Metro North Health COVID-19 and influenza Response Plan: 2022

Version 1.1

Metro North Health | Queensland Government

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DOCUMENT CONTROL

All amendments to this Response Plan must be dated and recorded in the document control section. Metro North Hospital and Health Service (Metro North HHS) takes no responsibility for the currency and accuracy of any uncontrolled copies of this Plan.
Proposed amendments to this Plan are to be forwarded to:

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Version Control

Version	Date	Comments
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V0.2	DRAFT	Consultation Draft 1
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Distribution and Approval

Internal approval

Version	Approver	Date
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1.1	Metro North Chief Operating Officer	28/06/2022

Distribution list (final versions only)

Version	Position	Date
1	MNH Executive Team	
	Facility/Directorate Executive Directors	
	MNH Emergency Management and Business Continuity	
	MNH Navigation Innovation Strategy	

Abbreviations

AEFI	Adverse Events Following Immunisation
AHPPC	Australian Health Protection Principal Committee
ARI	Acute Respiratory Illness *(consistent with Queensland Health language)*
BAU	Business as Usual
CE	Chief Executive, Metro North Hospital and Health Service
CHO	Chief Health Officer
COH	Community and Oral Health
CSCSD	COVID-19 Supply Chain Surety Division
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 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
IMS	Incident Management System
IMT	Incident Management Team
LDMG	Local Disaster Management Group
MNH – EMC	Metro North Health Emergency Management Committee
MNH – EMP	Metro North Health Emergency Management Plan
MNH - EMU	Metro North Health Emergency Management Unit
MNH – ERP	Metro North Hospital and Health Service Emergency Response Plan
MNH – IMT	Metro North Hospital and Health Service Incident Management Team
MNH	Metro North Health
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
PHU	Public Health Unit
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

This document is a living document and will be updated to reflect iterative changes to the plan as policy and guidelines are developed in response to the dynamic acute respiratory Illness, including COVID-19 and influenza, environment.

1. Introduction

1.1 Purpose and intent

The purpose of the Metro North Health (MNH) COVID-19 and Influenza Response Plan: 2022 (the Plan) is to ensure continuity of health services and manage the number of cases in the community.

The strategic objectives of the MNH response are:

- the safety of community by minimising the transmission of ARI, including COVID-19 or influenza, within the Metro North community and within healthcare settings through proactive identification and targeted testing, effective infection control activities and community messaging
- the safety of staff by minimising risk to all staff responding to acute respiratory illness (ARI), including COVID-19 or influenza, through appropriate training, personal protective equipment, and infection control practices
- ensure MNH maintains critical services continuity
- maximise the health outcomes of people with ARI, including COVID-19 or influenza.

The Plan outlines the communication pathways and basic concept of operations during the levels of activation of the Plan and includes:

- assessment criteria for impact of ARI, including COVID-19 or influenza, emergency department and acute bed capacity
- description of short-term capacity management actions, pre-emptive strategies to respond to predicted imbalances in patient flow
- outlines actions to recover or return the facility to normal operations as soon as possible.

This Plan supports the MNH Business Continuity Plan (BCP), MNH Acute Bed Capacity Plan and the COVID-19 Response Plan and should be read in conjunction with those plans.

1.2 Scope

This plan covers preparedness, response, and recovery actions to an ARI, COVID-19 and/or influenza, surge to ensure the continued delivery of critical clinical services to existing patients and the community. This does not extend to a full pandemic response which would be managed under existing emergency and disaster management plans and arrangements; although it does reference action specific to ARI stand up level of activation. The movement from a seasonal ARI response to a pandemic ARI response will be upon the advice of the Chief Health Officer.

1.3 Situation

ARI, including COVID-19 or influenza, is a viral respiratory disease of global public health importance. The propensity for ARI viruses to mutate, can change the prevalence of the circulating virus and impact on health care presentations and community public health recommendations. The seasonal pattern is one of outbreaks or epidemics in the winter months in temperate regions of the world; while in tropical areas, ARI 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 ARI season occurs annually in southern and central areas typically between May and October. An ARI surge can generally be identified and tracked; analysis of data suggests that ARI 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, between 2014 and 2019, an ARI surge has begun in last week of June / early July, peaked in the third week of August and settled by early October. In 2019, there was a wider distribution of ARI onset in Queensland between March and October, with the peak occurring in August. Modelling provided in May 2022 to COVID-19 Health System Response, indicates an earlier influenza season, predicting cases to peak much sooner than the usual in May/June 2022.

In late January 2020, under the Public Health Act, a Public Health Incident of State significance was declared in response to the COVID-19 outbreak in China. The World Health Organisation (WHO) declared COVID-19 a pandemic on 12 March 2020 and in April 2022 globally Countries are at different pandemic phases.

As public health restrictions are lifted, COVID-19/influenza co-infection are more likely to occur. The risk of co-infection will drive the requirement for vaccination against both SARS-CoV-2 and influenza viruses and inform criteria for the testing for influenza viruses to guide treatment options, including immunomodulatory and antiviral therapy.[1]

1.4 Governance

- The Executive Sponsor is the Chief Operating Officer, with oversight provided by the Metro North Operational Leadership Team (OLT)
- Directorate Executive Directors sponsor the plan within each of their directorates.
- Subject matter expert advice will be obtained from the relevant clinicians as required.
- The Patient Access and Coordination Hub (PACH) is the primary notification and analysis team.

1.5 Assumptions

This plan was developed based on the following assumptions:

- The incubation period of ARI, including COVID-19 and influenza, is in line with current WHO advice and CDNA/SoNG guidelines.
- Routes of transmission will be via large droplet and aerosol transmission from aerosol generating behaviours and treatment care interventions.
- The ARI, COVID-19 and influenza, virus is susceptible to antiviral agents
- Telecommunication networks (or adequate redundancies) are operating.
- The staff numbers to maintain critical service delivery (see MNH Business Continuity Plan) are available for the duration of the event.
- The Queensland Health ICT Network remains operational.
- Support services (e.g., Australian Red Cross Blood Bank, eHealth, HSQ (including linen and central pharmacy), Queensland Urban Utilities, Unity Water and ENERGEX) remain available.

[1] COVID-19 and Influenza Co-infection: A Systematic Review and Meta-Analysis. Published online 2021 Jun 25. doi: 10.3389/fmed.2021.681469

1.6 Principles

The following principles apply to all activities in this Plan:

Safety

- The safety of all patients, staff and visitors will be the primary consideration for management of patient flow across MNH.

Anticipation and prevention

- Preventing and acting early on potential mismatches between demand and capacity is crucial and will assist in improving patient outcomes and reducing avoidable delays in the patient journey.
- When a mismatch between demand and capacity persists, despite escalation procedures enacted, then a risk-based approach to managing patient flow will be used.

Effectiveness

- Effective access and capacity management is a MNH wide responsibility. All clinical programs and service lines will prioritise patient flow activities and support appropriate admission and discharges in line with patient care needs.

Incident management

- Emergency management and business continuity arrangements support integrated rapid decision making in circumstances of severe and extreme capacity issues and will be applied when managing capacity events.

2 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.

[2] Brisbane North PHN, 2019

[3] Department of Health, 2016

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

2.1 Infrastructure

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

Public Hospitals	Total beds	ED treatment spaces	ICU beds	Isolation rooms	Negative Pressure/Negative Flow Beds	Mortuary
Public	**2,126**	**155**	**68**	**423**		**61 Adult**
RBWH	834	47	36	67	40	19 adult, 17 baby
TPCH	569	56	18	142	24	18
Redcliffe	289	27	9	34	13	15
Caboolture	231	25	8	38	7	9
Kilcoy	21	0	0	4	0	0
STARS	182	NA	NA	135	0	0

*bed alternatives excluded

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

3 Community and Stakeholder engagement

MNH will continue to communicate and engage with a broad range of key stakeholders during the response.

3.1 Metro North Response

There have been several variants of ARI, including COVID-19 and influenza, and our response needs to be agile enough to respond to these known variants as well as any future variants. As the largest provider of public healthcare in the State, MNH will support Central West HHS and Norfolk Island in their ARI response and management. As numbers of ARI, including COVID-19 and influenza, positive people increase it is anticipated that several MNH staff will either be positive or furloughed and this may impact our response. In addition, MNH may be required to support other HHS either with access to beds, workforce or other services, including virtual services. All MNH facilities will treat ARI, including COVID-19 and influenza positive patients.

The MNH response ARI plan outlines business continuity management approach, ensuring that critical service functions can be maintained and timely recovered. 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 section 6.1.1. Note: Each Facility and/or Directorate has a local ARI Response Plan which aligns with the MNH response. Where a Directorate identifies the need to activate a change to service provision (such as provision of subacute services at one site) consultation and collaboration should occur with the Metro North executive and other facilities that may be impacted by the decision. Transitioning to another phase will require the prior approval of the MNH Chief Executive, who in turn will brief the MNH Board and Department of Health representative.
PPE risk will continue to be monitored separately. Further information on the implications for PPE use based on risk assessment is available in section 5.2.2.

4 Prevention and Preparedness

The following strategies will be employed by MNH from April to July to minimise the likelihood / severity of ARI surge and/ or create the capability / capacity to better manage the seasonal ARI surge:

4.1 Digital and IT Resources

4.1.1 Seasonal Surveillance Dashboard – Acute Respiratory Illness

The Seasonal Surveillance Dashboard – ARI will be operationalised, to enable early identification of likelihood/severity of ARI surge and/or create the capability/capacity to better manage the ARI surge. Seasonal Surveillance Dashboard – ARI will be used to ensure a targeted and coordinated capacity and access system-based strategy is implemented.

This dashboard is designed to provide daily information on patients presenting to MNHHHS with an ARI to assist facilities and directorates in service to ensure service continuity and minimise the impact on critical clinical services provided by MNHHHS, specifically during the ARI surge.
The dashboard provides Facilities and Directorates the total ARI presentations to Emergency Departments and admission to acute beds per facility, age group and geographical distribution. The information will be provided as:

- Total ARI presentation as proportion of total presentations
- ARI presentation via ED per discharge disposition
    - Admitted SSU D/C Transferred
- ARI presentations by Geographic distribution
- Age group distribution
- Identification of patient cohort per COVID-19 or ARI status
- Conversion rate of suspected COVID-19 and/or ARI to confirmed

Note: Comparison for each metric to the same period last year, for the previous 3 - 5 yrs.

4.1.2 Online Resources

Online resources for ARI, including COVID-19 and Influenza, will be developed, and regularly updated based on the phase of current activity. It can be accessed here: https://metronorth.health.qld.gov.au/extranet/coronavirus.

4.2 Vaccination

4.2.1 Staff Vaccination

Under workplace health and safety legislation MNH has a duty of care and responsibility to control and minimise risks related to the transmission of infectious diseases. Minimising the incidence of transmission through staff vaccination programs is designed to reduce the incidence of serious illness and avoidable deaths in staff, patients and other users of MNH services. All Metro North Staff must be vaccinated for COVID-19 in accordance with Health Employment Directive 12/21: Employee COVID-19 vaccination requirements (the Directive)

MNH will conduct a workforce flu vaccination campaign from April to July 2022. A multi-platform communication strategy will be used including QHEPS, posters, email advisories, newsletter messages, e-bulletins and social media. MNH strives for 85% of workforce to have influenza vaccination. The MNH Staff COVID19 extranet site, provides information about this program. It can be accessed here https://qheps.health.qld.gov.au/metronorth/flu

Each directorate within metro north has an Influenza Vaccination Program, with local communication advising access, location, and times. Any matters relating to influenza programs are to be escalated via EOC to the Incident Management Team.

4.2.2 Community Vaccination

There are separate vaccines available to protect individuals against influenza and COVID-19. Influenza vaccines can be co-administered (i.e., on the same day) with the COVID-19 vaccines. Whilst the flu vaccine will not prevent coronavirus infection it can reduce the severity and spread of flu, which may make a person more susceptible to other respiratory illnesses like coronavirus.

Community vaccination for Covid 19 and flu are available through General Practitioners and Pharmacies.

QH has conducted a large scale COVID 19 Vaccination Campaign and has achieved high rates of vaccination across the state.

Influenza Vaccination is required annually, as immunity from the vaccine decreases over time and the vaccine can change each year to cover the current virus strains. Vaccination usually takes up to 2 weeks to be effective. (Refer to Appendix 1)

4.2.3 Elective pre-admission screening and scheduling of patients

Patients scheduled for elective admission during the ARI season will be provided pre-admission information and booking documents that include a request that patients contact the hospital prior to arrival if they have respiratory symptoms and to ask their vaccination status. Pre- Procedural PCR Testing will be conducted dependent on the level of community transmission of COVID 19 and Influenza A/B.

4.2.4 Staff Training & information

MNH staff receive infection control training and fit testing as part of orientation, induction and work unit training programs including periodic refreshers as per Clinical Directorate requirements. The MNH Staff COVID19 extranet site, provides information and resources for staff training. It can be accessed here: https://metronorth.health.qld.gov.au/extranet/coronavirus

The infection management and prevention service within most hospitals will offer opportunistic infection control refresher training / briefing to all staff between April and July to all clinical

services areas to refresh these skills and provide opportunities for clinical areas to discuss work-unit specific processes, PPE and management.

4.3 Human Resources

The health, safety and wellbeing of all healthcare workers is a priority for MNH symptomatic staff should be tested and not attend the workplace if unwell.

4.3.1 Maintaining Service Delivery

MNH has a range of strategies to maximise the workforce during the ARI surge including:

- increasing casual pools and temporary staff
- increasing hours of part time staff on voluntary basis
- 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
- active leave management including absenteeism and fatigue

Note: 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 (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.

- reduction in total planned annual leave approved between MY - August and reduced routine training over this period.
- accelerated recruitment processes.

4.4 PPE Stockpiles, Clinical Consumables and Antivirals

Each Directorate will manage their PPE stockpiles and clinical consumables to determine and ensure appropriate stock levels are available to support BAU as well as expected surge. Where appropriate, the Metro North PPE Co-Ordinator model will be stood up and managed by Business Advisory and Commercial Services to assist in this process and to manage the relationship with CSCSD with a focus on items in short supply and/or on allocation. The provision of PPE most focus foremost on staff but is also required for patients and visitors in certain circumstances.

Recommended PPE escalation is according to risk assessment of unexpected ARI infections in clients of workers, including contractors and volunteers (in addition to standard precautions +/- transmission-based precautions if indicated for another reason). Refer to Pandemic Response Guidance v2.0 January 2022

Note: Central Pharmacy houses the State supply of antivirals. Pharmacies within all hospitals also have a supply of antivirals available and are responsible for approval and distribution though the hospital. Prior to July all Clinical Directorates will assess antiviral stocks and placement within the hospital and confirm ordering arrangements and processes to ensure sufficient on hand stocks during periods of surge.

5 Model of Care

5.1 Clinical Care Streams

People who are ARI* positive will be cared for via three care streams – ARI Well, ARI of Concern and Hospital care.

People identified as ARI of Concern will be admitted to MNH Virtual Care Ward and with those people identified as needing higher care needs will be admitted to an acute health facility to receive in-hospital care.

Allocation to care streams is determined according to the following principles:

Care Stream	Principles	Clinical Service
ARI Well	Risk stratification for deterioration is low and can be managed and monitored in a low interaction ambulatory environment • People who are asymptomatic or experiencing mild ARI symptoms • No or low risk social or medical factors	Primary Care Provider
ARI of Concern	Risk stratified as moderate. To be managed in a virtual environment they need high levels of governance, clinical interaction, and close observations, including but not limited to remote patient monitoring • People experiencing moderate clinical symptoms • People with complex social, public health or special care needs • At risk populations • Children with unwell parents • Parent/Carer or child with severe Mental Health illness • High density households / other environmental concerns	Metro North Virtual Care Ward
Hospital Care	Hospital care is the provision of clinical care in a designated hospital for people requiring complex coordinated clinical care and investigation that cannot be safely done elsewhere 1. People experiencing severe clinical symptoms 2. High risk social or medical factors	Acute Facility
*Note: This service is currently supporting persons who are confirmed positive COVID-19, with plan to expand to include persons who are confirmed positive with influenza		

5.2 Patient Placement Guide – Infection Control and Prevention

Patients are potentially at risk of acquiring, and transmitting, ARI to other patients and healthcare workers. Patients should be assessed on, and during admission, to ensure that their bed allocation is both appropriate and timely. Patient placement is an important element of transmission-based precautions, the Australian Commission on Safety and Quality in Healthcare has developed the Patient Placement Guide – Infection Prevention and Control to support staff in the appropriate bed allocation.

The placement of ARI patients in any clinical area should be considered, and risk assessed according to a number of factors, including, but not limited to:

- whether the patient is suspected or known to be colonised or infected with a highly transmissible or epidemiologically significant pathogen (such as a multidrug-resistant organism)
- whether the patient has signs and symptoms that raise suspicion of the presence of an infectious condition
- the known or suspected infectious organism is transmitted, and
- the period of time transmission-based precautions should be used.

5.2.1 Risk Assessment

Guidance on factors to be considered when conducting a risk assessment to inform patient placement

Table 1

Risk Factors	Source and modes of transmission	Clinical predictors of transmission	Clinical impact of transmission	Room availability
Questions for consideration	Is human to human transmission known? Is/are the mode/s of transmission known? Has the person recently returned from overseas travel? What is the infectivity of the organism?	Does the patient have factors that would increase the risk of transmission?	How susceptible are other patients in the area? What is the morbidity and mortality associated with the organism/condition disease? Will the safety of the individual who is to be isolated be affected?	What is the availability of negative pressure isolation rooms? What competing priorities exist for single room provision? Are single rooms with designated toilet facilities available? Are there other patients with the same organism, species and/or strain that could be cohorted
Examples	Suspected or confirmed acute respiratory infection Public health notification	Wandering Cognitive impairment Incontinence Broken skin Open/draining wounds Invasive devices Poor hygiene practices Clinical symptoms such as: -Diarrhoea-Vomiting-Coughing-Sneezing	Organism not easily transmitted but associated with high mortality rate Immunosuppressed patients Neonates and young children Elderly patients Patients with burns Renal patients Pregnant women	Patients requiring high security or one-on-one observation Patient requiring end-of-life care Privacy and dignity issues Existing cohort

When a single room is not available, or there are insufficient isolation facilities for the number of suspected or confirmed infectious patients, consultation with the local Infection

Management service is recommended to assess the various risks associated with other patient placement options (e.g., cohorting).

5.2.2 Prioritisation

Recommendations on the prioritisation of specific infectious conditions are provided in Table 2. Single rooms are preferred for all patients requiring isolation due to infectious conditions and are always indicated for patients with airborne precautions (ideally with negative pressure ventilation), including access to designated bathroom facilities and door to remain closed with appropriate signage. Transmission-based precautions should be applied in addition to standard precautions, in accordance with the Australian Guidelines for the Prevention and Control of Infections in Healthcare (2019), and jurisdictional guidance. Depending on the infectious organism and its mode of transmission, one or more types of transmission-based precautions may be required

Table 2

Priority Group	Disease/Clinical Symptoms	Infectious Period	Precautions Required**
First	Respiratory Viruses of concern, e.g., SARS, MERS Cov, pandemic ARI	Duration of illness*	S+C+D+A
	SARS-CoV-2	Refer to Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units	S+C+D (+A when performing aerosol generating procedures
Second	Influenza	72hrs post anti-ARI medications, or 5 days since onset or respiratory symptoms. Longer for young children, immunosuppressed or ICU patients	S+C+D
	Respiratory Syncytial Virus (RSV)	Duration of illness*	S+C+D

*duration of illness may differ among individuals; medical advice should be sought
Key: S= Standard; C = Contact; D= Droplet; A = Airborne

5.2.3 Guidelines for Placement of Patients with ARI

Placement of patients with ARI, are based on the following principles

- Transmission-based precautions should be applied in addition to standard precautions
- SARS-CoV-2 will not be cohorted with other infections
- Co-infection patients will not be cohorted
- Surgical masks will be provided at point of TRIAGE, but should be provided whenever the ARI is first recognised

Note: The process for admission of patients to Metro North Health facilities who are COVID-19 positive, is outlined in Appendix 12 and identification and communication strategy for COVID -19 capacity is outlined in Appendix 13.

Table 3

Preference	SARS-CoV-2	Other Respiratory Illness
1st	Negative Pressure with unshared ensuite	Single room with unshared ensuite
2nd	Entire Negative Flow Ward/Zone with shared ensuite	Singe room with shared ensuite
3rd	Single room with unshared ensuite and an air purifier.	Cohort ARI in designated ward with >/= 1 metre distance and curtains closed
4th		Four bed bays in a ward for cohorting – *as designated by facility/service line Executive.* (refer to Appendix 4 - 7)

Due to the dynamic nature of Emergency Departments (ED), the following risk mitigations strategies are to be considered

1. All ARI 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 ARI is first recognised
2. If the patient requires admission, the patients access to an inpatient bed is not be delayed waiting result of PCR testing – the patient is to be isolated/cohorted based on their ARI.

Note: Further information about Patient Placement Priority Guide can be found at the ACSQHC: Patient Placement Guide - Infection Prevention and Control

NOTE: Staff are to refer to local directorate-based transmission-based precautions procedures for local nuances for bed placement, including hierarchy for single room access

.

5.3 Formal panel testing for respiratory viruses

Polymerase chain reaction (PCR) panel testing for respiratory viruses is available through Pathology Queensland and is requested as clinically indicated by authorised requesting Clinicians. Full details are in Appendix 2. The tests can be ordered through usual ordering mechanisms.

Only patients with respiratory symptoms in at-risk categories should be considered for primary or reflex testing with the rapid PCR instrument. Clinical Directorates will highlight this information to clinical staff during May 2022,

4-plex GeneXpert which includes: Influenzas A and B, Respiratory Syncytial Virus and SARS-Cov-2. 4 plex GeneXpert can be turned around in approximately 90 minutes and can be used for symptomatic patients being admitted from Emergency Departments to assist with expediated decisions on bed placement.

6 Plan Activation

6.1 Response Activities

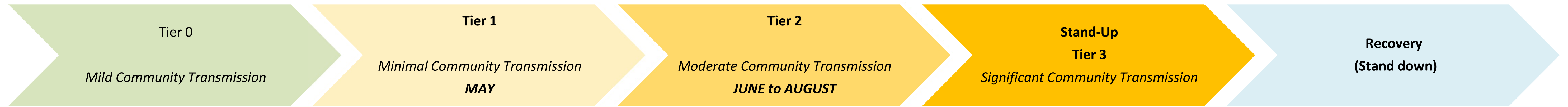
Phases of activation of Plan are as follows

Phase	Tier 0 *Mild Community Transmission*	Tier 1 *Minimal Community Transmission*	Tier 2 *Moderate Community Transmission*	Stand up Tier 3 *Significant Community Transmission*	Recovery
Trigger	Trigger	MAY	JUNE to AUGUST	Trigger	Trigger

The Seasonal Surveillance Dashboard – ARI will be operationalised, to enable early identification of likelihood/severity of ARI surge and/or create the capability/capacity to better manage the ARI surge. Seasonal Surveillance Dashboard – ARI will be used to ensure a targeted and coordinated capacity and access system-based strategy is implemented.

6.1.1 Metro North Criteria for COVID-19 and Influenza Response Plan Activation and Associated Actions – (Interact with Acute Bed and Emergency Department Capacity Plan-*draft*, Activation and Associated Actions - Appendices 9 and 10)

Criteria for movement through phases of activation and the associated actions for Metro North Emergency Management and Business Continuity Unit and Facilities. Triggers and actions include, but are not limited to, the below:



CRITERIA one of:

- Suspected ARI ED presentations:

Location	Daily Presentation =/<
CAB	5
RBWH	10
TPCH	10
RDH	5

- Suspected ARI ED presentations:

Location	Daily Presentation =/<
METRO NORTH HHS	30

- Suspected ARI admissions per day:

Location	Daily admits =/<
METRO NORTH HHS	5

- ICU admit for ARI per day:

Location	Daily
METRO NORTH HHS	0

- ARI Workforce absenteeism - Nil impact to service continuity

Other indicators

- <4 patients waiting isolation rooms in ED per facility.
- Nil or minor issues with:
  - ARI Vaccinations
  - Antivirals
  - PPE stock availability
  - Testing kits (GeneXP)
- PCR –turnaround time
  1. High through put testing TAT within 24 hrs
  2. Rapid testing, TAT within 4 hrs

Note: activity has direct impact on staffing, PPE utilisation and laboratory consumables

CRITERIA one of:

- Suspected ARI ED presentations

Location	Daily Presentation =/<
CAB	6 -15
RBWH	11 -20
TPCH	11 -20
RDH	6 -15

- Suspected ARI ED presentations:

Location	Daily Presentation =/<
METRO NORTH HHS	31 - 70

- Suspected ARI admissions per day:

Location	Daily admits
METRO NORTH HHS	6-10

- ICU admit for ARI per day:

Location	Daily
METRO NORTH HHS	1

- ARI Workforce absenteeism - Interruption to service continuity

Other indicators

- 4-6 ARI patients waiting suitable clinical location ED per facility.
- < 80% anticipated required:
- ARI Vaccinations
- Antivirals and/or
- PPE stock availability
- Testing kits (GeneXP)
- PCR –turnaround time
  1. High through put testing TAT greater than 24 hrs
  2. Rapid testing, TAT greater than 4hrs

CRITERIA one of:

- Suspected ARI ED presentations

Location	Daily Presentation =/<
CAB	16 -25
RBWH	21 - 40
TPCH	21 - 40
RDH	16 -25

- Suspected ARI ED presentations:

Location	Daily Presentation
METRO NORTH HHS	71 - 130

- Suspected ARI admissions per day:

Location	Daily admits
METRO NORTH HHS	11-20

- ICU admit for ARI per day:

Location	Daily
METRO NORTH HHS	1 -4

- ARI Workforce absenteeism - Interruption to service continuity

Other indicators

- 7-8 ARI patients waiting suitable clinical location in ED per facility
- 50%-30% anticipated required:
  - ARI Vaccinations
  - Antivirals and/or
  - PPE stock availability
  - Testing kits (GeneXP)
- PCR –turnaround time
  1. High through put testing TAT greater than 24 hrs
  2. Rapid testing, TAT greater than 4hrs

CRITERIA one of:

- Suspected ARI ED presentations

Location	Daily Presentation =/<
CAB	>25
RBWH	>40
TPCH	>40
RDH	>25

- Suspected ARI ED presentations:

Location	Daily Presentation
METRO NORTH HHS	>130

- Suspected ARI admissions per day:

Location	Daily admit
METRO NORTH HHS	>20

- ICU admit for ARI per day:

Location	Daily
METRO NORTH HHS	>4

- ARI Workforce absenteeism - Interruption to service continuity

Other indicators

- > 8 ARI patient waiting suitable clinical location in ED per facility available
- < 30% anticipated required
  - ARI Vaccinations
  - Antivirals and/or
  - PPE stock availability
  - Testing kits (GeneXP)
- PCR –turnaround time
  1. High through put testing TAT greater than 24 hrs
  2. Rapid testing, TAT greater than 4hrs

CRITERIA

- Transition from responding to an event back to normal core business and/or recovery operations.

ACTIONS HHS, FACILITY AND SERVICE LINE **Requirement to undertake:** [2]	ACTIONS METRO NORTH HEOC **Requirement to undertake:**	ACTIONS METRO NORTH HEOC **Requirement to undertake:**	ACTIONS METRO NORTH HEOC **Requirement to undertake:**	ACTIONS METRO NORTH HEOC **Requirement to undertake:**
○ **Staff vaccination campaign and reporting** (April – May) ○ **Staff education campaign:** handwashing, isolation, droplet contact, socialisation of Clinical Management Guidelines and Testing Algorithm ○ **Review** PPE/Testing Kits/ Vaccinations/Antivirals ○ **Staff management changes:** leave management, sick leave planning ○ **Activity management:** review planned/scheduled activity–manage post-op admission days ○ **Surveillance/Reporting changes:** commence surveillance activities ○ **Pathologist:** Cross-check status and determine impact on time to result Li	**Emergency Response Plan activated.** [2] Initiate, coordinate and collate twice a week ○ Facility/Directorate Business Impact Assessments ○ Metro North HHS COVID-19 Teleconference ○ Distribute SITREP and additional reporting **FACILITY AND SERVICE LINE** **Requirement to undertake:** [2] ○ As per *Tier 0* actions ○ Provide business impact assessment (BIA) as per request ○ Participate in teleconference ○ Vector tracking for transmission within and across ward ○ **Review** process changes at 'front door reception' e.g. Alternate ED triage stations ○ **Review PCR Collection Service–** hours of operation, additional clinic locations	**Emergency Response Plan activated** [2] ○ Initiate, coordinate and collate **daily** (minimum weekdays) ○ Facility/Directorate Business Impact Assessments ○ Metro North HHS COVID-19 Teleconference ○ Distribute SITREP and additional reporting **FACILITY AND SERVICE LINE** **Requirement to undertake:** [2] ○ As per *Tier 0 and 1* ○ **Review** process changes at 'front door reception' e.g. Alternate ED triage stations ○ **Review PCR Collection Service–** hours of operation, additional clinic locations ○ **Review non-critical clinical services** Reduce and/or suspend elective / non-urgent surgical cases and outpatient clinic appointments where possible. ○ **Review room allocation method** Use of isolation rooms and where required, cohorting of patients (with curtains drawn). ○ **Activate Private Hospital Facility Funding Arrangements (PHFFA)** in consultation with Department of Health ○ **Establish and distribute** internal and external communications.	**Emergency Response Plan activated.** [2] ○ Initiate, coordinate and collate **daily** (consider twice daily) ○ Facility/Directorate Business Impact Assessments ○ Metro North HHS COVID-19 Teleconference ○ Distribute SITREP and additional reporting **FACILITY AND SERVICE LINE** **Requirement to undertake:** [2] ○ As per *Tier 0, 1 and 2 actions* ○ **Review** Workforce Business Continuity Plan (BCP) and consider need for staff redeployment ○ **Review access controls** Entry to main hospital restricted to control access and patient movement within facilities limited to essential movements only ○ **Review non-critical clinical services** Elective surgery requiring in-patient admission of >72 hours postponed. ○ **Optimise Private Hospital Facility Funding Arrangements (PHFFA)** in consultation with Department of Health	○ Transition from responding to an event back to normal core business and/or recovery operations.

6.1.2 Tier 1 Action Plan – Commencing May or as Triggered

Upon activation to Tier 1 status every facility/directorate will undertake the following actions and report to MNH EOC via EOC-MetroNorth@health.qld.gov.au

SUGGESTED ACTIONS TO BE TAKEN BY: Business impact Assessment to be provided 30 minutes prior to the scheduled teleconference	**Positions**
MNH ID and IMPS Advisory Group (to IMT)	
Review of PCR Testing Criteria refer Appendix 5 – RVT. **Advise that the current Criteria remains suitable or has been updated.**	Chair
Review criteria for room allocation (isolation) as per clinical guidelines. **Single room vs cohort of patients now required?**	Chair (in consult with facility based IMPS)
Vector tracking within and / or across clinical units **Occurring / not occurring?**	Chair (in consult with facility based IMPS)
E/DMS Facility	
Review PPE stockpiles and place additional orders are required (refer section 2.4) – **provide status update**	Advise delegation
Pharmacy	
Provide MNH-wide status current anti-viral stocks **(meets requirements, order placed, stock issues)**	MNH Rep (with input from each facility pharmacy service)
Provide MNH-wide status on vaccination stocks **(meets requirements, order placed, stock issues)**	
MNH Communications	
Status of communication report (internal and external) **Meets requirement, additional required**	MNH Comms Rep
Public Health	
Tracking within community **Hotspots / Aged Care / Residential Homes / HR Groups**	MNH PH Rep
Status of service to meet demand **On request, delays, overwhelmed?**	MNH Pathology
Human Resources	
Status report emergent leave **Within expected above expected.** **Hot-spots by facility/service line?**	MNH HR Rep
As required	
Emergency Departments – **Impact**	
ICU – **Impact**	
MNH EOC	
Tier 1 Provide **SITREP** by 0845 Tuesday to IMT Tier 2 Provide **SITREP** by 0845 Tuesday and Thursday to IMT	MNH EOC Duty Manager

ACTION TO BE TAKEN ON: **Tuesday (June)** **Tuesday and Thursday (July)**	Positions
May - Initiate fortnightly teleconferences Tuesday 0910 June - Initiate weekly teleconferences Tuesday 1100 and Thursday 1100 **AGENDA** 1. Phase Confirmation 2. SITREP Issue Resolution. NB: All IMT members are expected to have read and understood the SITREP provided at 0845. a. Agree resolution actions, b. Agree action officers; and c. Agree timeframes 3. Questions / Safety Issues (around the table) 4. Next meeting confirmation	MNH EOC – IC MNH CMN MNHIMS (Chair) E/DMS (Per Facility) MNH PACH MNH Pharmacy Rep MNH Pathology MNH EM&BC MNH HR MNH Public Health MNH Comms As required: MNH ED Rep MNH ICU

6.1.3 Tier 2– Commencing June or as Triggered

Upon activation to Tier 2 status every facility/directorate will undertake the following actions and report to MNH EOC via EOC-MetroNorth@health.qld.gov.au

ACTION TO BE TAKEN	Positions
MNH ID and IMPS Advisory Group (to IMT)	
Review of PCR Testing Criteria refer Appendix 5 – RVT)	Chair
Review criteria for room allocation (isolation) as per clinical guidelines. **Single room vs cohort of patients required?**	Chair (in consult with facility based IMPS)
Vector tracking within and / or across clinical units **Occurring / not occurring?**	Chair (in consult with facility based IMPS)
E/DMS Facility	
Review PPE prepositioned within clinical surge areas – provide status update **– (meets requirements, order placed, stock issues)**	Advise delegation
Review non-critical clinical services Reduce and/or suspend elective / non-urgent surgical cases and outpatient clinic appointments. **Status of service by exception (those impacted) incl ICU.**	CMO
Pharmacy	
Provide MNH-wide status current anti-viral stocks (meets requirements, order placed, stock issues)	MNH Rep (with input from each facility pharmacy service)
Provide MNH-wide status on vaccination stocks (meets requirements, order placed, stock issues)	
Status of communication (internal and external) **Meets requirement, additional required**	MNH Comms Rep
Public Health	
Tracking within community **Hotspots / Aged Care / Residential Homes / HR Groups**	MNH PH Rep
Status of service to meet demand **On request, delays, overwhelmed?**	MNH Pathology
Human Resources	
Status report emergent leave **Within expected above expected. Hot spots by facility/service line?**	MNH HR Rep
Emergency Departments	
Review process changes at 'front door reception' e.g., Alternate ED triage stations / need for ARI clinic – **BAU or change?**	MNH ED Rep (in consult with ED at each facility)
MNH EOC	
Tier 2 Provide **SITREP** by 0845 Tuesday and Thursday to IMT	MNH EOC Duty Manager

ACTION TO BE TAKEN Daily	Positions
Initiate daily teleconferences AGENDA Phase Confirmation SITREP Issue Resolution. NB: IMT members are expected to have read and understood the SITREP provided at 0845. Agree resolution actions, Agree action officers; and Agree timeframes Questions / Safety Issues (around the table) Next meeting confirmation	MNH EOC – IC MNH CMN MNHIMS (Chair) E/DMS (Per Facility) MNH PACH MNH Pharmacy Rep MNH Pathology MNH EM&BC MNH HR MNH Public Health MNH Comms As required: MNH ED Rep MNH ICU

6.1.4 Stand Up Tier 3 –as Triggered

Upon activation to Stand Up Tier 3 status every facility/directorate are to **refer to their Emergency Response Plans. The following is specific to ARI and can be used to guide Business Continuity IMT actions** and undertake the following actions and report to MNH EOC via EOC-MetroNorth@health.qld.gov.au

ACTION TO BE TAKEN - Twice Daily	Positions
MNH ID and IMPS Advisory Group (to IMT)	
Review of PCR Testing Criteria refer Appendix 5 – RVT)	Chair
Review criteria for room allocation (isolation) as per clinical guidelines. **Cohort of patient's location and impacts on services (isolation timeframes)**	Chair (in consult with facility based IMPS)
Vector tracking within and / or across clinical units **Occurring / not occurring?**	Chair (in consult with facility based IMPS)
E/DMS Facility	
Emergency Response Plan Activated. **Tier activated?**	CMO
Review PPE prepositioned within clinical surge areas – provide status update **– (meets requirements, order placed, stock issues)**	Advise delegation
Suspend elective / non-urgent surgical cases with in-patient admission of >72hrs and outpatient clinic appointments. **Status of other service lines by exception (those impacted) incl ICU.**	CMO
Review access controls for patient and visitor movement within facilities (incl. intra-facility transfer).	CMO
Activate Workforce BCP. **Hot spots by facility/service line?**	Advise workforce delgate per professional group
Review needs for PCR Collection Service	CMO (SME as required)
Pharmacy	
Provide MNH-wide status current anti-viral stocks (meets requirements, order placed, stock issues)	MNH Rep (with input from each facility pharmacy service)

Provide MNH-wide status on vaccination stocks (meets requirements, order placed, stock issues)	MNH Rep (with input from each facility pharmacy service)
Status of communication (internal and external) **additional actions being taken**	MNH Comms Rep
Public Health	
Tracking within community **Hotspots / Aged Care / Residential Homes / HR Groups**	MNH PH Rep
Status of service to meet demand **On request, delays, overwhelmed?**	MNH Pathology
Emergency Departments	
Review process changes at 'front door reception' e.g., Alternate ED triage stations / need for ARI clinic – **BAU or change?**	MNH ED Rep (in consult with ED at each facility)
CMO	
Tier 3 Provide **SITREP** by 0845 daily to IMT	MNH EOC Duty Manager
Initiate twice daily teleconferences **AGENDA** 1. Phase Confirmation 2. SITREP Issue Resolution. NB: All ARI IMT members are expected to have read and understood the SITREP provided at 0845. a. Agree resolution actions, b. Agree action officers; and c. Agree timeframes 3. Questions / Safety Issues (around the table) 4. Next meeting confirmation	MNH EOC – IC MNH CMN MNHIMS (Chair) E/DMS (Per Facility) MNH PACH MNH Pharmacy Rep MNH Pathology MNH EM&BC MNH HR MNH Public Health MNH Comms As required: MNH ED Rep MNH ICU

6.1.5 Stand Down Recovery

Upon de-activation to STANDOWN status the following actions are to be taken:

ACTION TO BE TAKEN	Position
• As determined in final meeting of Stand Up Tier 3	MNH EOC IC
IMT STOOD DOWN - RECOVERY ACTIONS PROVIDED TO BAU/RECOVERY TEAM,	

Following the ARI Surge and analysis of the preparation and response will be completed by applying vRE-AIM and consolidated Framework of Implementation Reseach. This will be coordinated by the EMBC, supported by MNH CMO. This analysis will include a review of the data provided and the actions taken in response. The post-event analysis will also include members from MNH PACH, MNH Communications, QAS, Pharmacy, Patient Flow Directors and other health sector agency partners. The subsequent post event report will inform planning for the 2023 ARI Surge.

Appendix 1: Guidelines for prescribing oseltamivir for seasonal influenza in 2022 as per Queensland Infection Clinical Network

The purpose of this guideline is to remove administrative barriers to the use of oseltamivir in patients at high risk of adverse outcomes from influenza by facilitating compliance with restrictions in the List of Approved Medicines (LAM)

Oseltamivir prescribing guidelines

Children

For children, prescribe oseltamivir as recommended in the Queensland CEQ-endorsed Tri-State Paediatric Improvement Collaborative clinical practice guideline:

https://www.rch.org.au/clinicalguide/guideline_index/Influenza/

Adults

For adults:

- who are confirmed to have influenza by PCR, or
- for whom there is a strong clinical suspicion of influenza and there are significant barriers to accessing timely PCR results (e.g., in rural areas)

Prescribe oseltamivir for the indications in the Therapeutic Guidelines as listed below

1. Regardless of the duration of symptoms, for patients:
   - with established complications
   - who need to be admitted to hospital for management of influenza
   - with moderate-severity or high-severity community-acquired pneumonia, during the influenza season
2. Within 48 hours of illness onset for the following patients at higher risk of severe influenza:
   - adults aged 65 years or older
   - pregnant women
   - people with the following conditions:
   - heart disease
   - Down syndrome
   - obesity (body mass index [BMI] 30 kg/m2 or more)
   - chronic respiratory conditions
   - severe neurological conditions
   - immune compromise
   - other chronic illnesses
   - Aboriginal and Torres Strait Islander people of any age
   - residents of aged-care facilities or long-term residential facilities
   - homeless people.
3. To prevent disease transmission to contacts in the hospital setting, preferably on the advice of an infection control or infectious diseases team

Note: Access published guideline via link - Guidelines for prescribing oseltamivir for seasonal influenzas in 2022 (health.qld.gov.au)

Appendix 2: Guide for Formal panel testing for respiratory viruses (Pathology Queensland)

1. Rapid testing – 4hrs turn-around-time, depending on volume			
Rapid 1	Rapid 2	Rapid 3 - 4PLEX	Rapid 4 -
GeneXpert *for*	GeneXpert *for*	GeneXpert *for*	GeneXpert *for*
SARS-CoV-2	Influenza A/B	Influenza A/B	Influenza A/B
	RSV	RSV	SARS-CoV-2
		SARS-CoV-2	

2. High throughput testing – 24hrs turn-around-time pending on volume		
Resp 1 panel **	Resp 2 panel	Resp Panel 3
Influenza A/B	Influenza A/B	Influenza A/B
RSV	SARS-CoV-2	RSV
Parainfluenza 1 -4		SARS-CoV-2
Human Metapneumovirus		
Rhinovirus		
Adenovirus		
**SARS CoV-2 required, additional swab for single COVID testing – NCVPCR		

Appendix 3 - Clinical Guidelines for Acute Respiratory Illness (ARI) – Emergency Department

MN HHS Guidelines for acute presentation of patients with Acute Respiratory Illness (ARI)

PRESENTATION

TRIAGE

One of more other ARI Symptom

- Fever >/= 38° (C) or hx of fe
- Cough
- Fatigue
- Headache
- Shortness of breath
- Rhinorrhoea
- Myalgia
- Sore throat
- Vomiting and nausea
- Diarrhoea

=

POSITIVE SCREEN

ASSESSMENT

DEPARTMENT LOCATION

Assign to clinical area depending on clinical acuity of presentation.
Use droplet precautions to prevent possible transmission
If no single room accommodation, cohort suspected ARI patients with curtains pulled

RESPIRATORY PRECAUTIONS

Avoid nebulisers/NIV if possible
Patient to wear surgical mask. Educate on cough Etiquette
Staff entering patient area to clean hands and wear surgical mask and wear protective eyewear when executing aerosol generating procedures

CLINICAL ASSESSMENT

Standard assessment
Note high risk features – pregnancy, children Under 2yrs, immunocompromised, chronic health conditions

INVESTIGATIONS as per clinical best practice, and

if it will alter clinical care
PCR Swab Collection for Testing via 4PLEX, Influenza A/B and SARS-CoV-2
(rapid testing with 4-hour turnaround time)

MANAGMENT

OUTPATIENT MANAGEMENT

ARI advice sheet
Educate importance of

- Isolate pending notification of result
- social isolation and cough etiquette
- clinical review with GP within 72 hrs

If within 48 hrs of onset of symptoms

- offer antiviral Oseltamivir for high-risk patient cohort – pregnant women, children under 2yrs, immunocompromised, chronic health conditions
- offer outpatient prescription to non-high risk patient cohort

INPATIENT MANAGMENT

Refer to appropriate clinical service, including Virtual Ward
Continue management isolation pending notification of result, with appropriate use of precautions to prevent possible transmission
Management as per Guidelines for Placement of Patient with ARI

Results of PCR to be reviewed *if negative, cease Oseltamivir if prescribed*

Appendix 4 The Prince Charles Hospital Criteria for COVID-19 and Influenza Response Sub Plan (Provided by TPCH EOC 09/06/2022)

Associated actions for TPCH Leadership Team Triggers and actions include, but are not limited to, the below:

Tier 0 *Mild Community Transmission*	**Tier 1** *Minimal Community Transmission* ***MAY***	**Tier 2** *Moderate Community Transmission* ***JUNE to AUGUST***	**Stand-Up** **Tier 3** *Significant Community Transmission*	**Recovery** **(Stand down)**
ACTIONS ▪ COVID-19 admission- ACC ▪ Influenza admission- home ward single room or 1E if no single rooms ▪ Prioritise Influenza and co-infection to single rooms. **ED CONSIDER OVERFLOW AREAS** ▪ AED- 36 treatment spaces include 1x single room, 2x type 5 rooms ▪ ED SSU- 10x treatment spaces (2 x type 4) ▪ CED – 12x single treatment spaces (11 type 4 and 1 type 5) – emphasis on PPE **ICU (5)** ▪ Pod 2: 3 x Type 5 rooms for influenza ▪ Pod 3: 2x type 5 rooms for COVID **FEVER CLINIC** ▪ External to ED, community-based ▪ Temporarily in place- COVID funded **MENTAL HEALTH** ▪ BAU – 5 BEDS ALLOCATED (1G) includes 1 single room **WORKFORCE** ▪ BAU	**ACTIONS** ▪ Open W1E x12 Type 5 negative pressure rooms ▪ Prioritise Influenza and co-infection to single rooms. ▪ No Children's ward single rooms (12) transfer to QCH ▪ Increase Children's Ward to 16 beds, consider 20 beds **ED CONSIDER OVERFLOW AREAS** ▪ AED- 36 treatment spaces include 1x single room, 2x type 5 rooms ▪ ED SSU- 10x treatment spaces (2 x type 4) ▪ CED – 12x single treatment spaces (11 type 4 and 1 type 5) – emphasis on PPE ▪ Review to increase CED to utilise additional OPD - treatment spaces- x7 ▪ Increase staffing ▪ Utilise Virtual ED **ICU OVERFLOW (11)** ▪ Children requiring ICU treatment will be transferred from Children's ED via QAS to QCH ▪ ACC and W1E locations to provide high flow oxygen outside of ICU footprint ▪ **Pod3:** 2 Type 5 + 7 cohorted and **Pod2**: 2x Type 5 ▪ Prioritise Influenza and co-infection to single rooms. ICU consultant/ nursing team on service will determine the movement of pts to reduce transmission risk as far as possible **FEVER CLINIC** ▪ External to ED, community-based ▪ Temporarily in place- COVID funded **MENTAL HEALTH** ▪ BAU plus – 4 -8 BEDS ALLOCATED WITHIN TW/IMS **WORKFORCE** ▪ Tier 0 plus review all recruitment strategies and deployment and upskilling of workforce	**ACTIONS** ▪ Open W1G x 30 (20x cohorted +10 x single rooms) ▪ Prioritise Influenza and co-infection to single rooms. ▪ No Children's single rooms (12) transfer to QCH ▪ Increase Children's Ward to 20 beds **ED CONSIDER OVERFLOW AREAS** ▪ AED- 36 treatment spaces include 1x single room, 2x type 5 rooms ▪ ED SSU- 10x treatment spaces (2 x type 4) ▪ CED – 12x single treatment spaces (11 type 4 and 1 type 5) – emphasis on PPE ▪ Increase RAMs, SAU and CPAS to be staffed 24hrs from 16hrs to increase flow and capacity ▪ increased CED and utilise additional OPD - treatment spaces- x7 (total of 20) ▪ Virtual ED – increase capacity as demand requires **ICU OVERFLOW (18)** As per tier 1 plus: • Elective Surgery: Review non-critical clinical services with option to reduce and/or suspend elective/non-urgent surgical and SOPD cases where possible ▪ As per COVID patient flow, ICU increased to 27 beds with separation between the units based on airflow assessment ▪ **Pod3:** 2 Type 5 + 7 cohorted and **Pod2:** 7 beds + 2x Type 5 ▪ Prioritise Influenza and co-infection to single rooms. ICU consultant/ nursing team on service will determine the movement of pts to reduce transmission risk as far as possible **MENTAL HEALTH** ▪ Same as Tier 1 - prioritise admissions across MN **FEVER CLINIC** ▪ External to ED, community-based ▪ Temporarily in place- COVID funded **WORKFORCE** ▪ Consider deployed staff from areas of closed service	**ACTIONS** ▪ Open W1F x30 (20x cohorted +10 x single rooms) ▪ Prioritise Influenza and co-infection to single rooms. ▪ Children's Ward- reaching capacity- seek Metro North support ▪ ED Load Share and IHT's **ED CONSIDER OVERFLOW AREAS** ▪ AED- 36 treatment spaces include 1x single room, 2x type 5 rooms ▪ ED SSU- 10x treatment spaces (2 x type 4) ▪ CED – 12x single treatment spaces (11 type 4 and 1 type 5) – emphasis on PPE ▪ Increase RAMs, SAU and CPAS to be staffed 24hrs from 16hrs to increase flow and capacity ▪ increased CED and utilise additional OPD - treatment spaces- x7 (total of 20) ▪ ED OPALS space – Adult Respiratory Fast Track (multi chair spaces) **ICU OVERFLOW (27)** ▪ Expand into Stage 2 PACU (10 beds) and W2E and OT (*substantial additional equipment required and staffing* required- see challenges and considerations*) ▪ Utilise private hospital ICUs for COVID-19 patients ▪ **Pod3-** 2x Type 5 + 7x cohorted, + **Pod2**: 9x beds + 2x Type 5, + **Pod1**- 9x beds **FEVER CLINIC** ▪ External to ED, community-based Temporarily in place- COVID funded **MENTAL HEALTH** ▪ Same as Tier 1 – prioritise admissions across MN **WORKFORCE** ▪ Consider deployed staff from areas of closed service	**ACTIONS** **Requirement to undertake:** Transition from responding to an event back to normal core business and/or recovery operations

Appendix 5: The Royal Brisbane and Women's Hospital Criteria for COVID-19 and Influenza Response Sub Plan (Provided by RBWH EOC 07/06/2022)

Associated actions for RBWH Leadership Team Triggers and actions include, but are not limited to, the below:

Tier 0
Mild Community Transmission

ACTIONS

ED CONSIDER OVERFLOW AREAS
- No overflow from usual ED footprint.
- All staff in N95 and patients in surgical masks.
- Earlier engagement with treating teams.

PATIENT MANAGEMENT PROCESS

ETC management
- Triage. Divert patients to virtual ED where able.
- Usual triage, treatment, transfer arrangements.
- Active admission avoidance including RADAR, Virtual ward, and GP follow up
- Testing for patients with resp illness requiring inpatient admission only.

Patient flow
- If clinically stable admit to a Single Room (SR) or specialist unit SR as required.
- Daily ward rounds to identify early discharge/HITH
- Appropriate release from isolation
- Active management of single room beds

BED MANAGEMENT
- Preferential admission to single rooms in NHB, excluding 6AN/S

69 beds

- ICU single rooms- 4 beds

Refer to 004661: Influenza and Respiratory Illness Management (health.qld.gov.au)

WORKFORCE

BAU

Tier 1
Minimal Community Transmission

MAY

ACTIONS

ED CONSIDER OVERFLOW AREAS
- As per *Tier 0*

PATIENT MANAGEMENT PROCESS
- As per *Tier 0* plus
- PPE escalation in high-risk areas and patients wear surgical masks

BED MANAGEMENT
- As per Tier 0 then
- Utilise priority risk matrix for Transmission Based Precaution to determine single room use
- Consider cohorting patients into 4 bed bays

Refer to 004661: Influenza and Respiratory Illness Management (health.qld.gov.au)

Ward beds
- Single rooms- 69 beds

Up to 69 beds +

- Flexible use of 6C- 16 beds

ICU OVERFLOW
- As per *Tier 0*.
- No overflow - manage, within existing ICU footprint.

WORKFORCE

BAU

Tier 2
Moderate Community Transmission

JUNE to AUGUST

ACTIONS

ED CONSIDER OVERFLOW AREAS
- As per *Tier 0*

PATIENT MANAGEMENT PROCESS
- As per *Tier 1*

ETC Management
- ETC waiting room coordinators and NP to specifically manage ARI attendances ($)

Patient flow
- Inpatient Nurse Navigator utilised to expedite patient flow between ETC and wards ($)
- UpLATE service expanded ($)
- EPIC Rapid Review Clinic expansion ($)
- Increase staff capacity in ORC to manage influenza in pregnancy presentations ($)
- Increase Medical Imaging capacity ($)
- Increase Discharge Transit Centre to 7-day multidisciplinary service ($)
- IHT bed Coordinator to improve case management of patient transfers ($)
- Increase Infection prevention and control resources to manage beds efficiently for isolation and clearing of patients ($)

BED MANAGEMENT
- As per *Tier 1* then
- COVID patients moved to 6AN
- 6AS - 20 beds for Influenza
- Haem/Onc patients to be managed within existing Cancer Care Service Line single rooms
- Cohort influenza patients in 1 x 4 bed bay within IMS and SP&S Service Lines (8beds)
- Single rooms - 69 beds

Up to 97 beds +

- Flex use of 6C- 16 beds

ICU OVERFLOW
- 4 negative pressure single rooms
- 3 single rooms
- Activate respiratory ICU pod 3/4- 14 beds

21 beds

WORKFORCE
- Non-essential training and non- critical/patient safety meetings cancelled.
- Clinical staff redeployed to areas of greatest need.
- Indirect staff are brought online to provide direct patient care.

Stand-Up Tier 3
Significant Community Transmission

ACTIONS

ED CONSIDER OVERFLOW AREAS
- As per *Tier 0*

PATIENT MANAGEMENT PROCESS
- As per *Tier 2*

BED MANAGEMENT
- As per *Tier 2* then
- Staged increase of 4 bed bays across multiple wards.

Up to 150 beds +

- Flex use of 6C – 16 beds

ICU OVERFLOW
- As per Tier 2 then
- Infill 'B' beds - 10

Up to 31 beds

WORKFORCE
- Non-patient facing staff with clinical qualifications are utilised to assist with patient care activities.
- Redeployment of staff working under the direct supervision of staff in subspecialty areas may be required to maintain patient safety

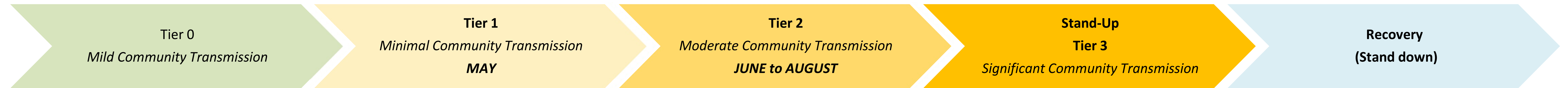
Recovery (Stand down)

ACTIONS

Requirement to undertake:
- Transition from responding to an event back to normal core business and/or recovery operations.

Appendix 6 Redcliffe Hospital Criteria for COVID-19 and Influenza Response Sub Plan (Provided by RDH EOC 27/05/2022)

Associated actions for RDH Leadership Team Triggers and actions include, but are not limited to, the below:



ACTIONS

ED CONSIDER OVERFLOW AREAS

BAU

RESPIRATORY WARD-

- Level 6 East East
  - Beds 13-24 (COVID only)
  - 2x negative pressure rooms
- Use of L6E single rooms with unshared ensuites

Other Respiratory Illness (Flu A)

- 2 negative pressure rooms
- Single rooms with unshared ensuite

ICU OVERFLOW

- 7 ventilated equivalent beds
- 10 physical bed spaces
  - 4x negative pressure
  - 2x isolation rooms
- Load share with Statewide ICU network

WORKFORCE

- Continue all over-recruitment strategies to support inactive FTE
  - Includes Allied Health, Facility and Nursing & Midwifery Services
- Pull all Nursing Support Unit staff back onto the emergent roster
- Increase casual pool RN, EN and AIN numbers to sustain workforce
- Review secondments and pull back as appropriate
- Review part-time staff capacity to increase hours

PPE Stockpiles, Clinical Consumables

- 10 Day holding of PPE requirements on-site
- 10 Day Holding of P2/N95 Masks

Equipment

- Air purifiers spreadsheet with location
- Maintenance schedule of filter changes

Logistics

- Increase touch point cleaning

ACTIONS

ED CONSIDER OVERFLOW AREAS
Tier 0 plus

- Virtual ED
  - Stand up: Computer workstation area set up in ED waiting room to allow patients to log onto virtual ED
  - RN Waiting Room- redirection of patients that meet virtual ED criteria

RESPIRATORY WARD
Tier 0 plus:
Other Respiratory Illness (Flu A)

- single rooms with shared ensuite
- cohort 4 bed bays with shared ensuite

ICU OVERFLOW
As per tier 0

WORKFORCE
Tier 0 plus

- Continual update of nursing staff with critical care skills/ experience and ventilator competence
- Continue to re-allocate staff to frontline as demand dictates
- Continue to recruit and deploy casual staff to frontline services
- Weekly staff forums, increase as appropriate
- Weekly Manager forums, increase as appropriate
- Continue infection control training
- Retraining/ refresher of previous ICU/ HDU/ perioperative nurses

PPE Stockpiles, Clinical Consumables

- Audit undertaken to increase stock on hand in the event of shortages and increased usage throughout the facility

Equipment

- Reporting of maintenance schedule of filter changes

ACTIONS

ED CONSIDER OVERFLOW AREAS
As per Tier 1

- Cohorting of ARI from vulnerable
- Chairs SSU

RESPIRATORY WARDS
Tier 1 plus:
Other Respiratory Illness (Flu A)

- Stand up Level 6 W: ARI ward- 30 beds
- Single rooms with unshared ensuite
- Cohorting of patients in 4 bed bays with own ensuite and air purifiers

ICU OVERFLOW
Tier 1 plus:

- Increase capacity to 10 ventilated beds
- Begin preparations for ICU expansion

WORKFORCE
Tier 1 plus

- Commence identification of nursing staff to assist in specialist units such as ICU, ED and NNU
- Commence ICU upskilling
- Minimize staff movement within wards and across facilities
- Review ability to provide ratio's
- Offer increased hours to part time staff at flexible start times and length of shift
- All indirect hours reviewed for clinical care
- Maintain Nurse Manager functions
- Continue to re-allocate staff to frontline as demand dictates

ACTIONS

ED CONSIDER OVERFLOW AREAS

- Expansion into SOPD 5 consult rooms – Ambulatory care
  - Joint NP and Medical led model of care
  - Aimed at increasing ED clinical footprint for non-infectious cat 3, 4 & 5 & minor injuries that are suitable to be assessed in SOPD environment
  - 16hr staffing model, 7 days a week

RESPIRATORY WARDS
Tier 2 plus:

ICU OVERFLOW

- ICU Pod 2 (L2W) triggered on 5th COVID-19 accepted referral
  - Capacity reached of ARI patients in ICU POD1-10 ventilated pts or equivalent COVID-19 patients

WORKFORCE

Tier 2 plus

Workforce Re-allocation/ Deployment as required or directed

- Redirect clinical staff where appropriate to support Clinical care
- Pharmacy to assist in medication preparation
- Allied Health to assist in the basic care requirements
- Review capacity CPO or escorts
- Centralise Nurse Manager functions, centralise rostering functions
- Monitor effectiveness of deployment resources to support staff in different working environments

Facility Services Workforce

- Deployment of Administration (non-clinical staff) to cover workforce shortage
- Identified task list updated to inform redeployed staff
- Inform the identified clinical and non-clinical staff not required in clinical capacity who could be re-deployed to assist
- Identified Non-Clinical Staff to undertake the appropriate training

ACTIONS

ED CONSIDER OVERFLOW AREAS

- Reduce Purple ED staffing to 8hr NP model

RESPIRATORY WARDS
Stand down level 6W as ARI ward

- Cohort ARI (Flu A) in L6E 4 bed bays rooms with air purifiers
- Single rooms L6E with air purifiers

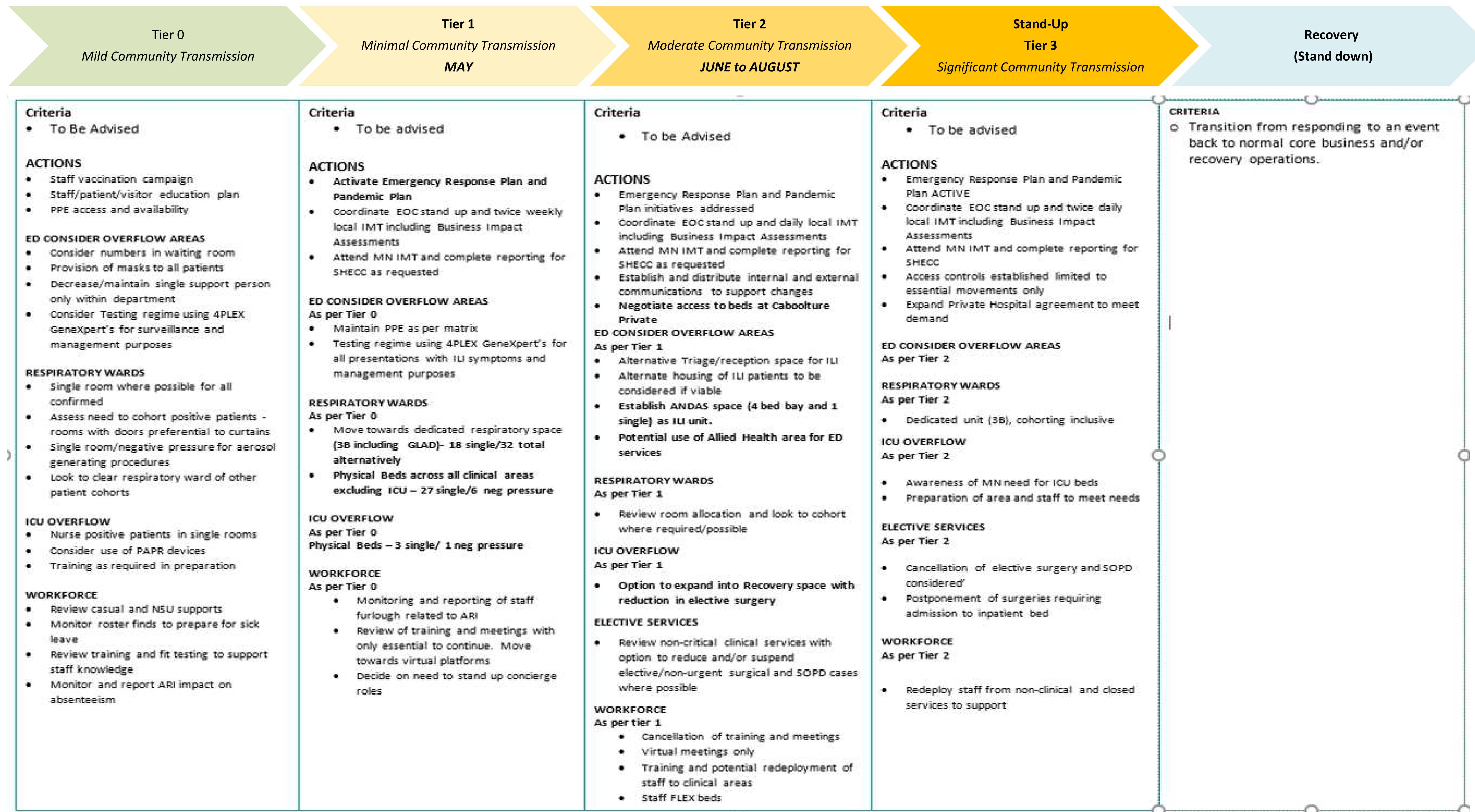
ICU OVERFLOW
Stand down L2W

WORKFORCE

- Return of planned care
- Deployed staff to return

Appendix 7: Caboolture, Kilcoy, and Woodford Directorate Criteria for COVID-19 and Influenza Response Sub Plan (Provided by CKW EOC 27/05/2022)

Associated actions for CKW Leadership Team Triggers and actions include, but are not limited to, the below:



Tier 0 *Mild Community Transmission*	**Tier 1** *Minimal Community Transmission* ***MAY***	**Tier 2** *Moderate Community Transmission* ***JUNE to AUGUST***	**Stand-Up** **Tier 3** *Significant Community Transmission*	**Recovery** **(Stand down)**
Criteria • To Be Advised **ACTIONS** • Staff vaccination campaign • Staff/patient/visitor education plan • PPE access and availability **ED CONSIDER OVERFLOW AREAS** • Consider numbers in waiting room • Provision of masks to all patients • Decrease/maintain single support person only within department • Consider Testing regime using 4PLEX GeneXpert's for surveillance and management purposes **RESPIRATORY WARDS** • Single room where possible for all confirmed • Assess need to cohort positive patients - rooms with doors preferential to curtains • Single room/negative pressure for aerosol generating procedures • Look to clear respiratory ward of other patient cohorts **ICU OVERFLOW** • Nurse positive patients in single rooms • Consider use of PAPR devices • Training as required in preparation **WORKFORCE** • Review casual and NSU supports • Monitor roster finds to prepare for sick leave • Review training and fit testing to support staff knowledge • Monitor and report ARI impact on absenteeism	**Criteria** • To be advised **ACTIONS** • **Activate Emergency Response Plan and Pandemic Plan** • Coordinate EOC stand up and twice weekly local IMT including Business Impact Assessments • Attend MN IMT and complete reporting for SHECC as requested **ED CONSIDER OVERFLOW AREAS** **As per Tier 0** • Maintain PPE as per matrix • Testing regime using 4PLEX GeneXpert's for all presentations with ILI symptoms and management purposes **RESPIRATORY WARDS** **As per Tier 0** • Move towards dedicated respiratory space **(3B including GLAD)- 18 single/32 total alternatively** • **Physical Beds across all clinical areas excluding ICU – 27 single/6 neg pressure** **ICU OVERFLOW** **As per Tier 0** **Physical Beds – 3 single/ 1 neg pressure** **WORKFORCE** **As per Tier 0** • Monitoring and reporting of staff furlough related to ARI • Review of training and meetings with only essential to continue. Move towards virtual platforms • Decide on need to stand up concierge roles	**Criteria** • To be Advised **ACTIONS** • Emergency Response Plan and Pandemic Plan initiatives addressed • Coordinate EOC stand up and daily local IMT including Business Impact Assessments • Attend MN IMT and complete reporting for SHECC as requested • Establish and distribute internal and external communications to support changes • **Negotiate access to beds at Caboolture Private** **ED CONSIDER OVERFLOW AREAS** **As per Tier 1** • Alternative Triage/reception space for ILI • Alternate housing of ILI patients to be considered if viable • **Establish ANDAS space (4 bed bay and 1 single) as ILI unit.** • **Potential use of Allied Health area for ED services** **RESPIRATORY WARDS** **As per Tier 1** • Review room allocation and look to cohort where required/possible **ICU OVERFLOW** **As per Tier 1** • **Option to expand into Recovery space with reduction in elective surgery** **ELECTIVE SERVICES** • Review non-critical clinical services with option to reduce and/or suspend elective/non-urgent surgical and SOPD cases where possible **WORKFORCE** **As per tier 1** • Cancellation of training and meetings • Virtual meetings only • Training and potential redeployment of staff to clinical areas • Staff FLEX beds	**Criteria** • To be advised **ACTIONS** • Emergency Response Plan and Pandemic Plan ACTIVE • Coordinate EOC stand up and twice daily local IMT including Business Impact Assessments • Attend MN IMT and complete reporting for SHECC • Access controls established limited to essential movements only • Expand Private Hospital agreement to meet demand **ED CONSIDER OVERFLOW AREAS** **As per Tier 2** **RESPIRATORY WARDS** **As per Tier 2** • Dedicated unit (3B), cohorting inclusive **ICU OVERFLOW** **As per Tier 2** • Awareness of MN need for ICU beds • Preparation of area and staff to meet needs **ELECTIVE SERVICES** **As per Tier 2** • Cancellation of elective surgery and SOPD considered' • Postponement of surgeries requiring admission to inpatient bed **WORKFORCE** **As per Tier 2** • Redeploy staff from non-clinical and closed services to support	**CRITERIA** o Transition from responding to an event back to normal core business and/or recovery operations.

Appendix 8: Community and Oral Health Directorate Criteria for COVID-19 and Influenza Response Sub Plan (Provided by COH EOC 27/05/2022)

Associated actions for COH Leadership Team Triggers and actions include, but are not limited to, the below:

Criteria • To Be Advised	**Criteria** • To Be Advised	**Criteria** • To Be Advised	**Criteria** • To Be Advised	**CRITERIA**
Patient Management- **Subacute-** • All symptomatic patients to be tested using GeneXpert 4Plex • Single rooms for all ARI confirmed cases **RTCP-** • All symptomatic patients to be tested using GeneXpert 4Plex • Confirmed ARI cases moved to single room with door (2 available) **Residential Services-** • All symptomatic patients to be tested using Genexpert 4Plex • Single rooms for all ARI confirmed cases	**Patient Management-** As per Tier 0 plus: **Subacute-** • Cohorting of like for like ARI confirmed cases in double and triple rooms • Begin preparations to open BBIS C wing to 4 beds-unstaffed beds currently **RTCP-** • Cohorting of like for like ARI confirmed cases in double rooms with doors (3 available) **Residential Services-** • If greater than 3 cases of confirmed ARI in RACF-outbreak declared • Consider visitor restrictions in line with current Covid-19 outbreak management plan (ie 1 support person per person even if confirmed ARI case)	**Patient Management-** As per tier 1 plus: **Subacute-** • Cohorting of like for like ARI confirmed cases in double or triple rooms • Non- ARI patients to be prioritised for single rooms • Open BBIS C wing to 4 beds as overflow cohort area **RTCP-** • Cohort confirmed ARI cases in 4 bed pods **Residential Services-** • As per Tier 1	**Patient Management-**As per Tier 2 plus **Subacute-** • Single or double rooms for all non-ARI patients • Cohort confirmed ARI cases on one ward with non-ARI patients on other • Open BBIS C wing to 8 beds as overflow cohort area **RTCP-** • Cohort confirmed ARI cases to either East or West Wing (30 beds each) **Residential Services-** • As per Tier 1	
Medical Governance- **Subacute-** No change **RTCP-** No change **Residential Services-** No change	**Medical Governance-** **Subacute-** No change **RTCP** - Consider increasing GP model of care **Residential Services-** Early notification to RADAR services of situation so they can prepare for increased support	**Medical Governance-** **Subacute-** Increase medical staffing to 7 days per week with RMO on-call overnight **RTCP-** Complement GP model of care with HITH/ CBRT/ RADAR physician support **Residential Services-** Engage with RADAR outreach service	**Medical Governance-** **Subacute-** Increase medical staffing to 7 days per week with onsite RMO overnight **RTCP-** 7 days per week medical model of care through either HITH, CBRT or RADAR **Residential Services-** Engage with RADAR rapid response teams on site	
Logistics- • As per BAU • PPE as per risk matrix	**Logistics-**As per Tier 0 plus: • Consider increasing stock holdings of PPE • Extra surgical masks available to ensure sufficient supply for visitors	**Logistics-**As per Tier 1 plus: • Increase stock holdings of PPE • Consider need for extra staff showers on site • Consider need for staff scrubs	**Logistics-**As per tier 2 plus: • Deploy extra showers on site for staff • Supply scrubs for staff to change into for work	
Workforce- • Review casual and NSU supports • Monitor roster finds to prepare for sick leave • Review training and fit testing to support staff knowledge • Monitor and report ARI impact on absenteeism	**Workforce-** As per Tier 0 plus: • Review training and meetings- where possible move to virtual • Consider concierge roles if not still in place due to Covid restrictions • Review staffing to open BBIS C wing to 4 beds if move up tier	**Workforce-**As per Tier 1 plus: • Move all training and meetings to virtual • Consider redeployment of non-frontline clinical staff to clinical areas	**Workforce-**As per tier 2 plus: • Cease all non-urgent meetings and education • Deploy non-frontline clinical staff to clinical areas	
Actions- • Continue staff flu vaccination program • COH EOC to be staffed 5 days per week • COH IMT as required • Virtual staff COH huddles as required	**Actions-**As per tier 0 plus: • Consider increasing frequency of staff flu vaccination program • COH EOC to be staffed 5 days per week • COH IMT once a week • Staff COH huddles / update once a week via TEAMS	**Actions-**As per tier 1 plus: • Increase frequency of staff flu vaccination program • COH EOC to be staff 5 days per week with on-call on weekends • COH IMT twice a week • Staff COH huddles twice a week via TEAMS	**Actions-**As per Tier 2 plus: • Cease staff flu vaccination program to redirect staff to clinical areas • COH EOC to be staffed 7 days per week • COH IMT daily • Staff COH huddles / update daily via TEAMS	

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Appendix 9: Mental Health Directorate Criteria for COVID-19 and Influenza Response Sub Plan (Provided by MHD EOC 27/05/2022)

Associated actions for MHD Leadership Team Triggers and actions include, but are not limited to, the below:

ACTIONS	ACTIONS	ACTIONS	ACTIONS	ACTIONS
ACUTE/SECURE MENTAL HEALTH WARDS • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment • If unable to facilitate single rooms, the MN ID Consultant to be consulted for consideration of cohorting • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways	**ACUTE/SECURE MENTAL HEALTH WARDS** • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment • If unable to facilitate single rooms, the MN ID Consultant to be consulted for consideration of cohorting • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways	**ACUTE/SECURE MENTAL HEALTH WARDS** • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment • If unable to facilitate single rooms, the MN ID Consultant to be consulted for consideration of cohorting • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways	**ACUTE/SECURE MENTAL HEALTH WARDS** • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment • If unable to facilitate single rooms, the MN ID Consultant to be consulted for consideration of cohorting • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways	**ACUTE/SECURE MENTAL HEALTH WARDS** • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment • If unable to facilitate single rooms, the MN ID Consultant to be consulted for consideration of cohorting • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways
COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU) • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment. Majority of SUSD/CCU are single rooms/units • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways	**COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)** • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment. Majority of SUSD/CCU are single rooms/units • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways	**COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)** • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment. Majority of SUSD/CCU are single rooms/units • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways	**COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)** • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment. Majority of SUSD/CCU are single rooms/units • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways	**COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)** • Testing of consumers with symptoms of ARI • Isolation of consumers with ARI to single room with air purifier placement as per risk assessment Majority of SUSD/CCU are single rooms/units • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways
COMMUNITY TEAMS • Referral of consumers of concern with ARI to MNH Virtual Care Ward	**COMMUNITY TEAMS** • Referral of consumers of concern with ARI to MNH Virtual Care Ward	**COMMUNITY TEAMS** • Referral of consumers of concern with ARI to MNH Virtual Care Ward	**COMMUNITY TEAMS** • Referral of consumers of concern with ARI to MNH Virtual Care Ward	**COMMUNITY TEAMS** • Referral of consumers of concern with ARI to MNH Virtual Care Ward
WORKFORCE • MH staff required for MH usual care. • Collaborative discussion with Facility regarding specialty workforce based on assessment of MH needs e.g. MH nurse special, security special.	**WORKFORCE** • MH staff required for MH usual care. • Collaborative discussion with Facility regarding specialty workforce based on assessment of MH needs e.g. MH nurse special, security special.	**WORKFORCE** • MH staff required for MH usual care. • Collaborative discussion with Facility regarding specialty workforce based on assessment of MH needs e.g. MH nurse special, security special.	**WORKFORCE** • MH staff required for MH usual care. • Collaborative discussion with Facility regarding specialty workforce based on assessment of MH needs e.g. MH nurse special, security special.	**WORKFORCE** • MH staff required for MH usual care. • Collaborative discussion with Facility regarding specialty workforce based on assessment of MH needs e.g. MH nurse special, security special.

Appendix 10: Metro North HHS Acute Bed Capacity Surge Plan Activation and Associated Actions (as per Metro North Acute Capacity Framework)

Criteria for movement through phases of activation and the associated actions for Facility/Directorate (Based on Protocol for managing capacity of Queensland public hospitals, QH-HSDPTL-025-3:2021) Triggers and actions include, but are not limited to, the below:

Tier 0

DEFINITION:

- All aspects for patient demand being met
- All services functioning within optimal performance

CRITERIA

- 3 or more facilities at Tier 1

MNH Patient Flow Strategies

Load sharing options within HS (balance for all facilities)

- Back transfer of patients out of facility or HS to referral hospital within agreed time frame (max. 48 hours)

Tier 1

DEFINITION:

- Individual service area within a facility experiencing a demand higher than usual
- Local level response by key clinicians to both communicate and implement action to combat the demand
- Communicate to Patient Flow/ Bed Management to HHS Patient Flow/PACH to monitor progress

CRITERIA

- Up to 2 facilities on Tier 2

MNH Patient Flow Strategies

- Coordination of HS-wide teleconference (as required)
- Activation of MN Business Continuity Plan – Alert

HS support made available:

- Prolonged targeted load sharing (to assist impacted facilities)
- Access PACH funding for acute beds (period of less <5days)
- Active distribution of targeted patients across HHS
- Access to PACH funding for physical beds in alternate facilities to create capacity in specialty areas (MNHHS capacity)
- Access to PACH funding for additional patient support services to meet cleaning and movement timeframes
- Access to PACH funding to open sub-acute beds
-

Tier 2

DEFINITION:

- Limited capacity to meet needs of the local community in the facility
- Facility wide response enacted with local executive teams driving actions and communications
- Local HHS Patient Flow/PACH overseeing the process to ensure assistance is provided from the HHS where possible

CRITERIA

- At least 2 facilities on Tier 2 **and** 1 Tier 3 for capacity

MNH Patient Flow Strategies

- Coordination of HS-wide daily teleconferences
- Activation of after-hours HS-wide staffing huddles (2000hrs)
- Activation of MNH Business Continuity Plan - Lean Forward
- Negotiate with external service partners (QAS, PHN) to prioritise hospital avoidance and alternate care paths

HS support made available as per Tier 1 plus:

- Approval and coordination support for intra-HS surge options (specialty areas excluding ICU)
- Conduit for collaboration of external stakeholders (QAS, RSQ) for patient transfers
- Access to private hospital beds (beyond pre-agreed levels)
- Access to additional PACH acute bed funding (periods beyond 5 days)
- Approval and coordination support for inter-HS surge options (specialty areas excluding ICU)
- Opening of all built bed, over-census bed (including chairs) capacity across MNH^

^ Opening of physical beds is dependant of capacity to staff beds.

Stand-Up Tier 3

DEFINITION:

- Limited capacity to meet the needs of the local community in the majority of facilities in the HHS
- HHS wide response enacted with HHS executive teams driving actions and communications
- HHS Patient Flow/PACH overseeing the process to monitor ongoing demand and sourcing and providing assistance where possible
- All capacity has been exhausted with no ability to manage ongoing demand
- HHS Executive Level response
- Communicated with QPACH

CRITERIA

- Minimum RBWH or TPCH on Tier 2 a**nd** Caboolture and Redcliffe on Tier 3

  OR
- Caboolture **and** Redcliffe **and** RBWH or TPCH on Tier 3

MNH Patient Flow Strategies

- Coordination of multiple HS-wide teleconferences daily
- Activation of MNH Business Continuity Plan – Stand Up

HS support made available as per Tier 2 plus:

- PACH funding models revert to by negotiation
- Approvals for changes to model of care (e.g. ratios, diversion of staff, reconfiguration of physical bed spaces, inpatient services delivered as outpatient service, use of Medihotel model etc)
- Approvals for clinical service delivery reduction and/or suspension across the HS or at specific facilities
- Support interhospital transfer options across HHS
- HS wide communication channels and resources
- Call-in to join MN IMT key external stakeholder executive e.g., QAS
- Approval and logistical support for reallocation of staff across the HS
- Requests inter HS staffing support*
- Liaison with RSQ to support Inter-Hospital transfer^
- Liaison with Department of Health / SHECC for additional funding, media /communication / inter-HS support

^ RSQ Resource and workload dependant
*It is noted that access to inter-HS staff is expected to be highly unlikely given MNH role within the system.

- .

Recovery (Stand down)

CRITERIA

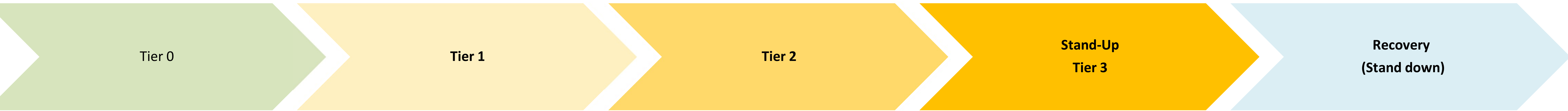
Transition from responding to an event back to normal core business and/or recovery operations

MNH Patient Flow Strategies

- Transition from responding to an event back to normal core business and/or recovery operations.

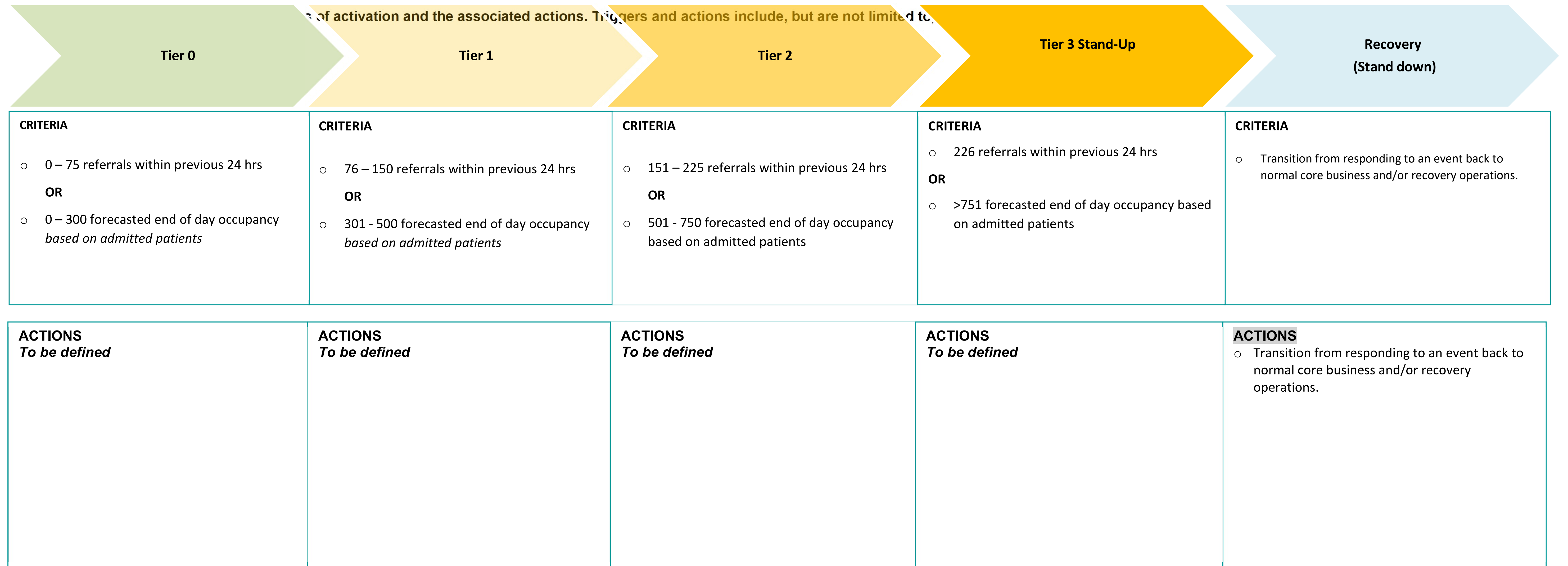
Appendix 11: Metro North HHS Emergency Department Capacity Surge Plan Activation and Associated Actions (as per Metro North Emergency Department Capacity Framework - Draft)

Criteria for movement through phases of activation and the associated actions for Metro North EMBC and Facilities. Triggers and actions include, but are not limited to, the below:



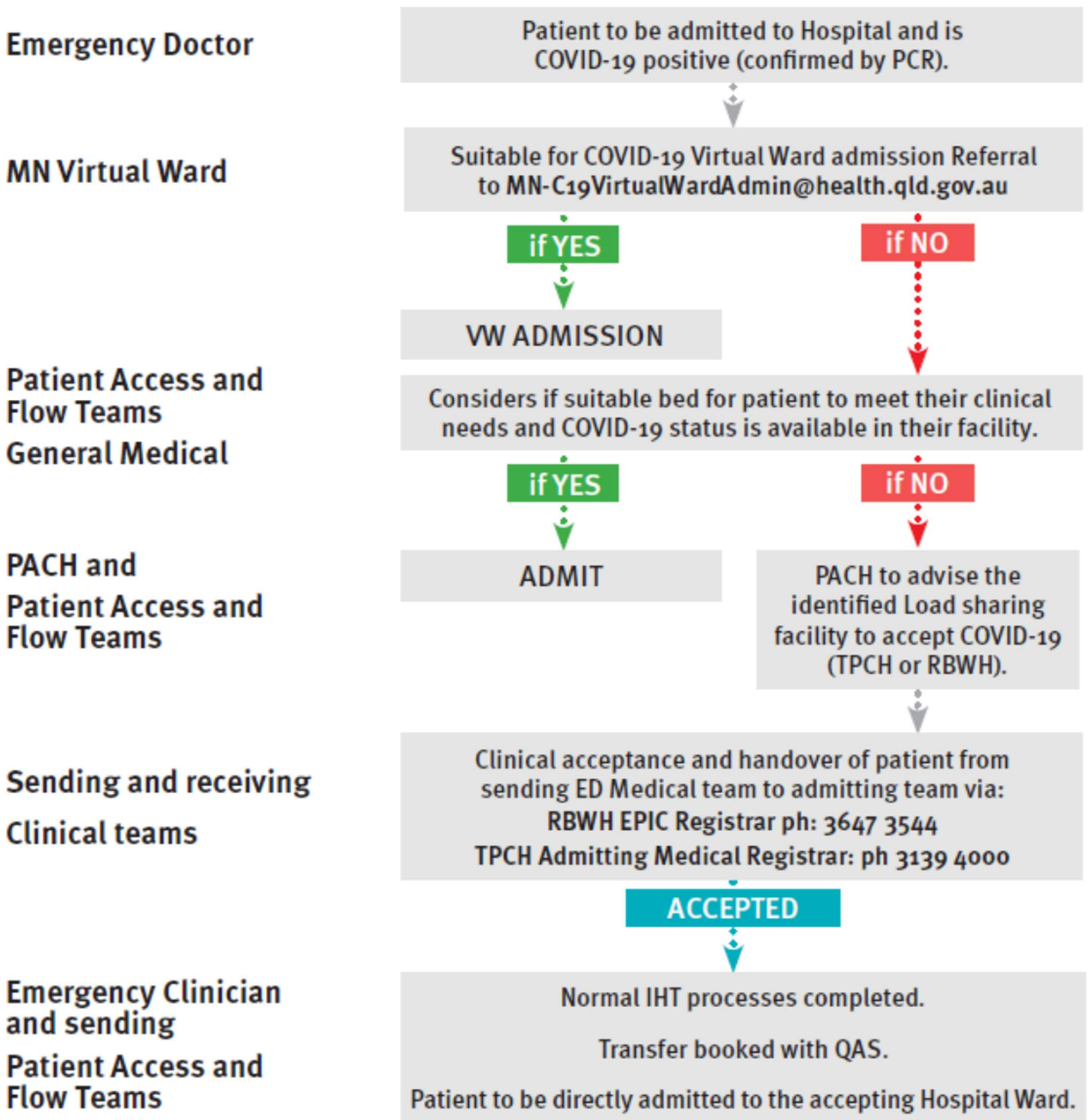
Tier 0	Tier 1	Tier 2	Stand-Up Tier 3	Recovery (Stand down)
CRITERIA – *per ED* one of ○ Zero patient waiting greater than 60 mins to be seen by treating clinician ○ Zero patient assessed with ATS 2 waiting greater than 10 minutes to be seen by treating clinician ○ Zero patients delayed greater than 20 minutes with QAS ○ Zero patients delayed greater than 1 hr pending transfer to Inpatient and/or SSU Bed ○ Zero patients delay pending transfer to ICU bed ○ Zero patients with ED length of stay (ED LOS) greater than 6 hours ○ 2 Resus Bay available ○ 3 Acute Bay available ○ 4 Short stay Unit (SSU) Bay available Linked to Acute Bed Capacity Surge Plan	**CRITERIA – *per ED* one of** ○ 1 – 8 patients waiting greater than 60 mins to be seen by treating clinician ○ 1- 4 patient assessed with ATS 2 waiting greater than 10 minutes to be seen by treating clinician ○ 1-3 patients delayed greater than 20 minutes with QAS ○ 1- 4 patients delayed greater than 1 hr. pending transfer to Inpatient and/or SSU Bed ○ 1 patient delay pending transfer to ICU bed ○ 1 patient with ED LOS greater than 6 hours ○ Up to 1 Resus Bay available ○ Up to 2 Acute Bay available ○ UP to 3 SSU Bay available Linked to Acute Bed Capacity Surge Plan	**CRITERIA – *per ED* one of** ○ 8 - 16 patients waiting greater than 60 mins to be seen by treating clinician ○ > than 4 patients assessed with ATS 2 waiting greater than 10 minutes to be seen by treating clinician ○ > than 3 patients delayed greater than 20 minutes with QAS ○ > than 4 patients delayed greater than 1 hr. pending transfer to Inpatient and/or SSU Bed ○ > than 1 patient delay pending transfer to ICU bed ○ 2 - 4 patients with ED LOS greater than 6 hours ○ Zero Resus Bay available ○ 1 Acute Bay available ○ 1 SSU Bay available Linked to Acute Bed Capacity Surge Plan	**CRITERIA – *ED* one of** ○ > than 16 patients waiting greater than 60 mins to be seen by treating clinician ○ > than 4 patients assessed with ATS 2 waiting greater than 10 minutes to be seen by treating clinician ○ > than 3 patients delayed greater than 20 minutes with QAS ○ > than 1 patient delayed greater than 1 hr. pending transfer to Inpatient and/or SSU Bed ○ > than 1 patient delay pending transfer to ICU bed ○ > than 4 patients with ED LOS greater than 6 hours ○ Zero Resus Bay available ○ Zero Acute Bay available ○ Zero SSU Bay available Linked to Acute Bed Capacity Surge Plan	**CRITERIA** ○ Transition from responding to an event back to normal core business and/or recovery operations.
ACTIONS **Business as usual** Including - ○ Virtual rounding via automated push notifications per identified triggers	**ACTIONS** **Requirement for ED** ○ Pause and consider to ○ identify cause, ○ develop targeted solution and implement plan **Tasked to** ○ Nursing Shift Coordinator/Team Leader *Review in 30 minutes* **If not resolved** ○ Clinical Director ○ Nursing Director ○ ED CNC/NUM	**ACTIONS** **Requirement for ED and Facility** ○ Pause and consider to ○ identify cause, ○ develop targeted solution and implement plan **Tasked to** ○ Clinical Director ○ Nursing Director ○ ED CNC/NUM *Review in 60 minutes* **If not resolved** ○ Director of Medical Services – Facility ○ ND Metro North PACH	**ACTIONS** **Requirement for ED and Facility** ○ Pause and consider to ○ identify cause, ○ develop targeted solution and implement plan **Tasked to** ○ Clinical Director ○ Nursing Director ○ Director of Medical Services – Facility ○ ND Metro North PACH *Review in 60 – 120 minutes* **If not resolved** ○ Executive Director - Facility ○ Clinical Director – Metro North PACH **If not resolved** ○ Metro North HHS ED Operations or on-call Executive	**ACTIONS** ○ Transition from responding to an event back to normal core business and/or recovery operations.

Appendix 12: Metro North Health Virtual Ward Service Capacity Surge Plan Activation and Associated Actions (as per Metro North Health Virtual Ward Model of Care



Tier 0	Tier 1	Tier 2	Tier 3 Stand-Up	Recovery (Stand down)
CRITERIA ○ 0 – 75 referrals within previous 24 hrs **OR** ○ 0 – 300 forecasted end of day occupancy *based on admitted patients*	**CRITERIA** ○ 76 – 150 referrals within previous 24 hrs **OR** ○ 301 - 500 forecasted end of day occupancy *based on admitted patients*	**CRITERIA** ○ 151 – 225 referrals within previous 24 hrs **OR** ○ 501 - 750 forecasted end of day occupancy based on admitted patients	**CRITERIA** ○ 226 referrals within previous 24 hrs **OR** ○ >751 forecasted end of day occupancy based on admitted patients	**CRITERIA** ○ Transition from responding to an event back to normal core business and/or recovery operations.
ACTIONS ***To be defined***	**ACTIONS** ***To be defined***	**ACTIONS** ***To be defined***	**ACTIONS** ***To be defined***	**ACTIONS** ○ Transition from responding to an event back to normal core business and/or recovery operations.

Appendix 13: Process for admission to Metro North Health Facilities who are COVID-19 Positive



Note. Notification for the idendification and communication of COVID-19 capacity is described in appendix 5
Communication facilitated by Metro North PACH

Appendix 14: Identification of COVID-19 capacity, communication, and notification strategy

<table>
<tr><th>How</th><th>Who</th><th>Action</th></tr>
<tr><td rowspan="2">Confirmation of COVID Capacity</td><td>Facility Based Patient Access and Flow Teams</td><td>Current and forecasted end of day COVID capacity is included in Acute Bed Capacity Impact Assessment/Safety Matrix, provided to MNH PACH 0815, 1130, 1630 and 2100 hrs</td></tr>
<tr><td>MNH PACH Team</td><td>Confirm Admitting strategy for each facility, with updates provided to reflect current situation, @ 0845, 1215, 1700 and with last update at 2130 hrs</td></tr>
<tr><td>Communication</td><td>MNH PACH Team</td><td>EMAIL Notification
Subject: MNH COVID Capcity @ <<insert date and time>>
Sent to: RBWH, RDH, CAB, TPCH Patient access and flow teams
CC: MNH EOC, MN PACH, MNH NIS
Body: Based on current MNH COVID Capacity, identified facility for admission of COVID positive patients @<<insert date and time>> is
<table>
<tr><th>Current at << date/time>></th><th>CAB</th><th>RDH</th><th>TPCH</th><th>RBWH</th></tr>
<tr><td>COVID admit to home unit</td><td>YES</td><td></td><td>YES</td><td>YES</td></tr>
<tr><td>COVID admit to alternate facility</td><td></td><td>Yes – TPCH</td><td></td><td></td></tr>
</table>
Note: Accepting clinician, *for*
RBWH – EPIC Registrar 3647 3544
TPCH – RAMS Registrar, via Switch, 3139 4000

Action Requested: Facility based Patient Access and Flow team to notify local Emergency Department Team Leader/Coordinator</td></tr>
</table>

The Plan is separate to the Metro North COVID-19 response plan and may be activated independently from other plans where the declared incident impacts is separate to surges related to COVID-19 activity and should only be used in conjunction with the Metro North Health acute capacity framework, for both acute bed and emergency departments.

Related Documents

Australian Health Management Plan for Pandemic ARI (AHMPPI)
Caboolture and Kilcoy Hospitals Pandemic Plan
Clinical Guidelines for ARI-Like Illnesses
MNHHHS Business Continuity Management Plan
MNHHHS Emergency Management Plan
Public Health Act (2005) and sub-ordinate regulation
Queensland Health Pandemic ARI Plan
RBWH Pandemic Plan
Redcliffe Hospital Pandemic Plan
TPCH Pandemic Plan
Patient Access to care health service directive
Clinical Services Capability Framework for Public and licensed Private Health Facilities version 3.2 retrieved from https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf
Australian Commission on Safety and Quality in Health Care: Patient Placement Guide - Infection Prevention and Control

Guidelines for prescribing oseltamivir for seasonal influenzas in 2022 (health.qld.gov.au)

C-ECTF-22/8952 - CHO & CHSRL MEMO - Management of confirmed COVID-19 and Influenza cases in Acute Care settings
C-ECTF-22/9372 – A/COO & CHO MEMO - Transition towards ‘COVID normal’