

Metro North Health ACUTE RESPIRATORY ILLNESS PLAN: 2024

Version 1.2

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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	<p>2023 planned review - feedback collated from all key stakeholders. Including and not limited to</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Consumer resources • TPCB Sub Plan
V1.1	Amended	<ul style="list-style-type: none"> • Repeal of COVID 19 Vaccine mandate for Queensland Health Employees • MNH Communication contact updated
V1.1	Amended 19/12/23	<ul style="list-style-type: none"> • TIER 2 Workforce, includes <i>“P2/N95 masks when caring for suspected/confirmed ARI, once defined – change accordingly (see appendix 3 & 4)”</i>
V1.2	Review	<p>2024 planned review - feedback collated from all key stakeholders. Including and not limited to</p> <ul style="list-style-type: none"> • 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
V1.2	Amended 07/05/2024	<p>Amended to include</p> <ol style="list-style-type: none"> 1. feedback collated from MNH Senior Executive Team membership, <ul style="list-style-type: none"> • MNH COO • MNH Health Service Strategic Planning Unit • MNH Procurement, supply chain and commercial analysis • MNH Emergency Management and Business Continuity • MNH Public Health Unit • COH IMT • STARS Leadership Team • RBWH Leadership Team

		<ul style="list-style-type: none"> CABH Leadership Team TPCH Leadership Team RDH Leadership Team MNH Mental Health Directorate Leadership Team MNH Virtual Care Services Leadership Team MN Norfolk Island Support Team Pathology Queensland <p>2. Additional Section 4.2.3 Opportunistic Vaccination</p>
V1.2	FINAL 17/05/2024	Endorsed
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Distribution and Approval (Internal approval)

Version	Approver	Date
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	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
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1.2	Glynis Shultz A/Metro North Health Chief Operating Officer	14/05/2024
	Alanna Geary Chief Nursing & Midwifery Officer, Office of Nursing & Midwifery Services	14/05/2024

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

	MNH Performance and Planning	
	MNH Access and Capacity Management	

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 respiratory syncytial virus (RSV) environment.**

1. Introduction

1.1 Purpose and intent

The purpose of the Metro North Health (MNH) Acute Respiratory Illness Plan: 2024 (the Plan) is to ensure continuity of health services during ARI surge and monitor the number of cases in the community for preparation purposes.

The strategic objectives of the MNH response are:

- minimising 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 PPE application / recommendations, vaccination availability 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 State Chief Health Officer (CHO).¹²

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.

¹ [Pandemic Influenza Plan - Queensland Health Disaster Management Plans - Publications | Queensland Government](#)

² [Declaration and management of a public health event of state significance | Queensland Health](#)

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 extended 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.

Each microbe has the potential to cause severe disease, particularly in certain subpopulations, and vaccination is the best way to prevent both disease and spread of infection.

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 for the specific organisms.
- Routes of transmission will mostly be via large droplet and aerosol transmission from aerosol generating behaviours and treatment care interventions, although transmission may also occur via fomites.
- Among the usual causative organisms, COVID-19 and influenza are treatable with antiviral agents
- Influenza, COVID-19 and RSV 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 (1,085,207 - 2022 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, Caboolture and Kallangur Satellite Hospitals 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 region³. 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 8 968 residential aged care places in the region, representing 85 residential aged care places in the region⁴.

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	Rivercity Private Hospital	Hospital
St Andrew’s War Memorial Hospital	Hills Day Surgery	Samford Road Day Hospital	Toowong Private Hospital
St Vincent’s Private Hospital Northside	Montserrat Day Hospitals (Indooroopilly)	Spring Hill Clinic	
The Wesley Hospital	Moreton Day Hospital	Spring Hill Specialist Day Hospital	
Northwest Private Hospital	North Lakes Day Hospital	Westside Private Hospital	

³ Brisbane North PHN, 2019

⁴ <https://www.gen-agedcaredata.gov.au/my-aged-care-region, March 19, 2024>

2.1 Infrastructure

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

Table 2

Public Hospitals	Total beds	ED treatment spaces	ICU beds	Single Room	Negative Pressure	Negative Flow	Medi Vent Capable	Mortuary
Total	2, 284	182	89	431	64	488	6	61 Adult 17 baby
RBWH	834	47	36	85	24	458	4	19 adults, 17 baby
TPCH	569	56 Adult: 41 Paed: 15	27	142	22	14		18
Redcliffe	269	28	9 7 Ventilated	5	7	16	2	15
Caboolture	245	51	7	58	11			9
Kilcoy	21			4				
STARS	182			96				
COH	164 **			41				

*Bed alternatives excluded// **does not include Residential Aged Care Facility (RACF) beds

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 HHS⁵ and Norfolk Island Health and Residential Aged Care Service (NIHRACS) in their ARI response and management of cases. As numbers of ARI positive 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

⁵ 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)

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.

4.1.1 Acute Respiratory Infection – Seasonal Enhanced Surveillance Dashboard

The Acute Respiratory Infection – Seasonal Enhanced Surveillance – Power BI has been developed to provide a high-level overview of notifications for Acute Respiratory Illness (ARI) assigned to the Metro North hospital and Health service area.

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

Australian Bureau of Statistics (ABS):

- 3235.0 ABS Regional Population by Age and Sex, 2021 (released 30/8/2022).
- Index of Relative Socio-economic Disadvantage, 2016 (released 27/03/2018).

Note: Respiratory Syncytial Virus (RSV) notifications are displayed from ISO week 1, 2022 to the most recently complete ISO week

4.1.2 MNH Staff Absence (Sick, Carers and Special Pandemic Leave) Dashboard

The MNH Staff Absence - Power BI which has developed to provide additional intel to support planning and preparedness for MNH and Facility Based ARI Response. The dashboard provides historical pay outcomes and ‘real time’ information-based staff absence as a result of “sick, carers and special pandemic leave”. There is also a staff absence forecasting function that has been built into the dashboard. The dashboard is a web-based Microsoft Power BI ® application that can be accessed via desktop and mobile devices.

Note: this dashboard does not replace any other formal reporting processes and is for operational/tactical planning ONLY.

Data Sources:

DSS HR Payroll SAP

DSS Roster Management (Workbrain)

Note: Data is updated form DSS at 0830 each day, with updates made in Workbrain no shown until following day. Roster data in Workbrain may not reconcile to pay outcomes due to the conversion from roster to paid award conditions. Details on paid overtime and fatigue outcomes can be ground in the HR Payroll SAP View.

4.1.3 Online Resources

Online resources for ARI have been developed and are accessible via QHEPS.⁶ 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.⁷ 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 \(health.qld.gov.au\)](https://www.health.qld.gov.au/flu-vaccination-program-for-staff).

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 RSV, 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 RSV, COVID-19 and influenza are available through General Practitioners and/or Pharmacies.⁸

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 effective⁹.

Note: Medicare Urgent Care Clinic (UCC) may provide opportunistic vaccination (e.g., for seasonal influenza or COVID-19) as part of the treating episode, with any administration of

⁶ [Acute Respiratory Illness – Staff Extranet \(health.qld.gov.au\)](https://www.health.qld.gov.au/acute-respiratory-illness-staff-extranet)

⁷ <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports/flu>

⁸ [Queensland Paediatric Respiratory Syncytial Virus Prevention Program | Queensland Health](https://www.health.qld.gov.au/queensland-paediatric-respiratory-syncytial-virus-prevention-program)

⁹ [Queensland Health 2024 Influenza vaccination advice | Queensland Health](https://www.health.qld.gov.au/queensland-health-2024-influenza-vaccination-advice)

vaccines to be communicated to the patient's usual General Practice and entered into the Australian Immunisation Register¹⁰

4.2.3 Opportunistic Vaccination

Each directorate within metro north to consider an Opportunistic Vaccination strategy which will incorporate the practice of checking the vaccination status of all people at every opportunity (admission, outpatient, Emergency Department presentation). By incorporating a vaccination assessment for patients accessing services from MNH, it may be feasible to assist in supporting vaccination of some hard-to-reach populations

Strategies to be considered *for*

- Ambulatory services
- Admitted services – bedded and virtual
- Emergency Department
- Minor Injury and Illness
- Vulnerable population

4.2.4 Staff Training & information

MNH staff receive infection control training and fit testing as part of orientation, induction and work unit training programs including periodic refreshers as per Clinical Directorate requirements. The MNH Staff 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”¹¹.

Note: Rapid Antigen Test (RAT) will be made available for members of staff who have been identified as requiring COVID19 screening. Arrangements for access to RATs will be as per local facility arrangements per Infection Management and Prevention (IMPS) advice.

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 (HCWs) out of their usual work area
- utilising healthcare students as assistants
- reviewing scope of practice

¹⁰ [Medicare Urgent Care Clinics – Operational Guidance \(health.gov.au\)](#)

¹¹ [PROC007213 | Exclusion Periods for Healthcare Workers \(staff\) with Infectious Illness | CGSQR | Metro North Health](#)

- 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.

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 Surety¹² (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 through the hospital. Prior to June of each year 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 can 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	<p>Risk stratification for deterioration is low and can be managed and monitored in a low interaction ambulatory environment</p> <ul style="list-style-type: none"> • People who are asymptomatic or experiencing mild ARI symptoms • No or low risk social or medical factors 	Self-Care and/or Primary Care Provider
ARI of Concern	<p>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</p>	Non-bedded Service - Metro North Virtual Care Ward

¹²<https://qheps.health.qld.gov.au/supply-chain-surety>

	<ul style="list-style-type: none"> • People experiencing moderate clinical symptoms • People with complex social, public health or special care needs • At risk populations • High density households / other environmental concerns 	
Hospital Care	<p>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</p> <ol style="list-style-type: none"> 1. People experiencing severe clinical symptoms 2. High risk social or medical factors 	Bedded Service – 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 HCWs. 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 Control¹³ 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	<p>Is human to human transmission known?</p> <p>Is/are the mode/s of transmission known?</p> <p>Has the person recently returned from overseas travel?</p> <p>What is the infectivity of the organism?</p>	<p>Does the patient have factors that would increase the risk of transmission?</p>	<p>How susceptible are other patients in the area?</p> <p>What is the morbidity and mortality associated with the organism/condition disease?</p> <p>Will the safety of the individual who is to be isolated be affected?</p>	<p>What is the availability of negative pressure isolation rooms?</p> <p>What competing priorities exist for single room provision?</p> <p>Are single rooms with designated toilet facilities available?</p> <p>Are there other patients with the same organism, species and/or strain that could be cohorted</p>

¹³ [Patient Placement Guide – Infection Prevention and Control | Australian Commission on Safety and Quality in Health Care](#)

Examples	Suspected or confirmed acute respiratory infection	Wandering Cognitive impairment	Organism not easily transmitted but associated with high mortality rate	Patients requiring high security or one-on-one observation
	Public health notification	Incontinence Broken skin Open/draining wounds Invasive devices Poor hygiene practices Clinical symptoms such as: -Diarrhoea-Vomiting- Coughing-Sneezing	Immunosuppressed patients Neonates and young children Elderly patients Patients with burns Renal patients Pregnant women	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 \(2019 Version 11.18, published 30/03/2023\)](#), 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
1 st	Negative Pressure with unshared ensuite	Single room with unshared ensuite
2 nd	Entire Negative Flow Ward/Zone with shared ensuite	Single room with shared ensuite
3 rd	Single room with unshared ensuite and an air purifier.	Cohort ARI in designated ward with \geq 1 metre distance and curtains closed
4 th		Four bed bays in a ward for cohorting – as <i>designated by facility/service line Executive</i> . (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 Polymerase Chain Reaction (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

5.3 Formal panel testing for respiratory viruses

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 5](#). 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 2024.

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.

Note: Rapid Antigen Test (RAT) will be made available for members of staff who have been identified as requiring COVID19 screening. Arrangements for access to RATs will be as per local facility arrangements per Infection Management and Prevention (IMPS) advice.

6 Plan Activation

6.1 Response Activities

Phases of activation of Plan are as follows

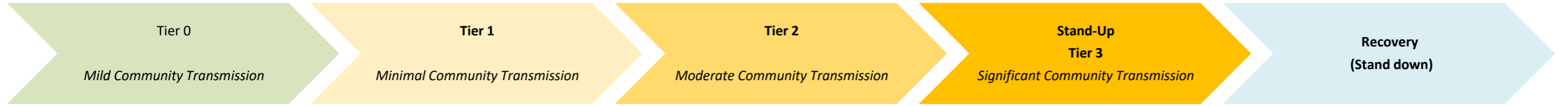
Phase	Tier 0	Tier 1	Tier 2	Tier 3	Recovery
Criteria	<i>Mild Community Transmission</i>	<i>Minimal Community Transmission</i>	<i>Moderate Community Transmission</i>	<i>Significant Community Transmission</i>	Trigger

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 <i>Mild Community Transmission</i>	Tier 1 <i>Minimal Community Transmission</i>	Tier 2 <i>Moderate Community Transmission</i>	Stand-Up Tier 3 <i>Significant Community Transmission</i>	Recovery <i>(Stand down)</i>																																																																																																																
<p>CRITERIA one of:</p> <ul style="list-style-type: none"> o Suspected ARI ED presentations: <table border="1"> <thead> <tr> <th>Location</th> <th>Daily Presentation =/<</th> </tr> </thead> <tbody> <tr> <td>CAB</td> <td>5</td> </tr> <tr> <td>RBWH</td> <td>10</td> </tr> <tr> <td>TPCH</td> <td>10</td> </tr> <tr> <td>RDH</td> <td>5</td> </tr> </tbody> </table> <ul style="list-style-type: none"> o Suspected ARI ED presentations: <table border="1"> <thead> <tr> <th>Location</th> <th>Daily Presentation =/<</th> </tr> </thead> <tbody> <tr> <td>METRO NORTH</td> <td>30</td> </tr> <tr> <td>HHS</td> <td></td> </tr> </tbody> </table> <ul style="list-style-type: none"> o Suspected ARI admissions per day: <table border="1"> <thead> <tr> <th>Location</th> <th>Daily admits =/<</th> </tr> </thead> <tbody> <tr> <td>METRO NORTH</td> <td>5</td> </tr> <tr> <td>HHS</td> <td></td> </tr> </tbody> </table> <ul style="list-style-type: none"> o ICU admit for ARI per day: <table border="1"> <thead> <tr> <th>Location</th> <th>Daily</th> </tr> </thead> <tbody> <tr> <td>METRO NORTH</td> <td>0</td> </tr> <tr> <td>HHS</td> <td></td> </tr> </tbody> </table> <ul style="list-style-type: none"> o ARI Workforce absenteeism - Nil impact to service continuity <p>Other indicators</p> <ul style="list-style-type: none"> o <4 patients waiting isolation rooms in ED per facility. o Nil or minor issues with: <ul style="list-style-type: none"> o ARI Vaccinations o Antivirals o PPE stock availability o Testing kits (GeneXP) o PCR –turnaround time <ol style="list-style-type: none"> 1. High through put testing TAT* within 24 hrs 2. Rapid testing, TAT within 4 hrs 	Location	Daily Presentation =/<	CAB	5	RBWH	10	TPCH	10	RDH	5	Location	Daily Presentation =/<	METRO NORTH	30	HHS		Location	Daily admits =/<	METRO NORTH	5	HHS		Location	Daily	METRO NORTH	0	HHS		<p>CRITERIA one of:</p> <ul style="list-style-type: none"> o Suspected ARI ED presentations: <table border="1"> <thead> <tr> <th>Location</th> <th>Daily Presentation =/<</th> </tr> </thead> <tbody> <tr> <td>CAB</td> <td>6 -15</td> </tr> <tr> <td>RBWH</td> <td>11 -20</td> </tr> <tr> <td>TPCH</td> <td>11 -20</td> </tr> <tr> <td>RDH</td> <td>6 -15</td> </tr> </tbody> </table> <ul style="list-style-type: none"> o Suspected ARI ED presentations: <table border="1"> <thead> <tr> <th>Location</th> <th>Daily Presentation =/<</th> </tr> </thead> <tbody> <tr> <td>METRO NORTH</td> <td>31 - 70</td> </tr> <tr> <td>HHS</td> <td></td> </tr> </tbody> </table> <ul style="list-style-type: none"> o Suspected ARI admissions per day: <table border="1"> <thead> <tr> <th>Location</th> <th>Daily admits</th> </tr> </thead> <tbody> <tr> <td>METRO NORTH</td> <td>6-10</td> </tr> <tr> <td>HHS</td> <td></td> </tr> </tbody> </table> <ul style="list-style-type: none"> o ICU admit for ARI per day: <table border="1"> <thead> <tr> <th>Location</th> <th>Daily</th> </tr> </thead> <tbody> <tr> <td>METRO NORTH</td> <td>1</td> </tr> <tr> <td>HHS</td> <td></td> </tr> </tbody> </table> <ul style="list-style-type: none"> o ARI Workforce absenteeism - Interruption to service continuity <p>Other indicators</p> <ul style="list-style-type: none"> o 4-6 ARI patients waiting suitable clinical location ED per facility. o < 80% anticipated required: o ARI Vaccinations o Antivirals and/or o PPE stock availability o Testing kits (GeneXP) o PCR –turnaround time <ol style="list-style-type: none"> 1. 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Note: activity has direct impact on staffing, PPE utilisation and laboratory consumables

*TAT = Turnaround Time

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.**

Governance	Workforce	Metro North Virtual Care Services and HiTH	Intensive Care Unit	Service operations	Meetings
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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% 	<ul style="list-style-type: none"> Promote Metro North Virtual Care Services – <i>targets per service to be confirmed</i> Virtual Emergency Care Services Virtual Ward HiTH 	<ul style="list-style-type: none"> Maintain ICU capacity plans. 	<ul style="list-style-type: none"> Business as usual 	<ul style="list-style-type: none"> Business as usual.
		<p>Emergency Department</p> <ul style="list-style-type: none"> Maintain ED capacity plans PCR as clinically indicated for symptomatic patients including those patients for admission 	<p>Bedded Services</p> <p>Placement of patients with ARI, are based on the following principles</p> <ul style="list-style-type: none"> 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 		<p>Training/Education</p> <ul style="list-style-type: none"> Business as usual.

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.

Governance	Workforce	Metro North Virtual Care Services and HiTH	Intensive Care Unit	Service operations	Meetings
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Promote Metro North Virtual Care Services – <i>stretch targets per service to be confirmed</i> Virtual Emergency Care Services Virtual Ward HiTH Weekly reporting on referral and utilisation of all services 	<ul style="list-style-type: none"> Review and refresh ICU capacity plans. 	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> Teams link to be included as option for all meetings for times when staff can't attend face-to-face
		<p style="text-align: center;">Emergency Department</p> <ul style="list-style-type: none"> Review and refresh ED capacity plans Review PCR collection services & testing criteria (Plan sect 5.3) 	<p style="text-align: center;">Bedded Services</p> <p>Placement of patients with ARI, are based on the following principles</p> <ul style="list-style-type: none"> 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. 		

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.**

Governance	Workforce	Metro North Virtual Care Services and HiTH	Intensive Care Unit	Service operations	Meetings
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Promote Metro North Virtual Care Services – <i>stretch targets per service to be confirmed</i> Virtual Emergency Care Services Virtual Ward HiTH Daily reporting on referral and utilisation of all services 	<ul style="list-style-type: none"> Review ICU capacity plans and prepare to activate over-census bed areas. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Teams link to be included in all meetings Face-to-face meetings only where essential; flat surgical masks required
		<p style="text-align: center;">Emergency Department</p> <ul style="list-style-type: none"> Review PCR collection services & testing criteria (Plan sect 5.3) Review ED capacity plans and prepare to activate over-census bed areas. 	<p style="text-align: center;">Bedded Services</p> <p>Placement of patients with ARI, are based on the following principles</p> <ul style="list-style-type: none"> 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. 		

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.**

Governance	Workforce	Metro North Virtual Care Services and HiTH	Intensive Care Unit	Service operations	Meetings
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Promote Metro North Virtual Care Services – <i>stretch targets per service to be confirmed</i> Virtual Emergency Care Services Virtual Ward HiTH Daily reporting on referral and utilisation of all services 	<ul style="list-style-type: none"> Review ICU capacity plans and prepare to activate over-census bed areas. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Cease meetings not directly related to clinical care or staff wellbeing that involve clinical staff.
		<p style="text-align: center;">Emergency Department</p> <ul style="list-style-type: none"> 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) 	<p style="text-align: center;">Bedded Services</p> <p>Placement of patients with ARI, are based on the following principles</p> <ul style="list-style-type: none"> 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 <p>Utilise over-census bed areas as per MNH Acute Capacity Framework.</p>		<p style="text-align: center;">Training</p> <ul style="list-style-type: none"> Restricted to essential clinical training and examinations for clinical staff only

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 identification 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	<p><u>MNH Representative:</u> 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 (secretariat)</p> <p><u>Clinical Advisory Group:</u> MNH Standard 3 Committee membership</p> <p><u>Facility Based Representatives:</u> Executive Director and/or delegate, E/DMS (Per Facility), Patient Access, Capacity and Flow Lead</p>
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 <i>Summarise HHS-wide impact once Directorate updates have been provided. Address any immediate safety issue.</i>
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	mnmh-tpch@health.qld.gov.au MNMHS-RBWH-AHNM@health.qld.gov.au MH-AHNM@health.qld.gov.au	(07) 3139 5603 (07) 3646 1137 (07) 5316 5689	Mental Health – after hours duty managers per service line
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
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Required to have situational awareness.

Facility/ Service	Generic e-mail Account	Position Mobile No.	Position
For situational awareness			
MNH CE	ce_mnhs@health.qld.gov.au	0432 757 191	MNH Chief Executive
MNH COO	MNHHSOperationsExecutive@health.qld.gov.au	0412 744 357	MNH Chief Operating 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 – PP	mn_nm_performanceandplanning@health.qld.gov.au	0499 790 903	MNH Performance and Planning 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

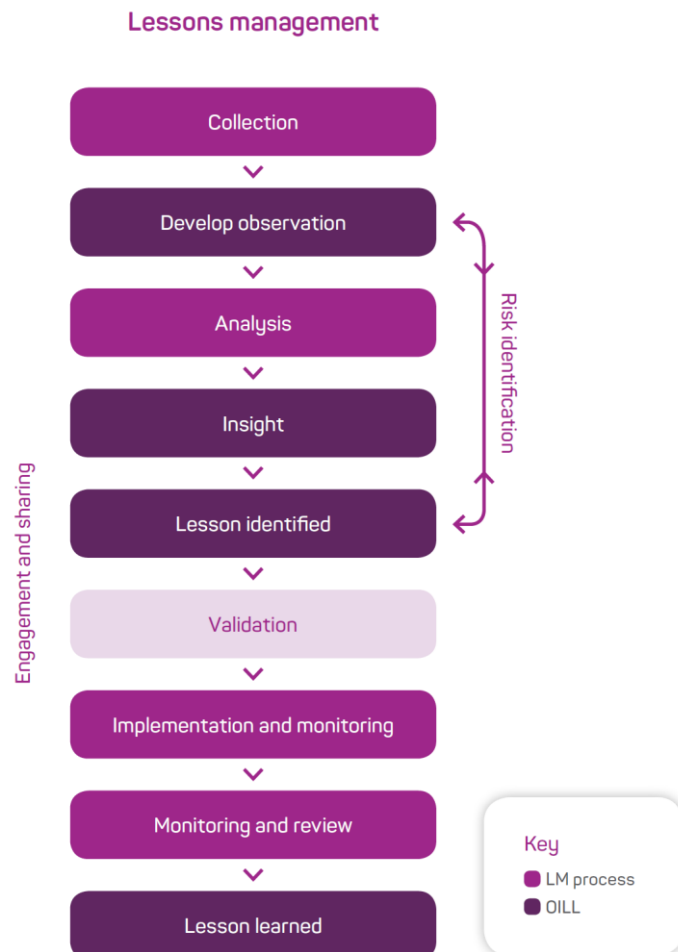
7.1 Lessons management

'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 ¹⁴
RBWH	24 beds <ul style="list-style-type: none"> 1 Q class Wattlebrae 15 Wattlebrae 4 ICU 1 Emergency Trauma Centre 2 Intensive Care Nursery 1 Short Stay Unit 	458 beds <ul style="list-style-type: none"> 14 ICU 30 Ward 6AS 30 Ward 8AS 30 Ward 8BS 	4 beds <ul style="list-style-type: none"> 1 CCU 1 Birth Suite 1 Ward 6B 1 outpatient Consult room (exhausted) <p><i>Note: Work to be completed 2 Emergency Trauma Centre (Resuscitation bays)</i></p>	85		479
TPCH	22 beds <ul style="list-style-type: none"> 12 Ward 1E 4 ICU 2 Adult Emergency Department 1 paediatric Emergency Department 2 paediatric general medicine 1 PACU 	14 beds <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 4 ICU 1 Emergency Department 2 Ward 6E 	16 beds <ul style="list-style-type: none"> 13 Ward 6E 3 Paediatrics 	2 bed spaces <ul style="list-style-type: none"> Medi Vent units available to be deployed into any room that can accommodate them 	34	3 bed spaces <ul style="list-style-type: none"> 3 HEPA filtered air purifiers available to be deployed to any room that can support external exhaust 	173
Caboolture	11 beds <ul style="list-style-type: none"> 6 adult (including 1 double room). 1 paediatric 1 neo-natal 2 Emergency Department 			58	4 Flex Bed unit Note: Woodford Correctional Facility has capacity to secure areas as required with advice from Caboolture hospital Infection Control.	72
Kilcoy				4	2 beds. <ul style="list-style-type: none"> Bed 7 and palliative care bed have separate airflow 	4
Mental Health						43
STARS				96		31
COH				41		66
TOTAL	63 60 Negative pressure 1 Q class	481	6	440 399 – Acute 41 – Sub Acute	20 16 Beds 4 Chairs	1026

¹⁴ 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. <i>The room is used for patients who require isolation to minimise the potential for infections being transmitted by contact or droplets</i>
Class P Positive Pressure	Patient Protection – Type 3	a single room with an ensuite that is not shared <i>The room is used to reduce the risk of airborne transmission of infection</i>
Class N ** Negative Pressure	Respiratory Isolation – Type 5	a single room with an ensuite that is not shared. <i>This room is used for patients who require isolation to reduce airborne transmission of disease (e.g. varicella, measles, pulmonary or laryngeal tuberculosis).</i>
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	<u>No Signs/symptoms</u> 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 – <u>NO ARI</u> (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	Nil Additional	Recommended use of surgical masks

Appendix 4: 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 5: Guide for Formal panel testing for respiratory viruses (Pathology Queensland (PQ))

Current up to May 2024

1. Rapid testing – 4hrs turn-around-time, <i>depending on volume</i>			
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, <i>depending on volume</i>			
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			

Planned revision/updates from June 2024

PQ have revised the current catalogue

- a. will no longer hold stock for the “Rapid 2” assay noting, the “Rapid 3”, 4PLEX on the GeneXpert, is the most ordered test.
- b. a new high-throughput assay will be made available, which will allow for the incorporation of SARS-CoV-2 into the Resp 1 panel (RESPCR). The new orderable code will be RESP11.

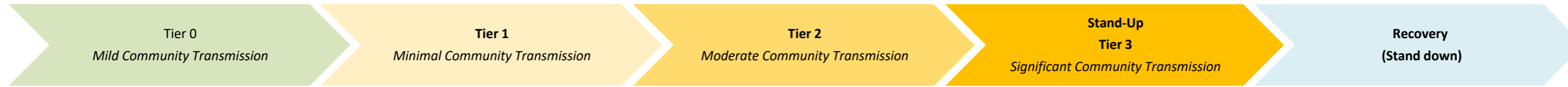
1. Rapid testing – 4hrs turn-around-time, <i>depending on volume</i>			
Rapid 1	Rapid 2	Rapid 3	Rapid 4
AUSLAB Code XPNCV	Pathology no longer holding stock	AUSLAB Code 4PLEX	AUSLAB Code LTNCV
GeneXpert for	GeneXpert for	GeneXpert for	LIAT for
SARS-CoV-2	Influenza A/B	Influenza A/B	Influenza A/B
	RSV	RSV	SARS-CoV-2
		SARS-CoV-2	
2. High throughput testing – 24hrs turn-around-time, <i>depending on volume</i>			
Resp 1 panel **	Resp 2 panel	Resp Panel 3	
RESP11 (RBWH and Prince Charles)	Pathology no longer holding stock	4RESP (RBWH only)	
SARS-CoV-2	SARS-CoV-2	SARS-CoV-2	
Influenza A/B	Influenza A/B	Influenza A/B	
RSV		RSV	
Parainfluenza 1 -4			
Human Metapneumovirus			
Rhinovirus			
Adenovirus			
**SARS CoV-2 required, additional swab for single COVID testing – NCVPCR			

Appendix 6: The Prince Charles Hospital Criteria for Acute Respiratory Illness Response Sub Plan Part 1 (Updated by TPCH ELT 01/05/2024)

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)								
<p>STRATEGY: Designated</p> <table border="1" data-bbox="74 499 549 541"> <tr> <td>Covid-19/ ARI Capacity</td> <td>12</td> </tr> </table> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> Type 5 single room 2 beds <p>ED AREAS</p> <ul style="list-style-type: none"> 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 Care Services, including Emergency Cares services and Ward, 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 <p>ICU (Pod 3)</p> <ul style="list-style-type: none"> Two (2) Type 5 rooms for influenza <p>MENTAL HEALTH</p> <ul style="list-style-type: none"> Managed as per Infection prevention and control guidelines for the management of COVID-19 in healthcare settings Queensland Health <p>ACUTE Inpatient Areas (BAU)</p>	Covid-19/ ARI Capacity	12	<p>STRATEGY: Designated/ Co-Located</p> <table border="1" data-bbox="608 499 1113 541"> <tr> <td>Covid-19/ ARI Capacity</td> <td>38</td> </tr> </table> <ul style="list-style-type: none"> 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 <p>ED CONSIDER OVERFLOW AREAS</p> <ul style="list-style-type: none"> As per Tier 0 Prepare to increase CED for additional adjacent OPD seven (7) treatment spaces Identify increased staffing models <p>ICU OVERFLOW (4/18)</p> <ul style="list-style-type: none"> Children requiring ICU treatment will be transferred by RSQ to QCH Pod 3: 2x Type 5 and Pod 2: 2x Type 5 <p>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</p> <p>MENTAL HEALTH</p> <ul style="list-style-type: none"> Consider need for surge beds 4 - 8 in the Thoracic Ward (TW) <p>ACUTE Inpatient BED MANAGEMENT (up to 24 COVID beds)</p> <p>Inpatient COVID co-located with programmes (Type 4 single rooms, risk mitigated for density)</p> <ul style="list-style-type: none"> 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) 	Covid-19/ ARI Capacity	38	<p>STRATEGY: Co-Located</p> <table border="1" data-bbox="1202 499 1706 541"> <tr> <td>Covid-19/ ARI Capacity</td> <td>55</td> </tr> </table> <ul style="list-style-type: none"> 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 <p>ED CONSIDER OVERFLOW AREAS</p> <ul style="list-style-type: none"> 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 <p>ICU OVERFLOW (11/27) As per tier 1 plus:</p> <ul style="list-style-type: none"> 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 <p>ACUTE Inpatient BED MANAGEMENT (open flex beds, up to 34 COVID beds)</p> <p>Inpatient COVID co-located with programmes (Type 4 single rooms, risk mitigated for density)</p> <ul style="list-style-type: none"> 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) 	Covid-19/ ARI Capacity	55	<p>STRATEGY: Designated/Cohorted/Co-Located</p> <table border="1" data-bbox="1810 499 2359 541"> <tr> <td>Covid-19/ ARI Capacity</td> <td>74</td> </tr> </table> <ul style="list-style-type: none"> 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 <p>ED CONSIDER OVERFLOW AREAS</p> <ul style="list-style-type: none"> As per Tier 2 ED OPALS space – Adult Respiratory Fast Track (multi chair space) <p>ICU OVERFLOW (18/37)</p> <ul style="list-style-type: none"> Expand into Stage 2 PACU (10 beds) and W2E and OT (<i>substantial additional equipment required and staffing* required- see challenges and considerations</i>) 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 <p>ACUTE Inpatient BED MANAGEMENT (cohorted in designated wards) up to 54 COVID beds</p> <p>Inpatient COVID designated /co-located for speciality</p> <ul style="list-style-type: none"> 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) <p>Non-traditional overnight inpatient areas</p> <ul style="list-style-type: none"> Over census enacted inpatient areas Stage 2 PACU 8 beds overnight inpatient 	Covid-19/ ARI Capacity	74	<p>ACTIONS</p> <p>Requirement to undertake: Transition from responding to an event back to normal core business and/or recovery operations</p>
Covid-19/ ARI Capacity	12											
Covid-19/ ARI Capacity	38											
Covid-19/ ARI Capacity	55											
Covid-19/ ARI Capacity	74											

The Prince Charles Hospital Criteria for Acute Respiratory Illness Response Sub Plan – Part 2 (Updated by TPCB ELT 01/05/2024)

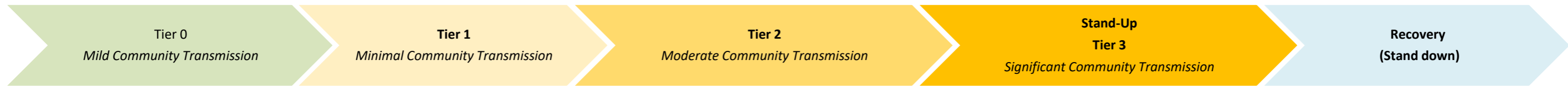


Tier 0 <i>Mild Community Transmission</i>	Tier 1 <i>Minimal Community Transmission</i>	Tier 2 <i>Moderate Community Transmission</i>	Stand-Up Tier 3 <i>Significant Community Transmission</i>	Recovery (Stand down)
<p>WORKFORCE</p> <ul style="list-style-type: none"> Monitor recruitment strategies and vacancy management as per BPF 	<p>WORKFORCE</p> <ul style="list-style-type: none"> Tier 0 plus review all recruitment strategies and deployment and upskilling of workforce 	<p>WORKFORCE</p> <ul style="list-style-type: none"> 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. 	<p>WORKFORCE</p> <ul style="list-style-type: none"> 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. 	<p>WORKFORCE</p> <ul style="list-style-type: none"> Staged de-escalation of workforce strategies. Resumption of essential training and meetings as clinical demands permit.

Appendix 7: The Royal Brisbane and Women's Hospital Criteria for Acute Respiratory Illness Response Sub Plan – Part 1 (Updated by RBWH ELT 30/04/2024)

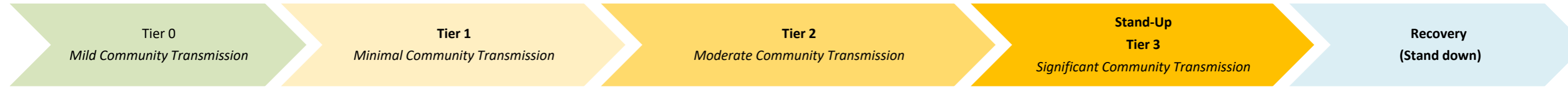
Associated actions for RBWH Leadership Team Triggers and actions include, but are not limited to, the below:

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)
<p>Consider-</p> <ul style="list-style-type: none"> ARI admission conversion rate <u>less than 20</u> preceding 24 hours 	<p>Criteria</p> <ul style="list-style-type: none"> ARI admission conversion rate ≤ 20 preceding 24 hours Small clusters of healthcare transmission within a ward Workforce deficits manageable within re-deployable resources or substitute staffing arrangements 	<p>Criteria</p> <ul style="list-style-type: none"> ARI admission conversion rate > 20/preceding 24 hours Cases cohorted in 4-bed bays according to infection type or single outbreak ward model of care required. Increasing clusters of healthcare transmission within a ward/s. Workforce and bed capacity deficits with minor impacts on service delivery in one or more service-lines. 	<p>Criteria</p> <ul style="list-style-type: none"> ARI admission conversion rate > 30/preceding 24 hours Extension of ICU Capacity required Sustained healthcare transmission leading to multiple outbreaks across multiple wards +/- multiple outbreak wards in operation Workforce and bed capacity deficits with impacts on clinical operations across multiple-service lines 	<p>Return to BAU</p>
<p>BED MANAGEMENT</p> <ul style="list-style-type: none"> Utilise priority risk matrix for Transmission Based Precaution to determine ward/ICU single room use Patients with ARI admitted to single room in home ward with air purifier where clinically indicated. High-risk patients (e.g., immune compromised) admitted to 6C. Daily ward rounds to identify early discharge/HITH/virtual Appropriate release from isolation. 	<p>BED MANAGEMENT</p> <ul style="list-style-type: none"> As per Tier 0 Active daily management of single room bed stock Daily virtual ward round of patients with respiratory tract infections (COVID, Flu, RSV) to optimise single room usage. 	<p>BED MANAGEMENT</p> <p>Actions per Tier 0 and 1 <u>plus</u></p> <ul style="list-style-type: none"> Single rooms preferentially used for patients with any virus requiring oxygen or CPAP/BIPAP followed by patients with COVID 19 Cohort respiratory viruses in 4-bed bays. Progressive use of 4-bed bays in single service-line ward location. Activation of negative airflow to one ward. Outbreak ward model of care for nosocomial transmission Consider cohorting close contacts in 2/4 bed bays or with patients with resolved infection. 	<p>BED MANAGEMENT</p> <p>Additional actions include</p> <ul style="list-style-type: none"> Progressive use of 4-bed bays in multiple ward locations across multiple service-lines. Activation of negative airflow to two or more wards. Consider activation of respiratory ICU (pod 3/4) 	<p>BED MANAGEMENT</p> <p>Staged de-escalation of wards</p> <ul style="list-style-type: none"> Outbreak wards/ respiratory ICU returned to BAU function. Management of patients in home wards using TBC and existing resources
<p>WORKFORCE</p> <ul style="list-style-type: none"> BAU Consider vaccinations for flu (annual), whooping cough (10 year), COVID-19 (risk based) Stay home if unwell with respiratory symptoms (5 days) No staff masking outside care for respiratory tract infections Sanitise hands regularly. 	<p>WORKFORCE</p> <ul style="list-style-type: none"> BAU PPE per escalation matrix 	<p>WORKFORCE</p> <ul style="list-style-type: none"> Indirect staff are brought online to provide direct patient care. Clinical staff redeployed to areas of greatest need. PPE per escalation matrix 	<p>WORKFORCE</p> <ul style="list-style-type: none"> Actions per Tier 2, plus 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. Staff masking in high-risk areas i.e., haem/onc, ICU, maternity. Type of mask being determined by the predominant virus 	<p>WORKFORCE</p> <ul style="list-style-type: none"> Staged de-escalation of workforce strategies supported by ad-hoc satellite support teams. Resumption of essential training and meetings as clinical demands permit
<p>GOVERNANCE</p> <p>BAU</p>	<p>GOVERNANCE</p> <p>As per Tier 0</p>	<p>GOVERNANCE</p> <ul style="list-style-type: none"> Briefings at planned daily and additional leadership scrums Consider impacts to patient access, flow, and operations. Consider activation of RBWH Emergency and Disaster Response Plan to Lean Forward. 	<p>GOVERNANCE</p> <ul style="list-style-type: none"> Consider activation of RBWH Emergency and Disaster Response Plan to Stand up Consider reductions to planned care IMT Tier 1/2 briefing 	
<p>PUBLIC MESSAGING</p> <ul style="list-style-type: none"> Stay away if unwell (sign) 	<p>PUBLIC MESSAGING</p>	<p>PUBLIC MESSAGING</p> <ul style="list-style-type: none"> As per Tier 0 	<p>PUBLIC MESSAGING</p> <ul style="list-style-type: none"> Visitors to wear masks on entry to hospital (sign) Stay away if unwell (sign) 	

Emergency and Trauma Centre

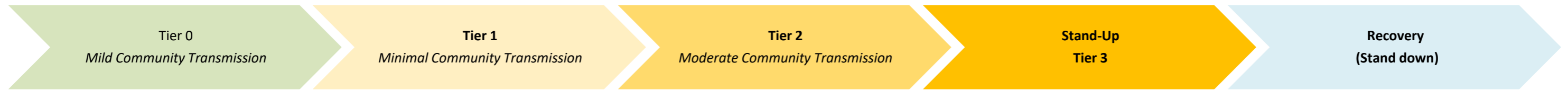


<p>Consider-</p> <p>ETC MANAGEMENT</p> <ul style="list-style-type: none"> Usual triage, treatment, transfer arrangements. Active admission avoidance including RADAR, Virtual ED/ward, and GP follow up Testing of patients with respiratory symptoms requiring inpatient admission and high-risk groups. 	<p>Criteria ETC attendances->10 of presentations for ARI</p> <p>ETC MANAGEMENT</p> <p>As per Tier 0- ARI</p> <ul style="list-style-type: none"> Flat surgical masks provided to patients with respiratory symptoms, if tolerated 	<p>Criteria ETC attendances->20% - 30% of presentations for ARI</p> <p>ETC MANAGEMENT</p> <p>As per Tier 1- ARI <u>plus</u></p> <ul style="list-style-type: none"> Consider clinical contraindications for cohorting immune suppressed patients within ETC (page 8 Transmission Based Precaution Procedure¹⁵). <p>BED MANAGEMENT</p> <ul style="list-style-type: none"> Active processes to expedite patient movement into appropriate single bed/ward accommodation <p>WORKFORCE</p> <ul style="list-style-type: none"> Indirect staff are brought online to provide direct patient care. Redeployment of staff within service line to support patient care activities. 	<p>Criteria ETC attendances->30% of presentations for ARI</p> <p>ETC MANAGEMENT</p> <ul style="list-style-type: none"> Consider activating respiratory isolation area to cohort patients presenting with ARI. <p>BED MANAGEMENT</p> <ul style="list-style-type: none"> As per Tier 2- ARI. 	<p>Return to BAU departmental configuration</p>
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¹⁵ [001837: Transmission Based Precautions \(health.qld.gov.au\)](#)

Appendix 8: Redcliffe Hospital Criteria for Acute Respiratory Illness Response Sub Plan (Updated by RDH ELT May 2024)

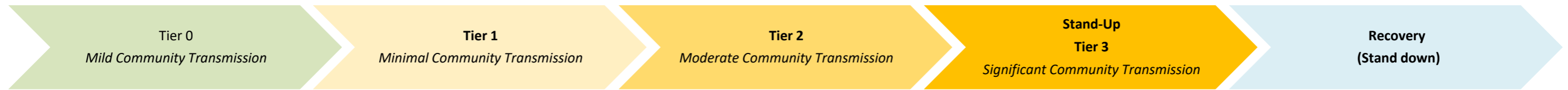
Associated actions for RDH Leadership Team Triggers and actions include, but are not limited to, the below:



Tier 0 Mild Community Transmission	Tier 1 Minimal Community Transmission	Tier 2 Moderate Community Transmission	Stand-Up Tier 3	Recovery (Stand down)
<p>ACTIONS</p> <p>ED Management</p> <ul style="list-style-type: none"> ○ 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 <p>Inpatient Units</p> <p>Prioritisation of Patient Placement</p> <ul style="list-style-type: none"> ● Novel Respiratory Virus, COVID 19, Airborne Precautions <ul style="list-style-type: none"> ○ 6 East Negative Pressure (x2) ○ 6 East Negative Flow (x5) ○ Paediatric Negative Flow (x1) ● Other ARI <ul style="list-style-type: none"> ○ home ward single room ● Co-infections- prioritise negative pressure rooms ● Results pending- MAU single room until result known ● Maternity Patients <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ Neonates who require isolation from mother <ul style="list-style-type: none"> ▪ Bed 13 Maternity ward <p>ICU</p> <ul style="list-style-type: none"> ● 7 ventilated equivalent beds ● 10 physical bed spaces <ul style="list-style-type: none"> ○ 4x negative pressure ● 2x isolation rooms 	<p>ACTIONS</p> <p>ED Management</p> <p>As per Tier 0</p> <p>Inpatient Units</p> <p>Tier 0 plus:</p> <ul style="list-style-type: none"> ● Virtual Ward <ul style="list-style-type: none"> ○ Promotion of virtual Ward <p>Prioritisation of Patient Placement</p> <p>As per Tier 0</p> <p>ICU</p> <p>As per tier 0</p> <p>Planned Care</p> <ul style="list-style-type: none"> ● Reduction in planned care as directed by Metro North 	<p>ACTIONS</p> <p>ED Management</p> <p>As per Tier 0 plus</p> <p>Consideration of expanding services</p> <ul style="list-style-type: none"> ○ Adult SSU overflow (4 additional chairs) 24h model ○ Ambulatory Care 24h nursing model to manage AWA greater than 10 ○ Medical Imaging for AWA. ○ Increase Paediatric Acute ED from 16-hour model to 24-hour model (5 additional beds) <p>Inpatient Units</p> <p>Tier 1 plus:</p> <ul style="list-style-type: none"> ● Cohorting of ARI from vulnerable patients <p>Prioritisation of Patient Placement</p> <ul style="list-style-type: none"> ● Novel Respiratory Virus <ul style="list-style-type: none"> ○ Adult trigger: 12 patients <ul style="list-style-type: none"> ▪ Consider opening 6 East “red zone” or; ▪ Utilise single rooms ○ Paediatric trigger >1 <ul style="list-style-type: none"> ▪ 6 East with paediatric nurse deployed, or; ▪ Open Paeds SSU as “red zone” ● Other ARI <ul style="list-style-type: none"> ○ cohort in home ward ● Co-Infections- prioritise negative pressure rooms <p>** Consideration to be given to isolation room requirements and overall bed demand to determine the most appropriate option.**</p> <p>ICU OVERFLOW</p> <p>Tier 1 plus:</p> <ul style="list-style-type: none"> ● Increase capacity to 10 ventilated beds ● Begin preparations for ICU expansion ● Load share with other ICU’s 	<p>ACTIONS</p> <p>ED Management</p> <p>As per Tier 2</p> <p>Consideration (depending on staffing levels)</p> <ul style="list-style-type: none"> ○ Increase Paediatric ED to 24-hour model to open beds across all areas including Fast Track (3-4 additional spaces) <p>Inpatient Units</p> <p>Tier 2 plus:</p> <p>Prioritisation of Patient Placement</p> <ul style="list-style-type: none"> ● Novel Respiratory Virus, COVID 19 <ul style="list-style-type: none"> ○ Trigger >18 patients <ul style="list-style-type: none"> ▪ Whole of 6 East becomes “red” zone ● Other ARI <ul style="list-style-type: none"> ○ Phase 1: 5W single rooms ○ Phase 2: Cohort in appropriate wards ● Co-Infections- prioritise negative pressure rooms <p>ICU OVERFLOW</p> <p>Tier 2 plus:</p> <ul style="list-style-type: none"> ● ICU expansion to 10 beds triggered on 5th patient requiring negative pressure accepted referral, or; ● Utilise isolation room with air purifiers 	<p>ACTIONS</p> <p>ED Management</p> <ul style="list-style-type: none"> ○ Revert to 16-hour Paediatric MOC with exception of Paed STTA <p>Inpatient Units</p> <p>RESPIRATORY WARDS</p> <ul style="list-style-type: none"> ● Stand down 5W as ARI ward beds ● Stand down 6 East ● Stand down Paediatric SSU <p>ICU OVERFLOW</p> <ul style="list-style-type: none"> ● Reduce back to 7 ventilated equivalent beds

Appendix 9: Caboolture, Kilcoy, and Woodford Directorate Criteria for Acute Respiratory Illness Response Sub Plan (Updated by CKW ELT 30/04/2024)

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



<p>Tier 0 <i>Mild Community Transmission</i></p>	<p>Tier 1 <i>Minimal Community Transmission</i></p>	<p>Tier 2 <i>Moderate Community Transmission</i></p>	<p>Stand-Up Tier 3 <i>Significant Community Transmission</i></p>	<p>Recovery (Stand down)</p>
<p>ACTIONS</p> <ul style="list-style-type: none"> Staff vaccination campaign if directed Staff/patient/visitor education plan PPE access and availability <p>ED CONSIDER OVERFLOW AREAS</p> <ul style="list-style-type: none"> 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 <p>RESPIRATORY WARDS</p> <ul style="list-style-type: none"> 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 <p>ICU OVERFLOW</p> <ul style="list-style-type: none"> 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 <p>WORKFORCE</p> <ul style="list-style-type: none"> 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 	<p>ACTIONS</p> <ul style="list-style-type: none"> Activate Directorate Emergency Response Plan and Pandemic Plan Weekly local IMT meeting including Business Impact Assessments Attend MN IMT and complete directorate reporting <p>ED CONSIDER OVERFLOW AREAS As per Tier 0</p> <ul style="list-style-type: none"> 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 <p>RESPIRATORY WARDS As per Tier 0</p> <ul style="list-style-type: none"> Move towards dedicated respiratory space (3B) Maintain PPE as per standard and transmission-based precautions with increased presentation risk assess need for local escalation <p>ICU OVERFLOW As per Tier 0</p> <p>WORKFORCE As per Tier 0</p> <ul style="list-style-type: none"> 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. 	<p>ACTIONS</p> <ul style="list-style-type: none"> 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 <p>ED CONSIDER OVERFLOW AREAS As per Tier 1</p> <ul style="list-style-type: none"> Alternate housing of ILI patients to be considered if viable Maintain PPE as per standard and transmission-based precautions <p>RESPIRATORY WARDS As per Tier 1</p> <ul style="list-style-type: none"> Review room allocation and look to cohort where required/possible <p>ICU OVERFLOW As per Tier 1</p> <ul style="list-style-type: none"> Identify and source equipment needed to expand service if required. <p>ELECTIVE SERVICES</p> <ul style="list-style-type: none"> Review non-critical clinical services with option to reduce and/or suspend elective/non-urgent surgical and SOPD cases where possible <p>WORKFORCE As per tier 1</p> <ul style="list-style-type: none"> Cancellation of training and meetings Virtual meetings only Training and potential redeployment of staff to clinical areas 	<p>ACTIONS</p> <ul style="list-style-type: none"> 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??) <p>ED CONSIDER OVERFLOW AREAS As per Tier 2</p> <p>RESPIRATORY WARDS As per Tier 2</p> <ul style="list-style-type: none"> Dedicated unit (4D), cohorting inclusive <p>ICU OVERFLOW As per Tier 2</p> <ul style="list-style-type: none"> Awareness of MN/State need for ICU beds Preparation of area and staff to meet needs with potential expansion into Theatre space. <p>ELECTIVE SERVICES As per Tier 2</p> <ul style="list-style-type: none"> Elective surgery and SOPD considered' Postponement of surgeries requiring admission to inpatient bed <p>WORKFORCE As per Tier 2</p> <ul style="list-style-type: none"> Redeploy staff from non-clinical and closed services to support Consideration of leave cancellation 	<p>ACTIONS</p> <ul style="list-style-type: none"> 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 10: Community and Oral Health Directorate Criteria for Acute Respiratory Illness Response Sub Plan (Updated by COH IMT 09/04/2024)

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

Tier 0 <i>Mild Community Transmission</i>	Tier 1 <i>Minimal Community Transmission</i>	Tier 2 <i>Moderate Community Transmission</i>	Stand-Up Tier 3 <i>Significant Community Transmission</i>	Recovery (Stand down)
<p>Criteria: Evidence of very low inpatients/residents with ARI in COH</p> <p>Patient Management: Subacute/RTCP/Residential Services</p> <ul style="list-style-type: none"> All symptomatic patients to be tested using GeneXpert 4Plex Single rooms for all ARI confirmed cases (if available) <p>Medical Governance: Subacute/RTCP/Residential Services</p> <ul style="list-style-type: none"> Business as Usual (BAU) <p>Logistics:</p> <ul style="list-style-type: none"> Business as Usual (BAU) PPE as per risk matrix <p>Workforce:</p> <ul style="list-style-type: none"> Business as Usual (BAU) <p>Actions:</p> <ul style="list-style-type: none"> 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 	<p>Criteria: Evidence of some inpatients/residents with ARI in COH</p> <p>Patient Management: - As per Tier 0 plus Subacute/RTCP</p> <ul style="list-style-type: none"> Cohort of like for like ARI confirmed cases in double and triple rooms, if single room not available <p>Residential Services</p> <ul style="list-style-type: none"> 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 <p>Medical Governance: - As per Tier 0 plus Residential Services</p> <ul style="list-style-type: none"> Early notification to RADAR services of situation so they can prepare for increased support <p>Logistics: - As per Tier 0 plus</p> <ul style="list-style-type: none"> Review current PPE stock holdings Consider increasing stock holdings of PPE Extra surgical masks available to ensure sufficient supply for visitors <p>Workforce: - As per Tier 0 plus</p> <ul style="list-style-type: none"> Review all recruitment strategies and deployment and upskilling of workforce <p>Actions: - As per Tier 0 plus</p> <ul style="list-style-type: none"> COH IMT minimum monthly Staff COH huddles/update as required via TEAMS 	<p>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</p> <p>Patient Management: - As per Tier 1 plus Subacute/RTCP</p> <ul style="list-style-type: none"> Open up to 4 beds if funding and staffing available Cohort ARI like for like cases if no single rooms available <p>Residential Services</p> <ul style="list-style-type: none"> As per Tier 1 plus <p>Medical Governance: - As per Tier 1 plus Subacute/RTCP</p> <ul style="list-style-type: none"> Review on call arrangements for after hours and weekends to optimise after hours decision making <p>Residential Services</p> <ul style="list-style-type: none"> Engage with RADAR outreach service <p>Logistics: - As per Tier 1 plus</p> <ul style="list-style-type: none"> Increase stock holdings of PPE <p>Workforce: - As per Tier 1 plus</p> <ul style="list-style-type: none"> Move all non-essential training and meetings to virtual Consider redeployment of non-frontline clinical staff to clinical areas <p>Actions: - As per Tier 1 plus</p> <ul style="list-style-type: none"> 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 	<p>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</p> <p>Patient Management: - As per Tier 2 Medical Governance: - As per Tier 2</p> <p>Logistics: - As per Tier 2 plus</p> <ul style="list-style-type: none"> PPE utilisation as per Infection Control risk matrix Review frequency of distribution of PPE <p>Workforce: - As per Tier 2 plus</p> <ul style="list-style-type: none"> Cancel all non-urgent meetings and education Deploy non-frontline clinical staff to clinical areas <p>Actions: - As per Tier 2 plus</p> <ul style="list-style-type: none"> COH IMT as required Staff COH huddles/update via TEAMS as required 	

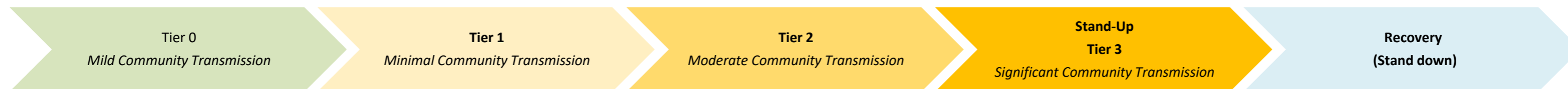
Appendix 11: Mental Health Directorate Criteria for Acute Respiratory Illness Response Sub Plan (Updated by MNH MH ELT 03/05/2024)

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

Tier 0 <i>Mild Community Transmission</i>	Tier 1 <i>Minimal Community Transmission</i>	Tier 2 <i>Moderate Community Transmission</i>	Stand-Up Tier 3 <i>Significant Community Transmission</i>	Recovery (Stand down)
<p>ACTIONS</p> <p>ACUTE/SECURE MENTAL HEALTH WARDS</p> <ul style="list-style-type: none"> • 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 comply with guidelines for placement of patients as per guidelines (Section 5.2.3 MNH ARI Response plan), the facility-based Infection Management and Prevention Team to be consulted • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways <p>COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)</p> <ul style="list-style-type: none"> • 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 <p>COMMUNITY TEAMS</p> <ul style="list-style-type: none"> • Referral of consumers of concern with ARI to MNH Virtual Emergency Care Services <p>WORKFORCE</p> <ul style="list-style-type: none"> • MH staff required for MH usual care. • Collaborative discussion with Facility regarding specialty workforce based on 	<p>ACTIONS</p> <p>ACUTE/SECURE MENTAL HEALTH WARDS</p> <ul style="list-style-type: none"> • 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 comply with guidelines for placement of patients as per guidelines (Section 5.2.3 MNH ARI Response plan), the facility-based Infection Management and Prevention Team to be consulted • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways <p>COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)</p> <ul style="list-style-type: none"> • 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 <p>COMMUNITY TEAMS</p> <ul style="list-style-type: none"> • Referral of consumers of concern with ARI to MNH Virtual Emergency Care Services <p>WORKFORCE</p> <ul style="list-style-type: none"> • MH staff required for MH usual care. • Collaborative discussion with Facility regarding specialty workforce based on 	<p>ACTIONS</p> <p>ACUTE/SECURE MENTAL HEALTH WARDS</p> <ul style="list-style-type: none"> • 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 comply with guidelines for placement of patients as per guidelines (Section 5.2.3 MNH ARI Response plan), the facility-based Infection Management and Prevention Team to be consulted • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways <p>COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)</p> <ul style="list-style-type: none"> • 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 <p>COMMUNITY TEAMS</p> <ul style="list-style-type: none"> • Referral of consumers of concern with ARI to MNH Virtual Emergency Care Services <p>WORKFORCE</p> <ul style="list-style-type: none"> • MH staff required for MH usual care. • Collaborative discussion with Facility regarding specialty workforce based on assessment of MH needs e.g. MH nurse 	<p>ACTIONS</p> <p>ACUTE/SECURE MENTAL HEALTH WARDS</p> <ul style="list-style-type: none"> • 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 comply with guidelines for placement of patients as per guidelines (Section 5.2.3 MNH ARI Response plan), the facility-based Infection Management and Prevention Team to be consulted • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways <p>COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)</p> <ul style="list-style-type: none"> • 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 <p>COMMUNITY TEAMS</p> <ul style="list-style-type: none"> • Referral of consumers of concern with ARI to MNH Virtual Emergency Care Services <p>WORKFORCE</p> <ul style="list-style-type: none"> • MH staff required for MH usual care. • Collaborative discussion with Facility regarding specialty workforce based on assessment of MH needs e.g. MH nurse 	<p>ACTIONS</p> <p>ACUTE/SECURE MENTAL HEALTH WARDS</p> <ul style="list-style-type: none"> • 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 comply with guidelines for placement of patients as per guidelines (Section 5.2.3 MNH ARI Response plan), the facility-based Infection Management and Prevention Team to be consulted • Referral to Facility for medical admission if required for severe clinical symptoms as per existing physical deterioration pathways <p>COMMUNITY RESIDENTIAL FACILITIES (SUSD/CCU)</p> <ul style="list-style-type: none"> • 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 <p>COMMUNITY TEAMS</p> <ul style="list-style-type: none"> • Referral of consumers of concern with ARI to MNH Virtual Emergency Care Services <p>WORKFORCE</p> <ul style="list-style-type: none"> • 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 12: Metro North Health Virtual Ward Service Capacity Surge Plan Activation and Associated Actions (as per Metro North Health Virtual Ward Model of Care 18/04/2024)

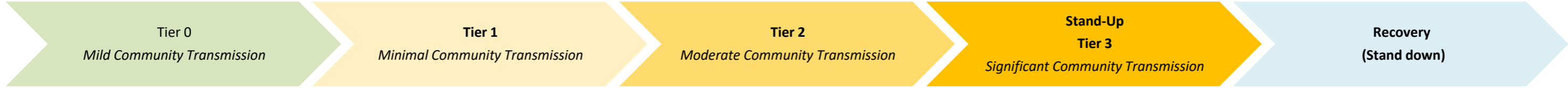
Criteria for movement through phases of activation and the associated actions. Triggers and actions include, but are not limited to, the below



CRITERIA	CRITERIA	CRITERIA	CRITERIA	CRITERIA
<ul style="list-style-type: none"> 0 – 12 referrals within previous 24 hrs <p>OR</p> <ul style="list-style-type: none"> 0 – 60 forecasted end of day occupancy based on admitted patients <p>OR</p> <ul style="list-style-type: none"> Increased patient acuity/ complexity 	<ul style="list-style-type: none"> 12 – 16 referrals within previous 24 hrs <p>OR</p> <ul style="list-style-type: none"> 61-80 forecasted end of day occupancy based on admitted patients. <p>OR</p> <ul style="list-style-type: none"> Increased patient acuity/ complexity 	<ul style="list-style-type: none"> 17-20 referrals within previous 24 hrs <p>OR</p> <ul style="list-style-type: none"> 81-100 forecasted end of day occupancy based on admitted patients. <p>OR</p> <ul style="list-style-type: none"> Unable to complete total consultations and/ or clinical escalations by close of business. 	<ul style="list-style-type: none"> > 20 referrals within previous 24 hrs <p>OR</p> <ul style="list-style-type: none"> >100 forecasted end of day occupancy based on admitted patients. <p>OR</p> <ul style="list-style-type: none"> Unable to complete total consultations and/ or clinical escalations by close of business. 	<ul style="list-style-type: none"> Transition from responding to an event back to normal core business and/or recovery operations.

ACTIONS	ACTIONS	ACTIONS	ACTIONS	ACTIONS
<p>Business as usual.</p> <ul style="list-style-type: none"> Assess and plan capacity for work from home capability for VW team. Continue to promote GP direct to VW referral pathway. 	<ul style="list-style-type: none"> To promote direct referral pathways for moderate risk ARI of concern patients Virtua Ward Team will increase engagement with Virtual Emergency Care Services (VECS), Primary healthcare Network (PHN), MN Minor Injury and Illness Services (MI&IS) Medicare Urgent Care centres (M-UCC), Norfolk Island Health and Residential Aged Care Service (NIHRACS). <p>Workforce-</p> <ul style="list-style-type: none"> Individual professional stream leads to review staffing and consider need for additional staffing as required. Consider use of part-time extra shifts/ overtime Review operating hours and consider extending if appropriate. <p>Workloads-</p> <ul style="list-style-type: none"> Individual professional stream leads to review priority worklists and enact where appropriate. Consider early discharge of clinically appropriate lower risk patients. <p>If not resolved escalate to: NUM Pharmacy TL SMO Delegate to escalate to Tier 1: Clinical Director-Virtual Ward</p>	<ul style="list-style-type: none"> As per Tier 1 plus: MDT daily huddle to review all areas ability to manage occupancy including re-allocation of tasks. Consider deployment of staff from offline roles to frontline 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. Virtual Meetings only Consider moving to remote working environment to reduce risk of workplace transmission. <p>If not resolved escalate to: Assistant Nursing Director- VHS Clinical Director- Virtual Ward</p> <p>Delegate to escalate to Tier 2: Clinical Director-Virtual Ward/ Operations Director- VHS</p>	<ul style="list-style-type: none"> As per Tier 2 Plus: HHS wide communication including to external key stakeholders through MN EMBC/ MN PACH e.g., VECS, Emergency Departments, PHN, GPLO, NIHRACS, M-UCC, MI&IS etc. Deploy staff from non-clinical and/ or closed services to support including rapid onboarding process. Consider urgent recruitment using short term contracts to support staffing. Cancellation of training and meetings <p>If not resolved escalate to: Operations Director- VHS</p> <p>If still not resolved escalate to: MN HHS COO or MN Exec on-call.</p> <p>Delegate to escalate to Tier 3: Operations Director- VHS or MN Exec- on-call.</p>	<ul style="list-style-type: none"> Transition from responding to an event back to normal core business and/or recovery operations. Staged de-escalation of workforce strategies implemented. Resumption of essential training and meetings as clinical demands permit <p>Delegate to move to Recovery or de-escalate: Operations Director- VHS</p>

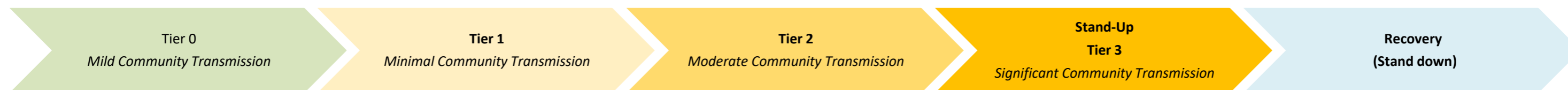
Appendix 13: STARS Directorate Criteria for Acute Respiratory Illness Response Sub Plan - Part 1 (Updated by STARS ELP 15/04/2024)



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.
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<p>Patient Management Sub Acute</p> <ul style="list-style-type: none"> - 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. <p>Patient Management Procedural</p> <ul style="list-style-type: none"> - 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. 	<p>Patient Management Sub Acute</p> <p>As per Tier 0</p> <ul style="list-style-type: none"> - 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. <p>Patient Management Procedural</p> <p>As per Tier 0</p>	<p>Patient Management Sub Acute</p> <p>As per Tier 1</p> <ul style="list-style-type: none"> • Review number of patients with pandemic virus and consider, in consultation with IMPS, collocating in the one dedicated area as needed. <p>Patient Management Procedural</p> <p>As per Tier 0</p>	<p>Patient Management Sub Acute</p> <p>As per Tier 1</p> <p>Patient Management Procedural</p> <p>As per Tier 0</p>	<p>Patient Management Sub Acute</p> <p>As per Tier 0</p> <ul style="list-style-type: none"> - Continue to monitor and screen for cases with a process for a return of BAU. <p>Patient Management Procedural</p> <p>As per Tier 0</p> <p>Continue to monitor and screen for cases with a process for a return of BAU</p>
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STARS Directorate Criteria for Acute Respiratory Illness Response Sub Plan – Part 2 (Updated by STARS ELP 15/04/2024)



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.
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<p>Medical Governance</p> <ul style="list-style-type: none"> - Business as usual (BAU) <p>Logistics</p> <ul style="list-style-type: none"> - Business as Usual (BAU) - Personal Protective Equipment (PPE) as per current PPE risk matrix - Review PPE capacity and numbers within STARS. <p>Workforce</p> <ul style="list-style-type: none"> - Business as usual (BAU) 	<p>Medical Governance</p> <ul style="list-style-type: none"> - Early notification from Geriatric Rehabilitation Liaison Service (GRLS) and triage process to identify patients for transfer to assist bed capacity at other hospitals. <p>Logistics</p> <ul style="list-style-type: none"> - 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. <p>Workforce</p> <ul style="list-style-type: none"> - 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. 	<p>Medical Governance</p> <ul style="list-style-type: none"> - As per Tier 1 - Review on call arrangements for after hours and weekends to optimise after hours decision making <p>Logistics</p> <ul style="list-style-type: none"> - As per Tier 0 and 1 plus - Increase stock holdings of PPE <p>Workforce</p> <ul style="list-style-type: none"> - 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 	<p>Medical Governance</p> <ul style="list-style-type: none"> - As per Tier 2 <p>Logistics</p> <ul style="list-style-type: none"> - As per Tier 0,1 and 2 plus - PPE utilisation as per current PPE risk matrix - Review frequency of distribution of PPE <p>Workforce</p> <ul style="list-style-type: none"> - As per Tier 0,1 and 2 plus - Cancel all non-urgent meetings and education - Deploy non-frontline clinical staff to clinical areas 	<p>Medical Governance</p> <ul style="list-style-type: none"> - As per Tier 2 <p>Logistics</p> <ul style="list-style-type: none"> - As per Tier 0,1 and 2 plus - PPE utilisation as per current PPE risk matrix - Review frequency of distribution of PPE <p>Workforce</p> <ul style="list-style-type: none"> - As per Tier 0,1 and 2 plus - Cancel all non-urgent meetings and education - Deploy non-frontline clinical staff to clinical areas
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STARS Directorate Criteria for Acute Respiratory Illness Response Sub Plan – Part 3 (Updated by STARS ELP 15/04/2024)



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.
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Actions <ul style="list-style-type: none"> - 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 for COVID-19 when available to prevent and minimise outbreaks 	Actions <ul style="list-style-type: none"> - As per Tier 0 plus - STARS IMT fortnight or as required. - Staff STARS huddles/updates as required via TEAMS 	Actions <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - As per Tier 0 plus
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<p>Bed information at STARS</p> <ol style="list-style-type: none"> Single Room capacity <ul style="list-style-type: none"> - Classifications of single rooms accommodation which have the potential to be used for patients with influenza- like illness (ILI). Room Types <ul style="list-style-type: none"> - STARS has 96 single rooms classified as Type 1 and Type 2 Inboard ensuite. These room types are defined by the Australian 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: <ul style="list-style-type: none"> Type 1 inboard ensuite Type 2 inboard ensuite Oxygen Ports <ul style="list-style-type: none"> - STARS Hospital has 600 oxygen outlets with Cushman and Wakefield monitoring the supply. 	<p>Mortuary Capacity</p> <p>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.</p> <ul style="list-style-type: none"> - 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.
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Appendix 14: Facility Based Situation Report (SitRep) Template

SitRep #			
Date: << >>			
Insert Facility: << >>			
Summary of current position		<i>highlight any immediate safety concerns</i>	
ARI Tier << >>	ABC Tier << >>		
Impact assessment on workforce – <i>** monitor staff sickness >3%</i>	Ok - Nil Impact	Shortfall- <i>identify impacted service</i>	Not Applicable
ED Impact Assessment			
ED LOS > 24 hrs <i>Confirmed plan to be executed within 2 hrs</i>			
QAS ToC > 2 hrs <i>Confirmed plan to be executed within 2 hrs</i>			
Service Impact Assessment			
Patient in Acute care Type admission Bed with LOS > 3 days, clinically appropriate for D/C or transfer <i>Confirmed plan to be executed within 2 hrs</i>			
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 15: 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 16: Consumer Resources

Coreflutes signage

Please help reduce the spread of acute respiratory illnesses

- You are encouraged to wear a mask when visiting patients
- Clean your hands
- Don't visit if you are unwell

Acute respiratory illnesses are increasing

Protect our patients:

- You are encouraged to wear a mask when visiting patients
- Clean your hands
- Don't visit if you are unwell

COVID-19 and Influenza

Acute respiratory illnesses are increasing

To help reduce the spread:

- Please wear a mask while you are in this facility
- Sanitise your hands when coming and going
- Stay home if you have COVID or flu symptoms

Appendix 17: 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
- TPCCH 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 \(2019 Version 11.18, published 30/03/2023\)](#)
- [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](#)
- [My aged care region - AIHW Gen \(gen-agedcaredata.gov.au\)](#)
- [Queensland Paediatric Respiratory Syncytial Virus Prevention Program | Queensland Health](#)
- [2024 Free Flu Vaccination Program | Queensland Health](#)
- [Medicare Urgent Care Clinics – Operational Guidance \(health.gov.au\)](#)
- [001837: Transmission Based Precautions \(health.qld.gov.au\)](#)

Appendix 18: Abbreviations

AEFI	Adverse Events Following Immunisation
AHPPC	Australian Health Protection Principal Committee
ARI	Acute Respiratory Illness (<i>consistent with Queensland Health language</i>)
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
UCC	Urgent Care Centre