Appendix 7: The Prince Charles Hospital Criteria for Acute Respiratory Illness Response Sub Plan Part 1 (Updated by TPCH ELT May 2023)

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*	**Tier 2** *Moderate Community Transmission*	**Stand-Up** **Tier 3** *Significant Community Transmission*	**Recovery** **(Stand down)**

STRATEGY: Designated

Covid-19/ ARI Capacity	12

- COVID-19 admission- as per Infection prevention and control guidelines for the management of COVID-19 in healthcare settings | Queensland Health
- High Flow Nasal Oxygen (HFNO), CPAP and BiPAP should be managed in Type 5 rooms
- **W1E**
  - Type 5 single room 8 beds
  - Prioritise Influenza /co-infection admissions to admitting program ward into Type 4 room or 1E if capacity and single rooms unavailable
- **Children's Ward (CW)**
  - Type 5 single room 2 beds

ED 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
- Patients to virtual ED where appropriate
- Usual triage, treatment, transfer arrangements.
- Active admission avoidance including RADAR, Virtual ED and GP follow up
- Testing for symptomatic patients with ILI for likely inpatient admission

ICU (Pod 3)

- Two (2) Type 5 rooms for influenza

MENTAL HEALTH

- Managed as per Infection prevention and control guidelines for the management of COVID-19 in healthcare settings | Queensland Health

ACUTE Inpatient Areas (BAU)

STRATEGY: Designated/ Co-Located

Covid-19/ ARI Capacity	38

- As per Tier 0
- W1E Type 5 single rooms (up to 12 beds)
- Prioritise Influenza and co-infection to Type 4 single rooms.
- CW use Type 4 single rooms (up to 12 beds)
- Increase CW acute inpatient staffing to 16 beds

ED CONSIDER OVERFLOW AREAS

- As per Tier 0
- Prepare to increase CED for additional adjacent OPD seven (7) treatment spaces
- Identify increased staffing models

ICU OVERFLOW (4/18)

- Children requiring ICU treatment will be transferred by RSQ to QCH
- **Pod 3:** 2x Type 5 and **Pod 2**: 2x Type 5

Prioritise Influenza and co-infection to single rooms. ICU consultant/ nursing team will determine the movement of patients to reduce transmission risk as far as possible

MENTAL HEALTH

- Consider need for surge beds 4 - 8 in the Thoracic Ward (TW)

ACUTE Inpatient BED MANAGEMENT (up to 24 COVID beds)

Inpatient COVID co-located with programmes (Type 4 single rooms, risk mitigated for density)

- Surgery (up to 4/34 Type 4 beds)
- Thoracic (up to 2/15 Type 4 beds)
- Cardiology (up to 2/12 Type 4 beds and 2/2 Type 3 single rooms CCU)
- Internal Medicine (up to 6 /17 Type 4 beds)
- Subacute (up to 2/16 beds)

STRATEGY: Co-Located

Covid-19/ ARI Capacity	55

- As per Tier 1
- If CW Type 4 single rooms (12) all used, arrange transfer to QCH
- Increase CW to 20 beds to maintain paediatric patient flow

ED CONSIDER OVERFLOW AREAS

- As per Tier 1
- Increase RAMs, SAU and CPAS MOC from 16 hours to 24 hours to increase inpatient flow and capacity
- Increase CED and utilise additional OPD treatment spaces x7 (total of 19)
- Virtual ED – increase capacity as demand requires

ICU OVERFLOW (11/27)

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
- ICU increase to 27 beds with separation between the units based on airflow assessment to maintain state-wide, tertiary, and quaternary service
- HVAC switched from economy mode to full exhaust/non-recirculated mode
- **Pod 3:** 2 Type 5 + 7 cohorted and **Pod 2:** 2x Type 5

ACUTE Inpatient BED MANAGEMENT (open flex beds, up to 34 COVID beds)

Inpatient COVID co-located with programmes (Type 4 single rooms, risk mitigated for density)

- Surgery (up to 8/34 Type 4 beds)
- Thoracic (up to 4/15 Type 4 beds)
- Cardiology (up to 4/12 Type 4 beds and 2/2 Type 3 single rooms CCU)
- Internal Medicine (up to 8/17 Type 4 beds)
- Subacute (up to 4/16 beds)

STRATEGY: Designated/Cohorted/Co-Located

Covid-19/ ARI Capacity	74

- As per Tier 2
- Recommission ACFC to ACC MOC Type 4 negative flow (14 beds) to a designated ward and
- Prepare W1F 30 beds (10 Type 4 and 20 standard cohorted); HVAC switched from economy mode to full exhaust/non-recirculated mode
- ED Load Share and IHT's

ED CONSIDER OVERFLOW AREAS

- As per Tier 2
- ED OPALS space – Adult Respiratory Fast Track (multi chair space)

ICU OVERFLOW (18/37)

- 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
- **Pod 3-** 2x Type 5 + 7x cohorted, + **Pod 2**: 9x beds + 2x Type 5, + **Pod 1**- 9x beds

ACUTE Inpatient BED MANAGEMENT (cohorted in designated wards) up to 54 COVID beds

Inpatient COVID designated /co-located for specialty

- Surgery (up to 2/34 Type 4 beds)
- Thoracic (up to 2/15 Type 4 beds)
- Cardiology (up to 2/12 Type 4 beds and 2/2 Type 3 single rooms CCU)
- Internal Medicine W1F 30 beds
- Subacute (up to 2/16 beds)

Non-traditional overnight inpatient areas

- Over census enacted inpatient areas
- Stage 2 PACU 8 beds overnight inpatient

ACTIONS

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

The Prince Charles Hospital Criteria for Acute Respiratory Illness Response Sub Plan – Part 2 (Updated by TPCH ELT May 2023)

Tier 0 *Mild Community Transmission*	**Tier 1** *Minimal Community Transmission*	**Tier 2** *Moderate Community Transmission*	**Stand-Up** **Tier 3** *Significant Community Transmission*	**Recovery** **(Stand down)**
WORKFORCE ▪ Monitor recruitment strategies and vacancy management as per BPF	**WORKFORCE** • Tier 0 plus review all recruitment strategies and deployment and upskilling of workforce	**WORKFORCE** • Non-essential face to face training cancelled • Non-critical face to face meetings cancelled • Virtual meetings only • Clinical staff redeployed from closed services to areas of greatest need. • Indirect staff to provide direct patient care activities as required.	**WORKFORCE** • Non-essential face to face training cancelled • Non-critical face to face meetings cancelled • Virtual meetings only • Clinical staff redeployed from closed services to areas of greatest need. • Indirect staff to provide direct patient care activities as required.	**WORKFORCE** • Staged de-escalation of workforce strategies. • Resumption of essential training and meetings as clinical demands permit.