Metro North Health ACUTE RESPIRATORY ILLNESS PLAN: 2023

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
V0.0	DRAFT	First version
V0.1.	DRAFT	Section 2 Infrastructure amended to reflect current situation
V0.2	DRAFT	Facility Sub Plans updated
V0.3	DRAFT	Facility Sub Plans all included,
V0.4	DRAFT	MNH Seasonal Surveillance Board now included
V0.5	DRAFT	Feedback collated from Facility/Directorates
V0.6	DRAFT	Queensland Health COVID-19 traffic light advice system included

V1.0	Version 1	Endorsed
V1.1	Review	2023 planned review - feedback collated from all key stakeholders. Including and not limited to • MNH Senior Executive Team membership, • Facility and/or Directorates leadership teams • MNH Standard 3 Clinical Advisory Group • MNH Emergency Management and Business Continuity • MNH Public Health Unit • Brisbane North PHN • Institute for Urban Indigenous Health • Norfolk Island Support Program • Central West Health Service
V1.1	Final	Endorsed
V1.1	Amended	• Consumer resources • TPCH Sub Plan
V1.1	Amended	• Repeal of COVID 19 Vaccine mandate for Queensland Health Employees • MNH Communication contact updated
V1.1	Amended 19/12/23	• TIER 2 Workforce, includes *"P2/N95 masks when caring for suspected/confirmed ARI, once defined – change accordingly (see appendix* 3 & 4)"

Distribution and Approval

Internal approval

Version	Approver	Date
1	Metro North Health Chief Operating Officer	11/11/2022
	Chief Nursing & Midwifery Officer Office of Nursing & Midwifery Services	11/11/2022
1.1	Jane Hancock Metro North Health Chief Operating Officer	23/06/2023
	Alanna Geary Chief Nursing & Midwifery Officer Office of Nursing & Midwifery Services	28/06/2023

Distribution list (final versions only)

Version	Position	Date
1	MNH Senior Executive Team	11/11/2022
	MNH Operating Leadership Team	11/11/2022
	Facility/Directorate Executive Directors	11/11/2022
	MNH Emergency Management and Business Continuity	11/11/2022
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	MNH Emergency Management and Business Continuity	28/06/2023
	MNH Navigation Innovation Strategy	28/06/2023

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 Office
CMO	Chief Medical Officer, Metro North Hospital and Health Service
CNMO	Chief Nurse and Midwifery Officer, Metro North Hospital and Health Service
COH	Community and Oral Health
COO	Chief Operating Officer
EMP	Emergency Management Plan
EOC	Emergency Operations Centre
ERP	Emergency Response Plan
GP	General Practitioners
HEOC	Metro North Hospital and Health Emergency Operations Centre
HIU	Health Improvement Unit
HIC	Health Incident Controller
IAP	Incident Action Plan
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IMS	Incident Management System
IMT	Incident Management Team
MNH	Metro North Health
MOU	Memorandum of Understanding
NDIS	National Disability Insurance Scheme
NMS	National Medical Stockpile
OLT	Operating Leadership Team
PACH	Patient Access and Coordination Hub
PCR	Polymerase chain reaction
PHU	Public Health Unit
PHFFA	Private Health Facility Funding Arrangement
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
RSV	Respiratory Syncytial Virus
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 (ARI), which includes **COVID-19, influenza and RSV environment.**

1. Introduction

1.1 Purpose and intent

The purpose of the Metro North Health (MNH) Acute Respiratory Illness Plan: 2023 (the Plan) is to ensure continuity of health services and monitor the number of cases in the community for preparation purposes.

The strategic objectives of the MNH response are:

- safety for staff, patients and visitors through minimising the transmission of ARI within healthcare settings through proactive identification and targeted testing, effective infection control activities and community messaging
- minimising risk to staff through appropriate training of personal protective equipment (PPE) and infection control practices
- to ensure MNH maintains continuity of critical services.

To maximise the health outcomes of people with ARI, The Plan outlines the communication pathways and basic concept of operations during the levels of activation and includes:

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

This Plan supports the MNH Acute Bed Capacity Response Framework and Metro North (MN) Business Continuity Plan (BCP) and should be read in conjunction with those plans.

1.2 Scope

The Plan covers preparedness, response, and recovery actions to an ARI surge to ensure the continued delivery of critical clinical services within MN. This does not extend to a full pandemic response which would be managed under existing emergency and disaster management plans (MN Pandemic Plan) 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 those caused by COVID-19, influenza and RSV, are of global public health importance. The propensity for ARI viruses to mutate can affect the epidemiology of the circulating viruses 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. Disease severity varies and may be mild to moderate in some people, but very severe in others. The very young, elderly, pregnant women and those with underlying medical conditions are at higher risk of 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 utilising MN data. Analysis of this data suggesting a surge is active will show a rapid rise in cases (e.g., a tripling of admissions over a six-week period) and an extension of dissipation (roughly taking 8-10

weeks to subside). Within MN, between 2014 and 2019, ARI surges generally began in the last week of June / early July, peaked in the third week of August and settled by early October.

The risk of COVID-19/influenza/RSV 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.

1.4 Governance

1. Executive Lead *for*;
    - system wide ARI Plan Response – Chief Nursing and Midwifery Officer (CNMO)
    - oversight operationalising of the ARI Plan – Chief Operating Officer (COO)
2. Directorate Executive Directors sponsor the plan within each of their directorates.
3. Subject matter expert advice will be obtained from the Metro North Standard 3 Committee and other the relevant clinicians as required.
4. The Nursing Director, Performance and Planning (office of CNMO) is the primary notification and analysis team.

1.5 Assumptions

This plan was developed based on the following assumptions:

- The incubation period of ARI 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 treatable with antiviral agents
- Influenza and COVID-19 vaccinations are available
- 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, Supply Chain Surety division (includes linen and central pharmacy), Queensland Urban Utilities, Unity Water and ENERGEX) remain available.

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 the managing of patient access across MNH.

Anticipation and prevention

- Anticipation through monitoring and surveillance for early indications of surge in ARI case notifications

- Prevention through early action on potential mismatches between demand and capacity is crucial and will assist in improving patient outcomes, reduce avoidable delays in the patient journey and minimise disruption to critical services.
- A risk-based approach to managing patient flow will be used when a mismatch between demand and capacity persists, despite escalation procedures enacted.

Effectiveness

- Effective access and capacity management is a MNH wide responsibility. All clinical programs and service lines will prioritise service access and capacity management in order to support appropriate admissions 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 enacted 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 and Kilcoy Hospitals, Kilcoy Hospital and Woodford Correctional Health Centre. Mental health, oral health, Indigenous health, subacute services, medical imaging, and patient services are provided across many sites including hospitals, community health centres, residential and extended care facilities, and mobile service teams. Metro North has a dedicated Public Health Unit. There are 341 general practices in the Metro North region[1]. Over one quarter of general practices (26.1 per cent or 89 practices) are located in the Brisbane Inner City sub region, followed by the Brisbane North sub region, with 19.6 per cent (67 practices).
There is a total of 7,113 residential aged care places in the region, representing 73 residential aged care places per 1000 people in the region[2].
There are 23 private hospitals in Metro North, 7 hospitals with general overnight beds, 14 with day surgery facilities and 3 mental health facilities (Table 1).

Table 1

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

2.1 Infrastructure

This section provides an overview of the baseline infrastructure across Metro North relevant to the response (Table 2),

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

Table 2

Public Hospitals	Total beds	ED treatment spaces	ICU beds	Single Room	Negative Pressure	Negative Flow	Medi Vent Capable	Mortuary
Total	**2,386**	**156**	**80**	**565**	**63**	**127**	**6**	**61 Adult 17 baby**
RBWH	834	47	36	85	24	104	4	19 adults, 17 baby
TPCH	569	56 Adult: 41 Paed: 15	27	142	22	14		18
Redcliffe	269	28	9 7 Ventilated	34	7	9	2	15
Caboolture	231	25	8	38	10			9
Kilcoy	21			4				
STARS	182			96				
COH	280			166				

*Bed alternatives excluded

Refer to Appendix 1 to access detailed mapping of ARI Inpatient Accommodation per facility, including allocation of Air Purifier assets.

Note: As demand on the health service fluctuates, MNH may establish contractual arrangements with several 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 External Stakeholder engagement

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

- Department of Health
- Queensland PACH (including other HHS PACH)
- Private hospital providers
- Brisbane North PHN to assist with communication to Brisbane North primary care organisations
- Relevant community organisations

3.1 Metro North Response

The MN response to ARI needs to be agile to ensure all known and future variants are responded to proficiently.

As the largest provider of public healthcare in the State, MNH will support Central West HHS[3] and Norfolk Island in their ARI response and management of cases. As numbers of ARI positive

[3] Clinical Support Services Agreement, Schedule 1, Schedule 3 and Schedule 4 between Central West and MN HHS, inclusive of specialist respiratory service (21/10/2022)

people increase it is anticipated that several MNH staff will either be affected or furloughed, and this may impact our response. In addition, MNH may be required to support other HHS's either with access to bedded services, workforce or other services, including virtual health care services. It is important to note that all MNH facilities will treat ARI positive patients.

Utilising a business continuity approach to this plan ensures that critical service functions are maintained and are recovered appropriately. 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 MN 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. Communication of the approved change in tiers will go out to all staff and stakeholders as described above.

PPE risk will continue to be monitored separately. Information on the requirements 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 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 MNHHS Seasonal Surveillance Dashboard

The MNHHS Seasonal Surveillance Dashboard (Power BI) reports for influenza, Respiratory Syncytial Virus (RSV) and COVID-19 to monitor trends from a number of perspectives, including laboratory confirmed notifications, emergency department presentations and admitted episodes of care. The data is presented in weekly counts.

This dashboard is designed to provide information on patients presenting to MNH with an ARI to assist facilities and directorates in service continuity and minimise the impact on critical clinical services provided by MNH, specifically during an ARI surge. The dashboard provides total ARI presentations to Emergency Departments and admission to bedded and virtual services age group and facility distribution.

The dashboard is a web-based Microsoft Power BI ® application that can be accessed via desktop and mobile devices.

Data Sources:

Notifiable Conditions System (NoCs): is the database used in Queensland to record notifiable conditions (as per Schedule 1 of the Public Health Regulation, 2018)

Enterprise Patients, Admissions and Discharges and Transfers (ePADT): is the database used in Queensland to record and manage public hospitalisations

Emergency Department Information System (EDIS): is one of two Emergency Department (ED) information systems used by Queensland Health to capture ED attendance data. EDIS

is an enterprise clinical information system which assists Queensland Health Emergency Department clinicians to triage and document the treatment and all ED attendances.

AUSLAB: is an integrated laboratory information system used in pathology, clinical measurements, forensics and public health laboratories. It provides real-time results which are uploaded by Queensland Health public pathology laboratories

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

4.1.2 Online Resources

Online resources for ARI have been developed and are accessible via QHEPS.[4] These resources are regularly updated based on the phase of current activity. Queensland Health publishes weekly surveillance reports for influenza, RSV and COVID-19 to monitor trends from several perspectives, including laboratory confirmed notifications and hospitalisations.[5] Refer to appendix 16 for all online resources.

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.

MNH will conduct a workforce flu vaccination campaign to coincide with public health advice. 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 can access information about this program here Flu vaccination program for staff | Metro North HHS (health.qld.gov.au).

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 through directorate vaccination program and/or Infection Management and Prevention teams.

Note: The legislation for COVID-19 vaccination requirement for Queensland Health and Queensland Ambulance Service employees was repealed. This took effect on Monday 25 September 2023.

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 influenza vaccine will not prevent coronavirus infection it can reduce the severity and spread of influenza, which may make a person more susceptible to other respiratory illnesses like coronavirus.

Community vaccination for COVID-19 and influenza are available through General Practitioners and Pharmacies.

[4] Acute Respiratory Illness – Staff Extranet (health.qld.gov.au)
[5] https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports/flu

The influenza vaccination is recommended required annually, as immunity from the vaccine decreases over time. The vaccine is re formulated each year to provide cover for the current influenza virus strains that are prevalent in the preceding northern hemisphere winter. The vaccination usually takes up to two (2) weeks to be effective[6].

4.2.3 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 Acute Respiratory Illness Response extranet site provides information and resources for staff training. It can be accessed here: Acute Respiratory Illness – Staff Extranet (health.qld.gov.au)

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 of ARI positive patients.

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. A reference guide for return to work in the event of any infectious disease is provided in the procedure "Exclusion Periods for Healthcare Workers (staff) with Infectious Illness 007213"[7].

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). Metro North intranet site provides information and guidelines relating to fatigue and fatigue management that can be accessed via this site About fatigue | Fatigue Risk Management | Metro North Health

- consideration of reduction in total planned annual leave approved between and reduced routine training to coincide with forecasted surge of ARI as per public health advice
- accelerated recruitment processes.

[6] https://www.health.gov.au/sites/default/files/2023-03/atagi-advice-on-seasonal-influenza-vaccines-in-2023.pdf

[7] PROC007213 |Exclusion Periods for Healthcare Workers (staff) with Infectious Illness | CGSQR|Metro North Health

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 Supply Chain Surety[8] (DoH) with a focus on items in short supply and/or on allocation. The provision of PPE must 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). (Appendix 3 and 4)

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 June 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

Both adults and children who are ARI* positive will be cared for via three care streams –

1. ARI Well
2. ARI of Concern
3. 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

[8] https://qheps.health.qld.gov.au/supply-chain-surety

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

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 continually assessed during their 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 Control9 to support staff in the appropriate bed allocation. (Appendix 1, 2, 3 and 4)

The placement of ARI patients in any clinical area should be considered, and risk assessed according to several 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 4

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

[9] Patient Placement Guide – Infection Prevention and Control | Australian Commission on Safety and Quality in Health Care

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 Prevention and 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 5. 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 Version11.18, published 30/03/2023), 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 5

Priority Group	Disease/Clinical Symptoms	Infectious Period	Precautions Required**
First	Respiratory Viruses of concern, e.g., SARS, MERS, pandemic ARI	Duration of illness*	S+C+A
	SARS-CoV-2	48 hours prior to onset of symptoms continuing for 7 days for hospitalised persons	S+C+A
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-infected (SARS-CoV-2 and Influenza) patients will not be cohorted
- Surgical masks will be provided at point of TRIAGE, but should be provided whenever the ARI is first recognised

Table 6

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 7 - 13)

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 allows. Ideally this is provided at point of TRIAGE but should be provided whenever the ARI is first recognised.
2. Where appropriate early testing whenever ARI is first recognised
3. If the patient requires admission, the patients access to an inpatient bed is not to be delayed waiting result of PCR testing – the patient is to be isolated/cohorted based on their ARI, with pending status to be documented in Patient Flow Manager (PFM)
4. For patients requiring admission who present with confirmed COVID diagnosis (within previous 7 days) do not require repeat test prior to transfer to inpatient bed

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

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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 6. 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 2023.

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 120 minutes from receipt in the laboratory and can be used for symptomatic patients being admitted from Emergency Departments to assist with expediated decisions on bed placement. Note, only the COVID results are provided via SMS message to patient's nominated mobile number.

6 Plan Activation

6.1 Response Activities

Phases of activation of Plan are as follows

Phase	Tier 0	Tier 1	Tier 2	Tier 3	Recovery
Criteria	*Mild Community Transmission*	*Minimal Community Transmission*	*Moderate Community Transmission*	*Significant Community Transmission*	Trigger

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.

The Plan may be activated independently from other plans where the activity impact is separate, and surges related to ARI activity should only be used in conjunction with the Metro North Health acute capacity framework.

6.1.1 Metro North Criteria for Acute Respiratory Illness Response Plan Activation – (Interacts with Acute Bed Capacity Response Framework)

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

Tier 0

Mild Community Transmission

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

*TAT = Turnaround Time

Tier 1

Minimal Community Transmission

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

Tier 2

Moderate Community Transmission

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

Stand-Up Tier 3

Significant Community Transmission

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

Recovery (Stand down)

CRITERIA

- Transition from responding to an event back to normal core business and/or recovery operations as per MNH BCP

6.1.2 Metro North Criteria for Acute Respiratory Illness Response Plan – Associated Actions with TIER 0 Response

Tier 0 **Minimal community transmission**

Stay at home if you are sick ▪ Get tested ▪ Stay 1.5m apart from other people ▪ Wash your hands with soap and water ▪ Sneeze or cough into your arm or a tissue

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

<table>
<tr><th>Governance</th><th>Workforce</th><th>Metro North Virtual Care Services and HiTH</th><th>Intensive Care Unit</th><th>Service operations</th><th>Meetings</th></tr>
<tr>
<td rowspan="3">Executive Lead for system wide ARI Plan Response – CNMO
Executive Lead to oversight operationalising of the ARI Plan - COO
Monitoring of MN and State surveillance, and National and overseas trends – ND Performance Planning, Office of the CNMO</td>
<td rowspan="3">PPE use as per transmission-based precaution procedures
Promote maintenance of up-to-date influenza/COVID vaccinations
Ensure staff are fit tested as per policy
Actively plan for use of high annual leave balances
Monitor & report staff sickness >3%</td>
<td>Promote Metro North Virtual Care Services – targets per service to be confirmed
Virtual ED
Virtual Ward
HiTH</td>
<td>Maintain ICU capacity plans.</td>
<td rowspan="3">Business as usual</td>
<td>Business as usual.</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Bedded Services</td>
<td>Training/Education</td>
</tr>
<tr>
<td>Maintain ED capacity plans
PCR as clinically indicated for symptomatic patients including those patients for admission</td>
<td>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 (SARS-CoV-2 and Influenza) patients will not be cohorted
Surgical masks will be provided at point of TRIAGE, but should be provided whenever the ARI is first recognised</td>
<td>Business as usual.</td>
</tr>
</table>

For more information, refer to Metro North Health Acute Respiratory Illness Plan – Click link to access https://metronorth.health.qld.gov.au/extranet/ari

Tier 1 Mild community transmission

Stay at home if you are sick ▪ Get tested ▪ Stay 1.5m apart from other people ▪ Wash your hands with soap and water ▪ Sneeze or cough into your arm or a tissue

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

<table>
<tr><th>Governance</th><th>Workforce</th><th>Metro North Virtual Care Services and HiTH</th><th>Intensive Care Unit</th><th>Service operations</th><th>Meetings</th></tr>
<tr>
<td rowspan="2">Stand up weekly MN Response Management meeting
Weekly reporting of MN and State surveillance, and monitoring of National and overseas trends – ND Performance Planning, Office of the CNMO
Communicate and collaborate with external stakeholders</td>
<td rowspan="2">P2/N95 masks when caring for suspected/confirmed ARI, once defined – change accordingly (see appendix 3 & 4)
Eye protection in line with PPE matrix (see appendix 3 & 4)
MNH Executive comms to all staff as required
Promote maintenance of up-to-date influenza/COVID vaccinations
Prioritise new staff fit testing and annual reviews for existing staff
Actively plan for fatigue recovery and use of high annual leave balances
Monitor & report staff sickness >3%
Review PPE, testing kits, antivirals & vaccine stocks weekly.</td>
<td>Promote Metro North Virtual Care Services – stretch targets per service to be confirmed
Virtual ED
Virtual Ward
HiTH
Weekly reporting on referral and utilisation of all services</td>
<td>Review and refresh ICU capacity plans.</td>
<td rowspan="2">Provide outpatient appointments across all urgency categories, prioritising long waits and Aboriginal and Torres Strait islander peoples
Provide surgery and procedures across all urgency categories, prioritising long waits and Aboriginal and Torres Strait islander peoples
Virtual outpatient care to continue to meet Metro North targets
Optimise and report monthly on Surgery Connect.
Review of private health facility funding arrangement (PHFFA)</td>
<td>Teams link to be included as option for all meetings for times when staff can’t attend face-to-face</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Bedded Services</td>
<td>Training/Education</td>
</tr>
<tr>
<td></td>
<td>Review and refresh ED capacity plans
Review PCR collection services & testing criteria (Plan sect 5.3)</td>
<td>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 (SARS-CoV-2 and Influenza) patients will not be cohorted
Surgical masks will be provided at point of TRIAGE, but should be provided whenever the ARI is first recognised
Utilise over-census bed areas as per MNH Acute Capacity Framework.</td>
<td>Maintain compliance with mandatory training programs,
Optimise virtual training where possible.</td>
</tr>
</table>

For more information, refer to Metro North Health Acute Respiratory Illness Plan – Click link to access https://metronorth.health.qld.gov.au/extranet/ari

Tier 2 Moderate community transmission

Stay at home if you are sick ▪ Get tested ▪ Stay 1.5m apart from other people ▪ Wash your hands with soap and water ▪ Sneeze or cough into your arm or a tissue

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

<table>
<tr><th>Governance</th><th>Workforce</th><th>Metro North Virtual Care Services and HiTH</th><th>Intensive Care Unit</th><th>Service operations</th><th>Meetings</th></tr>
<tr>
<td rowspan="2">Twice weekly MN Response Management meeting
Twice weekly reporting of MN and State surveillance, and monitoring of National and overseas trends – ND Performance Planning, Office of the CNMO
Communicate and collaborate with external stakeholders.</td>
<td rowspan="2">All staff providing clinical care are strongly encouraged to wear surgical masks.
P2/N95 masks when caring for suspected/confirmed ARI, once defined – change accordingly (see appendix 3 & 4)
Eye protection in line with PPE matrix (see appendix 3 & 4)
Review workforce business continuity plans and consider staff redeployment on a need’s basis
Where able, discourage congregation in tearooms and other shared spaces
Where able take breaks outdoors
Regular MNH Executive comms to all staff
Prioritise new staff fit testing and annual reviews for existing staff.</td>
<td>Promote Metro North Virtual Care Services – stretch targets per service to be confirmed
Virtual ED
Virtual Ward
HiTH
Daily reporting on referral and utilisation of all services</td>
<td>Review ICU capacity plans and prepare to activate over-census bed areas.</td>
<td rowspan="2">Provide new and review outpatient consultations for all urgency categories
Provide category 1 & 4, and long wait cat 2 & 3 surgery and cat 5 & 6 procedures,
Prioritise new appointments for long wait category 1 & 4 outpatients
Optimise virtual outpatient care where possible
Review room allocation methods (Plan sect 5.2)
Stand up extension of Private Hospital Facility Funding Arrangements (PHFFA) in consultation with DoH
Daily reporting on referral and utilisation of PHFFA services
Review and report weekly on Surgery Connect.</td>
<td>Teams link to be included in all meetings
Face-to-face meetings only where essential; flat surgical masks required</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Bedded Services</td>
<td>Training</td>
</tr>
<tr>
<td></td>
<td>Review PCR collection services & testing criteria (Plan sect 5.3)
Review ED capacity plans and prepare to activate over-census bed areas.</td>
<td>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 (SARS-CoV-2 and Influenza) patients will not be cohorted
Surgical masks will be provided at point of TRIAGE, but should be provided whenever the ARI is first recognised
Utilise over-census bed areas as per MNH Acute Capacity Framework.</td>
<td>Transition to all virtual training.
Face-to-face only where essential for mandatory training (e.g. OVP, BLS, ALS); flat surgical masks required</td>
</tr>
</table>

For more information, refer to Metro North Health Acute Respiratory Illness Plan – Click link to access https://metronorth.health.qld.gov.au/extranet/ari

Tier 3 Significant community transmission

Stay at home if you are sick ▪ Get tested ▪ Stay 1.5m apart from other people ▪ Wash your hands with soap and water ▪ Sneeze or cough into your arm or a tissue

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

<table>
<tr><th>Governance</th><th>Workforce</th><th>Metro North Virtual Care Services and HiTH</th><th>Intensive Care Unit</th><th>Service operations</th><th>Meetings</th></tr>
<tr>
<td rowspan="2">Daily MN Response Management meeting
Daily reporting of MN and State surveillance, and monitoring of National and overseas trends – ND Performance Planning, Office of the CNMO
Communicate and collaborate with external stakeholders.</td>
<td rowspan="2">P2/N95 masks and eye protection in all clinical areas
Stand up workforce business continuity plans and staff redeployment deployment
Discourage congregation in tearooms and other shared spaces
Take breaks outdoors
Regular MNH Executive comms to all staff
Continue to prioritise new staff fit testing and annual reviews for existing staff.</td>
<td>Promote Metro North Virtual Care Services – stretch targets per service to be confirmed
Virtual ED
Virtual Ward
HiTH
Daily reporting on referral and utilisation of all services</td>
<td>Review ICU capacity plans and prepare to activate over-census bed areas.</td>
<td rowspan="2">Defer all non-essential planned elective surgery; continue cat 1 and cat 4 surgery / procedures
Continue category 1 (urgent) outpatient new and reviews
Prioritise new appointments for long waiting category 1 outpatients
transition to virtual outpatient care where possible
Review room allocation methods
Assess current requirement of Private Hospital Facility Funding Arrangements (PHFFA) in consultation with DoH.
Daily reporting on referral and utilisation of PHFFA services
Assess current requirement of Surgery Connect arrangements.</td>
<td>Cease meetings not directly related to clinical care or staff wellbeing that involve clinical staff.</td>
</tr>
<tr>
<td>Emergency Department
Review ED capacity plans and prepare to activate over-census bed areas.
Review ‘front door reception’ process changes (e.g., alternate triage stations)
Continue to review PCR collection services & testing criteria (Plan section 5.3)</td>
<td>Bedded Services
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 (SARS-CoV-2 and Influenza) patients will not be cohorted
Surgical masks will be provided at point of TRIAGE, but should be provided whenever the ARI is first recognised
Utilise over-census bed areas as per MNH Acute Capacity Framework.</td>
<td>Training
Restricted to essential clinical training and examinations for clinical staff only</td>
</tr>
</table>

For more information, refer to Metro North Health Acute Respiratory Illness Plan – Click link to access https://metronorth.health.qld.gov.au/extranet/ari

6.1.6 Metro North Criteria for Acute Respiratory Illness Response Plan – Response Management Meeting

Where MNH Tier 1 – 3 response is activated, the primary methods of supporting MNH-wide communications will be via MNH-wide TEAMS ® meetings chaired by the MNH CNMO or delegate and supported by Metro North Patient Access and Communication Hub (MNH PACH)

Schedule for Response management meetings

TIER	Community Transition Criteria	Schedule
TIER 0	Mild	Nil
TIER 1	Minimal	Weekly
TIER 2	Moderate	Twice Weekly
TIER 3	Extreme	Daily

Guiding Principles

- Provide clear and standardised communication pathway and processes, including for escalation
- Commitment to activate strategies
- Reinforcing the focus on the right things
- Reinforcing the sense of team

The aim

Ensure timely, purpose-driven and effective communication and documentation that supports continuous, coordinated and safe care for patients by dentification and implementation of agreed strategies.

Minimum requirements

- Prior to each meeting, Directorates are required to complete a Business Impact Assessment (BIA) (refer to Appendix 15).
- Situation Report will be issued same day following the meeting.
- After each meeting, MNH PACH will provide an assessment of MNH current position and agreed action plan.

Agenda for Response management meetings

Title	MNH Response Management Meeting: ARI and Acute Bed Capacity Scrum
Time:	1400hrs
Location	TEAMS
Chair	MNH CNMO and/or delegate
Membership	MNH Representative: COO, CMO, MNH Pharmacy Rep, MNH Pathology, MNH EM&BC, MNH HRMNH Public Health, MNH Comms, MNH ED Rep, MNH ICU, ND PPP, MNH PACH (secratariat) Clinical Advisory Group: MNH Standard 3 Committee membership Facility Based Representavies: Executive Direcotor and/or delegate, E/DMS (Per Facility), Patient Access, Capacity and Flow Lead
Agenda	

1.	Acknowledgement of Country
	Metro North Hospital and Health Service (or this event) respectfully acknowledges the Custodians of the land where our health services are located. We pay our respects to the Aboriginal and Torres Strait Islander Elders and valued persons, past, present and future and recognise the strength and resilience that Aboriginal and Torres Strait Islander people and their ancestors have displayed in laying strong foundations for the generations that follow. For it is through building a joint understanding of land, water and community that we work together to reduce health inequities.
2.	MNH PACH provide Acute Bed Capacity and ARI overview of MN and SEQ status
3.	QAS to provide overview of QAS MN status
4.	Impact Summary for Acute Bed Capacity and ARI by Directorate (based on BIA) – request they highlight any immediate safety concerns *Summarise HHS-wide impact once Directorate updates have been provided. Address any immediate safety issue.*
5.	Confirm actions have been completed as defined by Tier Response (Action Register) - include requirement for escalation to MNH Senior Executive Team as needed
6.	Confirm Metro North actions available as defined by Tier Response - Request advice from Directorates if any / all of these actions needed to address capacity required over next 24 / 48 / 72 hrs and if they are required at one / all sites. - Confirm/clarify actions required
7.	Confirm/clarify additional escalation requirement to the Chair
8.	Questions or other concerns?
9.	Chair to provide summary of actions - Retain actions as per Tier Response as a minimum for another 24 / 48 / 72 hours - Undertake agreed additional Tier Response actions (list) for the next 24 / 48 / 72 hours - Confirm comms plan
10.	Chair to confirm - MNH TIER Response for ARI and Acute Bed Capacity - Timing for next meeting

Nominated central points of contact below are:

The Patient Access, Capacity and Flow Management Teams are nominated as the central point of contact for facility/directorates and are delegated responsibility for completing an action, e.g., business impact assessment, clinical response and/or managing the service capacity as per ARI Tier Response Plan

Directorate	Email Account	Position Mobile Number	Team
Responsible for completing an action/BIA			
RBWH	rbwh.pfs.bedallocations@health.qld.gov.au	0429130 855	Patient Flow Services
Redcliffe	RedH-Patient-Flow@health.qld.gov.au	0459 881 867	Patient Flow Services
Caboolture and Kilcoy	Cab_Nurse_Manager@health.qld.gov.au	0436 808164	Patient Access and Clinical Effectiveness
TPCH	TPCH-DutyNurseManager@health.qld.gov.au	0447 783 523	Patient Access and Flow
Community and Oral Health	COH-Nursing_Workforce@health.qld.gov.au	0407 759 988	COH Nursing Workforce, Duty Nurse Managers
Mental Health	shirley.anastasi@health.qld.gov.au	0438 022 135	MNH Mental Health - Governance and Quality Management
Public Health	mnphu-cd@health.qld.gov.au	0423 053 196	MNH Public Health
MN PACH	MN_PACH@health.qld.gov.au	0428 201 028	MNH PACH Operational Team
Directorate	**Email Account**	**Position Mobile Number**	**Team**
STARS	STARS_AHNM@health.qld.gov.au	0436 632 434	STARS Patient Access, Flow and Workforce Team

MNH Virtual Health Care Services	TBA	TBA	TBA

Required to have situational awareness.

Facility/ Service	Generic e-mail Account	Position Mobile No.	Position
For situational awareness			
MNH CE	MNHHSOperationsExecutive@health.qld.gov.au	0432 757 191	MNH Chief Operations Officer
MNH COO	MNHHSOperationsExecutive@health.qld.gov.au	0412 744 357	MNH Chief Operations Officer
MNH CNMO	MN_NursingandMidwifery@health.qld.gov	0412 560 785	MNH Chief Nursing and Midwifery Officer
MNH CMO	CMO-MNHHS@health.qld.gov.au	0419 962 594	MNH Chief Medical Officer
MNH – NIS	MN_NM_NIS@health.qld.gov.au	0499 790 903	MNH Navigation, Innovation and Strategy Team
MNH Duty Manager	MN EmergencyManagement@health.qld.gov.au	0484 937 128	MNH Emergency Management and Business Continuity Team
MNH Duty Executive	As per roster	0475 830 452	MNH Senior Executive Team – Duty Executive on call
MNH Communication	MetroNorth-Communications@health.qld.gov.au	07 3647 9522 0475 838 053	MN Communications Advisors

It is expected that the email and phone be monitored during business hours and that it will be allocated to a 'position' rather than a 'person' to ensure leave and other coverage.

(Note: forwarding of mobile number will not forward SMS/Text messaging). Directorates are responsible for ensuring continuity of incident notifications after-hours and during public holiday

7 After response review and lessons management

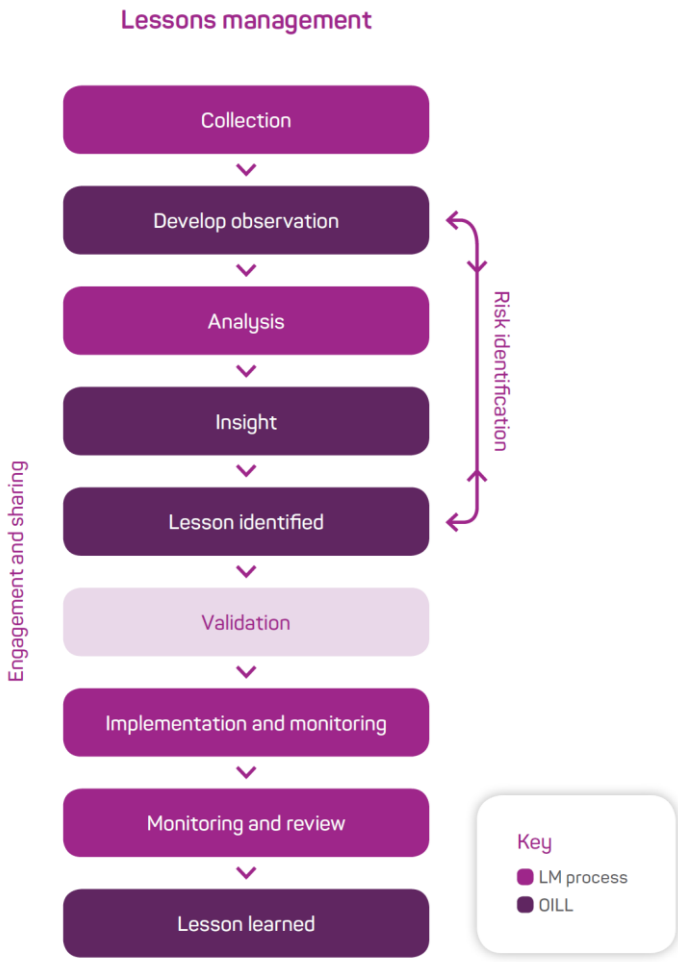
7.1 Lessons management

‘Lessons management’ is an overarching term that refers to collecting, analysing, and disseminating experiences from operations, exercises, programs and reviews. A consistent approach to the management of lessons is an essential component for MNH and its directorates to continue the cycle of improvement of capability. By adopting a
lessons management approach, we build MN’s ability to
develop and better plan and implement, may reduce public criticism and avoid missed opportunities for improvements.

The framework for managing lessons at MN includes the
following stages:

- collection of observations,
- coding and analysing observations,
- forming insights/findings,
- lesson identified,
- validate and assess action,
- implementation and dissemination,
- monitoring and measuring; and
- lesson learned

Figure 5.1. Elements of a lessons management process (AIDR Handbook 8, Lessons Management)



7.2 After action review

At the end of a TIER 3 Response an after-action-review (AAR) /debrief will occur to find and record observations, additional to the observations recorded during the activation. The purpose of the AAR is to communicate the experiences that occurred during the event so that observations can be identified. In some instances, the informal debrief process will identify work practices that can be modified immediately. However, these lessons need to be captured for broader consideration and implementation

The debrief focuses on improving the elements of capability that include people, process, organisation, support, technology, and training (PPOSTTE). It is important that all participants understand the elements of capability, and how sharing information and experiences will assist individuals and the organisation to learn and improve from an incident. The debriefs will remain focused on gathering observations for the lessons management process and is not used to apportion blame.

Appendix 1: Mapping of MNH ARI Inpatient Accommodation per facility.

Location	Negative pressure beds	Negative flow beds	Medi Vent capable	General single rooms	Temporary options	Air purifiers[10]
RBWH	24 beds • 1 Q class Wattlebrae • 15 Wattlebrae • 4 ICU • 1 Emergency Trauma Centre • 2 Intensive Care Nursery • 1 Short Stay Unit	104 beds • 14 ICU • 30 Ward 6AS • 30 Ward 8AS • 30 Ward 8BS	4 beds • 1 CCU • 1 Birth Suite • 1 Ward 6B • 1 outpatient Consult room (exhausted) *Note: Work to be completed 2 Emergency Trauma Centre (Resuscitation bays)*	85		479
TPCH	22 beds • 12 Ward 1E • 4 ICU • 2 Adult Emergency Department • 1 paediatric Emergency Department • 2 paediatric general medicine • 1 PACU	14 beds • 14 Ward ACC • ICU (three separate PODS that can be reconfigured (HVAC) for cohorted patient placement 9 patients per POD		142		158
Redcliffe	7 beds • 4 ICU • 1 Emergency Department • 2 Ward 6E	9 beds • 5 Ward 6E • 3 Paediatrics	2 bed spaces • Medi Vent units available to be deployed into any room that can accommodate them	34	3 bed spaces • 3 HEPA filtered air purifiers available to be deployed to any room that can support external exhaust	173
Caboolture	10 beds • 6 adult (including 1 double room). • 1 paediatric • 1 neo-natal • 2 Emergency Department			38	11 beds and 4 chairs • 4 Flex Bed unit • 11 (7 bed and 4 chair) * Emergency Department fast track *ED fast track space staffed 07:00 to 23:00 to open as part of the Caboolture hospital redevelopment. Note: Woodford Correctional Facility has capacity to secure areas as required with advice from Caboolture hospital Infection Control.	72
Kilcoy				4	2 beds. • Bed 7 and palliative care bed have separate airflow	4
Mental Health						43
STARS				96		31
COH				166		66
TOTAL	**63** *60 Negative pressure* *1 Q class*	**127**	**6**	**565** *399 – Acute* *166 – Sub Acute*	**20** *16 Beds* *4 Chairs*	**1026**

[10] Refer to Air Purifier, Management in Healthcare Setting 006735

Appendix 2: Types of Isolation Rooms

In accordance with the Australasian Health Facility Guidelines (AusHFG) , Part D – Infection Prevention and Control (Revision 7.0) there are four types of isolation room.

AusHFG	Definition (Standards Australia 2003c)	Details
Class S ** Standard	Standard Isolation Type 4	a single room with an ensuite that is not shared. *The room is used for patients who require isolation to minimise the potential for infections being transmitted by contact or droplets*
Class P Positive Pressure	Patient Protection – Type 3	a single room with an ensuite that is not shared *The room is used to reduce the risk of airborne transmission of infection*
Class N ** Negative Pressure	Respiratory Isolation – Type 5	a single room with an ensuite that is not shared. *This room is used for patients who require isolation to reduce airborne transmission of disease (e.g. varicella, measles, pulmonary or laryngeal tuberculosis).*
Class Q Quarantine**	Quarantine Isolation – Type 5 pule airlock	a single room with a dedicated ensuite that is not shared and includes all design requirements as described for a negative pressure room and requires an anteroom designed to function as an absolute airlock

**Isolation rooms Class S and Class N, when not required for the care of infectious patients, can accommodate other patients once the room is vacated and cleaned as per the infection prevention and control policy of the facility

*One hospital in each Australian capital city will have designated Class Q rooms providing facilities for patients with highly infectious pathogens such as haemorrhagic fevers and pneumonic plague. These patients require a further level of containment over and above the standard negative pressure isolation room.

Appendix 3: Recommended PPE Escalation for ARI according to Tier Response (in addition to standard precautions if indicated for another reason) as per MNH Standard 3 Committee

Tier Response →		Tier 1	Tier 2	Tier 3
Patient Category ↓		Standard and transmission-based Precautions	Standard and Transmission-Based Precautions	Standard and Transmission-Based Precautions, Plus measures to counter high risk of unexpected influenza/RSV infection
PPE for HCW caring for residents/ patients in these categories	**No** Signs/symptoms of ARI	Standard precautions	Standard Precautions	HIGH INFLUENZA RATES: Surgical mask and Protective eyewear *for* High-Risk areas, including, but not limited to OPD ETC/ ED, HEAM unit, ONC unit, RESP & Maternity HIGH COVID 19 RATES: N95/P2 all clinical areas
	Suspected ARI (symptoms and awaiting test results)	P2/N95 mask Protective eyewear		
	ARI	Influenza - Surgical mask, protective eyewear. If oxygen therapy/CPAP/BiPAP – P2/N95 mask COVID 19 - P2/N95 mask, protective eyewear		
PPE for HCW during activities other than direct patient care		Not Applicable		Surgical mask unless working alone in their own office
PPE for patient use – symptoms of ARI (awaiting test results) or confirmed ARI		If patient not in a single room surgical mask where tolerated	Surgical mask where tolerated, unless inpatient in own bed	
PPE for patient use – NO ARI (excluding children under 12)		Not Applicable		If patient on ward where patients with confirmed influenza and/or RSV and/or COVID-19, are being managed not in single rooms for surgical mask where tolerated
PPE for visitors		Nil Additional	Recommended use of surgical masks	

Appendix 4: Recommended PPE Escalation for COVID-19 according to Tier Response (in addition to standard precautions if indicated for another reason) as per Australian Guidelines for the Prevention and Control of Infections in Healthcare (2019 Version11.18, published 30/03/2023), - Appendix 6, Table 5

Tier Response → *For* COVID -19 **Patient Category ↓**		**Tier 1** Standard and transmission-based Precautions	**Tier 2** Standard and Transmission-Based Precautions	**Tier 3** Standard and Transmission-Based Precautions, Plus measures to counter high risk of unexpected COVID-19 infection
PPE for HCW caring for residents/ patients in these catogories	**No** Signs/symptoms of COVID-19 and NOT a close contact	Standard precautions	Surgical mask or P2/N95 masks in high-risk clinical areas Protective eye wear	P2/N95 masks Protective eyewear
	Symptoms of COVID-19 and NOT a close contact	Surgical mask Protective eyewear Gown or apron Gloves	P2/N95 masks Protective eyewear Gown or apron Gloves	
	Confirmed /probable COVID-19 OR Suspected COVID-19 (symptoms and awaiting test results) OR Close Contact	P2/N95 masks Protective eyewear Gown or apron Gloves		
PPE for HCW during activities other than direct patient care		Not Applicable	Surgical mask unless working alone in their own office	
PPE for patient use – symptoms of COVID-19 or close contact (excluding children under 12)		Patient to wear surgical mask where tolerated when outside of single room	Patient to wear surgical mask where tolerated when outside of single room	
PPE for visitors		Nil Additional	Recommended use of surgical masks	

Appendix 5: 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 6: 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	Rapid 4
AUSLAB Code XPNCV	AUSLAB Code XPRESV	AUSLAB Code 4PLEX	AUSLAB Code LTNCV
GeneXpert *for*	GeneXpert *for*	GeneXpert *for*	LIAT *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, *depending on volume*		
Resp 1 panel **	Resp 2 panel	Resp Panel 3
RESPCR (RBWH and Prince Charles)	Pathology no longer holding stock	4RESP (RBWH only)
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 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.

Appendix 8: The Royal Brisbane and Women's Hospital Criteria for Acute Respiratory Illness Response Sub Plan – Part 1 (Updated by RBWH ELT 13/062023)

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

Inpatient Area

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)**
Consider- • *ARI admission conversion rate <u>less than</u> 20 preceding 24 hours*	***Consider-*** • *ARI admission conversion rate <u>≤</u> 20 preceding 24 hours* • *Small clusters of healthcare transmission within a ward*	***Consider—*** • *ARI admission conversion rate > 20 – 30 preceding 24 hours* • *Extension of ICU Capacity required.* • *Single rooms at capacity with ARI. Cases now requiring cohorting in a single ward according to infection type* • *Increasing clusters of healthcare transmission within a ward/s.*	***Consider—*** • *ARI admission conversion rate > 31 preceding 24 hours* • *Significant workforce deficits across all service lines/support services requiring extensive intervention* • *Extension of ICU Capacity required* • *Opening of dedicated wards for cohorting required* • *Sustained healthcare transmission leading to multiple outbreaks across multiple wards.* •	***Consider-*** • *ARI admission conversion rate <u>less than</u> 20 preceding 24 hours*
BED MANAGEMENT • Utilise priority risk matrix for Transmission Based Precaution to determine single room use <u>Ward beds</u> • Flexible use of 6C — up to **16 beds** [a] • Single rooms in home wards with air purifier when clinical care indicated– **up to 69 beds** **(Up to 85 ward beds)** <u>ICU beds</u> • ICU Pod 3/4 negative pressure rooms—**4 beds** • ICU Pod 2 single rooms—**2 beds** **(4-6 ICU beds)** **PATIENT MANAGEMENT** • If clinically stable admit to a single room in an appropriate ward. • Daily ward rounds to identify early discharge/HITH/virtual • Appropriate release from isolation. Active management of single room beds	**BED MANAGEMENT** • As per Tier 0 **PATIENT MANAGEMENT** As per Tier 0- ARI <u>plus</u> • High-risk patients (e.g., immune compromised) admitted to 6C or remain in home ward with air purifiers **WORKFORCE** • BAU • PPE per escalation matrix **GOVERNANCE** • BAU, if tolerated.	**BED MANAGEMENT** As per Tier 0- ARI <u>then</u> • Begin planning for activation of designated isolation ward(s) from Flexible Bed Capacity (FBC) [b] • One isolation ward brought online. **(30 isolation beds)** <u>Ward beds</u> • As per Tier 0- ARI <u>plus</u> • Progressive use of dedicated wards (no cohorting of different respiratory viruses) [c] • Single rooms preferentially used for patients with any virus requiring oxygen or CPAP/BIPAP followed by patients with COVID 19 • FBC beds opened for respiratory presentations (+30) **(Up to 30 additional dedicated beds online)** <u>ICU beds</u> • Consider activation of respiratory ICU pod 3/4 [d]—**18 beds** • ICU Pod 2 single rooms – **2 beds** **(Up to 20 ICU beds)** **PATIENT MANAGEMENT** As per Tier 1- ARI <u>plus</u> • Active daily management of single room bed stock • Consider cohorting close contacts in 2 and 4 bed bays **WORKFORCE** • Indirect staff are brought online to provide direct patient care. • Clinical staff redeployed to areas of greatest need. • PPE per escalation matrix **GOVERNANCE** • Consider activation of RBWH Emergency and Disaster Response Plan to Stand up • Consider reductions to planned care • IMT Tier 1/2 briefing	**BED MANAGEMENT** As per Tier 2- ARI <u>then</u> <u>Ward beds</u> • Additional isolation wards from FBC capacity brought online. **(Up to 90 isolation ward beds)** <u>ICU beds</u> • Additional ICU infill 'B' beds opened as required (+10 beds) **(Up to 30 ICU beds)** **PATIENT MANAGEMENT** • As per Tier 2- ARI **WORKFORCE** • Non-essential face to face training and non- critical meetings cancelled to prioritise patient care. • Non-patient facing staff with clinical qualifications are utilised to assist with patient care activities. • Ad-hoc satellite support teams deployed to assist with patient care activities. • PPE per escalation matrix **GOVERNANCE** As per Tier 2- ARI •	**BED MANAGEMENT** **Staged de-escalation of wards** 1. Outbreak wards returned to BAU function. 2. Patients in 4-bedded bays transferred to dedicated ARI wards 3. Gradual return of negative flow wards to BAU function as demand decreases. 4. Management of patients as per Tier 0-ARI **WORKFORCE** 1. Staged de-escalation of workforce strategies supported by ad-hoc satellite support teams. 2. Resumption of essential training and meetings as clinical demands permit.

Notes.
Patient management priorities, see 004661: Influenza and Respiratory Illness Management (health.qld.gov.au)
a. Capacity for other infectious diseases within Wattlebrae should be maintained
b. FBC as determined by RBWH Executive
c. If the number of patients requiring ICU support exceed 4 patients

The Royal Brisbane and Women's Hospital Criteria for Acute Respiratory Illness Response Sub Plan – Part 2 (Updated by RBWH ELT 13/062023)

Emergency and Trauma Centre

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)**
Consider- *ETC attendances-less than 10% of presentations for ARI* **ETC MANAGEMENT** • Usual triage, treatment, transfer arrangements. • Active admission avoidance including RADAR, Virtual ED/ward, and GP follow up • Testing of patients with respiratory symptoms requiring inpatient admission and high-risk groups.	***Consider-*** *ETC attendances->10 – 20% of presentations for ARI* **ETC MANAGEMENT** As per Tier 0- ARI • Flat surgical masks provided to patients with respiratory symptoms, if tolerated.	***Consider-*** *ETC attendances->20% - 30% of presentations for ARI* **ETC MANAGEMENT** As per Tier 1- ARI plus • Consider clinical contraindications for cohorting immune suppressed patients within ETC (page 8 TBP procedure). **BED MANAGEMENT** • Active processes to expedite patient movement into appropriate single bed/ward accommodation **WORKFORCE** • Indirect staff are brought online to provide direct patient care. • Redeployment of staff within service line to support patient care activities.	***Consider-*** *ETC attendances->% of presentations for ARI* **ETC MANAGEMENT** • Consider activating respiratory isolation area to cohort patients presenting with ARI. **BED MANAGEMENT** • As per Tier 2- ARI of RBWH employed staff.	***Consider-*** *ETC attendances-less than 10% of presentations for ARI* **ETC MANAGEMENT** Return to BAU departmental configuration

Appendix 9: Redcliffe Hospital Criteria for Acute Respiratory Illness Response Sub Plan (Updated by RDH ELT May 2023)

Associated actions for RDH 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**	**Recovery** **(Stand down)**
ACTIONS **ED Management** ○ Triage: usual process ○ Utilisation of VED and Rapid Access Services as ED and Hospital Avoidance ○ Single room/patient co-horting where possible ○ Testing of respiratory patients: only when clinically indicated or when admission is required ○ Rapid PCR vs standard PCR: guided by HHS response ○ PPE for staff: Guided by HHS response **Inpatient Units** **Prioritisation of Patient Placement** • Novel Respiratory Virus, COVID 19, Airborne Precautions ○ 6 East Negative Pressure (x2) ○ 6 East Negative Flow (x5) ○ Paediatric Negative Flow (x1) • Other ARI ○ home ward single room • Co-infections- prioritise negative pressure rooms • Results pending- MAU single room until result known • Maternity Patients ○ ARI/Novel Resp Virus birthing mothers allocated to Birth Suite 1 & 2 with air purifiers ○ Birth suite 3 if more than 2 patients • Neonatal Patients ○ Neonates who require isolation from mother ▪ Bed 13 Maternity ward **ICU** • 7 ventilated equivalent beds • 10 physical bed spaces ○ 4x negative pressure	**ACTIONS** **ED Management** As per Tier 0 **Inpatient Units** Tier 0 plus: • Virtual Ward ○ Promotion of virtual Ward **Prioritisation of Patient Placement** As per Tier 0 **ICU** As per tier 0 **Planned Care** • Reduction in planned care as directed by Metro North	**ACTIONS** **ED Management** As per Tier 0 plus Consideration of expanding services ○ Adult SSU overflow (4 additional chairs) 24h model ○ Ambulatory Care 24h nursing model to manage AWA greaterthasn10 ○ Medical Imaging for AWA. ○ Increase Paediatric Acute ED from 16 hour model to 24 hour model (5 additional beds **Inpatient Units** Tier 1 plus: • Cohorting of ARI from vulnerable patients **Prioritisation of Patient Placement** • Novel Respiratory Virus ○ Adult trigger: 12 patients ▪ Consider opening 6 East “red zone” or; ▪ Utilise single rooms ○ Paediatric trigger >1 ▪ 6 East with paediatric nurse deployed, or; ▪ Open Paeds SSU as “red zone” • Other ARI ○ cohort in home ward • Co-Infections- prioritise negative pressure rooms ** Consideration to be given to isolation room requirements and overall bed demand to determine the most appropriate option.** **ICU OVERFLOW** Tier 1 plus: • Increase capacity to 10 ventilated beds • Begin preparations for ICU expansion • Load share with other ICU’s	**ACTIONS** **ED Management** As per Tier 2 Consideration (depending on staffing levels) ○ Increase Paediatric ED to 24-hour model to open beds across all areas including Fast Track (3-4 additional spaces) **Inpatient Units** Tier 2 plus: **Prioritisation of Patient Placement** • Novel Respiratory Virus, COVID 19 ○ Trigger >18 patients ▪ Whole of 6 East becomes “red” zone • Other ARI ○ Phase 1: 5W single rooms ○ Phase 2: Cohort in appropriate wards • Co-Infections- prioritise negative pressure rooms **ICU OVERFLOW** Tier 2 plus: • ICU expansion to 10 beds triggered on 5th patient requiring negative pressure accepted referral, or; • Utilise isolation room with air purifiers	**ACTIONS** **ED Management** ○ Revert to 16 hour Paediatric MOC with exception of Paed STTA **Inpatient Units** **RESPIRATORY WARDS** • Stand down 5W as ARI ward beds • Stand down 6 East • Stand down Paediatric SSU **ICU OVERFLOW** • Reduce back to 7 ventilated equivalent beds

Appendix 10: Caboolture, Kilcoy, and Woodford Directorate Criteria for Acute Respiratory Illness Response Sub Plan (Updated by CKW ELT 09/06/2023)

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*	**Tier 2** *Moderate Community Transmission*	**Stand-Up** **Tier 3** *Significant Community Transmission*	**Recovery** **(Stand down)**
ACTIONS • Staff vaccination campaign if directed • Staff/patient/visitor education plan • PPE access and availability **ED CONSIDER OVERFLOW AREAS** • Consider numbers in waiting room • surgical masks available for to all patients • Consider Testing regime using 4PLEX or GeneXpert depending on circulating virus/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 • Use of Air Purifiers if not in negative pressure room **ICU OVERFLOW** • Nurse positive patients in single rooms • Use of Air purifiers if not in negative pressure room • Upskilling and PPE training to commence as required in preparation for increased presentations **WORKFORCE** • Review casual and NSU supports • Monitor roster finds to prepare for sick leave • Review training and fit testing to support staff knowledge and preparedness • Monitor and report ARI impact on absenteeism and service provision	**ACTIONS** • Activate Directorate Emergency Response Plan and Pandemic Plan • Weekly local IMT meeting including Business Impact Assessments • Attend MN IMT and complete directorate reporting **ED CONSIDER OVERFLOW AREAS** **As per Tier 0** • Consider alternative triage/reception space for ILI • Maintain PPE as per standard and transmission-based precautions • Testing regime using 4PLEX or GeneXpert's for all presentations with ILI symptoms and to assist with patient flow management purposes **RESPIRATORY WARDS** **As per Tier 0** • Move towards dedicated respiratory space (3B) • Maintain PPE as per standard and transmission-based precautions • with increased presentation risk assess need for local escalation **ICU OVERFLOW** **As per Tier 0** **WORKFORCE** **As per Tier 0** • Monitoring and reporting of staff furlough related to ARI. • Review of scheduled training and meetings with only essential to continue. Move towards virtual platforms for all. • Decide on need to stand up concierge roles at entry points.	**ACTIONS** • Emergency Response Plan and Pandemic Plan initiatives addressed • daily local IMT meeting including Business Impact Assessments • Attend MN IMT and complete reporting for SHECC as requested if appropriate • Establish and distribute internal and external communications **ED CONSIDER OVERFLOW AREAS** **As per Tier 1** • Alternate housing of ILI patients to be considered if viable • Maintain PPE as per standard and transmission-based precautions **RESPIRATORY WARDS** **As per Tier 1** • Review room allocation and look to cohort where required/possible **ICU OVERFLOW** **As per Tier 1** • **Identify and source equipment needed to expand service if required.** **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	**ACTIONS** • Emergency Response Plan and Pandemic Plan ACTIVE • IMT meetings as per Tier 2 • Attend MN IMT and complete reporting for SHECC as required • Access controls established limited to essential movements only (is this patient movement or staff movement??) **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/State need for ICU beds • Preparation of area and staff to meet needs with potential expansion into Theatre space. **ELECTIVE SERVICES** **As per Tier 2** • 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 • Consideration of leave cancellation	**ACTIONS** • Transition from responding to an event back to normal core business and/or recovery operations. • All areas gradually move to BAU • Return to planned care • Post event debrief completed and documented • All learnings archived for future reference.

Appendix 11: Community and Oral Health Directorate Criteria for Acute Respiratory Illness Response Sub Plan (Updated by COH ELT 30/05/2023)

Associated actions for COH 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)**
Criteria: Evidence of very low inpatients/residents with ARI in COH	Criteria: Evidence of some inpatients/residents with ARI in COH	Criteria: Evidence of inpatients/residents with ARI in multiple bedded services throughout COH and the Chief Health Officer is reporting increased ARI impacting on the community	Criteria: Evidence of multiple areas with inpatients/residents with ARI in multiple bedded services throughout COH and/or the Chief Health Officer is reporting significant ARI impacting on the community	
Patient Management: **Subacute/RTCP/Residential Services** • All symptomatic patients to be tested using GeneXpert 4Plex • Single rooms for all ARI confirmed cases (if available)	**Patient Management:** - As per Tier 0 plus **Subacute/RTCP** • Cohort of like for like ARI confirmed cases in double and triple rooms, if single room not available **Residential Services** • If greater than 3 cases of confirmed ARI within 24 hours RACF – outbreak declared • Consider visitor restrictions in consultation with Infection Control Services and Safe Visiting Procedure	**Patient Management:** - As per Tier 1 plus **Subacute/RTCP** • Open up to 4 beds if funding and staffing available • Cohort ARI like for like cases if no single rooms available **Residential Services** • As per Tier 1 plus	**Patient Management:** - As per Tier 2	
Medical Governance: **Subacute/RTCP/Residential Services** • Business as Usual (BAU)	**Medical Governance:** - As per Tier 0 plus **Residential Services** • Early notification to RADAR services of situation so they can prepare for increased support	**Medical Governance:** - As per Tier 1 plus **Subacute/RTCP** • Review on call arrangements for after hours and weekends to optimise after hours decision making **Residential Services** • Engage with RADAR outreach service	**Medical Governance:** - As per Tier 2	
Logistics: • Business as Usual (BAU) • PPE as per risk matrix **Workforce:** • Business as Usual (BAU) **Actions:** • Annual staff flu vaccination program • Safety & Quality Facilitator – Emergency Management, available during business hours to support mild community response in COH facilities • COH IMT as required • Virtual staff COH huddles as required	**Logistics:** - As per Tier 0 plus • Review current PPE stock holdings • Consider increasing stock holdings of PPE • Extra surgical masks available to ensure sufficient supply for visitors **Workforce:** - As per Tier 0 plus • Review all recruitment strategies and deployment and upskilling of workforce **Actions:** - As per Tier 0 plus • COH IMT minimum monthly • Staff COH huddles/update as required via TEAMS	**Logistics:** - As per Tier 1 plus • Increase stock holdings of PPE **Workforce:** - As per Tier 1 plus • Move all non-essential training and meetings to virtual • Consider redeployment of non-frontline clinical staff to clinical areas **Actions:** - As per Tier 1 plus • COH EOC to be staffed 5 days per week with on-call weekends • COH IMT once a week • Staff COH huddles once a week via TEAMS	**Logistics:** - As per Tier 2 plus • PPE utilisation as per Infection Control risk matrix • Review frequency of distribution of PPE **Workforce:** - As per Tier 2 plus • Cancel all non-urgent meetings and education • Deploy non-frontline clinical staff to clinical areas **Actions:** - As per Tier 2 plus • COH IMT as required • Staff COH huddles/update via TEAMS as required	

Appendix 12: Mental Health Directorate Criteria for Acute Respiratory Illness Response Sub Plan (Updated by MNH MH ELT 09/06/2023)

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

Tier 0
Mild Community Transmission

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

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

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.

Tier 1
Minimal Community Transmission

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

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

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.

Tier 2
Moderate Community Transmission

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

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

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.

Stand-Up
Tier 3
Significant Community Transmission

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

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

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.

Recovery
(Stand down)

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

COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)

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- 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

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 13: Metro North Health Virtual Ward Service Capacity Surge Plan Activation and Associated Actions (as per Metro North Health Virtual Ward Model of Care Provided by COH Virtual Ward Leadership Team 09/09/2022)

Criteria for movement through phases of activation and the associated actions. 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)**
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 **OR** ○ Unable to complete total consultations and/ or clinical escalations for 'moderate' or lower risk groups.	**CRITERIA** ○ > 226 referrals within previous 24 hrs **OR** ○ >751 forecasted end of day occupancy based on admitted patients **OR** ○ Only able to complete daily consultations and/ or clinical escalations for 'very high' and 'high' risk groups	**CRITERIA** ○ Transition from responding to an event back to normal core business and/or recovery operations.
ACTIONS ***Business as usual.***	**ACTIONS** ***Nursing-*** • Team Leader and NUM meet to review staffing and consider need for additional staffing. • Offer Part-Time Extra shifts to current staff • Contact COH workforce to message all previously trained Virtual Ward nursing staff for availability. **Medical-** • SMO to review staffing and consider need for additional staffing. **Admin-** • SAO to review staffing and consider need for additional staffing ***Pharmacy-*** • Team Leader to review staffing and consider need for additional staffing ***If not resolved escalate to:*** *NUM* *Assistant Nursing Director* *SMO*	**ACTIONS** • As per Tier 1 plus: • Contact MN Nurse Bank re staffing availability • Team Leaders MDT daily huddle to review all areas ability to manage occupancy including re-allocation of tasks • Nursing staff to complete Initial Assessments for 'Self-care' and 'Low' risk patients if >24 hours since VW admission and Initial Assessment not performed • Consider deployment of staff from non-clinical areas e.g., Education, Innovation & Research, CSDS etc • NUM/ SAO to review number of workspaces available to ensure enough in case of increasing staffing being required • Review of training and meetings with only essential to continue ***If not resolved escalate to:*** *Nursing Director* *Clinical Director*	**ACTIONS** • As per Tier 2 Plus: • Nursing Staff to complete Initial Assessments for all risk groups if > 48 hours since VW admission and Initial Assessment not performed. • HHS wide communication including to external key stakeholders through MN IMT e.g., Virtual ED, Emergency Departments, PHN, GPLO etc • Tele-Conference with Norfolk Island and CWHHS to advise of Tier 3 stand up • Deploy staff from non-clinical and/ or closed services to support including rapid onboarding process • Ensure indirect staff and brought online to provide direct patient care ***If not resolved escalate to:*** *Executive Director COH* *MN Director of Medical Services* *If still not resolved escalate to:* *MN HHS COO or On-Call executive*	**ACTIONS** ○ Transition from responding to an event back to normal core business and/or recovery operations.

Appendix 14: STARS Directorate Criteria for Acute Respiratory Illness Response Sub Plan - Part 1 (Updated by STARS ELP 05/06/2023)

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)**
Criteria – Evidence of low in patients with Acute respiratory Illness (ARI)	**Criteria** - Evidence of some inpatients, with ARI	**Criteria -** Evidence of inpatients/residents with ARI in multiple bedded services throughout STARS and the Chief Health Officer (CHO) is reporting increased ARI impacting on the community	**Criteria -** Evidence of multiple areas with inpatients/residents with ARI in multiple bedded services throughout STARS and/or the CHO is reporting significant ARI impacting on the community	**Criteria –** Reduction in community cases through either general herd immunity from viral infection and or vaccine induced. Cessation to be announced by MN-EOC.
Patient Management Sub Acute - All symptomatic ARI patients require COVID-19 PCR and a full respiratory panel PCR. - Only Consider GeneXpert for patients who are critically unwell and require transfer or patients who are expressing aerosol generating behaviours. - COVID-19 clinical screening questionnaire is required on all admissions. Statewide questionnaire within the ieMR. - Single room transmission-based precautions and air purifier in situ. **Patient Management Procedural** - COVID-19 clinical screening questionnaire is required on all admissions. Statewide questionnaire within the ieMR - COVID-19 screening to be completed by the pre-admissions booking teams. - All symptomatic patients who present will be tested for ARI and rebooked as required.	**Patient Management Sub Acute** **As per Tier 0** - Consider cohorting only on the advice of Infection Management and Prevention Service (IMPS). Given STARS large number of single rooms recommended that single rooms be utilised first. **Patient Management Procedural** **As per Tier 0**	**Patient Management Sub Acute** **As per Tier 1** • Review number of patients with pandemic virus and consider, in consultation with IMPS, collocating in the one dedicated area as needed. **Patient Management Procedural** **As per Tier 0**	**Patient Management Sub Acute** **As per Tier 1** **Patient Management Procedural** **As per Tier 0**	**Patient Management Sub Acute** **As per Tier 0** - Continue to monitor and screen for cases with a process for a return of BAU. **Patient Management Procedural** **As per Tier 0** Continue to monitor and screen for cases with a process for a return of BAU

STARS Directorate Criteria for Acute Respiratory Illness Response Sub Plan – Part 2 (Updated by STARS ELP 05/06/2023)

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)**
Criteria – Evidence of low inpatients with Acute respiratory Illness (ARI)	**Criteria** - Evidence of some inpatients, with ARI	**Criteria -** Evidence of inpatients/residents with ARI in multiple bedded services throughout STARS and the Chief Health Officer (CHO) is reporting increased ARI impacting on the community	**Criteria -** Evidence of multiple areas with inpatients/residents with ARI in multiple bedded services throughout STARS and/or the CHO is reporting significant ARI impacting on the community	**Criteria –** Reduction in community cases through either general herd immunity from viral infection and or vaccine induced. Cessation to be announced by MN-EOC.
Medical Governance - Business as usual (BAU) **Logistics** - Business as Usual (BAU) - Personal Protective Equipment (PPE) as per current PPE risk matrix - Review PPE capacity and numbers within STARS. **Workforce** - Business as usual (BAU)	**Medical Governance** - Early notification from Geriatric Rehabilitation Liaison Service (GRLS) and triage process to identify patients for transfer to assist bed capacity at other hospitals. **Logistics** - As per Tier 0 plus - COVID-19 clinical screening questionnaire is required on all admissions. Statewide questionnaire within the ieMR - COVID-19 screening to be completed by the pre-admissions booking teams. - All symptomatic patients who present will be tested for ARI and rebooked as required. **Workforce** - As per Tier 0 plus - Review all recruitment strategies and deployment and upskilling of workforce. - Review staffing plans and options in the event of staff shortages of 50%, planning for future Tier Levels. - Ensure fit testing is being completed and all staff are fit tested for up to 2 masks. Prioritise as needed. - Ensure PPE training has been completed and continue to prioritise training as needed.	**Medical Governance** - As per Tier 1 - Review on call arrangements for after hours and weekends to optimise after hours decision making **Logistics** - As per Tier 0 and 1 plus - Increase stock holdings of PPE **Workforce** - As per Tier 0 and 1 plus - Move all non-essential training and meetings to virtual - Consider redeployment of non-frontline clinical staff to clinical areas	**Medical Governance** - As per Tier 2 **Logistics** - As per Tier 0,1 and 2 plus - PPE utilisation as per current PPE risk matrix - Review frequency of distribution of PPE **Workforce** - As per Tier 0,1 and 2 plus - Cancel all non-urgent meetings and education - Deploy non-frontline clinical staff to clinical areas	**Medical Governance** - As per Tier 2 **Logistics** - As per Tier 0,1 and 2 plus - PPE utilisation as per current PPE risk matrix - Review frequency of distribution of PPE **Workforce** - As per Tier 0,1 and 2 plus - Cancel all non-urgent meetings and education - Deploy non-frontline clinical staff to clinical areas

STARS Directorate Criteria for Acute Respiratory Illness Response Sub Plan – Part 3 (Updated by STARS ELP 05/06/2023)

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)**
Criteria – Evidence of low inpatients with Acute respiratory Illness (ARI)	**Criteria** - Evidence of some inpatients, with ARI	**Criteria -** Evidence of inpatients/residents with ARI in multiple bedded services throughout STARS and the Chief Health Officer (CHO) is reporting increased ARI	**Criteria -** Evidence of multiple areas with inpatients/residents with ARI in multiple bedded services throughout STARS and/or the CHO is reporting significant ARI	**Criteria –** Reduction in community cases through either general herd immunity from viral infection and or vaccine induced. Cessation to be announced by MN-EOC.
Actions - Continue regular VPD screening processed to ensure staff compliance to limit staff sickness to other VPDs. - Annual influenza vaccination program to continue - Dedicated pandemic vaccination clinics as needed for staff (When available). - Continue to offer inpatient vaccinations when available to prevent and minimise outbreaks	**Actions** - As per Tier 0 plus - STARS IMT fortnight or as required. - Staff STARS huddles/updates as required via TEAMS	**Actions** - As per Tier 0 and 1 plus - Consider dedicated staff in the STARS IMT. to be staffed 5 days per week with On-Call weekends - STARS IMT once a week or as required.	**Actions** - As per Tier 0,1 and 2 plus - STARS IMT as required – Possible daily dependent on patients currently within STARS and staffing impacts on service.	**Actions** - As per Tier 0 plus

Bed information at STARS

1. Single Room capacity

- Classifications of single rooms accommodation which have the potential to be used for patients with influenza- like illness (ILI).

2. Room Types

- STARS has 96 single rooms classified as Type 1 and Type 2 Inboard ensuite. These room types are defined by the Australian Asian Health Facility guidelines (AusHFG).
- These are single rooms with an ensuite shower and toilet that is not shared. Suitable for patients with infections transmissible by means other than the airborne route and are designed to minimise the potential for such infections to be transmitted to other patients and staff.
- There are no dedicated negative pressure rooms and no anterooms within STARS
- Refer to AusHFG for full details:

  Type 1 inboard ensuite

  Type 2 inboard ensuite

3. Oxygen Ports

- STARS Hospital has 600 oxygen outlets with Cushman and Wakefield monitoring the supply.

Mortuary Capacity

STARS have a capacity of 2 in the Body Hold in the Basement with an agreement with Pathology Queensland about using the Mortuary at the RBWH if required. The risk of respiratory / pandemic influenza infection from deceased persons is low and is minimised by the use of transmission-based precautions.

- All staff handling persons who have died while infectious with a pandemic organism must wear the appropriate PPE in line with Transmission Based Precautions and current guidelines.
- All bodies prior to release from mortuary require clearance for release by the approved delegate.
- Refer to guidance of Deceased Persons -Certifying COVID-19.
- For management of the deceased person, refer to appendix 7: Management of the deceased persons of the Infection prevention and control guidelines for the management of COVID-19 in the healthcare settings for full details.

Appendix 15: Facility Based Situation Report (SitRep) Template

SitRep # Date: << >>				
Insert Facility: << >>				
Summary of current position		*highlight any immediate safety concerns*		
ARI Tier << >>	ABC Tier << >>			
Impact assessment on workforce – ***monitor staff sickness >3%*		Ok - Nil Impact	Shortfall- *identify impacted service*	Not Applicable
ED Impact Assessment				
ED LOS > 24 hrs *Confirmed plan to be executed within 2 hrs*				
QAS ToC > 2 hrs *Confirmed plan to be executed within 2 hrs*				
Service Impact Assessment				
Patient in Acute care Type admission Bed with LOS > 3 days, clinically appropriate for D/C or transfer *Confirmed plan to be executed within 2 hrs*				
Planned Care				
Surgical Emergency Boards				
Surgery Connect (if applicable)				
OPD activity				
PHFAA Arrangement (if applicable)				
Virtual Health Care Services and HiTH				
Referrals/Utilisation *of*				
Virtual Ward				
HiTH				
Agreed Actions				Status
1.				
2.				
3.				
4.				
5.				
Identified strategies – next 48 – 72 hrs				**Who**
1.				
2.				
3.				

Appendix 16: Additional Online Resources

Platform/Format	Link
Extranet Site	Acute Respiratory Illness – Staff Extranet (health.qld.gov.au)
FOCUS Activity Board	Seasonal Surveillance Acute Respiratory Illness
PBI	MNH COVID 19 - https://app.powerbi.com/groups/me/reports/cf5be12b-449f-4682-b356-3bab863e48ef/ReportSection?experience=power-bi
PBI	PQ Respiratory Board - https://app.powerbi.com/groups/me/apps/c0c48251-5e1e-4c32-b186-202155c06d77/reports/d6477d53-fb96-44c4-a68e-b52325370554/ReportSection56123684d63d518e7840?clientSideAuth=0&experience=power-bi
PBI	MNPHU_COVID19_Case Overview https://app.powerbi.com/groups/me/reports/7a2f8e7c-2790-4ef8-a5ee-922a709351a7/ReportSectioncb0e7b494d39d6452e51?ctid=0b65b008-95d7-4abc-bafc-3ffc20c039c0&experience=power-bi
PDF Report	QLD Weekly INFL and RSV Surveillance Report https://www.health.qld.gov.au/__data/assets/pdf_file/0009/1220400/influenza-rsv-qld.pdf
PDF Report	QLD Weekly COVID-19 Surveillance Report https://www.health.qld.gov.au/__data/assets/pdf_file/0024/1229550/qld-covid19-weekly-report.pdf
PDF/Word Report	Australian Influenza Surveillance Report (AISR) – fortnightly Australian Influenza Surveillance Reports – 2023 | Australian Government Department of Health and Aged Care

Appendix 17: Consumer Resources

Coreflutes signage

Appendix 18: 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
MNH Acute Bed Capacity Response Framework
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'
Queensland Health Advice COVID-19 - Traffic Light Advice System
PROC007213 |Exclusion Periods for Healthcare Workers (staff) with Infectious Illness | CGSQR|Metro North Health
Mandatory vaccinations for staff | Queensland Health Intranet
B70. Employee COVID-19 vaccination requirements (health.qld.gov.au)
Australian Guidelines for the Prevention and Control of Infections in Healthcare (2019 Version11.18, published 30/03/2023),
Australian Technical Advisory Group on Immunisation (ATAGI) Clinical Advice
Statement on the Administration of Seasonal Influenza Vaccines in 2023 (Issue Date: March 2023)

Repeal of COVID-19 vaccine mandate for Queensland Health and Queensland Ambulance Service employees, Monday 25 September 2023