪ For paper-based records, attach the CIMHA summary to the Alert Form, for RBWH update the ieMR. **ECT** ▪ Screening questions for outpatient ECT – day before and day of ▪ Review requirements for maintenance ECT for individual consumers – can frequency be reduced if required in higher Tier activation ▪ For consumers who reside at nursing homes who receive maintenance ECT, prior to being transferred to the service for treatment, confirmation is to be gained from the nursing home that the consumer can return. ▪ Clinical Directors/Directors ECT liaison with Anaesthetic services re ongoing clinical services as Tier activation increases ▪ Remove all non-essential staff from ECT treatment and recovery room ▪ Consider substitute ECT staff/training needed if ECT impacted in higher Tier activation

			MHRT – will advise if they are attending face to face or virtual **RBWH Pharmacy plan** ▪ Prioritise admissions and discharges on inpatient wards (reduced chart reviews of inpatients, nil MDT round attendance) ▪ Cease comprehensive clinical pharmacy service: for inpatients and outpatients and ambulatory medication review clinic. TDM, blood reviews, metabolic monitoring. ▪ Cease non-patient contact work: e.g. meetings, committee, in- services, service development, educations, consumer forums, QUM projects. ▪ Cease current projects: Clozapine brand substitution and service expansion (6-day service, service to PEC, pharmacists in community mental health teams, MDT round attendance)
Facility – MH inpatient/community residential	**Facility – MH community (includes Consultation Liaison Psychiatry, MHCALL), Consumer & Carer Services, Resource Team**	**Facility – Alcohol and Drug – community (includes AOD Consultation Liaison)**	**Facility – Statewide (QFMHS, QHVSS, MH Clinical Cluster, MH Clinical Collaborative, Insight, Dovetail, Adis)**
▪ BAU with some modifications as required ▪ Visitor restrictions may be introduced/ceased at varying times in line with CHO and/or MNHHS direction. ▪ Risk assessment of leave provisions based on rates of community transmission	▪ BAU with some modifications as required ▪ Screening questions prior to clinic appointments and home/off site visits ▪ Additional public health considerations for boarding houses/hostel accommodation ▪ Services to RACFs as per CHO and/or HHS directions	▪ BAU with some modifications as required ▪ Screening questions prior to clinic appointments ▪ Services provided at multiple facilities are able to function independent of each other	▪ BAU with some modifications as required **Qld Forensic MH Service** ▪ Screening questions prior to consumer appointments/assessments off site e.g. custodial settings

▪ When restrictions are in place, virtual care options to support contact with family/friends ▪ NGO/support workers considered essential health workers and not visitors ▪ When accepting patients with mental health issues who may have symptoms and/or from home/hotel quarantine, the inpatient units of the designated hospitals – ie. RBWH and TPCH – to request rapid testing prior to transfer to the MH unit. ▪ In the absence of rapid testing, or if risk assessment continues to indicate need e.g. non-compliance with masks, agitation - Inpatients who are suspected/quarantine/awaiting test results: • ideally, single room/own bathroom • staff to use aerosolising precautions • staff who are caring for COVID-19 consumers should not look after non-COVID-19 consumers ▪ Identify additional acute inpatient beds that can be opened if acute capacity demands require this (8 beds across MNMH) in higher tier activation ▪ Community residential facilities – consider trigger points for change of model of service e.g. cease step up and/or when these services may close ▪ Based on Tier 1 exploration of designated MH COVID ward, plan for the operationalization of this ward in higher tier activation	▪ Review open consumers/clients who can receive services via telehealth/telephone informed by risk assessment, legislative requirements and vulnerabilities should reduction in face to face contact be required in higher Tier activation ▪ Prepare consumers, carers/family, support services/NGOs of the change in approach during the event period – ensure they and carers are aware of how to contact their service routinely and in an emergency ▪ Where possible/clinically safe, consultant reviews of consumers be brought forward to meet legislative timeframes of 3/12 review ▪ Identify tasks that can be completed in advance e.g. Assessment and Risk Management Committee (ARMC) ▪ Specialist teams e.g. Perinatal, EP to consider capacity for new referrals, prioritisation of services if higher Tier activation **CL Psychiatry** ▪ BAU and alignment with facility restrictions/clinical indicators of increased risk in order to continue with face to face CL ▪ Plan for virtual care options in higher Tier activation **Consumer and Carer Services** ▪ BAU **Resource Team** ▪ BAU	▪ Prepare processes to enable prioritization and possible suspension of accepting OPD referrals (category ▪ 3) when advised. NOTE: suspension of activity not to occur without authorisation from the Chief Executive ▪ Monitor and manage potential increase in support required for patients admitted with COVID-19 who may require support with detoxing from substances. This support to be provided by Alcohol and Drug CL (CL ADS) service to the non-MH wards ▪ Identify staff who could be diverted to other service areas such as AOD CL or other priority ADS services ▪ Liaise with MH Branch re OTP contingency planning **CL AOD** ▪ BAU and alignment with facility restrictions/clinical indicators of increased risk in order to continue with face to face CL ▪ Plan for virtual care options in higher Tier activation ▪ coordinating feedback across the state regarding prisons, watch houses, Courts etc ▪ Review all meetings internal and stakeholder. Identify which meetings can occur via	▪ All 7 South -East Qld Court Liaison Service sites function independently of each other ▪ Plan for minimisation of staff movements, whilst still meeting priority clinical needs as a statewide service ▪ As per CHO and/or MNHHS, statewide travel may need to be revised at this stage or higher Tier activation <u>MH Liaison Services QPS and QAS</u> ▪ Police Staff working in Communications Centre and MHLS-Qld Ambul ance Service operate off-site with nil face to face consumer contact providing direct support to QPS and QAS communications <u>Community Forensic Outreach</u> <u>Service</u> ▪ Bring forward reviews for open cases to ensure that there are adequate management plans for management in higher Tier activation. ▪ Consult with HHSs regarding ongoing planning for ARMCs. ▪ Screening questions prior to client appointments QHVSS <u>IMHIP</u> ▪ Monitor current consumer release dates and pre-plan for potential lock out of corrective services facilities (SQCC, BWCC and WCC)

▪ Ensure testing/trial of Model of service, clinical pathways, escalation pathways in preparation for Tier 2 activation ▪ Plan for possibility that MH COVID ward may be operationalized earlier than Tier 2 ▪ Inter-hospital MNMH transfers (e.g. TPCH MH to RBWH MH) to continue unless risk assessment indicates differently	▪ Consider which positions could be reduced/deployed and which are critical e.g. Forensic Liaison Officers; Identify skills/training of those who could be deployed to inpatient or community services ▪ Plan for minimisation of staff movements. **Indigenous MH Workers** ▪ BAU ▪ Teams to identify consumers who identify as Aboriginal or Torres Strait Islander for additional support from IMHW at higher Tier activation ▪ Plan for virtual care options in higher Tier activation	telehealth/be cancelled in Tier 2 and 3 **Adis** ▪ Liaise with MH Branch regarding additional resources to support increased demand on statewide functions of Adis **Insight/Dovetail** • Minimise face to face delivery, utilise virtual means for delivery of activities, consider which training may need to be ceased in higher Tier activation **Queensland Eating Disorders Service** • Services identified to remain in normal operation - Assessment clinic Mondays - 1 to 1 therapy –done via telehealth with physical health parameters completed by GP where appropriate • Plan for reducing intake and consultation service in higher Tier activation	▪ Continue to work closely with WMHHS Prison MHS for shared consumers <u>Statewide Team</u> ▪ The SW team are the primary contacts for the SW forensic service response to COVID-19. Staff are liaising with stakeholders, coordinating feedback across the state regarding prisons, watch houses, Courts etc ▪ Review all meetings internal and stakeholder. Identify which meetings can occur via telehealth/be cancelled in Tier 2 and 3 **Adis** ▪ Liaise with MH Branch regarding additional resources to support increased demand on statewide functions of Adis **Insight/Dovetail** ▪ Minimise face to face delivery, utilise virtual means for delivery of activities, consider which training may need to be ceased in higher Tier activation **Queensland Eating Disorders Service** ▪ Services identified to remain in normal operation - Assessment clinic Mondays - 1 to 1 therapy –done via telehealth with physical health parameters completed by GP

			where appropriate ▪ Plan for reducing intake and consultation service in higher Tier activation

6.1.3 Tier 2: response: 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.

During Tier 2, only designated COVID-19 facilities will accept patients with COVID-19

Governance and Logistics	Personnel	Fever Clinic	ICU
▪ Participate MNHHS EOC as required – up to 7 days ▪ MNMH IMT active - COVID-19 planning daily – depending on situation, could reduce to 3 times per	▪ Flexible work arrangements as required for teams/work units who cannot maintain physical distancing requirements or who are at higher risk/vulnerable staff	N/A	▪ N/A
		ED/Acute Assessment	**Hospital inpatient response – MH response – Confirmed, Suspected, Quarantine COVID-19**

week ▪ Complete BIA reports for MNHHS EOC as required ▪ Director Governance and Quality Management is Emergency Duty Manger ▪ Consideration re additional staffing resource for dedicated COVID-19 activities e.g. MH COVID-19 Coordinator for Directorate priorities ▪ PPE stock centralised and monitored at each MH facility ▪ Increase PPE meetings as required ▪ Maintain levels of PPE for community including clinics and home and offsite visits ▪ Access to medication supply and pharmacy support monitored at each MH facility ▪ *Mental Health Act 2016* requirements, including temporary changes, as per Chief Psychiatrist directions	▪ Responsible workforce management strategy in place with recruitment, with priority for essential frontline ▪ In line with visitor restrictions, interviews for recruitment to be done via virtual ▪ MNHHS staff, including statewide staff, to reduce movement between catchments/sites/teams as indicated by community transmission rates, HHS EOC directions and/or MH IMT determination ▪ Staff who work between HHS and RACFs and/or HHS and private practice to be asked to consider limiting to one site/service only ▪ Videoconference/ teleconference should be utilised. Risk assessment/need for continuity of care will inform which staff can move in order to support specific consumer/client needs ▪ Student placements as per CHO directions – if permitted, can continue to provide the level of clinical services as indicated for the tier activation ▪ PPE in line with DOH PPE risk matrix	▪ As per Tier 1 ▪ Fill gaps in staffing with suitably skilled staff from across MNMH ▪ Guided by facility and/or ED COVID-19 plans/subplans.	▪ As per Tier 1

Meetings	Training	Service Operations	Clinical Considerations
As per Tier 1 plus: ▪ Virtual meetings only ▪ Suspension of non-essential meetings	As per Tier 1 plus: ▪ Suspension of non-essential training ▪ Orientation for new starters online ▪ OVP and BLS essential training ▪ Cancellation of non-essential training. ▪ Requisite clinical training to continue via virtual means or face to face if standard precautions able to be taken	▪ Concierge, check in app screening questions for consumers/clients attending clinics, visitors and staff ▪ Volunteers and consumer/carer representatives to cease attending in person – by virtual means as feasible ▪ Communicate with NGO/support services regarding restrictions, changes and impact on service delivery ▪ Maintain essential administration services across inpatient services, community teams, MH CALL, Adis ▪ All outpatient patients to wear level 1 surgical masks in waiting rooms ▪ All inpatients to wear level 1 surgical masks when away from immediate bed area ▪ IPRAs – in consultation with NGO partner, consider reducing face to face services, use of telehealth and/or flexible work arrangements to maintain services ▪ Volunteers and consumer/carer representatives continue to be ceased. ▪ Engage with private health facilities re planning for access to additional inpatient services, in collaboration with MNHHS Planning	▪ Separate medical staff between inpatient and community to minimise movement across teams ▪ Prioritisation vulnerable/high risk groups including, but not limited to, consumers/clients who require/may be: – MHA 2016 – Depot medication – Opioid replacement – ECT, including those in RACFs – Homeless/at risk homeless – Forensic settings – Aboriginal and Torres Strait Islander peoples – Vulnerable groups such as older persons, eating disorders, young people, perinatal ▪ Continuous review of this list of consumers/clients for emerging vulnerable/high risk ▪ Medical staff to consider option of providing consumer with 5 repeats prescription to reduce attendance at clinics at clinical discretion **ECT** ▪ As per Tier 1 with continuation of inpatient and outpatient ECT ▪ Identify where possible, to bring forward maintenance ECT to

			prevent requirement to complete during higher level Tier activation ▪ Explore possibility of centralizing ECT at one MH facility - includes transporting of consumers and/or staffing as required if required in Tier 3 **MHRT** – virtual **RBWH Pharmacy** Plan for / activate reduction/reprioritization of services as required to meet demand and possible deployment: ▪ Prioritising short term leave and discharges over admission medication histories. ▪ Nil metabolic monitoring. ▪ Limited chart reviews of in-patient, TDM and blood result reviews for high risk drugs/patients only. ▪ Minimise non-patient contact work. ▪ Pause current projects including clozapine brand substitution and weekend service. ▪ Nil ambulatory medication reviews. ▪ No Valley Clinic

Facility – MH inpatient/community residential	Facility – MH community (includes Consultation Liaison Psychiatry, MHCALL)	Facility – Alcohol and Drug – community (includes AOD Consultation Liaison)	Facility – Statewide (QHFMHS, QHVSS, MH Clinical Cluster, MH Clinical Collaborative, Insight, Dovetail, Adis)
▪ BAU clinical care with some modifications as required ▪ Designated MH Ward stood up ▪ Visitor restrictions likely in place in line with CHO and/or MNHHS direction ▪ Risk assessment of leave provisions based on rates of community transmission – leave likely restricted with some exceptions e.g. discharge planning ▪ When restrictions are in place, virtual care options to support contact with family/friends ▪ NGO/support workers considered essential health workers and not visitors ▪ Group programs – both MNMH and NGO – to be ceased. ▪ Minimise inter-hospital transfers of suspected COVID-19 patients unless higher level care is indicated – requires Operations Director approval ▪ Leave restrictions: no leave other than linked with discharge planning and essential care ▪ CCU/SMHRU/Community residential – restricted leave - linked with treatment plans/recovery goals	▪ As per Tier 1 ▪ Screening questions prior to and day of attendance at outpatient clinics/home visit ▪ Where a consumer/client reports respiratory symptom, the appointment should be postponed if possible and rescheduled as a virtual appointment ▪ The consumer/client is to be encouraged to attend their nearest Fever Clinic to be tested for COVID-19 ▪ Group programs – both MNMH and NGO – to be ceased. ▪ If appointment cannot be avoided, the staff should visit the consumer to prevent to the consumer having further contact with members of the community. Staff should wear the full PPE ▪ Minimise face to face as indicated by the following, but not limited to: • Community rates of transmission • Screening questions • Risk assessment, depot requirements, consumer/client vulnerabilities, legislative requirements • PPE requirements ▪ Increase use of virtual care for	▪ As per Tier 1 ▪ Plan for suspension of new referrals and wait-list which may be required if capacity/demand indicates during Tier 2 or in higher Tier activation ▪ Group programs – both MNMH and NGO – to be ceased. **CL AOD** ▪ Minimise face to face/utilise PPE for face to face as per home ward requirements ▪ Implement identified strategies for virtual care / assessments for CL consumers on the non-mental health wards	**Queensland Forensic MH Service** ▪ Activate minimisation of staff movements, whilst still meeting priority clinical needs as a statewide service <u>QPS and QAS Liaison</u> ▪ BAU for service provision with QAS ▪ Workload decrease at Police Communications Centre in line with roster arrangements ▪ Team meetings and clinical reviews to be conducted via telehealth <u>CFOS</u> ▪ Business as usual with increased use of telehealth options. ▪ For cases that are already open to CFOS who require updated assessments, arrangements for telehealth/teleconference ▪ For new referrals from HHS MHSs to CFOS that meet referral criteria and are assessed as requiring CFOS input – to be done via telehealth/teleconference wherever possible to minimise staff entering hospitals and inpatients units. Where a

▪ **Acute Inpatient** - restrict inter-hospital transfers patients unless higher level care is indicated – requires Operations Director approval ▪ **Caboolture Short Stay Unit** - BAU ▪ Cab SSU may be required to be repurposed to provide accommodation for suspected or confirmed mental health consumers with COVID-19 in higher Tier activation. This will be considered in consultation with MNHHS and Cab Hospital. ▪ Consider opening of additional beds • RBWH – one bed each adult ward • TPCH – one bed on each adult ward • Cab – three adult beds (surge beds) ▪ Hospital Alcohol and Drug Service (HADS) - planned admissions to be booked seven days ahead only ▪ Plan for Tier 3 when new admissions may need to be suspended ▪ Through discussion with RBWH/MNHHS, confirm if/when the beds in HADS will be required for MH or RBWH emerging requirements (20 beds) and/or higher Tier activation **CCUs** ▪ BAU – however, review all new	continuity of usual care in cases where face to face not able to occur ▪ Specialist/small teams e.g. Perinatal, EP to activate strategies for capacity management of for new referrals, prioritisation of services identified in Tier 1 **CL Psychiatry** ▪ Minimise face to face/utilise PPE for face to face as per home ward requirements ▪ Implement identified strategies for virtual care / assessments for CL consumers on the non-mental health wards **Resource Team** ▪ Non-essential staff to be reallocated to community and inpatient services as identified in Tier 1 ▪ Complex Care Coordinators to work across all facilities to assist in supporting patient flow from inpatient services ▪ Activate plan for minimisation of staff movements. Consumer and Carer Services ▪ Director Recovery to plan for impact of reduced staffing, including options for any increase of casual peer workers ▪ Develop a process of referring consumers/carers who would benefit from a wellbeing telephone ▪ call from Consumer and Carer services ▪ Ensure consumer and carer workers have clear escalation process to clinical teams if they have concerns		referral requires face to face assessment (cannot be done via telehealth/teleconference) case by case discussion with treating clinical team and CFOS management ▪ CFOS has weekly multidisciplinary team meetings. This includes a single intake/new referral meeting which all team members attend. New referrals could be instead considered within the smaller Red and Blue team meetings avoiding the need for the single larger referral meeting. Telehealth/teleconference to be used as required. <u>CLS</u> ▪ Prioritisation of watch house presentations and deprioritise medico-legal reports at affected sites. ▪ Prioritise workflow to assessment of category 1 and 2 referrals. ▪ Deprioritise Form 2 and Form 3 reports. ▪ Liaison with stakeholders regarding medico-legal report delays. ▪ All non-urgent meetings cancelled. ▪ Professional activities (i.e. clinical supervision and all education) and any project work suspended. <u>IMHIP</u> ▪ All team members provide consumer updates to clinical lead and Manager. Ensure CIMHA notes with actions are

admissions to the units, including those transitioning ▪ Each CCU to have a supply of frozen/convenience food available for consumers who require support when they are unable to provide for themselves **SMHRUs** ▪ BAU – however, review all new admissions to the units, including those transitioning **Nundah House** ▪ Temporary cessation of 'step up referrals' ▪ Consider requirements if NH to close in higher Tier activation, including options for NGO partner to provide alternative support services **Caboolture Youth SUSD** ▪ Temporary cessation of 'step up referrals' ▪ Consider requirements if SUSD to ▪ close in higher Tier activation, including options for NGO partner to provide alternative support services	following an interaction with a consumer/carer ▪ Identify support/training/supervision needs to support these strategies ▪ Consumer and Carer Services staff to continue to work on ward but not where COVID-19 confirmed consumers ▪ cease face to face forums and/or minimise consumer meetings and/or ensure physical distancing/precautions if face to face. **Indigenous MH Workers** ▪ IMHW to develop a process of supporting consumers/carers via telephone/telehealth ▪ Liaise with community clinical services to identify Aboriginal and Torres Strait consumers within the community who may require support ▪ Provide telephone/video support as required		updated as soon as practicable to manage risk associated with staff leave. ▪ Work with SW-PMHS Program Coordinator regarding access to QCS sites to support ongoing care, including telehealth options should lock-out occur. <u>Statewide Team</u> ▪ Referrals for clinical work accepted based on staffing capacity with OCP referrals prioritized. ▪ Continue to liaise with stakeholders, coordinate communication and support **Qld Eating Disorders Service** As per Tier 1 ▪ Cat 2 and Cat 3 assessments to continue via telehealth. ▪ Cat 1 assessments to be clinically prioritized – and seen face to face as indicated by the following, but not limited to: o Community rates of transmission o Screening questions o Risk assessment, physical health risks, depot requirements, consumer/client vulnerabilities, legislative requirements o PPE requirements ▪ Individual therapy – cease face to face - virtual. Risk assess for physical health checks and determine if face to face required.

			▪ Group programs – both MNMH and NGO face to face – to be ceased. Virtual. ▪ Cease non-essential education/forums education/forums ▪ Place all non-essential management/service development/research/ quality improvement activities on hold **Dovetail/Insight** ▪ Utilise virtual methods for ongoing delivery ▪ Plan for possible cessation of training and education delivery and deployment of clinical staff (allied health and nursing) to clinical services as may be required in higher Tier activation **QHVSS** As per Tier 1 **MH Clinical Collaborative** - activities suspended – staff redeployed as required **MH Clinical Cluster** – continue to support MH executive committee as required

6.1.4 Tier 3, 4 and 5: Significant community transmission

The following assumes at least Tier 2 response and only identifies additional actions by exception.

During Tier 3, 4 and 5, all facilities will accept COVID-19 patients.

<table>
<tr><th>Governance and Logistics</th><th>Personnel</th><th>Fever Clinic</th><th>ICU</th></tr>
<tr>
<td>▪ As per Tier 2</td>
<td>As per Tier 2 plus
▪ Fill gaps in staffing with suitability skilled staff from across MNMH
▪ All non-frontline clinical staff, identified in earlier Tiers, to be re-allocated to relevant clinical services. Staff to receive appropriate orientation and training for the assigned work unit
▪ Flexible work arrangements as required for teams/work units who cannot maintain physical distancing requirements or who are at higher risk/vulnerable staff
▪ MNHHS staff, including statewide staff, to cease movement between catchments/sites/teams.
▪ Staff who work between HHS and RACFs and/or HHS and private practice to be asked to limit to one site/service only.
▪ Videoconference/ teleconference should be utilised. Risk assessment/need for continuity of care will inform which staff can move in order to support specific consumer/client needs
▪ Student placements as per Tier 2 or as per HHS direction</td>
<td>N/A
ED/Acute Assessment
As per Tier 2</td>
<td>▪ N/A
Inpatient COVID-19
As per Tier 2</td>
</tr>
</table>

Meetings	Training	Service Operations	Clinical Considerations
▪ All non-clinical meetings, with the exception of COVI9-19 meetings cancelled ▪ Clinical meetings e.g. MDTR, ward rounds, ARMC to continue to support continuity of care, meet legislative requirements	▪ All training (except OVP and BLS) cancelled	As per Tier 2 plus ▪ Communicate with NGO and other key stakeholders regarding emergency response status and impacts ▪ Communicate with consumers/clients/carer regarding changes to service delivery ▪ IPRAs – as per Tier 2 ▪ Access to private MH facilities as available/required to support demand	**MHRT** - virtual **RBWH Pharmacy** Reduced services: ▪ Supply only service (e.g. if down to 1 pharm and 1 assistant, all phones diverted to MHC satellite pharmacy, no ward visits) supply meds, leaves, discharges, outpatients - not all will receive medication lists) ▪ All phone directed to 1 pharmacist – remote dispensing from level 1. ▪ All wards and outpatients to attend level 1 pharmacy for supplies

Facility – MH inpatient/community residential	Facility – MH community (includes Consultation Liaison Psychiatry, MHCALL)	Facility – Alcohol and Drug – community (includes AOD Consultation Liaison)	Facility – Statewide (QHFMHS, QHVSS, MH Clinical Cluster, MH Clinical Collaborative, Insight, Dovetail, Adis)
Acute inpatient ▪ Activate plans to open additional beds as required ▪ Inter MNMH transfers will be completed on individual basis, non-COVID suspected/confirmed and will depend on staff availability at each site to support the transfers **Caboolture Short Stay Unit** BAU unless decision to re-purpose beds is made by MNMH, Caboolture Hospital and or MNHHS **Hospital Alcohol and Drug Service (HADS)** ▪ HADS to close ▪ Reallocate staff to AOD CL, DABIT and MH services as required ▪ HADS may be opened to support MH consumers or non-mental health (RBWH) requirements as directed – staffing to be allocated as required **SMHRUs** ▪ Cease new referrals Cease transition discharges	▪ Continuation (until otherwise advised) of temporary positions MH COVID-19 Clinical Advisor roles - funded by MNHSS EOC. ▪ Minimise/cease face to face as indicated by the following, but not limited to: – Community rates of transmission – Screening questions – Risk assessment, depot requirements, consumer/client vulnerabilities, legislative requirements – PPE requirements ▪ Increase use of virtual care for continuity of usual care in cases where face to face not able to occur ▪ Prioritise workload from all teams – Depot medication – Forensic consumers – High risk consumers which will be an emerging list – Clozapine consumers – Ensure consumers have access to medication – home delivery drop off only no face to face contact except through barrier (window)	▪ No new referrals to be accepted by ADS ▪ Wait-list enacted for new registrations and contact with clients on waitlist to be managed by Adis 24/7 Alcohol and Drug Support ▪ Home visiting practices to be commenced to provide QOTP services to clients who are quarantined in their own homes. Will require 2 x nursing staff and 1 x security staff from RBWH/TPCH ▪ Re-allocate staff to community services as required <u>Medically assisted services</u> ▪ Needle and Syringe Programs to continue to operate at Redcliffe and Caboolture ▪ RedCab Clinic to be reduced to skeleton staffing and nursing and medical staff to be reallocated to Melaleuca Clinic or Biala sites ▪ Consultation Liaison Services at Redcliffe Hospital, Caboolture Hospital, TPCH and Watch House are to not be physically backfilled if staff are absent – phone consultation will be available via BACS staff or ADCAS ▪ Biala NSP Nurse to be reallocate/utilised by other services at Biala	**Queensland Forensic MH Service** ▪ Cease staff movements, meeting priority clinical needs as a statewide service via telehealth/telephone <u>QPS and QAS Liaison</u> ▪ Continue to maintain all service provision if possible, on limited roster ▪ Liaise with QAS and PCC in relation to responses expected from clinicians and assist in evaluation of 000 calls and redistribution of emergency services if possible ▪ Clinical reviews to be conducted by telehealth <u>CFOS</u> ▪ As per Tier 2. Referrals prioritised based on risk and need assessment. ▪ Utilisation of case conferencing to support HHS's in the absence of capacity to complete assessments <u>CLS</u> ▪ Continued provision of urgent watch house assessments ▪ Staff to be reallocated across zones to cover shortages for urgent watch house assessments. ▪ Consideration given to assessments via telehealth across zones

CCUs

- Cease new referrals
- Cease transition discharges

Nundah House

- NH to close
- QH staff to be redistributed to other services across MNMH
- Liaison with NGOs re options for re-allocation of NGO staff to support continuing care teams
- Consider options to re-purpose facility for consumers post discharge e.g. short-term stay awaiting rehabilitation – need to identify staffing model for this

Caboolture Youth SUSD

- Cab Youth SUSD to close.
- QH staff to be redistributed to other services across MNMH
- Liaison with NGOs re options for re-allocation of NGO staff to support continuing care teams
- Consider options to re-purpose facility for consumers post discharge e.g. short-term stay awaiting rehabilitation

need to identify staffing model for this

Resource Team

- Non-essential staff to be reallocated to community and inpatient services as identified in previous Tiers
- Complex Care Coordinators to work across all facilities to assist in supporting patient flow from inpatient services

Consumer and Carer Services

- Activate community support process identified in Tier 2 - provide telephone/video support as required
- Consumer and Carer Services staff to continue to work on ward but not where COVID-19 confirmed consumers
- Escalate any concerns about consumers who are contacted to clinical staff

Indigenous MH Workers

- Activate community support process identified in Tier 2 - provide telephone/video support as required

Escalate any concerns about consumers who are contacted to clinical staff

Psychosocial Services

- Psychosocial Service to consider offering increased telephone intervention/appointments for clients
- Adis to provide support for clients who are on the wait list for registration with ADS
- Clients accessing treatment provided by satellite clinics at Redcliffe, Caboolture and Melaleuca Clinic to be informed that there may be changes in higher Tier activation requiring move to Biala as primary site for accessing treatment – communication with pharmacies and clients via a letter informing of potential clinic closures and contact details for Biala

- Provision of assessments for Category 1 and 2 referrals only
- Capacity to provide medicolegal reports severely diminished
- Intake meetings to review acceptance of referrals
- Liaison with stakeholders regarding the diminished capacity to provide reports
- All clinical reviews to be conducted over the phone in order to minimise staff travel
- Psychiatrists to provide phone advice and support from central location (Biala) with limited capacity to provide face to face assessment

IMHIP

- Suspend new referrals
- Ongoing service provision in line with capacity regarding staffing and access to QCS sites, including via telehealth options

Statewide Team

- Continue to liaise with stakeholders, coordinate communication and support planning across forensic services state-wide.
- Continue to retain all service provision if possible

Adis

- Consideration be given to increased Adis staffing numbers/increased shifts

			during this period – potential impact of state-wide telephone calls **Dovetail/Insight** As per Tier 2 **QuEDS, QHVSS** As per Tier 2 **Clinical Collaborative MH Team, MH Central Clinical Cluster** As per Tier 2

NOTE – information from this point forward is not Metro North Mental Health specific

6.1.5 Contact tracing

Metro North has public health nurses and environmental health officers authorised as contact tracers. These officers have the associated function of serving the legal notices by the Emergency Officer (General) appointed under the Public Health Act.
In the event of a surge, capacity can be quickly increased by providing training and authorisation and drawing on staff from other areas of Metro North and local government environmental health officers available.

6.1.6 Airport management

Metro North Public Health Unit is responsible for supporting health screening activities at the Brisbane Airport. Border Force will 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 inbound passengers and cabin crew will be screened to determine if they are required to quarantine and directed accordingly.

6.1.7 Quarantine hotel management

Metro North is responsible for the health overlay at a number of designated Quarantine hotels in Brisbane North. Personnel are located at the hotels to provide on-site support and management of any health related queries or issues that may arise for people in quarantine.

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.

"The Queensland ethical framework to guide clinical decision making in the COVID-19 pandemic" can be found at https://www.health.qld.gov.au/__data/assets/pdf_file/0025/955303/covid-19-ethical-framework.pdf. This Framework supports clinical decision making and should be used by Metro North staff to assist during the pandemic.

6.1.8.1 Reception

Patients can present at a number of locations including:

- onsite fever clinics

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

Metro North will have fever clinics located at:

- Royal Brisbane and Women's Hospital
- The Prince Charles Hospital
- Pine Rivers Community Health Centre
- Quarantine Hotels Mobile clinic.

In addition, pop up clinics in additional locations will be established as required.

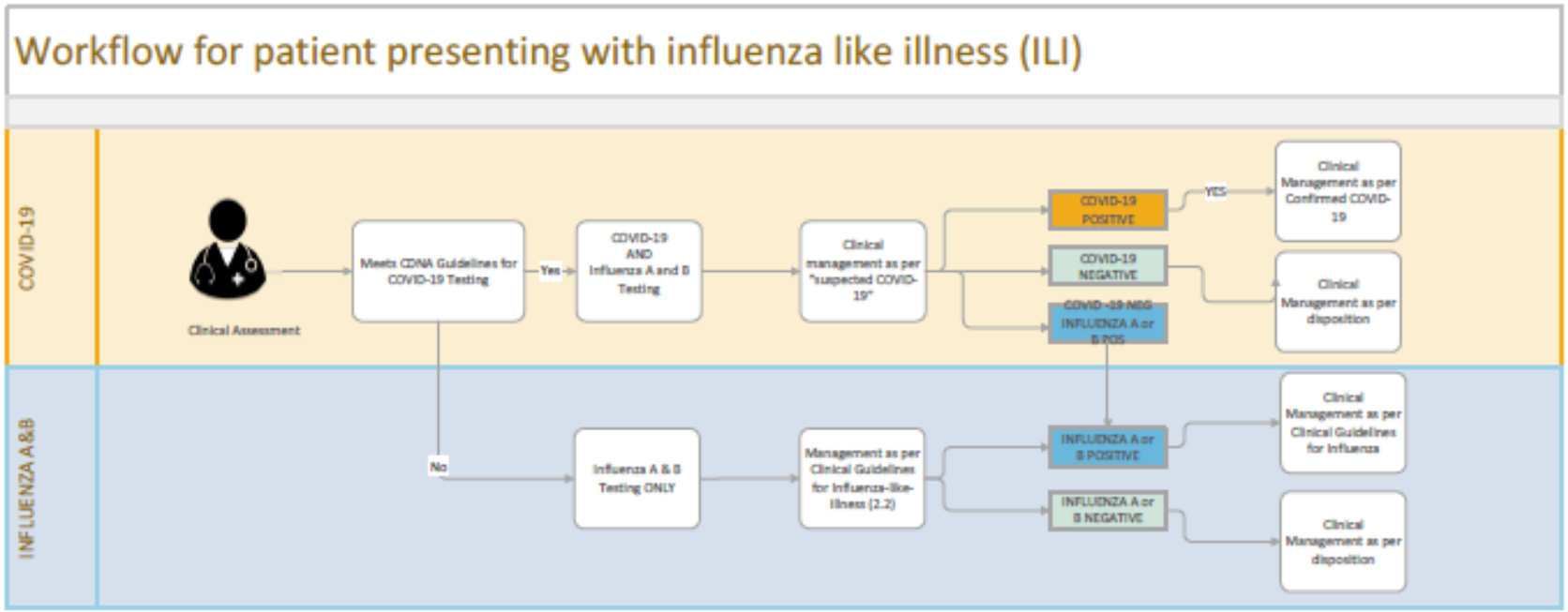
6.1.8.2 Clinical Guidelines

Metro North have enabled enhanced testing within our Hospital and Health Service to test beyond the suspect case definition (Refer to COVID-19 Enhanced Testing Policy for details)

6.1.8.3 Diagnostics for Reception

Patients presenting to the Fever Clinics will be assessed for testing in accordance with the Communicable Diseases Network of Australia (CDNA) guidelines. Those who meet the current criteria will be tested with a single swab passed to the 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 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.
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.



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.

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, for example:

mild to moderate symptoms – admit to low acuity care or virtual ward as per current policy advice

major symptoms, altered vital signs, saturations <92% - admit to cohorted ward or single room

Deteriorating vital signs, incipient respiratory failure – admit to ICU if appropriate

The decision to either admit, or manage via “virtual ward” will be 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.

Virtual Care

The Virtual Ward provides support for patients who are confirmed COVID-19 positive but are well and able to manage at home, in line with policy advice at the time.

The Virtual ED is also designed as an in-reach service for health professionals to have direct real-time consultations with ED clinicians regarding patients under their care. The service is a clinician to clinician consultation only. Target clinicians are:

- GPs
- QAS
- Registered nurses at residential aged care facilities (RACF)
- Clinicians from Residential Aged Care Assessment and Referral service (RADAR)
- Metro North Community Health clinicians.

PPE for staff

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 droplet precautions for routine care of patients
    - 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.

Droplet - Contact and Standard Precautions for *Standard Care* i.e.:

- surgical mask
- long sleeve impermeable gown
- gloves
- protective eyewear / face shield.

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.

Metro North Respiratory Protection Program

Metro North has developed a Respiratory Protection Program (RPP) to establish a hierarchy of risk to exposure to COVID-19 and subsequent guide to prioritise testing in the setting of an outbreak. The objectives of the Respiratory Protection Program are to:

Introduce and maintain a RPP focussed on practical risk reduction for staff in Metro North.
Identify appropriate staff who work in capacities that place them at risk of exposure to aerosol generating procedures (AGPs) or behaviour (AGBs).
Establish a program for education of staff regarding the choice and use of appropriate RPE to be used in conjunction with the existing guidelines for PPE.
Establish a program of fit-testing relevant staff for P2/NP5 masks and PAPR.
Outline the role of Powered Air Purifying Respiratory (PAPR) for the respiratory protection of staff.

Outline appropriate selection, storage and cleaning protocols for PAPR

Establish a program for ongoing regular review and retesting of staff to reduce the need for “just-in-time” testing in the future.

PPE use and escalation will also be determined based on assessment of risk of community transmission of COVID-19. The Pandemic Response Guidance: Personal protective equipment outlines the definitions of risk and recommendations for PPE use in:

- Healthcare settings
- Community health settings and in-home care
- Residential aged care and disability accommodation
- Correctional services.

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

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.

Clearances

Patients must be free of symptoms including fever for 72 hours prior to clearance. There is no requirement for additional testing. Refer to CDNA SoNG for latest updates.

Coronavirus Disease 2019 (COVID-19) CDNA National guidelines for public health units: https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm

6.1.9 Designated COVID-19 Hospital Network

6 The Chief Health Officer introduced the Designated COVID-19 Hospital Network Direction to establish designated COVID-19 hospitals. These hospitals have inpatient capacity. Infrastructure, workforce and services that support a high degree of clinical capability to manage the spectrum of acuity of COVID-19 positive patients. Within Metro North, RBWH and TPCH has been designated as COVID-19 Hospitals.

6.1.10 Low intensity COVID-19 Care

7 The Chief Health Officer's Self Isolation for Diagnosed Cases of COVID-19 Direction requires persons diagnosed with COVID-19 to self-isolate in order to limit the spread of COVID-19. Metro North has implemented two locations for implementation of "low intensity COVID-19 Care" system of management for persons diagnosed with COVID-19 who are otherwise well and do not require admission to an acute hospital bed either for their COVID-19 symptoms or comorbidities. The virtual COVID-19 Care model will provide the assessments, reviews and management of these asymptomatic or mildly symptomatic positive COVID-19 cases within the designated areas at RBWH and TPCH. In the instance of clinical deterioration, the usual escalation pathways for virtual care patients will be followed.

6.1.11 Digital resources

8 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.
- 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

6.1.12 Resource management

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.

6.1.13 Operational support

Environmental cleaning of patient care areas:

Cleaners should observe contact and droplet precautions signage

Environmental cleaning and disinfection of infection control areas will occur in line with current Queensland Health and Metro North Guidelines

Frequently touched surfaces such as doorknobs, bedrails, tabletops, light switches, patient handsets in clinical areas and patient room should be cleaned daily

Frequently touched surfaces such as doorknobs, bedrails, tabletops, light switches, patient handsets in non-clinical areas will be cleaned more frequently

Perform terminal cleaning of all surfaces (as above plus floor, ceiling, walls, blinds) after a patient is discharged

A combined cleaning and disinfection procedure should be used; this is either

- 2-step - detergent clean, followed by disinfectant; or
- 2-in-1 step - using a product that has both cleaning and disinfectant properties.

Any hospital-grade, TGA-listed disinfectant that is commonly used against norovirus is suitable, if used according to manufacturer’s instructions.

6.2 COVID-19 Vaccination

All Metro North Staff must have received their first vaccination by 31 September 2021 and their second vaccination by 30 October 2021. Exemptions will be initially considered at a facility level before escalating to a Metro North committee for a decision.

Metro North has a number of COVID-19 vaccination hubs to support the vaccination rollout as per below.

Clinic	Clinic type	First appointment	Last appointment	Location
Caboolture Square Community Vaccination Clinic	Ages 12 and up Ages 12 and up First Nations clinic	Mon - Fri: 0800 Saturday: 0800 Saturday: 1200	Mon - Fri: 1700 Saturday: 1530 Saturday 16:00	Caboolture Square Shopping Centre, 60-78 King Street, Caboolture QLD
Community Vaccination Clinic - Boondall Vaccination Clinic	Ages 12 and up	Mon - Sun: 0830	Mon - Sun: 1830	Brisbane Entertainment Centre, 1 Melaleuca Drive, Boondall QLD
Community Vaccination Clinic – Doomben Racecourse	Ages 12 and up	Mon - Sun: 0800 **Closed:** 10-11 Sep 2021	Mon - Sun: 1550 **Closed:** 10-11 Sep 2021	Doomben Racecourse, 75 Hampden St, Ascot QLD
Community Vaccination Clinic – Kippa Ring	Ages 12 and up	Mon - Sun: 0800	Mon - Sun: 1550	425-427 Elizabeth Avenue, Kippa Ring QLD (Former Village Wholesale Centre)
Royal Brisbane and Women's Hospital	Ages 12 and up	Mon - Fri: 0800 Sat: 0800	Mon - Fri: 1650 Sat: 1650	Ground Floor, Royal Brisbane and Women's Hospital Butterfield Street, Herston QLD

6.3 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.

6.3.1.1 Staff management

A range of strategies to ensure adequate workforce are available during the control phase of pandemic will be implemented in line with the tiered response 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.

6.3.1.2 Managing ill workers

Ill or quarantined workforce will be managed in line with the Queensland Health Human Resources Guidelines available on the intranet.

Leave and returning to work

Different leave types, either paid or unpaid, may be granted to employees directly affected by this event. Refer to the MNHHS COVID-19 Virus Pandemic Factsheet for information regarding specific leave options.

Quarantine

All 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.

6.3.1.3 Staff wellbeing strategy

The Metro North Wellbeing Strategy – COVID-19 covers the emotional, financial, physical and social domains of wellbeing.

Metro North's values of compassion, integrity, respect, teamwork and high performance form the foundation of decisions and actions relating to the wellbeing strategy during COVID-19. The Chief Wellbeing Officer is accountable for the strategy.

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 included below:

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.

6.3.1.4 Industrial relations

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

6.3.1.5 Reallocation

Metro North may be required to reallocate staff in response to the COVID-19 activities. These reasons could include (but are not limited to) are:

vulnerable staff that are unable to be reallocated within their own teams

service changes including reduction or closure of services

reduction in workload due to business focus changes.

A range of resources are published on the Metro North extranet page, that support the process of staff reallocation ensuring a streamlined approach.

6.3.1.6 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.

6.3.1.7 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.

6.4 Aboriginal and Torres Strait Islander people

All Aboriginal and/or Torres Strait Islander peoples are considered part of a vulnerable group when considering ILI and COVID-19. Practitioners should assess all Aboriginal and/or Torres Strait Islander peoples presenting with ILI for chronic diseases and other risk factors.

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 HHS's to address the COVID-19 needs of Aboriginal and Torres Strait Islander Queenslanders are available online at https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/information-for/first-nations.

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 on the Extranet Metro North Hospital and Health Service webpage and also the Australian Government Aboriginal and Torres Strait Islander Advisory Group on COVID-19 communiques.

6.5 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.

6.5.1 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.

6.5.2 People with disabilities

Resources for people with disabilities are available at https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/information-for/people-with-disability-and-carers. In addition the NDIS and other organisations have also developed resources available on their websites.

6.5.3 Residential aged care residents

9 Residential aged care facilities (RACFs) increased advanced care planning and pandemic planning with virtual services to increase support to RACFs and reduce physical outreach have been established. The COVID-19 Outbreak Management: Preparing and responding – Guidance for Residential Aged Care Facilities in Queensland and the *Preparing and Responding – COVID-19 in Residential Aged Care Facilities* has been developed to provide information on how to manage an outbreak in an RACF, including staffing considerations, communication, cleaning and medication management.

6.6 Financial management

Cost identification and capture processes are to be included in incident response cost centres in Directorates (one for screening and indirect costs and one for direct costs of patient care).

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. Adjustments are made to monthly performance reports to identify incident related costs.

COVID-19 is expected to have a negative impact on total Weighted Activity Units (WAUs) for Metro North. Baseline performance metrics have been collated for key metrics and the impact of these have been modelled in line with escalation of activity in line with the response plan.

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.

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.

Activity capture

COVID -19 Data Definitions For purpose of reporting and operational response.[4]

Metric	Definition
Confirmed case (Communicable Diseases Network Austraila, 2020)	any person with a positive laboratory test for COVID-19
Probable (Communicable Diseases Network Austraila, 2020)	without positive laboratory test but which is treated like a confirmed case based on exposure history and clinical symptoms
Suspected (Communicable Diseases Network Austraila, 2020)	without positive laboratory test but which is treated like a confirmed case based on clinical symptoms and epidemiological criteria
Active Case (Communicable Diseases Network Austraila, 2020)	Confirmed case, that has not recovered or died. Active does not mean that these cases are infectious
Cleared -Admitted Virtual Ward	Confirmed Case that are at least 10 days since onset and have not exhibited symptoms for 72 hrs, and have been cleared by the health professional responsible for their monitoring
Cleared - Admitted -Acute Bed (incl ICU)	Confirmed Case that are at least 10 days since onset and have not exhibited symptoms for 72hrs, with 2 negative test result a minimum of 7 days after onset of symptoms
Total Recovered (Queensland Health, 2020)	"Recovered cases are cases reported as recovered by the responsible Public Health Unit plus cases that have a notification date of 30 days or more"

[4] Queensland Government COVID-19 statistics; Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units (13/05/2020)

Metric	Definition
COVID -19 death (Communicable Diseases Network Austraila, 2020)	death resulting from a clinically compatible illness, in a probable or confirmed COVID-19 case, unless there is a clear alternative to cause of death that cannot be related to COVID-19 (e.g. trauma)
Significant cluster	there are ten or more cases connected through transmission and who are not all part of the same household - includes both confirmed and probable cases.
Enhanced Testing (Communicable Diseases Network Austraila, 2020)	testing beyond suspect case definition

Inpatient activity

To be sourced via Digital Metro North (DMN) data set– based on matching pathology results with inpatient data.

Retrospective capture of information / patients to be achieved through coded patient information and application of specific COVID-19 ICD code.

ED activity

To be sourced via DMN data set based on reporting flags within EDIS. Existing dashboards and reporting frameworks to be updated to incorporate.

Outpatient activity

Initial screening activity to be sourced via EOC and information collated by HFDI for reporting.

- COVID-19 Tier 2 clinic code has been issued and business rules issued to support its use.
- DNA - Likely to utilise specific reason codes for DNAs across all sites.
- DoH advice / guidelines received and provided to Directorates.
- Fever clinics - Likely to be scheduled / registered using local tool (eg. ESM, HBCIS, HCare or EDIS).

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

10

6.7 Private Hospitals

On 1 April 2020 an agreement was reached between the Commonwealth and private hospitals to support delivery of health services during the pandemic. Queensland Department of Health has subsequently signed an Agreement with private providers setting out all contractual arrangements. Metro North has a framework and operational guidelines to support our interaction with the private facilities in the HHS to explore what services, equipment and resources they could assist with.

6.8 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 the COVID-19 response plan.

1.1 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 an 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.

1.2 Influenza Vaccination program

1.2.1.1 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.

1.2.1.2 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.

1.2.1.3 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.

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.

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.

The *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* outlines activities associated with this phase including:

support and maintain quality care

cease activities that are no longer needed, and transition activities to normal business or interim arrangements

monitor for a subsequent wave of the outbreak

monitor for the development of resistance to any pharmaceutical measures

communicate to support the return from emergency response to normal business services

evaluate systems and responses and revise plans and procedures.

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: Metro North-wide COVID-19 Committee list

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Meeting	Contact
MN Response – Strategic Planning Group	EDHSSPU
MN COVID-19 IMT	MN EOC
MN EOC Logistics Team Meeting	CFCO
MN PPE Usage update (last 24 hours)	CFCO
MN PPE Clinical Advisory group meeting	CE
MN Digital COVID-19 Response Group (DCRG)	CDHO
MN ELP Alumni - COVID meeting	CE
MN Vaccination Taskforce	MN EOC

Appendix 2: 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 Tier 4 212 + private providers 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

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Metro North Health COVID Ward Surge Plan- 3 August 2021				
Hospital / Facility	***Current COVID rooms***	***Tier 1***	***Tier 2***	***Room Configuration***
RBWH				16 single only rooms can accommodate a maximum of 16 persons.
RBWH Watt	8 Negative pressure	8	8	
RBWH Watt	8 S Class	8	8	
RBWH Low Acuity care Ward	12(6AS)	12(6AS)+14(6AN)	26	6AS 12 rooms can accommodate a maximum of 26 persons. In the process of moving to resp acute ward. 6AN 14 rooms can accommodate a maximum of 14 persons. 3 weeks for infrastructure work
RBWH unwell wards		14	14+14	14 Rooms with 28 people
RBWH ICU	4	4+32	36	4 negative pressure and 32 general ICU beds with ventilators.
RBWH Total	32	92	106	
TPCH				
TPCH – 1E		14	14	14 Rooms
TPCH Low Acuity Care Ward	14	14	14	14 rooms which can accommodate up to 22 people.
TPCH unwell wards		14 (1F)	14(1F) +14(1G)	14 Rooms with 28 people
TPCH- ICU	2	2+7	9+18	9 negative pressure and 18 general ICU beds with ventilators.
TPCH Total	16	51	83	
Metro North Health Total				
Total ICU Capacity	6	45	63	
Overall Total	48	143	189	

Appendix 3: Fever Clinic capacity

	Fever Clinics *Minimum number of people that can be seen per day*	Fever Clinics *Maximum number of people that can be seen per day*
Metro North HHS	**925**	**2,070**
RBWH	200	600
TPCH	200	400
Redcliffe	100	300

	Fever Clinics *Minimum number of people that can be seen per day*	Fever Clinics *Maximum number of people that can be seen per day*
Caboolture	Nil	100
Kilcoy	15	25
COH	410*	645**

Notes:* includes Hotel Quarantine Day 10 Testing Program which equates to 160 persons per day
*****includes Hotel Quarantine Day 10 Testing Program which equates to 300 persons per day.***

Appendix 4: Definition of essential meeting

An essential meeting or workshop:

1. directly relates to essential functions of Metro North HHS (as outlined in business continuity plans)
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 5: 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[3] Protective eyewear[3] (within 1.5m)	Surgical mask[3] Protective eyewear[3] Gown or apron[4]	Surgical mask[3] Protective eyewear[3] (within 1.5m)	Surgical mask[3] Protective eyewear[3] 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[3] Protective eyewear[3] Gown Gloves		P2/N95 respirator Protective eyewear[3] Gown Gloves		P2/N95 respirator Protective eyewear[3] Gown Gloves	
	Confirmed COVID-19 OR Suspected COVID-19 (clinical evidence WITH epidemiological evidence[2] of COVID-19) OR Those subject to quarantine or other public health requirements	P2/N95 respirator Protective eyewear[3] Gown Gloves		P2/N95 respirator Protective eyewear[3] Gown Gloves		P2/N95 respirator Protective eyewear[3] Gown 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 As advised by Queensland Health	Moderate risk As advised by Queensland Health, or Restricted Correctional Centre[2] - Stage 2 or 3	High risk As advised by Queensland Health, or Restricted Correctional Centre[2] - Stage 4
STAFF[1]	No clinical evidence of COVID-19 AND no epidemiological evidence[6]	nil additional	Surgical mask[3] Protective eyewear	Surgical mask[3] Protective eyewear
	Clinical evidence of COVID-19 WITHOUT epidemiological evidence[6] of COVID-19	Surgical mask[3] Protective eyewear Gown Gloves	P2/N95 respirator[4] Protective eyewear Gown Gloves	P2/N95 respirator[4] Protective eyewear Gown Gloves
	Staff doing activities other than direct client care	Not appliable	Surgical mask	Surgical mask
	Confirmed COVID-19 cases OR Suspected COVID-19 (clinical evidence WITH epidemiological evidence[6] of COVID-19) OR Those subject to quarantine or other public health requirements	P2/N95 respirator[4] Protective eyewear Gown Gloves	P2/N95 respirator[4] Protective eyewear Gown Gloves	P2/N95 respirator[4] Protective eyewear Gown 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 Surgical mask	Personal and professional visitors (excluding health staff) are likely to be prohibited 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 → Client category ↓	Low risk	Moderate Risk As advised by Queensland Health, and Restricted Hospital[4]	High Risk As advised by Queensland Health
STAFF[1]	NO clinical or epidemiological evidence[2] of COVID-19	Standard precautions	Surgical mask[3] Protective eyewear	Surgical mask[3] Protective eyewear
	Clinical evidence of COVID-19 WITHOUT epidemiological evidence[2] of COVID-19	Surgical mask[3] Protective eyewear Gown Gloves	P2/N95 respirator Protective eyewear Gown Gloves	P2/N95 respirator Protective eyewear Gown Gloves
	Confirmed COVID-19 OR Suspected COVID-19 (clinical evidence WITH epidemiological evidence[2] of COVID-19) OR Those subject to quarantine or other public health requirements	P2/N95 respirator[6] Protective eyewear Gown Gloves	P2/N95 respirator[6] Protective eyewear Gown Gloves	P2/N95 respirator[6] Protective eyewear Gown 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 where tolerated, unless inpatient in own bed	Surgical mask where tolerated, unless inpatient in own bed	Surgical mask where tolerated, unless inpatient in own bed
PPE for patient use - non-COVID-19 (excluding children under 12)		Nil	Surgical mask where tolerated, unless inpatient in own bed	Surgical mask where tolerated, unless inpatient in own bed
PPE for visitors		Nil	Surgical mask OR Own mask if adequate[3]	Surgical mask OR 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 6: MH Directorate - isolation rooms

Mental Health: Total = 21

Ward/Area	Specialty	Room No	Room Type	Total
Caboolture Ward 2	Mental Health	25, 26, 27, 28 single rooms two additional rooms being converted from a common area		4
RBWH G Floor		5, 6, 7, Single rooms – but shared ensuite 9, 10, 11, 12 Four bedded		7
Mental Health West Wing		1 – 8 single 9a and 9b double room		10