WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Whanganui District Health Board

Hospital

COVID-19

Pandemic Guidelines

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WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

HOSPITAL COVID-19 PANDEMIC GUIDELINES

Procedure

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Whanganui District Health Board</td><td>Authorised by: Manager Patient Safety, Quality and Innovation.</td></tr>
<tr><td>Contact person: Infection Control Team</td></tr>
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2. Purpose

This procedure is for the safe management of patients during the event of a pandemic COVID-19.
A pandemic entails not only the emergence of a new viral subtype, but also the capacity of that virus to spread efficiently from person to person and cause significant human illness. This document outlines the infection prevention and control considerations for the care of a suspected, probable or confirmed case of COVID19. Reducing the rate of spread of COVID-19 reduces the potential demand on the health sector and provides time for us to learn about the virus, ensuring that our policies and procedures will be effective as the situation changes.

This procedure meets the Health and Disability Service (safety) standards
NZS: 8134.3.1
NZS: 8134.3.2
NZS: 8134.3.3

3. Scope

This procedure applies to all Whanganui District Health Board (WDHB) employees (permanent, temporary and casual), visiting medical officers, and other partners in care, contractors, consultants and volunteers.

4. Prerequisites

- Pandemic outbreak as decided by the MoH (MoH).
- The Whanganui District Health Board Pandemic Plan will be used.
- Staff assigned to care for probable or confirmed COVID-19 patients should meet the occupational health policy for fitness to work in this situation and should be fully vaccinated (there should be adequate staff allocated to work in this area, with high staff to patient ratio ensured).
- Staff who were not wearing adequate PPE for an interaction with a positive COVID-19 patient or who had a PPE breach that is considered significant by the IPC team are required to isolate at home, under the direction and monitoring of the Occupational Health team with advice from the Medical Officer Of Health.

5. Definitions

WHO – World Health Organisation
COVID-19 – New stain of coronavirus
MoH – Ministry of Health
WDHB – Whanganui District Health Board
MOH – Medical Officer of Health
CDEM – Civil defence emergency management
ECC – Emergency coordination centres
EOC – Emergency operations centres
Cases – People with confirmed illness

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Contacts – people who may have been exposed to the virus but have not yet developed symptoms
PPE – Personal protective equipment

Suspect case
A suspect case satisfies the following clinical criteria:
- Any acute respiratory infection with at least one of the following symptoms: cough, sore throat, shortness of breath, coryza, and anosmia with or without fever.
- Symptomatic close contacts of suspect or probable cases should be considered suspect cases. (View definitions of close and casual contacts)

All people meeting the suspect case definition for COVID-19, or where the clinician has a high degree of suspicion, should be tested to confirm or exclude a diagnosis.
See **Appendix 1.** Whanganui CBAC/ED/WAM COVID-19 HIS form.

Priority groups for investigation and testing
Should there be local capacity issues, the following should be prioritised:
- close contacts of probable or confirmed cases.
- people meeting the clinical criteria who have travelled overseas in the last 14 days, or have had contact, in the last 14 days, with someone else who has recently travelled overseas.
- hospital in patients who meet the clinical criteria.
- health care workers meeting the clinical criteria.
- other essential workers meeting the clinical criteria.
- people meeting the clinical criteria who reside in (or are being admitted into) a vulnerable communal environment including aged residential care.
- people meeting the clinical criteria who reside in large extended families in confined household/ living conditions such as Māori and Pacific communities/families.
- people meeting the clinical criteria who may expose a large number of contacts to infection (including barracks, hostels, halls of residence, shelters etc.).

In addition, more extensive testing, including testing of people who are asymptomatic, may be required on advice from the local Medical Officer of Health:
- when an outbreak or cluster is suspected or being investigated.
- when a case is identified in a vulnerable residential institution such as an aged residential care facility.

Testing of individuals who are asymptomatic is NOT recommended unless requested by the local Medical Officer of Health.

Note that close contacts of confirmed cases that meet the clinical criteria for a suspect case should be considered a probable case (epi-link to a case), and managed appropriately, including any contact tracing as appropriate, and therefore don't need to be tested. However, healthcare workers meeting the clinical criteria who are close contacts of confirmed cases should continue to be tested.

Under investigation case
A suspect or probable case that meets the prioritisation criteria for testing above, but information is not yet available to classify it as confirmed or not a case.

Probable case
- A case that meets the clinical criteria where other known aetiologies that fully explain the clinical presentation have been excluded and either has laboratory suggestive evidence or for whom testing for SARS-CoV-2 is inconclusive; or
- a close contact of a confirmed case that either meets the clinical criteria and for whom testing cannot be performed; or
- is a negative result but a public health risk assessment indicates they should be classified as a probable case.

Laboratory suggestive evidence requires detection of coronavirus from a clinical specimen using pan-coronavirus NAAT (PCR).

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Confirmed case

A case that has laboratory definitive evidence of at least one of the following:

- detection of SARS-CoV-2 from a clinical specimen using a validated NAAT (PCR).
- detection of coronavirus from a clinical specimen using pan-coronavirus NAAT (PCR) and confirmation as SARS-CoV-2 by sequencing.
- significant rise in IgG antibody level to SARS-CoV-2 between paired sera (when serological testing becomes available).

Note: If all COVID-19 laboratory tests are negative, other respiratory pathogens should be excluded.

Not a case

An 'under investigation' case that has a negative test.

Managing suspect cases who are not tested

The key principle is to reduce transmission from person to person. That means reducing the contact that people who may have the virus have with others while they are infectious.

Managing close contacts of cases under investigation

Any household contacts of cases under investigation should self-quarantine while awaiting test results. They should be meticulous with physical distancing, hand hygiene and cough etiquette, and immediately isolate and phone Healthline if symptoms develop.

Managing close contacts of a confirmed or probable case

Household and other close contacts of confirmed or probable cases should self-quarantine and be managed at home with monitoring for symptoms. If they develop symptoms they should be tested and stay in isolation until results are available. Further advice on the management of close contacts of probable and confirmed cases is available in the Advice for Health Professionals.

Close contact is defined as any person with the following exposure to a confirmed or probable case during the case's infectious period, without appropriate personal protective equipment (PPE):

- direct contact with the body fluids or the laboratory specimens of a case.
- presence in the same room in a health care setting when an aerosol-generating procedure is undertaken on a case.
- living in the same household or household-like setting (e.g., shared section of in a hostel) with a case.
- face-to-face contact in any setting within two metres of a case for 15 minutes or more.

Clinical criteria:

Fever or a history of fever ≥38°C and acute respiratory illness with at least one of the following symptoms: shortness of breath, cough or sore throat.

6. Roles, responsibilities and criteria

Roles	Responsibilities	Criteria
▪ Outbreak management team (chair is usually the MOH) ▪ Duty Nurse Manager ▪ Chair of Infection Control Committee (if not current MOH) ▪ Representative from Nurse Leadership team ▪ Manager Patient Safety & Service Quality (proxy Clinical Nurse Specialist Infection Control)	The outbreak management team will decide whether to escalate the outbreak response to have the EOC opened. Situation assessment. Control measures to be taken: ▪ Isolation ▪ Exclusion ▪ Testing	This team may be mandated by the Ministry of Health

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▪ Medical Officer of Health and/ or Deputy (Health Protection Officer) ▪ Communications Manager ▪ Emergency Manager as required ▪ Stores Manager ▪ Te Hau Ranga Ora ▪ Ventia Services Manager ▪ Facilities manager ▪ And/or any other person/s as deemed necessary by the chair of the committee.	▪ Management actions required e.g. future admissions ▪ Surveillance required ▪ What public health action is required if any ▪ Media involvement. The team chairperson will communicate the outbreak plan to the Chief Executive, relevant managers, clinical directors and Team Leaders of the Units involved.	
MoH	Lead agency nationally planning and response	Authorised by the Minister of Health
Whanganui District Health Board WDHB	Lead agency regionally planning and response	Co-ordinates with Medical Officer of Health, public health, civil defence emergency management
Medical Officer of Health	Lead Public Health Official for region	Receives notification of communicable disease. Formation of advisory group. Civil defence emergency permits special powers
Public Health (health protection officer)	Develop and implement plans for public health emergencies. Investigating cases and contacts	Ensures advice and action consistent across the country
Civil Defence	Supports the response via local EOC and ECC	Liaise between WDHB and public health
Emergency Management Coordinator WDHB.	Pandemic planning and response WDHB	Liaises with all other relevant organisations. Member of advisory group
Manager Patient Safety, Quality and Innovation.	Pandemic planning and response WDHB Supports Public Health Response	Liaison with executive leadership team WDHB, member of advisory group
Te Hau Ranga Ora	Recognition of specific needs of Maori in pandemic planning, role of Maori health providers in planning and response for pandemic planning	Member of advisory group
Communications Manager WDHB	Communication inward and outward communications	Ensure consistent and effective communication regionally and nationally. Member of advisory group
CNS Infection Prevention WDHB	Co-ordinates internal planning Supports public health response Directed by MoH guidance for health care professionals Use of engineering controls	Ensures consistent advice for health care professionals Including use of pandemic plan, correct PPE, hand hygiene, transmission, and collection of specimens. Member of advisory group.

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All regulated and non-regulated staff and health care professionals WDHB.	Co-ordinated safe care for consumers Safe delivery of services for health care professionals using guidance from MoH Medical staff are able to contact infectious diseases physicians or microbiologists if pandemic advice required. Scrubs will be provided to wear when working in a COVID stream, as well as a shower for staff use	Direct guidance on safe practice for health care professionals from MoH. Staff awareness of pandemic, safe collection of specimens, transmission, correct use of PPE, appropriate use of hand hygiene, cleaning policies, correct use of anti-viral medication if prescribed, and provide advice to consumers. No paper notes are to enter the room
Roster Coordinator	Will ensure that all clinical and non-clinical areas have safe rostering guidelines to use when setting up COVID, mixed and non-COVID areas. Use the vulnerability assessment criteria for staff rostering.	Roster will include runners and PPE observers (buddies) Roster will ensure that safe staffing is maintained, with infection prevention principles.
Occupational Health team	Will provide staff vulnerability assessment criteria for staff rostering. Will complete mask fit testing for all clinical staff working in the COVID stream.	Provide vulnerability assessment criteria to managers and roster coordinator.
Integrated Operations Centre ▪ Duty nurse manager team ▪ Nurse resource team ▪ Entrance monitor/s when required ▪ Trendcare team	Will monitor patient admissions and have bed management strategies available to assist in the reduction of infection spread. Will monitor the staffing of the affected area and staff utilization within the affected area. Liaise with Clinical Nurse Manager, infection control and be co-opted onto the outbreak management team by the Chair if required. Liaise with family/visiting afterhours.	Will follow the direction given by the outbreak management team. Visitor recording and monitoring as per visiting policy for contact tracing purposes. Paper records are stored with PSQI for 3 months then discarded.

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Clinical Nurse Manager or afterhours delegate	Will monitor the patient admissions to an area and have patient/ bed management strategies available to assist in the reduction of the spread of the outbreak. Have educational material available for both staff and families in the context of the illness, care given, visitor numbers and expectations for the patient and cares needed. This will be individualised and made in agreement with each family. All education given is to be documented in the patient clinical notes. Ensure that Trendcare electronic records are maintained. Limit all non -essential staff to the area.	Will follow the direction given by the outbreak management team and direct guidance on safe practice for health care professionals from MoH. Ensure safe collection of specimens, transmission, correct use of PPE, appropriate use of hand hygiene, cleaning policies, correct use of anti-viral medication if prescribed, and provide advice to consumers.
Runner	Support staff working in isolation rooms. Does not enter room.	
Observer / Buddy	Checks donning and doffing of PPE.	Completes checklists. See Appendices 8 and 9.
Laboratory	Will notify all agencies required as per WDHB agreement and MOH guidelines.	All departments requiring notification of outbreak will be completed.

7. Equipment and Resources

Equipment

In addition to standard precautions, contact and droplet precautions should be taken.
Medical masks, P2/N95 particulate respirators, gowns and eye protection can be worn continuously for up to 4 hours when providing care to patients in a cohorting setting. Gloves need to be replaced between each patient encounter. Hand hygiene must be performed with change of gloves. If during continuous use the PPE becomes damp, soiled or contaminated with blood or body fluids, then all PPE, including the gown, will need to be replaced.

- Disposable gloves to be used. Hand hygiene is required before and after using gloves as per hand hygiene New Zealand guidelines.
- Disposable gowns or aprons to be worn as supplied.
- Eye protection is required, either a face shield or disposable eye goggles.
- Scrubs will be supplied to be worn in COVID care areas.
- Masks – Surgical masks for droplet precaution and particulate filter respirator N95 to be available for direct contact with respiratory secretions particularly via aerosol generating procedures.
  NB. In the event of a pandemic outbreak all staff requiring them will be fit tested for N95 masks by members of the infection prevention team.

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8. Procedure

This procedure is for the management of patients in the acute setting during an outbreak of pandemic COVID-19. We will be guided by the MoH in the levels of care that will be provided with the resources that we have. The below is in accordance with the National Hospital Escalation Framework.

GREEN	No COVID cases in facility; any cases in the community are being managed and under control; managing service delivery as usual with only staffing and facility impact being for training and readiness purposes.
YELLOW	One or more positive cases in facility; any cases in your community are being managed; isolation capacity and ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps.
ORANGE	Multiple COVID positive patients in facility, community transmission is not well controlled; isolation capacity and ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered.
RED	(individual or cumulative) Multiple COVID-19 positive patients in your facility; community transmission uncontrolled; isolatio9n and ICU at capacity; all available staff redeployed to critical care.

All patients presenting with respiratory infections or pyrexia of unknown origin are to be asked if they have had any resent overseas travel history.

Admit pandemic COVID-19 patients to appropriate clinical area, as directed by the duty nurse manager. The duty nurse manager may receive guidance from infection prevention teams regarding patient placement.

Daily hospital status will reflect the National Hospital Escalation Framework. See **Appendix 11.**

Hospital Engineering Controls

Engineering controls can be used to reduce or eliminate exposure of healthcare workers and other patients to infected patients. They include the use of physical barriers and dedicated pathways, remote triage areas, airborne infection isolation rooms and single patient spaces rather than shared open bays in recovery areas. Engineering controls also focus on maintaining the quality of the indoor air.

Once the National Hospital Escalation Framework has passed orange or any local cases exist the IPC nurse and in consultant with the facilities manager will place the hospital into "full fresh air mode". This will ensure that all air is fresh, and no recirculation occurs.

Infection Prevention and Control Precautions

Standard Precautions and Transmission Based Precautions must be adhered to when managing patients with probable or confirmed COVID-19, or who meet the Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19. In addition to practices carried out by health care workers when providing care, all individuals (including patients and visitors) should comply with infection control practices in health care settings. The control of spread from the source is essential to avoid transmission of COVID-19.

Standard Precautions

These processes always apply to any patients. Standard Precautions are the basic level of infection control precautions which are to be used, as a minimum, in the care of all probable or confirmed COVID-19 patients, or those who meet the Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19. Hand hygiene is a major component of Standard Precautions and one of the most effective methods to

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prevent transmission of infection. Respiratory hygiene and cough etiquette by the patient are also considered parts of Standard Precautions as a source control measure.

All staff, patients and visitors should wash their hands with soap and water or decontaminate their hands with alcohol-based hand rub (ABHR), containing at least 60 percent alcohol, when entering and leaving areas where patient care is being delivered.

Hand hygiene must be performed immediately before every episode of direct patient care and after any activity/task or contact that potentially results in hands becoming contaminated, including before and after putting on and removing personal protective equipment (PPE), and after equipment decontamination and waste handling.

In addition to hand hygiene and physical distancing, to reduce the risk of direct contact from infectious droplets from the patient to the health care worker (HCW), the use of PPE should be guided by a risk assessment of the anticipated extent of patient contact and exposure to blood, body fluids, respiratory secretions or excretions, and exposure to contaminated equipment and surfaces.

HCWs should assess the likelihood of exposure to infectious agents before selecting the appropriate actions and/or PPE to minimise the risk of exposure for the specific patient, other patients in the environment, HCWs, visitors and others.

Key elements of Standard Precautions:

- Hand hygiene - perform hand hygiene before and after touching a patient/client, before and after clean or aseptic procedures, after touching patient surroundings, as well as before and after putting on and taking off PPE.
- PPE - assess the risk of exposure to body substances or contaminated surfaces before any health care activity. Select PPE based on an assessment of likely exposure risks. For example, gloves if your hands may be in contact with body fluids, an apron or gown to prevent soiling of clothing, a face shield/mask/goggles if droplets or splashes are likely to be generated near your face, for example, taking a nasopharyngeal swab.
- Respiratory hygiene and cough etiquette - sneezing or coughing into the crook of your elbow or covering coughs and sneezes with a tissue, then putting the tissue in a bin and cleaning your hands
- Safe use and disposal of needles and other sharps.
- Aseptic 'non-touch' technique - for all invasive procedures, including appropriate use of skin antisepsis.
- Patient care equipment – clean, disinfect and reprocess reusable equipment between patients.
- Appropriate cleaning and disinfection - of environmental and other frequently touched surfaces.
- Safe waste management.
- Safe handling of linen.

Transmission-based Precautions

Transmission-based Precautions are used when Standard Precautions alone are insufficient to prevent cross transmission of an infectious agent when caring for a patient with a known or suspected infectious agent.

Contact Precautions

Used to prevent and control infection transmission via direct contact or indirectly from the immediate care environment (including care equipment). Examples include diarrheal illnesses, multi drug resistant organisms, COVID-19, open infectious wounds.

In addition to Standard Precautions listed above:

- gloves and an apron or fluid-resistant long sleeve gown should be worn by the health care worker for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment.
- see Use of PPE section for additional information on whether an apron or gown should be worn.
- the patient should be allocated a single room and a toilet.

Droplet Precautions

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Used to prevent and control infection transmission over short distances via droplets (>5μm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. For example: Influenza, COVID-19, Pertussis, Meningococcal meningitis.

In addition to Standard Precautions listed above:
- wear a surgical mask to protect the nose and mouth for all interactions with a known or suspected infectious patient, which is generally donned upon room entry or when interactions mean that physical distancing of 1 metre cannot be maintained.
- wear eye protection (goggles or face shield) if exposure to respiratory secretions is anticipated by touching the eyes or patient coughing or sneezing.
- a mask should be worn by the patient whilst awaiting assessment, or for any movement outside of a single room, along with strict adherence to respiratory hygiene and cough etiquette.

Airborne Precautions:
Used to prevent and control infection transmission over any distance via aerosols (<5μm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. Infections transmitted by the airborne route include measles, pulmonary and laryngeal tuberculosis and chicken pox and health care workers must adhere to airborne precautions when caring for patients with these pathogens.

Examples include pulmonary and laryngeal tuberculosis, measles and chicken pox. See also the Aerosol Generating Procedures section for additional information related to COVID-19.

In addition to Standard Precautions listed above:
- wear a N95/P2 respirator that you fit check before room entry for all interactions with a known or suspected infectious patient. Refer to fit checking section in Role of face masks and respirators.
- a respirator should be worn by the patient whilst awaiting assessment, or for any movement outside of a single room, along with strict adherence to respiratory hygiene and cough etiquette.
- patients in a hospital setting should be placed in an airborne infection isolation room (negative pressure room).

For patients admitted to a DHB acute-care hospital who are probable, or confirmed COVID-19 cases, or meet the Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19, the implementation of Standard, Contact, and Droplet precautions are required. If a medical procedure that generates aerosols, an aerosol generating procedure (AGP), is being undertaken, then Airborne Precautions are required in addition to Contact Precautions.

Ward Management
- Patients to be cared for in droplet or airborne precautions as per infection prevention and control manual.
- They usually require an airborne infection isolation room (negative pressure room) where possible, however a single room or in a case of multiple admissions cohorting of cases may occur.
- Two or more patients with confirmed COVID-19 can be cohorted together in a multibedded room or bay. The decision to create cohort rooms or wards should be undertaken in discussion with senior management, COVID-19 response team, clinical microbiologists, infectious diseases physicians, and the IPC service.
- A room must be stocked to ensure patient specific equipment is in the room and not moved out for other patients use unnecessarily.
- A room must also not have extra equipment stored in it
- Health workers donning on and off PPE must be check for compliance with a buddy; see **Appendices 6 – 9.** These forms will be kept and reviewed by infection control or designated person.
- PPE donning and doffing can occur outside of a room if no other anteroom exists, however this must occur as a procedure where no other donning occurs.
- Wear a N95 mask for airborne precautions when face to face with aerosolised procedures occurring otherwise a surgical mask is required for droplet precautions; see **Appendix 5** for 'Log of staff with patient contact'.

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- PPE includes eye protection, gowns, masks and gloves. These supplies are ordered through the supply department. Extra supplies after hours are available via the Duty Nurse Manager.
- Strict adherence to hand hygiene as per the five moments of hand hygiene New Zealand guidelines
- Patients, staff and visitors are encouraged to minimise potential transmission through good hygiene practices such as disposable tissues, & respiratory hygiene.
- Whanau/family visiting patient who meet the pandemic visiting policy, must be educated in wearing PPE. This education is to be recorded in patient notes.
- Make electronic tablets available for patients to communicate for their families if they do not have access to a cell phone.
- Consider psychosocial support. Isolation/lock down can be a lonely and stressful time for some patients.
- Managing Medical ward – designated respiratory whilst at National Escalation GREEN and YELLOW ward: zones define how the ward is management; negative pressure rooms and side rooms for probable and confirmed. Once negative tests are received the patient is to move to next zone, medium risk YELLOW (doors to be kept shut but can cohort), then to low risk respiratory GREEN zone. If WDHB is at ORANGE then we would manage the ward positives side rooms, then use 2 and 4 bed bays, doors closed; cells would shut down to localise effected areas.
- Supplies and equipment within the room must be kept to a minimum and be replenished daily as necessary. Use disposable equipment where available. Additional supplies should not be kept in rooms as once patient is moved; they would need to be disposed of.
- Patient/s will not share dishes, drinking glasses, cups, eating utensils, towels, pillows or other items.
- Minimise the time spent in shared spaces such as bathrooms as much as possible and keep shared spaces well ventilated. Wipe down hard surfaces with appropriate cleaning solution such as Viraclean, neutral detergent wipes, 70% alcohol wipes or antimicrobial wipes, after use and avoid touching them after they have been cleaned.
- All non-disposable equipment such as blood pressure cuffs, stethoscopes and including mobile units such as x-ray machines, IV pumps etc. must be decontaminated immediately on leaving room. Use appropriate cleaning solution such as Viraclean, neutral detergent wipes, 70% alcohol wipes or antimicrobial wipes. At a minimum, items will require surface wiping with a disposable impregnated cloth and usual disinfectant processes should be used for items normally reprocessed by these methods.
- Any supplies used from the pandemic supplies store will be authorised for use by the EOC.
- Nurse caring for patient will use a white board for communication to the ward runner person to collect or task requirements.
- Medications are still require checking by the giving nurse as per guidelines. This may involve some input from pharmacy to package medications as a single dose package.

Observer / Buddy role

This role is to ensure the safety of the staff and patients in the ward. They are to remain in non-contact roles.
- They report to the ward coordinator/CNM.
- Orientate to PPE stores and resuscitation equipment location.
- Wear a surgical mask and use PPE as required.
- Observe donning and doffing of PPE and assist via verbal commands as required.
- Complete the doffing task sheet for each doffing and once completed store this with the area CNM.
- Will immediately speak up if patient or staff safety is compromised either actually or potentially.

This role **does not:**
- Take a patient load or have direct contact with an infectious or potentially infectious patient.
- Enter any other area unless directed for staff or patient safety.
- Touch or handle any infection waste, equipment, linen or PPE.
- Does not perform any infectious cleans.

Runner role

This role is to support staff working in isolation areas. The runner does not enter the isolation area, but provides support to enable staff to stay in the isolation area. The runner is considered part of the team and stays in the COVID ward.

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Patient discharge

The treating team will determine when the patient is well enough for discharge from hospital. The infectious diseases specialist, or IPC Service should be involved in discharge planning and the Public Health Unit notified.

1. Clearance from isolation:
    - Mild cases can be released from isolation after ≥10 days have passed since the onset of symptoms AND there has been resolution of the acute symptoms for ≥72 hours.
    - Most hospitalised moderate & severe cases will require a further 10 days of isolation after discharge.
    - Patients with prolonged illness, long hospital stay, or major immunosuppression will require case-by-case review by infectious diseases consultant (CCDHB).
    - Note – repeat swabs are generally discouraged (but may be requested on a case-by-case basis).
2. Appropriate follow-up:
    - Patients who have had significant respiratory failure and/or persistent dyspnoea or hypoxia may require respiratory follow up and support on discharge e.g. pulmonary rehabilitation, short-term oxygen.

For further information refer to Updated advice for health professionals: novel coronavirus (COVID-19)
https://www.health.govt.nz/system/files/documents/pages/adviceforhealthprofessionals-

Food Service

- Tray and drinks supplied by Compass will be left outside room for to be taken in by nursing staff wearing PPE.
- Tray once finished which has remained outside room, is returned to the food services trolley for return to kitchen to be cleaned in the usual manner.

Linen and waste handling

- Follow the normal procedures for disposal of soiled linen and waste as per the infection control procedures. Severe linen shortages may occur, conserve where possible.
- Do not shake dirty laundry, as this can disperse the virus through the air.
- The laundry will be informed by the EOC of the pandemic outbreak and requirements for supplies.

Daily Cleaning

- Ventia services will be aware of the pandemic outbreak though the EOC. Cleaning requirements will be decided through this centre.

Moving and transferring isolated patients

Moving Patients Within the Same Hospital
Transporting patients with COVID-19, within the hospital with COVID-19, can be transferred within the hospital, including to radiology, as per usual Isolation Precautions Policy, including cleaning requirements after the patient leaves.

- the movement and transport of patients from their single room/cohort area should be limited to **essential** purposes only. Staff at the receiving destination must be informed that the patient has possible or confirmed COVID-19.
- if transport/movement is necessary, ensure the patient wears a surgical face mask during transportation when this can be tolerated, to minimise the dispersal of respiratory droplets and providing this does not compromise clinical care.
- patients must be taken straight to and returned from clinical departments and must not wait in communal areas.

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- Care must be taken when touching surfaces. All surfaces must be wiped after touching with a detergent wipe to ensure indirect contamination does not occur.
- Ventia must be notified of transmission-based precautions to be used. So planned move around the hospital will need to occur in order that harm potential is minimised to both staff and public.

Allied Medical care/s

All symptomatic patients requiring radiology will be scanned on the portable x-ray machine in the Emergency Department and or ward/CCU/theatre area. There is a portable USS and x-ray machine available. If additional diagnostic procedures are required in the radiology department recommended PPE and cleaning precautions will apply.

The plain film unit at the rear of the emergency department will be maintained as a clean facility for NON-COVID patients.

- if possible, patients should be placed at the end of clinical lists

Transfer from primary care/community settings

- if transfer from a primary care facility or community setting to hospital is required, the ambulance service should be informed of the infectious status of the patient. They will need to infectious clean their ambulances.
- staff of the receiving ward/department should be notified in advance of any transfer and must be informed that the patient has possible or confirmed COVID-19. This is via the ambulance or directing facility (e.g. CBAC).

Moving patients between different hospitals

Patient transfer from one healthcare facility may be undertaken if medically necessary for specialist care arising out of complications or concurrent medical events (for example, cardiac angioplasty and renal dialysis). If transfer is **essentia**l, the ambulance service and receiving hospital must be advised in advance of the infectious status of the patient. PPE must be worn by the staff and patient to wear a mask (if able) for source control.

- A dedicated lift will be used. This lift will be marked and not able to be used for any other purpose.
- All staff accompanying patient are to wear full PPE.
- The receiving ward/area must be contacted prior to transport to ensure seamless transition occurs.
- Receiving ward is to be prepared to accept patient into isolation room, primarily this will be the medical ward or COVID dedicated ward using a negative pressure, or side room.
- The clean bed, from the receiving ward is taken to the collection point, the patient is in PPE, no exposed linen to be transported with patient. Property bag to be double bagged. The patient is to be covered using clean linen.
- Care must be taken when touching surfaces. All surfaces must be wiped after touching with a detergent wipe to ensure indirect contamination does not occur.
- The staff of the receiving ward/department should be notified in advance of any transfer and must be informed that the patient has possible or confirmed COVID-19. This is via the ambulance or directing facility (e.g. CBAC).
- Patient transfer between other healthcare facilities may be undertaken if medically necessary for specialist care arising out of complications or concurrent medical events (for example, cardiac angioplasty and renal dialysis). If transfer is essential, the ambulance service and receiving hospital must be advised in advance of the infectious status of the patient. PPE must be worn by the staff and patient to wear a mask (if able).
- If patients are being transferred inter-hospital, then the receiving team will make a decision on appropriateness of transfer. The transport vehicle (plane or ambulance) will require cleaning after transport. This is via the use detergent wipes plus Viraclean.

Resuscitation Guidelines during the COVID-19 Pandemic

Whanganui District Health Board controlled document. The electronic version is the most up-to-date version. WDHB will not take responsibility in the event of an outdated paper copy being used which may lead to an undesirable consequence.

Treatment escalation plans (TEPs) with resuscitation orders should be considered and completed for all patients admitted. Refer to IMT for guidance around the Ceiling for care for Covid positive patients.

There are patients who will still have a cardiac arrest that can be treated with the traditional algorithm. However, the following recommendations should be practiced:

- If the patient is unresponsive and you cannot see any signs of normal breathing (look for chest rise only) – dial 777 for the cardiac arrest team.
- Apply defibrillator ASAP and shock if indicated (one shock with AED, up to 3 shocks with manual defibrillator), then start compression only CPR.
- Airway of choice is an LMA once the team arrives.

In the patient who is in isolation awaiting COVID-19 swabs/attends ED with unknown COVID-19 status or is COVID-19 positive:

- If the patient is unresponsive and you cannot see any signs of normal breathing (look for chest rise only) – dial 777 for the cardiac arrest team.
- PPE must be applied prior to starting any resuscitation attempt (using a N95 mask).
- CPR and intubation are considered aerosol generating procedures.
- The first person to enter the room should apply the defibrillator and shock if indicated (one shock with AED, up to 3 shocks with manual defibrillator).
- CPR should be commenced as compression only until the rest of the team has applied PPE.
- Airway of choice is an LMA in the absence of a doctor who is skilled at intubation (ED physician or anaesthetist).

Oxygen therapy

The use of High-Flow Nasal Cannula is preferred over NIPPV in COVID patients with acute hypoxemic respiratory failure. This is considered an aerosolising procedure requiring staff to use an N95 mask. Once equipment is for disposal then this goes into the biohazard waste stream.

The use of High-Flow Nasal Cannula is preferred over NIPPV in COVID patients with acute hypoxemic respiratory failure. This is considered an aerosolising procedure requiring staff to use an N95 mask.

On discharge

- At release from isolation the patient and their family/whānau should be given advice about cough etiquette and hand hygiene.
- The room is to be cleaned as per Ventia' isolation room clean procedures.
- Equipment and bed will be cleaned be nursing staff using viral disinfectant solution.
- All disposable equipment is discarded as per biohazard waste procedure
- Bed made and equipment restocked ready for the next patient once Ventia advice they have completed their isolation clean.
- Re-usable curtains to be steam cleaned if not soiled. If soiled, then they will require laundering.
- If disposable curtains are soiled, they will require changing. If non-soiled, then no action is required.

Advice for staff

- Staff who have respiratory symptoms or signs are required to stay away from work until medically cleared to return to do so by the occupational health team.
- Staff must be familiar with all droplet precautions in protecting themselves, patients and families.
- Be familiar with hospital and area specific pandemic response plans.
- Read all available information from the MoH relating to COVID-19 at this time.
- Vaccination against COVID-19 is a highly effective action to minimise and potentially eliminate COVID-19 and is the best prevention and protection available to health workers. We strongly urge all health workers to get vaccinated and to encourage their family members to do the same.

Whanganui District Health Board controlled document. The electronic version is the most up-to-date version. WDHB will not take responsibility in the event of an outdated paper copy being used which may lead to an undesirable consequence.

- Occupational Health status of staff members is available on TrendCare or from the Occupational Health team. Area Managers have been informed of the options available for vulnerable staff.
- Vaccination is not mandatory for healthcare staff working in DHBs, therefore DHBs should work with their Occupational Health team to develop a policy to manage staff who are not vaccinated against COVID-19.
- For further information, refer to: **https://www.health.govt.nz/our-work/diseases-andconditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-information-healthprofessionals**

Uniform

Staff working in the COVID stream will wear scrubs as provided. These will be removed at the end of each shift with a shower available for use.

Visitors

- Front door will be manned at level 4 and 3.
- All visitors must either scan in using the QR code or register on paper. This is then sent to patient safety for storage where it is either used for contact tracing or destroyed after six weeks.
- Visiting must follow the pandemic guidelines. Visitors should be instructed on hand hygiene and wearing of surgical masks where applicable; visitor communications will be released.
- Visitors should not visit other patients after contact with COVID-19 patients.
- Nursing staff are responsible for ensuring visitors comply with isolation procedures and are to explain and assist as necessary.
- Involvement with Haumoana services will be essential.

NB. This information is subject to change as updates and direction come from the WHO, CDC and the NZ MoH.

Care of the Deceased

PPE must be worn when handling the deceased. The body should be placed in a fluid-proof body bag and once this has occurred Standard Precautions should be followed.
Refer to below link for further advice.

https://www.health.govt.nz/system/files/documents/pages/management-ofdeaths-due-to-covid-9-information-for-funeral-directors-19082020.pdf

9. References

New Zealand Influenza Pandemic Plan: A framework for Action.
NZIPAP 2nd ed 2010 published Aug 2017.

National Health emergency plan
https://www.health.govt.nz/system/files/documents/publictaions/national-health-emergencyplan-oct15-v2.pdf

Whanganui DHB Health emergency plan
https:wdhb.org.nz/contented/clientfiles/whanganui-district-health-board/files/wdhb-health-emergency-plan-2014-2016.pdf

WDHB Pandemic Plan 2019 -2022
Policies/Procedures/Guidelines – Emergency Management.

Interim advice for Health Professionals: Novel Wuhan Coronavirus (COVID-19).
Helath.govt.nz/our-work/diseases-and-conditions/novel-coronavirus-china-COVID-19

COVID-19 (novel coronavirus) - Resources for health professionals | Ministry of Health NZ

WHO recommendations on clinical management of severe acute respiratory infection
who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/patient-management

Whanganui District Health Board controlled document. The electronic version is the most up-to-date version. WDHB will not take responsibility in the event of an outdated paper copy being used which may lead to an undesirable consequence.

10. Related Whanganui District Health Board documents

- WDHB infection prevention and control manual
- Whanganui DHB health emergency plan
- https:wdhb.org.nz/contented/clientfiles/whanganui-district-health-board/files/wdhb-health-emergency-plan-2014-2016.pdf
- WDHB Pandemic Plan 2019 -2022
- Policies/Procedures/Guidelines – Emergency Management.
- WDHB-1012 Wearing of Personal Protective Equipment (PPE) during pandemic for patients in self-isolation (quarantine)

Governance documents

- Whanganui DHB Pandemic Plan 2019 – 2022
- Whanganui DHB COVID-19 Hospital Pandemic Guidelines (reviewed August 2021)
- Whanganui DHB COVID-19 Response Plan (reviewed August 2021)
    - Section A: Hospital Response plans
        1. Emergency Department
        2. ICU
        3. Hospital Inpatient (with Maternal, Child and Youth)
        4. Hospital Mental Health Inpatient
    - Section B: Primary and Community Response

11. Appendices

Appendix 1: Whanganui CBAC/ED/WAM COVID-19 HIS
Appendix 2: Coronavirus Presentation Flowchart
Appendix 3: Coronavirus Admission of Suspected Case Flowchart
Appendix 4: Medlab request
Appendix 5: Staff log
Appendix 6: PPE diagram don
Appendix 7: PPE diagram doff
Appendix 8: Buddy checklist donning
Appendix 9: Buddy checklist doffing
Appendix 10: Visitor information
Appendix 11: National Hospital COVID-19 Escalation Framework

12. Key words

Pandemic Influenza Isolation Outbreak EOC Infection Prevention Control Flu Coronavirus COVID-19

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13. Appendix 1. Whanganui CBAC/ED/WAM COVID-19 HIS

WHANGANUI CBAC/ED/WAM COVID-19 HIS

Patient Label	
Surname:	**NHI:**
First Names:	**Ward:**
Address:	**DOB:**
	ACC No:
GP:	
Consultant:	

Assessment date/time: ______________________ Triage person: ______________________

CASE DEMOGRAPHICS			
Isolation address (if diff than above):			
Phone:	**Cell:**	**Email:**	
Occupation:		Workplace:	
High risk occupation (aged-care/healthcare/essential worker)?		☐ Yes ☐ No ☐ Unk	
COVID Vaccine: ☐ No ☐ 1st ☐ 2nd			
ILLNESS DETAILS			
☐ **Asymptomatic**	☐ **Symptomatic** (complete below)	**Date of Onset:**	
☐ **Shortness of breath**	☐ **Anosmia (no smell)**	☐ **Dysgeusia (no/altered taste)**	***[high-risk symptoms]***
☐ Fever (at least 38°C)	☐ Cough	☐ Runny nose	☐ Sore throat
☐ Joint pain	☐ Headache	☐ Diarrhoea	☐ Abdominal pain
☐ Muscle pain	☐ Irritability/confusion	☐ Nausea/vomiting	☐ Other:
Are these symptoms **new or worsening** and not attributable to seasonal/environmental allergies?			☐ Yes ☐ No ☐ Unk
Have you been referred by: ☐ Self-referral ☐ Healthline ☐ Public Health ☐ GP/WAM ☐ ED			

HIGH INDEX OF SUSPICION (HIS CRITERIA) - Case is symptomatic AND in the 14 days before onset:			
☐	Had contact with a confirmed/ probable COVID-19 case	☐	Travelled internationally (excluding travel by air from a country/area with which New Zealand has quarantine-free travel (QFT)*)
☐	Had direct contact with a person who has travelled overseas in past 14 days (excluding QFT countries/area), e.g. Customs and Immigration staff, staff at MIQs.	☐	Cleaned at an international airport or maritime port in areas/conveniences visited by international arrivals (exc. areas/conveniences for travellers by air from QFT country/area).
☐	Travelled from an area with an evolving COVID-19 community outbreak (including in New Zealand and in any country/area with which New Zealand has QFT),	☐	Worked in a cold store facility that receives imported chilled and frozen goods directly from an international air or maritime port
☐	Worked on an international aircraft or shipping vessel (excluding aircraft from a QFT country/area).	☐	Exited an MIQ facility (excluding recovered cases)

- A list of QFT countries/areas can be found on the Unite Against COVID-19 website. QFT only refers to travel by air at this point.
- A person who has travelled internationally from a QFT country/area in the last 14 days is not automatically considered to meet the HIS criteria. They may however meet the HIS criteria for other reasons. **Travellers must be asked if they have visited any overseas current locations of interest in the previous 14 days** (MoH Locations of Interest).

COVID-19 ASSESSMENT		
☐ **UNLIKELY**	☐ **POSSIBLE**	☐ **HIGH INDEX OF SUSPICION (HIS)**
• *No illness, no risk exposure/s* • *No swab/no follow-up* • *Swab if directed (surveillance)*	• *Symptoms but no risk exposure/s* • *Surveillance swab and isolate*	• *Symptoms and identified risk exposure/s* • *Swab and isolate* • *Report to PHS/rapid test request* • *Second test may be required*

ACTIONS			
Patient has consented to examination and also for this information to be forwarded to appropriate medical professional if required (e.g. ED, GP, PHS)?			☐ Yes ☐ No
Case swabbed?	☐ Yes ☐ No	Type: ☐ Nasopharyngeal ☐ Oropharyngeal/throat	
Swabbed by:		PHS notified of HIS case ASAP?	☐ Yes ☐ No
Swab test fast tracked (HIS cases)?	☐ Yes ☐ No	Date and time delivered:	
Advice given re self-isolation**:	☐ Yes ☐ No	Advice given re worsening symptoms:	☐ Yes ☐ No
Advice re return to work:	☐ Yes ☐ No	CBAC isolation/medical certificate provided?	☐ Yes ☐ No

****ISOLATION REQUIREMENTS**	
NON-HIS cases:	*Pt to isolate at home until negative result received. Can return to work 24 hours after symptoms resolve. No restrictions on household contacts.*
HIS cases:	*Follow current MoH advice – discuss with Public Health if uncertain.*

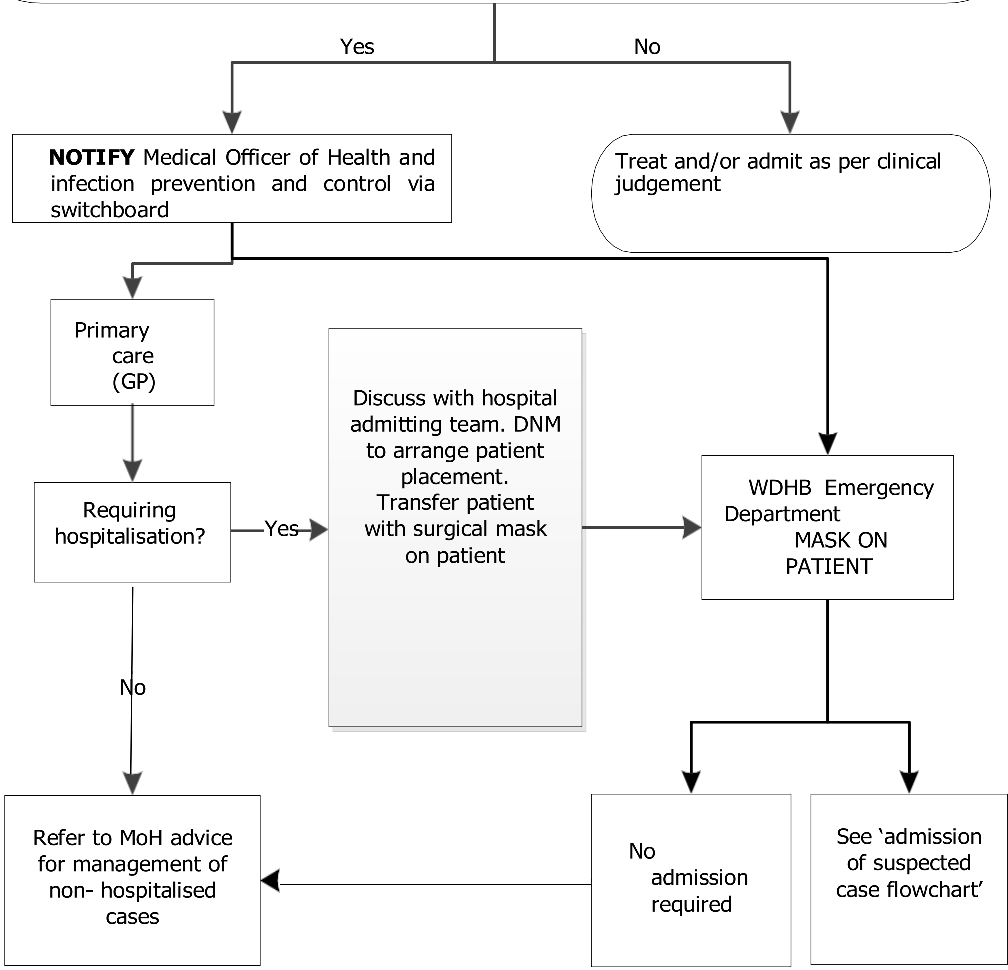
Name: **Designation:** **Date:**

Signature:

CBAC Triage Form. Aug 2021

Whanganui District Health Board controlled document. The electronic version is the most up-to-date version. WDHB will not take responsibility in the event of an outdated paper copy being used which may lead to an undesirable consequence.

14. Appendix 2. Suspected case COVID-19 admission flowchart



Whanganui District Health Board controlled document. The electronic version is the most up-to-date version. WDHB will not take responsibility in the event of an outdated paper copy being used which may lead to an undesirable consequence.

15. Appendix 3: suspected case COVID-19 admission flowchart

Patient meets suspect case definition
Empiric isolation in CONTACT and DROPLET precautions.
Decision to admit patient completed.

Is Lab testing completed?

Yes

Patient undergoing aerosolising procedures e.g. nebulisers air suctioning, intubation etc.

Yes

Negative pressure room
AIRBORNE PRECAUTIONS

No

Standard single or cohort room
DROPLET PRECAUTIONS

Isolation lifted when patient asymptomatic with no fever or respiratory symptoms.
Transfer to next level of care area or discharge to home isolation if appropriate

No

Testing required for anything else?
e.g. respiratory PCR

Approval for Coronavirus testing required from: Medical Officer of Health via switchboard

Lab notified of testing to be done
Follow Medlab advice for swab type and location
Swabs will be provided by public health or infection prevention team
Please state on the bag which swab is for which site
Include travel details on lab form

Airborne precautions required for sample collection

Double bag samples, perform hand hygiene between bags and call orderly to deliver to lab

16. Appendix 4: Sample collection

MEDLAB CENTRAL
MEDLAB HAWKES BAY
MEDLAB WANGANUI
TLAB GISBORNE

MEDLAB CENTRAL GROUP STAFF GUIDELINE

Sample Collection for Novel Coronavirus (2019-nCoV)

Note that this information may be updated 11 February 2020
Please continue to check for the latest version

INTRODUCTION
This document details the recommended samples to be taken for suspected cases of 2019-nCoV and can be referred to on receiving queries from clinical staff.
NB: Clinicians must contact Public Health Unit. Approval from a Canterbury Health Laboratories (CHL) Microbiologist is required BEFORE taking the sample. Clinical criteria must be met before samples will be tested.
Samples will be referred to CHL for testing.

SAMPLES REQUIRED:
Nasopharyngeal AND oropharyngeal swabs
AND Lower Respiratory Tract samples if available
Place IMMEDIATELY into SEPARATE collection tubes

1. Nasopharyngeal swab **CHL Respiratory Virus or Measles PCR Collection Pack**
Orange swab and red top vial (fig.1 and 3)
Paediatric white top swab (fig.2) - may be used in place of orange top swab if needed.

These are available separately on request

2. Oropharyngeal swab **Green** top Virus Transport tube (fig.4)

3. Lower Respiratory Tract (LRT) samples – 2 of each if possible (to include routine culture) e.g. Sputum, BAL, Endotracheal secretions. LRT samples are more sensitive in detecting
COVID 2019 compared to upper respiratory samples.

Figure 1.

Figure 2.

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Figure 3.

Figure 4.

REQUEST FORM MUST INCLUDE

1. Contact details of the requester in case follow up information is required or for notification of critical results

2. Clearly indicate testing required - Novel Coronavirus and Respiratory panel PCR

3. Request forms are to be filled out carefully and **MUST** include:

a. clinical symptoms including onset date
b. relevant patient history
c. relevant travel or exposure history including dates

SAFETY

1. Specimen shall be sent in double biohazard bag with request form placed in the outer pocket of the biohazard bag.
2. Perform hand hygiene between

2. Specimen should be delivered by hand and/or courier.

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17. Appendix 5: staff log

NHI

Log of staff with patient contact

WHANGANUI DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Date & Time	Full name	Duration of contact	Mask	Gloves	Gown	Eye protector

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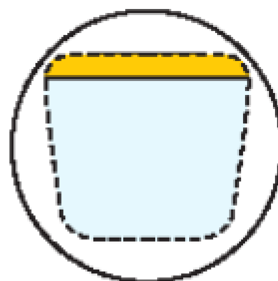
18. Appendix 6: Personal protective Equipment (PPE), Donning

Steps to put on PPE safely

1.

2.



3.

New Zealand Government

MINISTRY OF HEALTH
MANATŪ HAUORA

HP7353

Whanganui District Health Board controlled document. The electronic version is the most up-to-date version. WDHB will not take responsibility in the event of an outdated paper copy being used which may lead to an undesirable consequence.

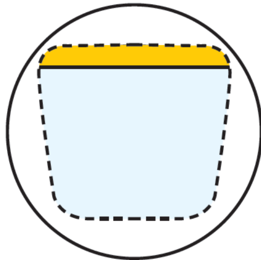
19. Appendix 7: Doffing PPE

Steps to remove PPE safely (ANTEROOM)

1.

2.

3.



4.

New Zealand Government

HP7353

MINISTRY OF HEALTH
MANATŪ HAUORA

20. Appendix 8: Checklist for health worker donning PPE

Checklist for health worker donning PPE

Buddy nurse to initial each step to confirm compliance

Date **Time**							
Buddy Nurse Name							
Health Worker Name							
1. Ensure that you have everything you need before donning PPE (group cares) 2. Complete staff Log for persons entering room 3. Remember that all processes are slow and gentle and that the buddy nurse is there to assist							
4. Perform hand hygiene and allow to dry 5. Don gown 6. Tie the neck straps then the waist ties							
7. Put on face mask							
8. Put on eye protection							
9. Put on appropriate mask, handling by straps							
10. Put on gloves, ensure glove is over the cuff of the gown							

Whanganui District Health Board controlled document. The electronic version is the most up-to-date version. WDHB will not take responsibility in the event of an outdated paper copy being used which may lead to an undesirable consequence.

21. Appendix 9: Checklist for health worker doffing PPE

Checklist for health worker doffing PPE

Buddy nurse to initial each step to confirm compliance

Date **Time**							
Buddy Nurse Name							
Health Worker Name							
Doffer Signals to leave patient room 1. Buddy prepares ante room for doffing process 2. Once room ready Buddy signals for nurse to enter dirty area in ante room and process will begin 3. Remind the doffing nurse that all processes are slow and gentle and that you are here to assist 4. Buddy to visually inspect nurse for contaminant. Doffing Nurse to hold arms out and slowly turn around.							
5. Remove gloves 6. Pinch the top band with your thumb and index finger and lift then gently pull down and rolling into a ball 7. Place the dirty glove in the other hand then slide your finger under the top of the other glove, lift and roll down over the dirty glove 8. Discard in waste bin 9. Perform hand hygiene and allow to dry							
10. Remove gown 11. Untie the neck straps then the waist ties 12. Pull the gown away from your neck and shoulders touching only the inside of the gown 13. Turn the gown inside out as you remove it, rolling into a ball or bundle 14. Discard into waste bin 15. Perform hand hygiene							
16. Remove eye protection 17. Grasp earpieces or head band, carefully and gently lift away from head 18. Place into appropriate bin for reprocessing or bin for disposal 19. Perform hand hygiene							
20. Remove face mask (N95) 21. Grasp the strap at the temple, bend your head forward and lift over and off your head. Lift lower strap overhead and gently lift mask away from face 22. Discard shield in bin 23. Perform hand hygiene							

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24. Remove face mask (surgical- with ties) 25. Untie the top tie 26. Untie the lower tie and gently lift the mask away from head by holding the ties and place into waste bin 27. Perform hand hygiene							
28. Remove face mask (surgical with elastic) 29. Gasp ear elastics using both hands together and lift over ears and discard in waste bin 30. Perform hand hygiene							
31. Head Cover (if worn, not recommended by MoH) 32. Tilt head slightly back, 33. Lift off head by gently lifting at the crown of the head upward then bend your head slightly forward and pull the hood back and to the neck. 34. Perform hand hygiene and allow to dry							

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22. Appendix 10: Visitors' instructions

Visitors' instructions for infection outbreak.

Staff on this ward are working hard to control an outbreak of infection. In order to assist them please follow the instructions below:

- Is your visit necessary? Please consider delaying the visit if possible
- Children are discouraged from visiting, but not banned
- Please **wash your hands with soap and water** or **apply the alcohol gel** before entering and leaving the area
- Please **do not** use the toilets, kitchen or staff areas in the ward.
- Toilets will be identified for use by visitors, please follow the signs
- **Do not** visit any other area of the hospital today
- Please do not visit if you have had symptoms of the infectious illness in the last 48 hours

By following these simple rules, we aim to keep you and our patients safe.

Authorised by the Infection Prevention Department

This may be overruled by the Ministry of Health or District Health Board Executive Board at any time in the interests of patient, public or staff safety.

Whanganui District Health Board controlled document. The electronic version is the most up-to-date version. WDHB will not take responsibility in the event of an outdated paper copy being used which may lead to an undesirable consequence.

23. Appendix 11. National Hospital COVID-19 Escalation Framework

All District Health Boards

National Hospital COVID-19 Escalation Framework

COVID-19 Hospital Readiness

GREEN ALERT

Trigger Status: No COVID-19 positive patients in your facility; any cases in your community are managed and under control; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes

- Screen patients for COVID-19 symptoms & epidemiological criteria for any Emergency Department attendances, pre-op sessions, planned admission, or clinic attendance
- Maintain ability to return, if necessary, to triage physically outside the Emergency Department (or outside the hospital building)
- Maintain a separate stream for COVID-19 suspected cases in the Emergency Department
- Undertake regular training and exercises for management of a COVID-19 suspected case in the Emergency Department, Wards, Theatres, ICU/HDU
- Maintain PPE training for COVID-19 care in the Emergency Department, wards, theatres, ICU/HDU, outpatients, other relevant settings
- Maintain plan for isolation of a single case & multiple cases/cohorting
- Maintain capability for instigation, if necessary, of Early Supported Discharge, aggressive discharge and step-down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers)
- Maintain ability to instigate, if necessary, separate streams for staffing, cleaning, supplies management and catering
- Plan for management of referrals, and increased workload on booking and call centre teams
- Plan to have a COVID-19 capable theatre for acute surgery for a known or suspected positive patient
- Maintain ability to instigate, if necessary, a dedicated COVID-19 ward
- Maintain engagement with alternative providers (such as private) regarding assistance during higher escalation levels, and to fast-track urgent, lower complexity care procedures
- Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients
- Planned Care surgery, acute surgery, urgent elective and non-deferrable surgery to operate as usual, National Services to operate as usual, NTA to operate as usual
- Review patients on the waiting list (surgery, day case, other interventions) and group patients by urgency level
- Prioritise Planned Care surgery and other interventions by focusing on those with the most urgent need, and where ICU/HDU **is** required

COVID-19 Hospital Initial Impact

YELLOW ALERT

Trigger Status (individual or cumulative): One or more COVID-19 positive patients in your facility; any cases in your community are being managed; isolation capacity & ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps

- Continue screening for COVID-19 symptoms and epidemiological criteria as per Green Alert
- Activate plans as described in Hospital Green Alert, as appropriate
- Activate Emergency Department triaging in a physically separate setting
- Activate streaming of known or suspected COVID-19 positive and non-positive patients as planned across Emergency Department, Wards, Theatres, ICU/HDU, and have dedicated COVID-19 capable theatre available
- Activate Early Supported Discharge, aggressive discharge and step-down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers)
- Engage across other DHBs to appropriately discharge out of area patients back to domicile hospital or other setting (to be considered in conjunction with current Hospital Alert Level at other DHBs)
- Acute surgery, urgent elective, and non-deferrable surgery to operate as usual, with consideration given to repatriation processes if patient is non-domicile
- Maximise the provision of pre-op assessments and outpatient appointments to be undertaken virtually, or in an off-site setting as necessary
- Plan to defer non-urgent pre-assessments and non-urgent clinic patients if necessary, ensuring clinical and equity risk is managed
- Activate any outsourcing arrangements, and engage on options for supporting 'cold trauma' cases and less-complex urgent cancer surgery
- Planned Care surgery and other interventions to be prioritised based on urgency, and where ICU/HDU **is not** required, delivery should continue as much as possible, in accordance with agreed regional plan
- Redeployment of staff as needed/available to ensure perioperative workforces are in place to run theatre, including anaesthesia, anaesthetic technicians, nursing. Scale back delivery of non-urgent Planned Care only as essential

COVID-19 Hospital Moderate Impact

ORANGE ALERT

Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission is not well controlled; isolation capacity and ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered

- Continue screening for COVID-19 symptoms and epidemiological criteria as per Green Alert
- Activate plans as described in Hospital Green and Yellow Alert levels
- Work with palliative care and other providers to agree alternative end of life services for non-COVID patients
- Provide Emergency Department services with prioritisation on high acuity medical and trauma care. Provide advice in non-contact settings where possible
- Fully activate any agreements with other hospitals or providers, including private
- Acute surgery to operate as staffing and facilities allow, with priority on trauma cases
- Prioritise urgent non-deferrable Planned Care cases not requiring ICU/HDU care
- Review and manage all non-urgent, high risk Planned Care surgery requiring HDU/ICU, adjusting the prioritisation threshold for surgery with Senior Clinicians for non-deferrable cases
- Increase ICU/HDU capacity as needed, retaining cohorting of known or suspected COVID-19 and non-positive patients, including moving non-COVID-19 ICU/HDU to theatre complex
- Implement acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases as staffing allows
- Manage outpatient referrals to ensure clinical and equity risk is understood and managed
- Activate regional management arrangements to support service delivery and minimise risk of patients waiting for services

COVID-19 Hospital Severe Impact

RED ALERT

Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission uncontrolled; isolation and ICU at capacity; all available staff redeployed to critical care

- Emergency Department services limited to high acuity medical and trauma care
- Activate plans as described in Hospital Green, Yellow and Orange Alert Levels
- Work with palliative care and other providers to agree alternative end of life services for non-COVID-19 patients
- Continue acute surgery as staffing and capacity allows, prioritising non-deferrable, life-saving surgery
- Cancel non-acute surgery to reduce transmission risk, and reprioritise capacity
- Activate additional streaming, including non-COVID-19 ICU/HDU to theatre complex, or private provider if agreement reached
- As a last resort, move ventilated COVID-19 patients to repurposed ICU/HDU theatre complex for overflow; aim is to not impact on ability to meet non-deferrable, life-saving acute surgery
- Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows
- Only accept urgent outpatient referrals, but ensure clinical risk is understood and managed
- If other hospitals in the region are at the same Alert Level, activate out of region management arrangements

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MINISTRY OF HEALTH
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