COVID-19 (CORONAVIRUS)

The Prince Charles Hospital

(TPCH) COVID-19 Response Plan – Control phase

Edition 11th October 2021

Metro North Hospital and Health Service

Queensland Government

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Abbreviations

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

1 Introduction

1.1 Situation

In December 2019, China reported cases of viral pneumonia caused by a previously unknown pathogen that emerged in Wuhan, China. The pathogen was identified as a novel (new) coronavirus (recently named *severe acute respiratory syndrome coronavirus 2* (SARS-CoV-2)), which is closely related genetically to the virus that caused the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS). SAR-CoV-2 causes the illness now known as Coronavirus disease (COVID-19). Currently, there is no specific treatment, vaccine or antiviral against this 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 COVID-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. 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.

[1] 25 February 2020

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.
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 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.

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

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

3.1 Infrastructure

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

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

*bed alternatives excluded

RBWH and TPCH are designated COVID-19 facilities, under the CHO directions.

Single rooms accommodation for TPCH that have the potential to be used for patients with ILI as part of the pandemic response plan.

Classifications: Type 4
Single rooms with an ensuite shower and toilet that is not shared. Suitable for patients with infections transmissible by means other than the airborne route and are designed to minimise the potential for such infections to be transmitted to other patients and staff.

Type 5 (Negative Pressure)

Single rooms with an ensuite that is not shared and preferably with an anteroom. Suitable for patients requiring respiratory precautions, e.g. pulmonary tuberculosis, varicella zoster virus (chickenpox), disseminated herpes zoster (shingles), and measles, SARS and Pandemic / Avian Influenza.

Positive Pressure Isolation Rooms TPCH Total = 141 (**119 type 4** and **42 Type 5**)

Program	**Area**	**Room Type**	**Total**
Hospital Wide	Adult Emergency Department	Acute Isolation Room Type 5 Resuscitation Bay 5 Type 5 SSU Type 4 OPD-Yellow Type 5 single rooms (no-ensuite)	1 1 2 7
	Children's Emergency	Isolation Type 5	1
	Children's Ward	Isolation Type 5 Isolation Type 4	2 10
Internal Medicine	Ward 1E Ward 1F Ward 1G Ward RAS Ward RED	Isolation Type 5 (designated COVID Room 5 unavailable to be used as anteroom) Isolation Type 4 Isolation Type 4 Isolation Type 4 Isolation Type 4	11 10 10 6 8
Surgery & Critical Care	<u>Surgery</u> Ward 2A Ward 2B Ward 2C Ward 2D <u>Intensive Care</u> POD 1-3	 Isolation Type 4 Isolation Type 4 Isolation Type 4 Isolation Type 4 Isolation Type 5	 6 6 6 5 6

Heart and Lung	<u>Cardiology</u> Ward 1A Ward 1B Coronary Care <u>Thoracic</u> Ward 1C Ward 1D LACC/ACFC (no anteroom) <u>Cardiac Surgery</u> Ward 2E	 Isolation Type 4 Isolation Type 4 Isolation Type 4 Isolation Type 4 Isolation Type 4 Isolation Type 4 (Enhanced/Separate air conditioning) Isolation Type 4	 6 6 2 6 9 14 7
Internal Medicine (subacute)	CAM Palliative Care	Single rooms but geographically distanced from acute campus with minimal acute services (oxygen and suction outlets)	
		Type 4 Type 5 **Total**	119 30 **149**

4 Community and Stakeholder engagement

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

5 Roles and responsibilities

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.

- Health Alliance
- Primary Health Network
- GPs

- Aged Care
- Public Health
- Australian Defence Force (Enoggera)
- Queensland Ambulance Service
- Private Hospitals
- Non-government / NGO homes services
- Critical infrastructure and suppliers e.g. Airport
- State Health Emergency Coordination Centre (SHECC)
- Department of Health (DoH)

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 TPCH Response

TPCH 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 6.1.6.7.

6.1.1 Tier 0: Prevent local transmission

<table>
<tr><th>Governance</th><th>Personnel</th><th>Fever Clinic</th><th>ICU</th></tr>
<tr>
<td>▪ IMT active
▪ EOC – stood up
▪ Report PPE daily, weekly PPE stocktake
▪ Medication stocktake at each site weekly
▪ MN Response – Strategic Planning Group
▪ SHECC twice weekly reporting</td>
<td>Staff
▪ wipe down personal iPad/phones; wipe down hard surfaces
▪ establish weekly communication with staff – vidcasts, emails, as appropriates
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
Consumer representation
▪ complete Consumer COVID checklist, risk assess roles</td>
<td>External to ED, community-based – adjust capacity based on demand (8 cubicles)
ED
▪ Identify locations in ED for patients with ILI symptoms.
▪ ED reconfigured – SSU to be designated Red Zone (10 beds and 2 chairs)
▪ Current Green Zone repurposed to SSU (10 beds and 2 chairs)
▪ OPALS – repurposed to TIN (3 beds and chairs)
▪ Amber 1-17 beds available for BAU workload
▪ Blue Zone – decommissioned to be repurposed to RED waiting zone
▪ CED – 12 single treatment spaces (11 type 4 and 1 type 5) – emphasis on PPE</td>
<td>▪ Maintain as is
COVID-19 positive patients
▪ Single rooms, isolate suspected/confirmed COVID-19 patients or those in quarantine
▪ LACC 14 type 4 rooms (14-27 acuity dependent)
▪ Virtual Ward – as required
▪ Staff surveillance program
▪ Minimise movement of inpatients with confirmed or suspected COVID-19 within wards or across the hospital, use portable x-rays and ultrasounds where able.
▪ All blood collection and ancillary services managed within the ward
▪ Low intensity COVID-19 ward</td>
</tr>
<tr><th>Meetings</th><th>Training</th><th>Service Operations</th><th>Facility</th></tr>
<tr>
<td>▪ Adhere to social distancing
▪ Virtual meetings where able
Activate Metro North meetings –
▪ MN COVID-19 IMT – twice weekly</td>
<td>▪ No restrictions – social distancing to be observed
▪ PPE training for all staff
▪ Assess PAPR protocols, cleaning and training</td>
<td>▪ Implement hypervigilant screening/ testing
▪ All non-urgent review appointments to be done virtually.</td>
<td>▪ Signage at entrances alerting patients, visitors and staff not to enter a health service if unwell</td>
</tr>
</table>

▪ MN Response – Strategic Planning Group – twice weekly ▪ MN EOC Logistics Team ▪ MN PPE Usage update ▪ MN PPE Clinical advisory group – determine frequency as appropriate		▪ Consider patients wearing masks for OPD clinics where social distancing is not possible ▪ Increase procedural and outpatient clinic activity to address any demand issues – maximise category 1 and 2, focus on category 3 waiting longer than 240 days and current long waits. ▪ Utilise flexible theatre templates ▪ Outsource activity where appropriate	▪ Entrances/Exits – separate staff entrances, sanitising stations at all entrances ▪ Fast track all patients with screening questionnaire for risk stratification to ED Triage or Fever Clinic ▪ Security – maintain ▪ Cleaning - frequent touch point cleaning ▪ Pharmacy – maintain 6-month supply of pharmacy stocks (based on usual supply)
Meetings	**Training**	**Service Operations**	**Facility**
		▪ Outpatients supplied with one month of medication. ▪ Outreach services to continue	▪ Consider allocation of CT scanner for suspected or confirmed COVID-19 patients ▪ Food, linen and waste services – use PPE in accordance with Queensland Health and Metro North guidance

6.1.2 Tier 1: Limited community transmission

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

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

Governance	Personnel	Fever Clinic	ICU
▪ PPE stocktake - if stocktake variance exceeds 5% (of prior day's closing balance) for three consecutive weeks, change to daily stocktake	Staff ▪ All staff must be vaccinated ▪ PPE wearing as per PPE risk level ▪ All staff to be fit tested for at least 2 masks ▪ minimise staff movement across wards and facilities ▪ develop staff teams and minimise contact between teams	▪ Increase and/or reallocate staff	▪ Children requiring ICU treatment will be transferred via QAS to QCH ▪ Investigate locations to provide high flow oxygen outside of ICU footprint ▪ LACC 14 beds airflow assessment and improvements to increase patient acuity and capacity

	▪ consider roles that can work remotely ▪ discourage congregation in tearooms and other shared spaces ▪ enact staff management plans ▪ activate COVID-19 HR hotline – hours as demand indicates ▪ daily communication with all staff Volunteers and consumers - engage in low risk roles, onsite arrangements as per visitor directions unless individual has had first vaccination at least 10 days ago and consent to be on site Visitors – as per CHO Direction Students – as per CHO Direction	**ED** ▪ Relocate ED patient cohorts to alternate location outside ED as required e.g. fast track to OPD, to allow space for influenza like illness patients to be separated ▪ Establish an assessment zone external to the ED for o Pre-screening assessment and consideration for patient placement o Assessment and treatment area for known COVID coming from virtual/alternative care requiring hospitalisation (anticipated 8 spaces) ▪ CED fast track to OPD -Yellow, consider adult and children combined in this zone ▪ Increase and/or reallocate staff ▪ Utilise Virtual ED	**COVID-19 positive person** ▪ Assess need for Designated COVID-19 wards ▪ As per COVID patient flow appendix ▪ GP pathway for COVID-19 positive patients implemented as appropriate ▪ Virtual Ward capacity increased ▪ Low intensity COVID-19 ward Staff surveillance program ▪ Increase and/or reallocate staff ▪ Minimise inter-hospital transfers of suspected or confirmed COVID-19 patients unless higher level care is indicated ▪
Meetings	**Training**	**Service Operations**	**Facility Protection**
▪ Discretionary suspension of non-essential meetings where they impact on clinicians' time to respond to COVID-19 ▪ Activate Directorate IMT and related meetings – determine frequency as appropriate Increase frequency of	▪ Discretionary suspension of non-essential training where they impact on clinicians' time to respond to COVID-19 ▪ Adhere to social distancing ▪ Essential training to be delivered virtually where able ▪ Continue PPE training	▪ Patients to wear level 1 surgical masks for OPD clinics ▪ Maintain activity and critical referrals in from other HHSs ▪ Increase virtual care ▪ Increase HITH capacity including virtual capability	▪ Security – review model, measure need for enhanced traffic management, evaluate need for security present at building entrances ▪ Reduce hospital access points ▪ Concierge at key entrances

▪ MN IMT – based on need ▪ MN Response – Strategic Planning – based on need	▪ Continue PAPR training ▪ Continue OVP training ▪ Continue infection control training ▪ Commence ICU upskilling ▪ Commence identification of nursing staff to assist in specialist units such as ICU and CIU	▪ Increase use virtual models for outreach services where able ▪ Stand-up CART – COVID response to emergency intubation. ▪ Identify locations outside of the outpatient clinic to provide virtual clinics ▪ Outbreak management – reallocation of staff to other sites. ▪ Reallocate staff to frontline roles as demand dictates ▪ Prepare processes to enable suspension of Category 3 and 6 surgery, medical and non-emergency dental procedural activity when advised. **NOTE**: suspension of activity not to occur without authorisation from the Chief Executive. ▪ Prepare processes to enable suspension of accepting Category 3 OPD referrals when advised. **NOTE**: suspension of activity not to occur without authorisation from the Chief Executive. ▪ Specialty services (such as renal dialysis and NICU/SCN to document alternate models of care in case of workforce shortages)	

6.1.3 Tier 2: Moderate community transmission

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

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

Governance	Personnel	Fever Clinic	ICU
As per Tier 1 plus:	As per Tier 1 plus: Staff	As per Tier 1	As per Tier 1 plus:

▪ IMT daily ▪ Report PPE daily, twice weekly PPE stocktake – if stocktake variance exceeds 5% (of prior day's closing balance) for three consecutive weeks, change to daily stocktake ▪ SHECC daily reporting ▪ Communicate to external stakeholder ▪ Enact contract with private hospitals as required (when required)	▪ develop staff teams and minimise contact between teams ▪ consider reallocation of workload for vulnerable staff ▪ all staff PPE wearing as per PPE Risk matrix No volunteers engaged onsite No consumer representatives engaged on site Visitors – as per CHO Direction No students onsite		▪ Expand ICU footprint and into adjacent alternative areas as required ▪ As per COVID patient flow, ICU increased to 27 beds with separation between the units based on airflow assessment
		ED	**COVID-19 positive person**
		As per Tier 1 plus: ▪ Expansion of ED spaces to other locations as required e.g. into SSU and relocate SSU to accommodate all patients maintaining separation of patients ▪ Assessment and treatment area for known COVID coming from virtual/alternative care requiring hospitalisation (increased by 8 spaces) ▪ SSU to be relocated to RAMS to increased ED treatment spaces, therefore, internal Red Zone increased from 12 to 24 treatment spaces ▪ Mental health enables identified process for fast tracking consumers through ED ▪ Virtual ED – increase capacity as demand requires	As per Tier 1 plus: ▪ Virtual Ward – increase capacity ▪ Low intensity COVID-19 ward reconfigured to higher acuity ▪ Designated COVID-19 wards for unwell patients Ward 1E and Ward 1G ▪ Staff surveillance program ▪ HITH – increase in capability including virtual capability ▪ COVID-19 positive children unwell and deteriorating children will require transfer to QCH as per CHO Designated COVID Hospital Direction
Meetings	**Training**	**Service Operations**	**Facility Protection**
As per Tier 1 plus: ▪ Virtual meetings only ▪ Suspension of non-essential meetings (see Appendix 4)	As per Tier 1 plus: ▪ Suspension of non-essential training ▪ Orientation for new starters online	Outpatients ▪ All virtual appointments ▪ Urgent face-to-face appointments only where virtual not clinically appropriate ▪ All OPD patients must wear masks in waiting rooms ▪ Outsource activity as able	As per Tier 1 plus: ▪ Concierge and signage at entrances, alerting patients, visitors and staff not to enter a health service if unwell ▪ Known COVID positive to be assessed for admission outside of ED ▪ 24-Hr Concierge at ED Triage to screen arrivals for COVID-19 symptoms

		▪ Repurpose OPD areas as appropriate Surgery/procedures ▪ Only urgent elective surgery and procedures ▪ Repurpose surgical wards to medical wards as demand dictates ▪ Increased scope of services to private sector Dental ▪ Inpatients wear level 1 surgical masks ▪ Maintain activity and critical referrals in from other HHSs.	▪ Fast track all patients with COVID-19 symptoms to ED Triage or Fever Clinic ▪ Cleaning – frequent touch point cleaning teams enhanced ▪ QR posters available at all access points ▪ Identify locations for static fit testing stations TPCH Education Centre ▪ Increase PPE stockholding to 40 days at medium risk

6.1.4 Tier 3, 4 and 5: Significant community transmission

The following assumes at least Tier 2 response and only identifies additional actions by exception.
During Tier 3, 4 and 5, all facilities will accept COVID-19 patients.

	Governance	Personnel	Facility Protection	Fever Clinic	ICU	Service Operations	Meetings	Training
Tier 3	As per Tier 2	As per Tier 2	▪ Installation of IR heat cameras at ED triage to ensure arrival temperatures <37.5 ▪ Cleaning –engage contract cleaning service to meet demand. Initiate HHS-wide cleaning rapid response team	As per Tier 2 ED	▪ Expand into Stage 2 PACU and OT ▪ Utilise private hospital ICUs for COVID-19 patients COVID-19 positive person	▪ Utilise campus wide clinical area (partner organisations) ▪ Convert non-clinical areas to clinical ▪ Implement alternate	As per Tier 2	No face to face training, essential training delivered virtually

			▪ Security – engage additional security and traffic control providers to meet demand	As per Tier 2 plus ▪ Divert patients to private sector	As per Tier 2 plus ▪ Multiple designated wards or floors or designated COVID-19 hospital where airflow is separate to the remainder of the facility	models of care based on staffing availability		
	Governance	Personnel	Facility Protection	Fever Clinic	ICU	Service Operations	Meetings	Training
Tier 4	Consider Metro North and Metro South HHS combined EOC	Consider recruitment of non-clinical staff to assist with clinical load where appropriate	As per Tier 3	As per Tier 3 ED As per Tier 3	Increase virtual ED capacity to enable calls from the public COVID-19 positive person ▪ Utilise overcensus bed areas ▪ Utilise private hospitals designated wards for COVID-19 patients	▪ Emergency activity only ▪ Utilise private hospitals for emergency medical and surgical activity ▪ Utilise other facilities such as residential and other health care facilities for patient still requiring medical care	Frequency of meetings reviewed	As per Tier 3
	Governance	Personnel	Facility Protection	Fever Clinic	ICU	Service Operations	Meetings	Training
Tier 5	As per Tier 4	Activate workforce for temporary facilities	As per Tier 4	As per Tier 4 ED As per Tier 4	As per Tier 4 COVID-19 positive person Establish field hospital with designated COVID-19 areas	Increase HITH capacity	Frequency of meetings reviewed	As per Tier 4

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 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.

6.1.6.1 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.

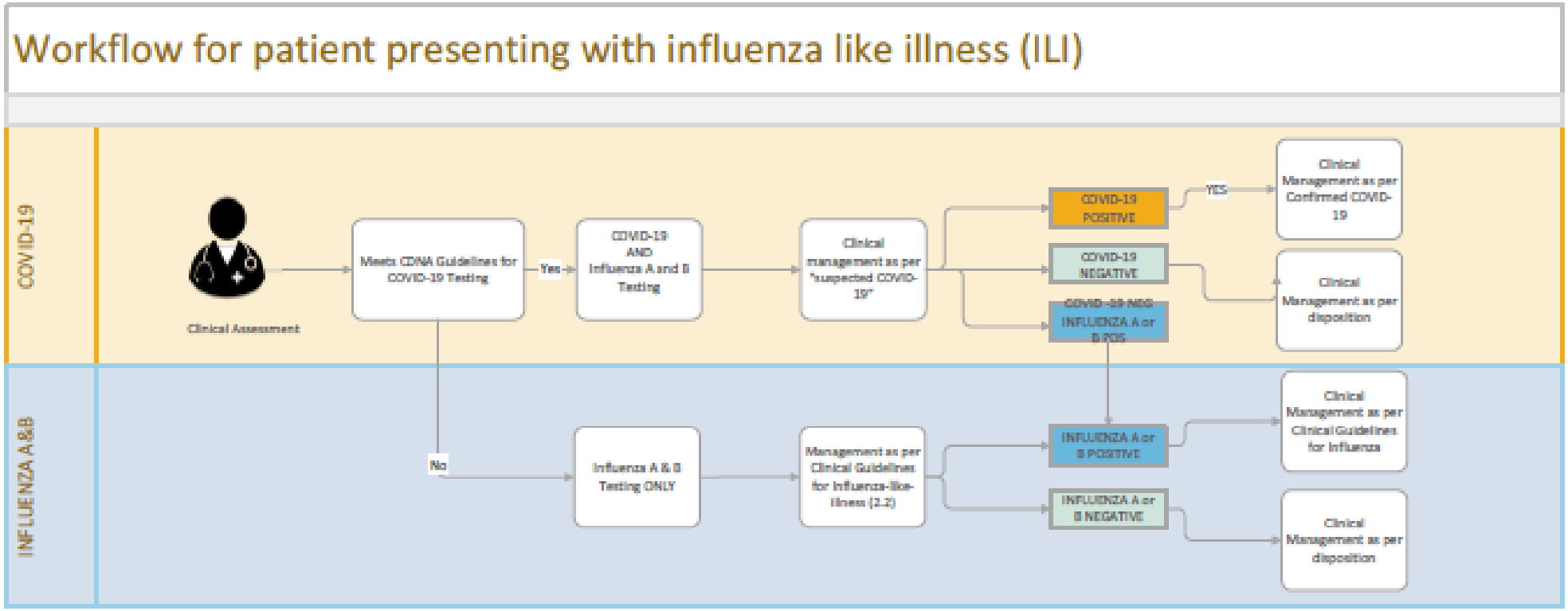
6.1.6.2 Clinical Guidelines

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)

6.1.6.3 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.



6.1.6.4 Patient disposition

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

Minimising emergency resuscitation will entail:

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

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

6.1.6.5 Baseline for admission

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

A decision to admit will depend on the clinical presentation, 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.

6.1.6.6 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.

6.1.6.7 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.

6.1.6.8 Diagnostics for patients admitted to hospital

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

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

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

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

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

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

6.1.6.9 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

6.1.7 Designated COVID-19 Hospital Network

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.

6.1.8 Low intensity COVID-19 Care

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.

6.1.9 Digital resources

The following digital resources are available:

- Syndromic activity board – COVID-19
- COVID-19 dashboard – provides the following data elements:
    - total ILI presentation as proportion of total presentations
    - ILI presentation via ED per discharge disposition
    - SSU admitted, D/C or Transferred
    - ILI presentations by Geographic distribution
    - age group distribution.
- COVID-19 intranet site https://metronorth.health.qld.gov.au/extranet/coronavirus
- Alerts in Patient Flow Manager and Wardview for COVID-19 positive patients
- Incoming Passenger app – supports screening and registration of people at any Brisbane airport.

- DcoVA –enables statewide registration of patients with COVID-19, and support management of patients under Public Health Orders (PHOs). It has a direct feed from AUSLAB for COVID-19 results and there is further potential for natural language processing of medical imaging results.
- WAT- workforce attendance tracker. This allows real time reporting of staff absences.
- Virtual care digital resources - https://qheps.health.qld.gov.au/metronorth/digital-metro-north/virtual-care

6.1.10 Resource management

6.1.10.1 PPE stockpiles and clinical consumables

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

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

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

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

6.1.11 Operational support

Environmental cleaning of patient care areas:

1. Cleaners should observe contact and droplet precautions signage
2. Environmental cleaning and disinfection of infection control areas will occur in line with current Queensland Health and Metro North Guidelines
3. Frequently touched surfaces such as doorknobs, bedrails, tabletops, light switches, patient handsets in clinical areas and patient room should be cleaned daily
4. Frequently touched surfaces such as doorknobs, bedrails, tabletops, light switches, patient handsets in non-clinical areas will be cleaned more frequently
5. Perform terminal cleaning of all surfaces (as above plus floor, ceiling, walls, blinds) after a patient is discharged
6. A combined cleaning and disinfection procedure should be used; this is either
    a. 2-step - detergent clean, followed by disinfectant; or

b. 2-in-1 step - using a product that has both cleaning and disinfectant properties.

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

6.2 COVID-19 Vaccination

All Metro North Staff must have received their first vaccination by 30 September 2021 and their second vaccination by 31October 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

Clinic	Clinic type	First appointment	Last appointment	Location
The Prince Charles Hospital	Ages 12 and up, staff and their families, and campus partners	Mon – Fri 0830	Mon – Fri 1630	Education Centre TPCH, Rode Rode, Chermside 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

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.

6.6.1 Medicare ineligible patients

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

6.6.2 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	without positive laboratory test but which is treated like a confirmed case based on clinical symptoms and epidemiological criteria

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

Metric	Definition
(Communicable Diseases Network Austraila, 2020)	
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"
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

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.

6.8.1 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.

6.8.2 Influenza Vaccination program

6.8.2.1 Staff influenza vaccination

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

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

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

6.8.2.2 Community influenza vaccination

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

6.8.2.3 Inpatient / outpatient influenza vaccination

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

6.9 Recovery strategies

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

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

7 Recover

The Recovery Phase is characterised by the pandemic being under control in Australia however further waves may occur if the virus drifts and/or is reimported into Australia. During this phase there is ongoing evaluation of the response, revision of plans and activation of recovery strategies.

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

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

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		11	11	12 Rooms * designated once infrastructure completed
TPCH Low Acuity Care Ward	14	14	14	14 rooms which can accommodate up to 22 people.
TPCH unwell wards		14 (1G)	+14(1F)	14 Rooms for 30 people, initial aim to maintain lower density with 20 patients per ward
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	600

	Fever Clinics *Minimum number of people that can be seen per day*	Fever Clinics *Maximum number of people that can be seen per day*
Redcliffe	100	300
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]
STAFFs	No clinical evidence of COVID-19 AND no epidemiological evidence[2]	nil additional	Surgical mask	Surgical mask[5] Protective eyewear[3] (within 1.5m)	Surgical mask[5] Protective eyewear[3] Gown or apron[4]	Surgical mask[5] Protective eyewear[3] (within 1.5m)	Surgical mask[5] 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[5] 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[5] Protective eyewear	Surgical mask[5] Protective eyewear
	Clinical evidence of COVID-19 WITHOUT epidemiological evidence[2] of COVID-19	Surgical mask[5] 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

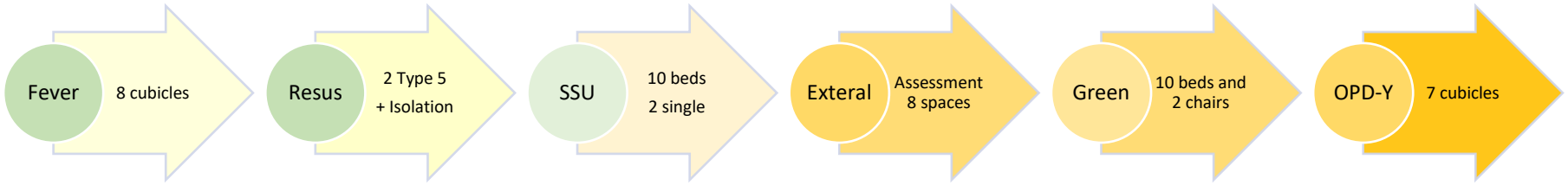
[4]Restricted Hospital as per Chief Health Officer Public Health Directions.

[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.

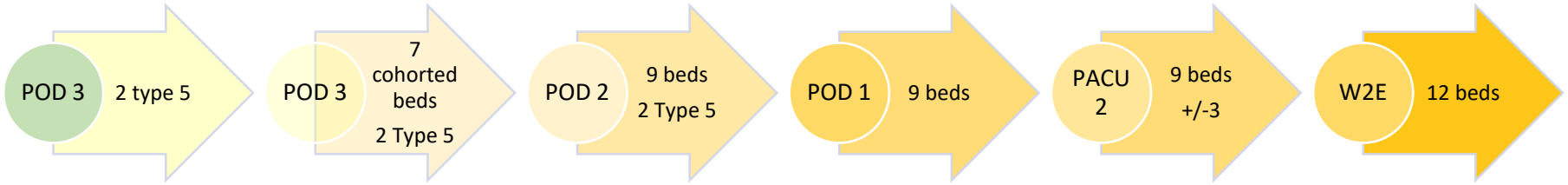
Appendix

Emergency Department (COVID-19 mild to severe symptoms)	**Medical Team Emergency Medicine Thoracic/ Cardiology/Internal Medicine/Surgery**



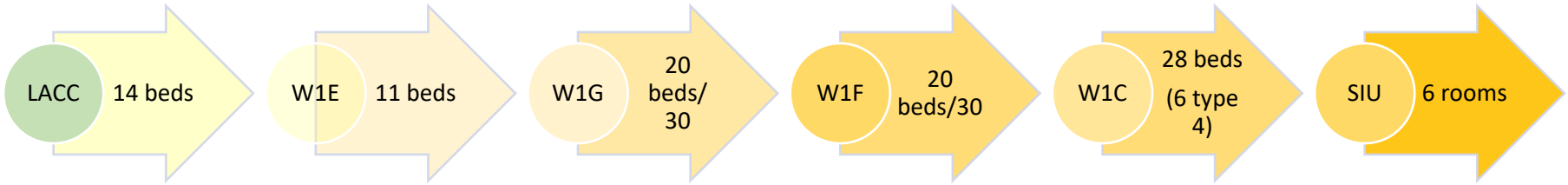
- Negative Pressure for high aerosolization procedure and treatments
- External assessment area to ED (8-16 treatment spaces) – options to be explored field hospital (tent) or demountable building
- Hybrid SSU to RAMS
- Facilitate rapid assessment and direct admission to wards for confirmed COVID-19 requiring hospitalisation

Intensive Care (COVID-19 severe symptoms)	**Medical Team Intensive Care/Anaesthetics/Surgery/Thoracic**



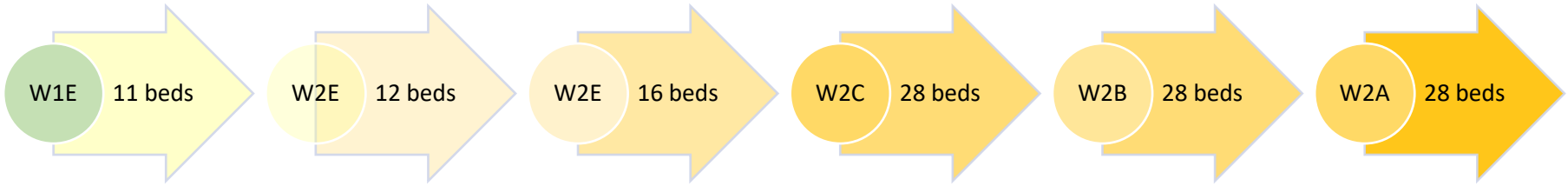
- Negative Pressure for high aerosolization procedure and treatments
- W1E Step Up for ICU and W2E Step Up and Down

Acute Inpatient (COVID-19 mild to moderate symptoms)	Medical Team Infectious Diseases/Thoracic/ Internal Medicine/Cardiology

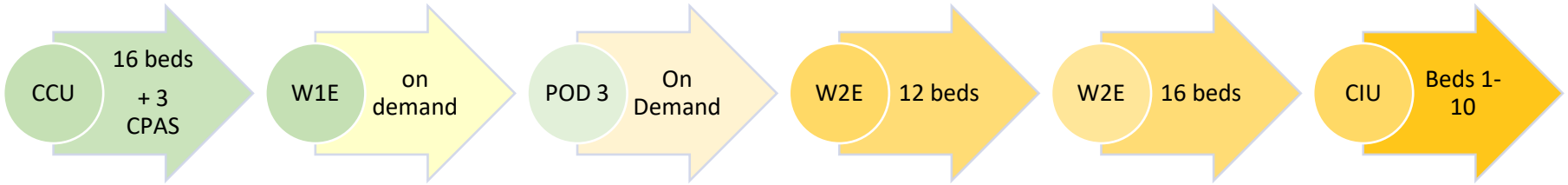
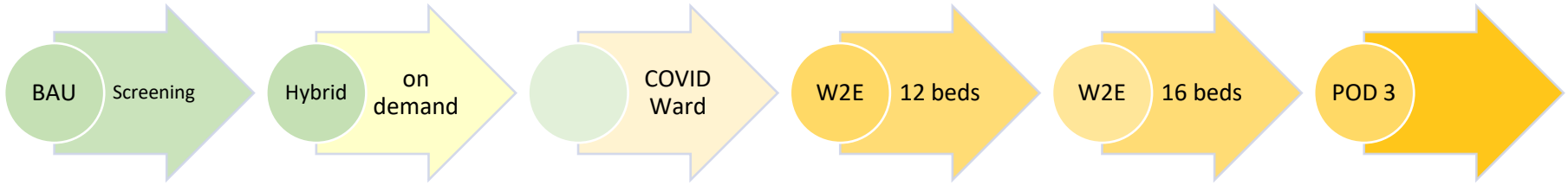


- Single rooms for COVID-19 (high dispersers), patients pending results and patient acuity
- Cohorted model for confirmed low density
- Early decision making for requirements/appropriateness for higher dependency care (HDU/ICU)

Acute Inpatient (severe to moderate) Step Down ICU	Medical Team Infectious Diseases ICU/Surgical/Anaesthetics/Thoracic/ Cardiology



- W1E type 4 (negative pressure) for high respiratory management
- Early decision making for requirements/appropriateness for stepping up or down from higher dependency care (HDU/ICU)
- These patients are likely to have had protracted LOS and may not be considered infectious, however this will need to be determined before patients are allocated beds with this pathway

Coronary Care (moderate to severe)	**Medical Team** Cardiology/**Thoracic consultation**
	
• W1E for COVID-19 Coronary Care patients (if available) • POD 3 ICU Type 5 – cohorted if capacity • Cohorted model for ICU step down and CCU patients, note as per above LOS	
Procedural Flow Category 1	**Medical Team Surgery/Cardiology/Thoracic/MID**
	
• Aim is to maintain building 1 (MAB) and procedural areas as non-infectious patient cohorts, this will require thorough screening and POC testing in some circumstances • Pending patients with low probability will need to be managed in single rooms in the programmes as per TPCH ILI planning document • Time Critical procedures should not be delayed pending results with appropriate treating teams	