

SDMS Number: P20/338

THS – Hospitals South

COVID-19

Escalation Management Plan

May 2022

Version 4.0

## **Version Control**

| **Version Number** | **Creation Date** | **Description of Change** |
| --- | --- | --- |
| 1.0 | 03/04/2020 | Approved by the Secretary – Department of Health |
| 2.0 | 3/6/2020 | Approved by Secretary - Department of Health |
| 3.0 | 19/12/20 | Approved by Secretary - Department of Health |
| 3.1 | 26/7/21 | Replace Triggers table (page 11) with new version Approved by THS EOC. |
| 3.2 | 30/8/2021 | Updated Triggers and changes associated with vaccination and COVID variants |
| 3.3 | 5/10/2021 | Updated standard sections across all Regional Plans |
| 3.3 | 7/12/2021 | Approved by Secretary - Department of Health |
| 3.4 | 16/12/2021 | Update references to multiple employment consistent with the COVID-19 DoH Workers in High-Risk Settings with External Employment Policy. |
| 3.5 | 22/02/2022 | Updated following experience with COVID surge Jan 2022. Reconfigured ICU Response. Added Winter Plan Appendix. |
| 4.0 | 13/5/2022 | Approved by Secretary - Department of Health |

## 

# Table of Contents

[**Version Control** 2](#_Toc91063180)

[Table of Contents 3](#_Toc91063181)

[Abbreviations 4](#_Toc91063182)

[Introduction 6](#_Toc91063183)

[**Health Facility Response** 6](#_Toc91063184)

[**Aims** 7](#_Toc91063185)

[**Communication Methods** 7](#_Toc91063186)

[**Business Continuity Planning** 8](#_Toc91063187)

[Governance 8](#_Toc91063188)

[**THS-S Local Response** 10](#_Toc91063189)

[Current triggers and actions for escalation levels 12](#_Toc91063190)

[Summary of COVID-19 Statewide Surge Capacity 16](#_Toc91063191)

[**ICU Surge Capacity** 16](#_Toc91063192)

[**Expanding ICU Capacity in Tasmania** 16](#_Toc91063193)

[Escalation Level Response 17](#_Toc91063194)

[Level 1 Reponses- Preparation Phase 17](#_Toc91063195)

[Level 2 Reponses - Activation Phase 17](#_Toc91063196)

[Level 3 Response 22](#_Toc91063197)

[Level 4 Response 25](#_Toc91063198)

[**Appendix1: Staff and Workforce** 27](#_Toc91063199)

[**Appendix 2: Training** 30](#_Toc91063200)

[**Appendix 3: Infection Prevention** 31](#_Toc91063201)

[**Appendix 4: Outbreak Management** 34](#_Toc91063202)

[**Appendix 5: COVID-19 Patient Transfers Between Hospitals** 35](#_Toc91063203)

[**Appendix 6: Hospital Avoidance Measures** 36](#_Toc91063204)

[**Appendix 8: Clinical Support Strategies** 37](#_Toc91063205)

[**Appendix 9 – Increased ICU Capability** 38](#_Toc91063206)

[**Appendix 10 – Pharmaceutical Supply** 39](#_Toc91063207)

[**Appendix 11 – Access to State Emergency Medical Stockpile (SEMS) Personal Protective Equipment (PPE)** 40](#_Toc91063208)

# Abbreviations

|  |  |
| --- | --- |
| 10KW | General Medical/Respiratory Ward |
| 2J | Older Persons Unit, RHH |
| ACT | Aged Care Assessment Team |
| ADON | Assistant Director of Nursing |
| APU | Assessment Planning Unit |
| ARI | Acute Respiratory Infection |
| ARIA | Acute Respiratory Infection Assessment (ARIA) |
| ATEOC | Ambulance Tasmania Emergency Operations Centre |
| BCP | Business Continuity Plan |
| CBD | Central Business District |
| CDC | Centres for Disease Control and Prevention |
| CDNA | Communicable Disease Network Australia |
| CDU | Cardiac Day Unit |
| CNC | Clinical Nurse Consultant |
| ComRRS | Community Rapid Response Service |
| CT | Computerised tomography |
| DNA’s | Did Not Attends |
| DoH | Department of Health |
| ECC | Emergency Coordination Centre |
| ECR | Endovascular Clot Retrieval |
| ED | Emergency Department |
| EMU | Emergency Management Unit |
| EOC | Emergency Operation Centres |
| EPRU | Emergency Preparedness and Response Unit |
| GP | General Practitioner |
| HDU | High Dependency Unit |
| HPH | Hobart Private Hospital |
| ICU | Intensive Care Unit |
| ID  IPCU | Infectious Disease  Infection Protection and Control Unit |
| NDIS | National Disability Insurance Services |
| NHMRC | National Health and Medical Research Council |
| NNICU | Neonatal Intensive Care Unit |
| OPS | Outpatient Department |
| P1 | Peacock Unit, Repat Hospital |
| PHEOC | Public Health Emergency Operations Centre |
| PMI | Patient Master Index |
| PPE | Personal Protective Equipment |
| RHEMT-S | Regional Health Emergency Management Team – S |
| RHH | Royal Hobart Hospital |
| SARS-CoV-2 | Severe Acute Respiratory Syndrome Coronavirus 2 |
| SCC | State Control Centre |
| TBP | Transmission-Based Precautions |
| TEMA | Tasmanian Emergency Management Arrangements |
| THS EOC | Tasmanian Health Service Emergency Operations Centre |
| THS-S | Tasmanian Health Services/Hospitals South |
| WHO | World Health Organisation |

# Introduction

The current outbreak of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) was first reported from Wuhan, Hubei Province, China, in December 2019. SARS-CoV-2 is a new strain of coronavirus that is causing disease in humans and spreading from person-to-person.

The epidemiology of COVID-19 has changed over the course of the pandemic. This requires an adaptive response to planning and escalation strategies. Most people with COVID-19 experience mild symptoms that can be managed at home with limited medical intervention. Some people with coronavirus infection may get very sick very quickly, requiring hospitalisation and days of ventilatory support. The current case fatality rate in Australia is reported as 2.7 per cent[[1]](#footnote-2). A small number of people experience long term effects from the disease known as ‘long-COVID syndrome’.

SARS-COV-2 can be transmitted through respiratory droplets, smaller particles (aerosols), direct physical contact with an infected individual, and indirectly through contaminated objects and surfaces .

While the exact relative contributions of these routes remain unclear, those who have been in close contact with a COVID-19 case are at highest risk.

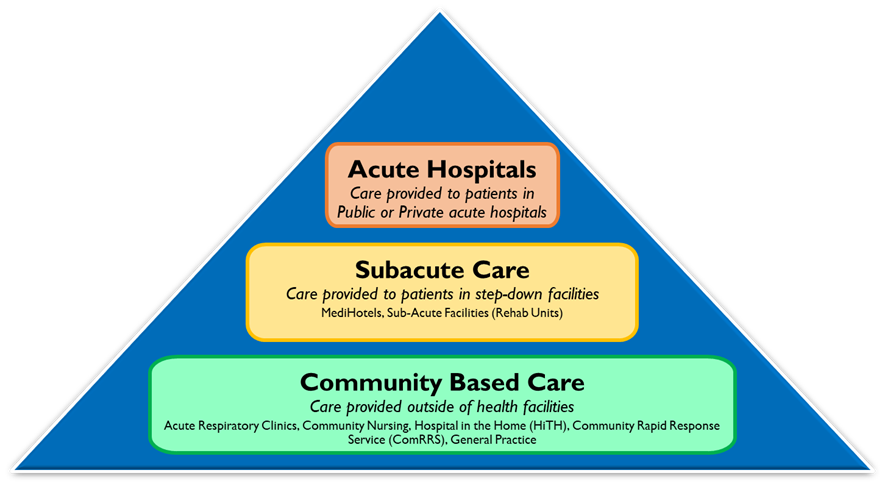
As the pandemic unfolds, SARS CoV-2 has become more divergent, and a number of these divergent strains have been designated as variants of concerns (VoC) by the World Health Organisation and in Australia by the Communicable Diseases Genomic Network. A variant of concern contains mutations that impact or have the potential to impact vaccine or drug efficacy or demonstrate high rates of transmission. It is anticipated that VoC will continue to emergence, with the potential to cause explosive outbreaks in the future.

The short infectious period and high transmissibility of SARS CoV-2 place a significant burden on public health resources and contract tracing. Newer variants are also impacting younger adults and school age children, requiring health services to consider their response to supporting a younger age group in addition to increasing overall capacity to manage unwell adults with severe respiratory disease.

The COVID-19 vaccination rollout has reached an advanced stage in the Tasmanian community. As the pandemic progresses, vaccine recommendations have been and will continue to be modified to reflect national recommendations.

## **Health Facility Response**

Patients diagnosed with COVID-19 will be treated in a way that best meets their needs ensuring hospital resources are reserved for those patients who have the greatest capacity to benefit. The latest Guidelines for prevention, assessment and management of SARS-CoV-2 are updated and available at [Department of Health | Coronavirus Disease 2019 (COVID-19)](https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm)[[2]](#footnote-3).



On 20 March 2020 the Tasmanian Government declared a State of Emergency for Tasmania in response to COVID-19.

The State Control Centre (SCC) has been activated, meaning the whole-of-government response to COVID-19 is being led by the State Controller in close liaison with Secretary of the Department of Health and Director of Public Health.

The THS South COVID-19 Escalation Management Plan (the Plan) has been developed in response to the *State Special Emergency Management Plan (SSEMP): COVID-19* and is the operational document that describes the actions and duties taken by the Royal Hobart Hospital and related facilities in response to COVID-19.

This plan will be subject to regular updates due to the changing epidemiology of this outbreak.

## **Aims**

The aim of this expanded plan is to document the ‘THS-South’ response and recovery arrangements and how they align with agreed national and health sector arrangements, in order to minimise state and local-level health impacts.

The objectives of this plan are to:

* document the THS- South command, control and coordination arrangements for COVID-19
* outline the actions that the THS-South will undertake to prevent disease transmission between staff, patients and visitors
* clarify the roles and responsibilities across the THS-South and partners for the response to and recovery from a COVID-19 pandemic
* assist all sites and campuses of the THS-South to manage COVID-19 effectively, including management of outbreaks, and
* outline surge capacity and response of the THS in the event of an escalation.

## **Communication Methods**

Communication Management

All communication provided to stakeholders including government agencies, state employees, local authorities, media and members of the public ***will be in line with*** the Public Information Document developed by the Public Information Unit within the Department of Premier and Cabinet and published at [www.coronavirus.tas.gov.au](http://www.coronavirus.tas.gov.au/).

***External*** communicationismanaged and coordinated through the Public Information Unit within the Department of Premier and Cabinet.  The Public Health Service within the Department of Health is the primary health communicator with private and public health care providers which includes general practitioners.

***Internal*** communication is managed through the Department of Health COVID-19 Emergency Coordination Centre (ECC). Regional Health Commanders submit communications to the ECC for approval prior to their release to local stakeholders, including health employees, general practice and local service providers such as Private Hospitals and Ambulance Tasmania.

Spokespersons

The ***external*** spokespersons for COVID-19 are the Premier, State Controller, Minister for Health and the Director of Public Health.  The ***internal*** spokespersons for COVID-19 are the Head of State Service, State Health Commander, Department of Health Chief Medical Officer and Regional Health Commander.

## **Business Continuity Planning**

The objective of the Business Continuity Plan (BCP) is to outline how the THS-S will maintain business continuity management functions during an outbreak of COVID 19 in order to ensure that the Tasmanian community is provided with essential health services. Business Continuity Plans have been developed for all clinical service streams.

District Hospital Escalation Plans are in a separate document.

# Governance

The Department of Health (DoH) is responsible for the delivery of integrated health services that maintain and improve the health and wellbeing of individual Tasmanians and the Tasmanian community. The DoH has several emergency advisory, prevention, preparedness, response and recovery roles and responsibilities under the Tasmanian Emergency Management Arrangements (TEMA)[[3]](#footnote-4). Details of how these responsibilities are performed and managed are contained in DoH system-level and service-level emergency management arrangements.

At the operational level, DoH service groups, including the Tasmanian Health Service, and Community, Mental Health and Wellbeing (including Ambulance Tasmania, State-wide Services and Public Health Services) provide the capability and capacity to deliver health services to the Tasmanian community in alignment with the policies, plans and standards set at the departmental level[[4]](#footnote-5),[[5]](#footnote-6).

**Department of Health COVID-19 Emergency Coordination Centre (ECC):** responsible for strategic, system-wide COVID-19 consequence management, including the strategic leadership, direction, coordination and management of system-wide and service level COVID-19 response operations and consequence management.

The COVID-19 Emergency Coordination Centre (ECC) is the central point within the DoH for strategic, system-wide COVID-19 consequence management, planning and communications. This includes functioning as a central point for strategic information flow into and out of DoH, providing short, medium and long-term consequence management of COVID-19 response planning at a strategic level. This is to ensure that DoH operational/service groups are not overloaded or unduly diverted from their core business functions. In addition, the ECC provides coordination support across all DoH Emergency Operation Centres (EOC’s) activated to give direction and coordinate the operational and health service delivery response to COVID-19.

The ECC will bring together public and private health sector capacity and capability to manage the DoH COVID-19 response. The primary responsibilities of the ECC include:

* Monitoring the strategic coordination of DoH COVID-19 response operations and consequence management.
* Procurement and deployment of clinical, clinical support and corporate resources (human, financial and material) to support DoH COVID-19 response operations and consequence management
* Collection, assessment, validation and distribution of information on the current and predicated situation
* Establishing and maintaining liaison with key stakeholders at the intra/inter-agency and intergovernmental level
* Facilitating and coordinating requests for information and/or assistance from and between the Australian Government and other States and Territories, as it relates to the health-system response, and
* Through the DoH Incident Controller, providing advice and support to the Secretary DoH and portfolio Minister/s as required.

**Public Health Emergency Operations Centre (PHEOC):** responsible for the coordination and management of Public Health Services COVID-19 response operations and consequence management.

**Tasmanian Health Service Emergency Operations Centre (THS EOC):** responsible for the coordination and management of Tasmanian Health Service COVID-19 response operations and consequence management. The THS EOC is a communication and decision- making forum. Membership includes the Commander THS EOC, Regional Health Commanders (South, North, North-West), Chief Executive Hospitals-South, Chief Executive Hospitals-North/West and the Deputy Secretary, Community Mental Health and Wellbeing. Representatives from ECC and EOCs attend as observers.

The THS EOC is supported by three Regional Health Emergency Management Teams, led by Regional Health Commanders, each responsible for the management and coordination of THS regional-level COVID-19 emergency response operations, in accordance with direction of the THS EOC Commander.

All decisions to change local service arrangements require approval through the Department of Health COVID-19 Emergency Coordination Centre and State Health Commander.

**Ambulance Tasmania Emergency Operations Centre (ATEOC):** responsible for the coordination and management of Ambulance Tasmania COVID-19 response operations and consequence management.

**Aged Care/Disability Sector Emergency Operations Centre (ACEOC):** responsible for undertaking a system wide, coordination function in preparing and responding to COVID-19 outbreak in Tasmanian Residential Aged Care Facilities (RACF’s) and Disability Services.

**Tas Vax Emergency Operations Centre (TVEOC):** responsible for coordination of COVID vaccine rollout. THS Operating Model

The below model outlines the operating model for the Department of Health, with THS COVID Response elements in blue.

## **THS-S Local Response**

A Regional Health Emergency Management Team (RHEMT-S) has been established and the Executive Director of Medical Services has been appointed as the Regional Health Commander in the South. Lines of communication between the RHEMT-S and the THSEOC have been established.

The RHEMT-S meets as necessary and weekly at a minimum to support progression of the actions outlined in the plan, identify risks develop mitigation strategies and escalate as appropriate. Daily COVID-19 huddles are scheduled to keep the THS-S Executive up to date with all activity and information.

The membership RHEMT-S includes:

* Regional Health Commander / Executive Director Medical Services
* Chief Executive Hospitals South
* Executive Director of Nursing
* Director Allied Health
* Nursing Director COVID Response
* Deputy Exec Director Medical Services/Registrar Medical Administration
* Director, Medical Education & Training
* Clinical Director - Women’s Adolescent & Children’s Services
* Nursing Director - Women’s Adolescent & Children’s Services
* Nursing Director - Cancer, Chronic Disease & Sub-acute Care
* Clinical Director - Cancer, Chronic Disease & Sub-acute Care
* Nursing Director – Critical Care, Clinical Support & Investigation
* Clinical Director – Critical Care, Clinical Support & Investigation
* Nursing Director – Surgical & Perioperative Services
* Clinical Director – Surgical & Perioperative Services
* Nursing Director – Acute Medical Services
* Clinical Director – Acute Medical Services
* Director - Emergency Department
* Director – Infectious Diseases/Microbiology
* Nursing Director – Integrated Operations
* Director - Corporate Services
* Project Manager – F&EM
* Nurse Unit Manager – Infection Prevention and Control Unit
* Medical Advisor – Infection Prevention and Control Service
* Manager ICT THS/Hospitals South
* Manager - Medical Orderlies / Security Services
* ADON – Integrated Operations Centre
* Emergency Management Coordinator
* Work Health and Safety Consultant
* Manager Communications
* Southern Region GP Liaison
* Rural facilities GP (where possible)
* Manager Media and Communications
* Pharmacy Site Manager
* Human Resource Manager
* Tasmania Police Liaison
* Ambulance Tasmania Liaison

The current objectives and priorities of the RHEMT are:

* Early detection and health service response to community cases
* Implement THS-S incident management arrangements
* Establish effective models of care in response to evolving situation
* Coordinate the implementation of departmental business continuity management plans
* Effective human resource management
* Effective engagement of THS partners
* Effective logistics management
* Development of internal communications plan and manage ongoing communications
* Ongoing review of Infection Protection and Control Measures

The RHEMT is supported by five key subgroups:

* Operations
* Clinical Planning
* Planning
* Logistics
* Communications and Media

The THS-S RHEMT has responsibility for a number of District Hospitals. These facilities each have a dedicated Escalation Management Plan.

# Current triggers and actions for escalation levels

The THS Emergency Operations Centre has agreed to the following statewide health service escalation trigger response plan. Declaration of Level 3 or above must be approved by the Secretary (as State Health Commander) in consultation with the Chief Executive and Regional Commander at each site. The triggers on their own do not mean an automatic change in level of response however they are designed to allow the RHEMT to consider the need for an escalation in response.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Level 1 Response - 'Business As usual'** | **Trigger points of consideration of escalation** | **THS South** | **THS North** | **TH NW -NWRH** | **TH NW -MCH** | **State** |
| Patients Admitted with COVID-19 for treatment (not quarantine/isolation) | <5 | <5 | ≤6 | ≤5 | ≤21 |
| Patients Admitted requiring ICU | <5 | <3 | 0 | 0 | <8 |
| Community | Endemic transmission in Tasmanian community with no new variants | | | | |
| Staffing | Staffing levels managed flexibly under existing THS patient flow escalation protocols | | | | |
| **Level 2 Response** | **Trigger points of consideration of escalation** | **THS South** | **THS North** | **TH NW -NWRH** | **TH NW -MCH** | **State** |
| Patients Admitted with COVID-19 for treatment (not quarantine/isolation) | 5-10 | 5-10 | 7-9 | 6-8 | 23-37 |
| Patients Admitted requiring ICU | >5 | <4 | 1\* | 0 | 8-10 |
| Community | Endemic Transmission in Tasmanian Community with an emerging variant of concern | | | | |
| Staffing | Staffing levels managed with only minimal service delivery impact | | | | |
| **Level 3 Response** | **Trigger points of consideration of escalation** | **THS South** | **THS North** | **TH NW -NWRH** | **TH NW -MCH** | **State** |
| Patients Admitted with COVID-19 for treatment (not quarantine/isolation) | 11-28 | 11-25\*\* | 10-14 | 9-10 | 42-54 |
| Patients Admitted requiring ICU | >8 | >5 | >1 | 0 | >14 |
| Community | Community outbreak within a region with an emerging variant of concern | | | | |
| Staffing | Staffing Service delivery significantly compromised due to staffing levels - Consider service reconfiguration. | | | | |
| **Level 4 Response** | **Trigger points of consideration of escalation** | | | | | |
| Patient Presentations / Inpatients | Facility is at capacity and is unable to receive additional presentations or manage current bed numbers, including admitted or critical care cases. | | | | |
| Responses for level 4 beyond this point is managed by a State-wide response | | | | |
| Staffing | Service delivery compromised due to staffing levels. Services either requiring reduction or treatment unable to be provided due to insufficient staff. | | | | |

*\* Awaiting transfer*

*\*\* Number may decrease in the latter half of 2021 due to reduced capacity to allow for upgrades to the Acute Medical Ward.*

|  |  |
| --- | --- |
| **Level 1 Response-**  **‘Business as Usual'** | Level 1 is the ‘Business as Usual’ (BAU) Phase, which involves maintaining business continuity while plans are made for the region to prepare for an escalation to Level 2.   * Plan and quantify staffing, additional resources & equipment requirements enabling an imminent Level 2 Response including in rural facilities (includes identification of staff working at more than one physical location) * Maintain business continuity in line with THS Escalation Principles (‘Business as Usual’) * Regular communication and dissemination of information on emergency level and preparedness and containment strategies to all staff * Ensure all staff have updated their contact details and emergency contact details * Maintain appropriate and consistent signage at entrances, reception and waiting areas * Ensure hand hygiene stations at all entrances and reception areas, and maintain visitor screening and restrictions at hospital entry points including rural facilities * Maintain staff screening prior to work attendance. Staff understand and take responsibility for monitoring their own health status and know that they are not to come to work if experiencing any respiratory symptoms or feeling unwell * Maintain staff training in PPE use * Maintain effective acute respiratory response in the ED * Maintain restricted access to Emergency Dept to essential staff only * Initiate triage COVID testing for symptomatic patients prior to entry to ED * Consider alternative triage locations and holding areas prior to COVID status * Maintain an Acute Respiratory Ward (K10W) with increased infection control precautions in preparedness to manage patients potentially infected with Coronavirus COVID –19 in a separate designated area of the ward. * Implement and maintain COVID Safe Workplace Measures (physical distancing, signage and entry points) * All meetings and gatherings to comply with physical distancing requirements. * Maintain staff wellness strategies for physical and mental health * Ensure rural and subacute facilities have access to education and training, and are establishing processes to support the acute services in a Level 2 phase * Consider scenario training * Development of Incident Action Plan * Comply with Patient Transfer Protocol and Policy for transfer of inpatients to RACF’s and other facilities * Identify and train contact tracing team. |
| **Level 2 Response**  **‘Activation Phase’** | Level 2 is the Response Activation Phase, involving an operationalisation of some plans and actions in preparation for an escalation to Level 3.  Identify logistics gaps and clarify supply chains.   * Plan and commence reconfiguration of clinical spaces by:   + discharging patients (wherever possible) relocate to alternative treatment locations (Regional hospitals, hospital in the home or Community nursing) to create a COVID ward with restricted access (K10W)   + direct admitting of COVID positive patients to avoid Emergency Dept as clinically appropriate * Maintain COVID patient travel pathways through Hospital * Activate Community Case Management Facility for low risk COVID-19 positive patients * Planned preservation of surgical and medical capability – engagement with private hospitals and private day procedure centres * Planned preservation of medical activity only currently available in public sector * Review elective activity including elective surgery and general outpatient clinics, to determine whether there is a need for rescheduling or cancellations * Where negotiated move surgical activity to Private Hospitals and day surgical units to increase capacity * Planned staffing, rostering and management of additional resources and equipment requirements enabling an anticipated/imminent Level 3 Response including review of staff working at other facilities * Consider allocation of alterative duties for identified vulnerable staff * Ensure regular communication and sharing of updated information with all THS-S staff and local general practitioners (subject to approval) * Establish alternative triage locations and holding areas prior to COVID status knowledge * Actively monitor staffing, equipment & resources (especially PPE) to ensure availability in highest risk clinical areas * Ensure all staff and visitors undertake screening and only admit as per current visitor access rules. Restricted access to areas with COVID patients. * Provide ongoing training and education on IPC and PPE practices, conduct competency assessments and complete site audits * Ensure adequate, and appropriately trained, cleaning staff available to conduct terminal cleans and increase cleaning of frequent touch point areas * Review to ensure all scheduled regular maintenance, contractor visits and delivery of goods to the site are deemed essential * Reallocate staff at risk from high COVID risk areas |
| **Level 3 Response** | Level 3 is the Response Phase, involving activation of strategies and actions to respond to an increase in COVID19 presentations and inpatients that require treatment.  Escalation to Level 3 requires THS EOC Commander approval.   * Include Private Hospital representation on RHEMT * Designate COVID only wards (K10W and K10E) * Establish Rapid Intervention Zone in Emergency Dept * Limit numbers of patients in ED * Discharge noncritical inpatients to provide inpatient capacity in COVID designated wards * Reallocate appropriately prepared clinical staff to COVID-19 wards, and ICU * Offer alternative clinical duties to staff who cannot safely work in COVID-19 wards, * Use alternative Critical Care areas to increase capacity for ventilated patients (Theatre recovery, HDU areas) * Restrict access to clinical areas of hospitals to essential staff only - visitors and non-essential staff to be excluded reducing the chances of transmission through casual contact * Continue to ensure regular communication and dissemination of information on emergency level, preparedness and containment strategies with all THS-S staff and local GPs (as approved) * All non-essential outpatient services and visiting health services to be suspended to minimise staff exposure, contain community transmission and ensure effective use of resources * Ensure representation at Emergency Operation Centre meetings and dissemination of information out to stakeholders * Actively monitor staffing, equipment and resources, especially PPE and medications, to ensure adequate stock and availability given rural location and delivery times * Ensure all staff have completed PPE training and competency assessment and maintain training and assessment documentation for auditing purposes * Conduct regular auditing of IPC practices and PPE donning and doffing * Continue to review staffing levels and rostering and allocate additional resources where required * Staff testing in line with Public Health and Infectious Diseases direction. |
| **Level 4 Response**  **(Disaster)** | Level 4 is a heightened Response Phase, where Level 3 capacity has been exceeded and a State-wide system response is necessary to manage the impact of COVID-19 on the State’s health system  Escalation to and from Level 4 requires approval from the State Health Commander.  Focus of Level 4 response will be:   * Move to a whole of state system response   Other activities include:   * Maintain communication and sharing of information with all staff members and local GPs as approved * Facility to be closed to all visitors * Maintain communication and sharing of information with all staff members * Notify the general public and clients of any cessation of services * Maximise bed capacity within hospital with appropriate separation of COVID positive and negative patients * Private facilities to be integrated into the public system * Staff movement between facilities, wards and departments is ceased * Consider cancellation of leave * Seek assistance from external health care providers |

# Summary of COVID-19 Statewide Surge Capacity

The following table provides a summary of the surge response capacity for the State (non ICU)

**Table 1: COVID-19 surge response capacity at Level 41**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **South** | **North** | **North West** | **Statewide** |
| COVID19 positive beds (excluding negative pressure beds) | 151 | 123 | 22 | 296 |
| Private Hospital Beds | 151 | 65 | 12 | 228 |
| Negative Pressure Rooms2 | 14 | 9 | 10 | 33 |
| Community Case Management Facility Beds | 50 | 25 | 0 | 75 |
| Capacity to manage COVID +ve patients in the community |  |  |  | 4 5003 |

1. These numbers may vary based on input variables factors, including workforce availability.
2. Planned capital works may temporarily affect these numbers.
3. This number is for moderate and high risk patients only based on the number of monitoring devices currently available and will depend on the balance between children and adults.

## **ICU Surge Capacity**

The Statewide [THS - Intensive Care Surge Capacity Plan](https://cm.health.local/pandp/showdoc.aspx?recnum=P20/341) outlines the surge capacity of Tasmanian ICU’s. Please refer to this plan for most up to date statistics.

There are currently 34 ICU beds in Tasmania that are staffed and operational. This includes six beds at the Calvary Health Care Tasmania hospital at Lenah Valley and 28 beds in the THS

In addition, to this there are currently 26 beds available within ICUs around the State but are not currently staffed. Therefore, the total available existing capacity within Tasmanian ICU is 60 beds.

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital** | **Location** | **ICU Beds Staffed** | **Total ICU Bed Capacity** |
| Royal Hobart Hospital | South | 15 | 23 |
| Calvary Lenah Valley | South | 6 | 11 |
| Launceston General Hospital | North | 9 | 18 |
| North West Regional Hospital | North West | 4 | 8 |
| **TOTAL** |  | **34** | **60** |

## **Expanding ICU Capacity in Tasmania**

The THS EOC agreed that the THS will increase ICU capacity capable of supporting critical care patients in Tasmania, utilising 34 current operational ICU beds and adding a further 80 beds ring fenced for COVID-19 positive patients, of which there is a pharmacy stockpile to ensure 100% of patients can be continuously ventilated if clinically appropriate. The existing 34 operational ICU beds will be a mix of ventilated and non-ventilated patients and will be receiving critical care that may or may not be related to COVID-19.

# Escalation Level Response

The below information provides a summary of the major actions currently being undertaken within the THS-S in order to meet the health service demands of the coronavirus. Further details concerning the hospital responses are contained in the *THS-S Departmental Business Continuity Sub Plans for the Management of Health Services COVID-19.*

## Level 1 Reponses- Business as Usual

|  |
| --- |
| **Level 1 Response - ‘Business As Usual’** |
| * Other measures detailed under Level 1 Business as Usual * Maintain business continuity in line with THS Escalation Principles (‘Business as Usual’) * Plan and quantify staffing, additional resources & equipment requirements enabling an imminent Level 2 Response * Watching brief on current situation * Identification and training of staff to perform contact tracing * Review and amend accordingly Outbreak Management Plans   **Emergency Department**   * Identify as COVID Positive versus COVID Negative +/- needing Transmission Based Precautions and testing * Staff and Visitors: Screening with security * PCR and RAT:   + All Admissions   + Risk factors for COVID -symptoms or household contacts   + No testing for patients being discharged without risk factors * Bed allocation of COVID positive patients in ED   + Acutely unwell = R4   + Others to single rooms in EMU:   + Admit EMU   + Include in EMU numbers   + Maintain 2 single rooms for COVID positive patients   + If more than 2 rooms in use clear a third single room   + If three single rooms in use for COVID positive patients and unlikely to clear quickly escalate to NUM/DEM/PFM   + Utilise EMU Waiting Room with door closed for well COVID positive patients   Intensive Care   * Utilise the three DCCM negative pressure rooms and the five single rooms on the Derwent side (for intubated patients where the McMonty hood is able to be used appropriated) for suspected or confimred COVID-19 patients. Indications for use of the negative pressure rooms for suspected or confirmed COVID-19 patients include:   + Non-intubated patients requiring AGP   + McMonty hood not able to be used (e.g. not tolerated, poor compliance)   + High risk AGP such as extubation * Placement and use of air purifying units in bedspaces used for suspected or confirmed COVID-19 patients. |

## 

## Level 2 Reponses - Activation Phase

|  |
| --- |
| **Level 2 Response ‘Activation Phase’** |
| **Emergency Department Capacity**   * Direct admission to COVID-19 inpatient unit where possible * Single room in ED if assessment in ED required (undifferentiated or needing immediate resuscitation)   Remain external to ED until appropriate treatment space identified and pathway to this space is cleared   * Patients able to wait 20 minutes for a test result an external single person waiting area for triage/screening/clerking/testing * Risk matrix determines patient’s subsequent location in the ED * Direct access to single room for patients unable to wait to receive emergency care   Managed in single rooms in ED  If no single room, patient remains external to ED until single room available.   * Patients managed in ED in spaces without doors * If patient is ambulance arrival and is unable to be rapidly offloaded, ramping will occur in the area identified in Level 1 * Increased restrictions – where possible only vaccinated visitors * Geographical rostering including breaks * Limit attendance at RHH when not rostered to work clinically * Limit presence in the ED clinical areas * Inpatients teams to avoid entry to ED with the preferred method of admission being via an Interim Management Plan |
| **Intensive Care Capacity**   * Utilise the three DCCM negative pressure rooms and the five single rooms on the Derwent side (for intubated patients where the McMonty hood is able to be used appropriated) for patients with suspected or confirmed COVID-19. Indications for use of the negative pressure rooms for suspected or confirmed COVID-19 patients include:   + Non-intubated patients requiring AGP   + McMonty hood not able to be used (e.g. not tolerated, poor compliance)   + High risk AGP such as extubation * Review hospital elective surgery requiring ICU/HDU care and postpone/refer to private if appropriate * Develop and maintain an ICU Capacity Surge Plan to provide a staged increase in ICU capacity supported by additional equipment * Review and activate training plan in place to upskill staff for ICU duties * State-wide Critical Care Network enables clinicians to consult, share and collaborate to make informed recommendations in relation to ICU:   + Bed capacity   + Equipment and consumables   + Workforce   + Admission/discharge protocols   + Patient Transport. |

|  |
| --- |
| **Inpatient ward reconfiguration- Creation of COVID-19 dedicated ward**  **Creation of COVID-19 dedicated ward**   * The creation of a COVID-19 ward minimises the risk of staff and other patients being exposed to COVID-19. This is particularly the case for vulnerable patients (pregnant women, children, the elderly and those with chronic condition or immunocompromise) * The THS-S has 18 negative pressure rooms available in wards (not counting ICU NPICU and ED), and 18 staffed ICU beds with capacity to flex to 23 beds * Negative Pressure Rooms (N Class) across Hospitals South THS-S: * K6E - Children’s (2) * K6W - Adolescents (1) * K7E - Birthing & Delivery (2) * K7W - Maternity (2) * K8E - Neonatal & Paediatric ICU (4) * K8W - Neurosurgery (2) * K9E - Orthopaedics & surgical (1) * K9W - General Surgical (2) * K10W - General Medicine (4) – these are included in the COVID isolation bed numbers * K10E – General Medicine (1) * 2J - Older Persons Unit (1) * Department of Critical Care medicine (3) – Nb. one is a Q class * Emergency Department (ED) (1) Lower Ground J block * ARIED / Lower ground H block (1) * K10W has been designated as the COVID-19 isolation ward. This Ward can accommodate up to 18 acute respiratory illness patients with an additional 10 patients depending on the escalation level. As the demand increases Ward K10E will move to take further patients with expansion into level K9 as required. |
| **Surgical Services Response**   * Preparation of theatre and surgical ward reconfiguration * Review hospital elective surgery program   + Review Dental Surgery theatre sessions   + Review endoscopy sessions and focus on urgent colonoscopy cases * Postpone all non-urgent multiday stay elective procedures. Continue performing urgent multiday stay and same day/overnight surgeries for all urgency categories * Ring all patients with booked appointments- advising to call OPD if they are showing signs of flu or fever.   **Private Hospital negotiations to mitigate impact on bed numbers and elective surgery**   * Negotiations complete to purchase available private beds to assist with elective surgery and inpatient capacity for both elective and emergency patients. * Review the need for the extra surgical capacity * Working with the Private Sector (HPH & Calvary, Hobart Day Surgery) to outsource clinically appropriate elective surgeries * Direct elective surgery patients to Hobart Private across the following specialties:   + Orthopaedic   + Gynaecology   + General Surgery   + Ear Nose and Throat   + Neurosurgery   + Neurology   + Ophthalmology |
| **Outpatient Services Response**   * Review current outpatient bookings and provide appointments via Telehealth or telephone consultation if clinically appropriate for all specialties * Review all outpatient appointment patient cancellations for Cat 1 and 2 and Did Not Attends (DNAs) to ensure urgent cases are not missed * Patient screening at entry * Ensure Outpatient Website COVID-19 information and Health Pathways information aligns * Communicate changes to referrers in newsletters and the public in appointment letters |
| **Residential Aged Care**   * All sub-acute and interim care beds in rural medical facilities to be utilised to decant THS-S patients, when clinically appropriate * Ensure all inpatients that are to be transferred from an acute facility to a subacute facility, aged care home, group home have returned a COVID-19 test * Review alternative placement for patients in facilities external to THS |
| **Equipment, Supplies and Consumables (PPE)**   * Inventory of current equipment is available, identify gaps and risk assess for availability * Weekly review & monitoring of stock / orders / delivery dates * Locking down pandemic supplies, counting and escalating to Australian Government regarding shortages (Delays, non-delivery etc.) * Setup of additional storage spaces with COVID and Non-COVID areas * Securement of PPE pandemic store. Amendment to PPE use for Transmission Based Precautions and determination of exact use for COVID-19 positive patients * Managing working from home equipment shortages e.g. computers * Communication tools – e.g. mobile phones, walkie talkies, iPads / tablets (plus covers) to facilitate communication between COVID / non-COVID areas, patients and families. * Determining state-wide equipment supplies and consistency of availability. |
| **Hospital Avoidance Strategies**  Hospital Avoidance Strategies are aimed at reducing the burden on the hospital by redirecting patients that are not acute to alternate services.   * Increase in Community Rapid Response Service (ComRRS) to assist in self-isolation and follow-up * Working with PHS and Communities Tasmania to support patients in self-isolation being maintained in the community and to assist with the discharge of recovered COVID-19 patients. * Work activities underway to support/implement physical isolation initiatives across high-risk areas * Identified alternative accommodation for hospital staff co-habiting with suspected or isolated cases * Review district site/community nursing roles/capacity * Alternative models of care e.g. Telehealth, Telephone * Promote GP consultation and engagement to reduce COVID Positive presentations * Alerting community nurses and GPs to existing self-isolated patients (Nominated GPs of COVID@Home patients are automatically notified but patients who opt out of the program are not) * Facilitate Community Case Management for well COVID patients, including Community Case Management Facility beds and COVID@Home model of care. * Direct admission pathways for COVID-positive patients requiring admission. |
| **Hospital Infection Control Measures**  These measures are aimed at reducing unnecessary movement of people into the hospital. These strategies are part of COVID Safe Work Measures.   * Limiting visitors and / or ceasing access on all wards * Restrict hospital entry points to enable oversight of visitor flow / compliance with visiting hours * Restrict access to wards – swipe card access for designated COVID areas * Amendment to visitor policy and communication across organisation and community regarding this change * Establish consistent patient/visitor information across all facilities * Staff training and compliance with PPE * Staff allocated to either COVID or non-COVID areas * Environmental separation of COVID positive and Non-COVID patients across all ward areas * Non-essential access ceased * Any essential contractors screened * Change facilities for staff |
| **Staff management and planning**   * Vulnerable staff - identified and management plan * COVID Immunisation status identified * Staff Quarantine - as per public health guidelines * Contingencies (Identifying redeployment staff) * Emotional health and wellbeing awareness and support for staff * Staff education * Upskilling staff for different roles to usual * Review capacity for student placement/ roles * Staff flu vaccination program promoted to maximise adoption * HR input required re. redeployment, recruitment, leave * Cease volunteers   **Staff Recruitment**   * Plan to recruit above establishment numbers to enable prompt response to escalation |
| **Communication Management**  Daily staff updates  Regular staff forums Regional Health Commander/Nurse Director, Operations  Situation reports to RHEMT  Individual unit-based action plans and training  GP Briefing and increased email communication to ensure alignment with THS-S response and feedback is received to support RHEMT |
| **Private Hospitals**   * Advise Private Hospitals of Escalation Level * Commence joint preparations for private hospitals to accept public patients * Weekly meetings between THS-S and Private Hospitals to assist in joint planning and response |

## Level 3 Response

|  |
| --- |
| **Level 3 Response** |
| **Testing, Screening and Assessment**  **COVID-19 Respiratory Clinics**  Consider need for Respiratory Clinic expansion and mobile clinics activation as required providing assessment and management to assist in Emergency Dept attendance avoidance.   * Maintaining Pathology and Forensic Services capacity   + Reduction of outpatient clinic and elective surgery reducing demand   + Monitor mortuary holding capacity (25 at THS-S) |
| **Emergency Department Capacity**   * Emergency Specialist with a team of two junior doctors and two nurses rapidly assess patients and act to divert as many as possible out of the ED * Pathology, ultrasound and mobile x-ray undertaken in this zone when not able to be streamed directly into ED * When no appropriate clinical space in ED patients stream out to an external waiting area – positive (patients can be in a single area), suspect (patients need to be kept segregated) and low risk (patients can be collocated in a single area depending on the rate of COVID-19 in the community) * Referral pathways made available to patients who could be assessed by telemedicine services or via a primary care service close to the hospital where patients can be referred directly from ED * 4 Resuscitation patients – assumes bays with doors and negative flow * 18 ‘River’ Acute patients – assumes bays with doors and negative flow for positive and suspect cases * 10 ‘Mountain’ patients (4 paediatric and 6 ambulatory) – assumes bays with doors and negative flow in paediatrics * 12 EMU patients – assumes good ventilation in the current EMU floorspace |
| **Intensive Care Capacity** Once the capacity to manage positive COVID-19 patients is reached in the three negative pressure rooms and in the five DCCM Derwent side single rooms with McMonty hoods (as well as limited capacity at LGH ICU), implement plan outline below:   * + Non-COVID (Standard) ICU will relocate to 4K PARU – capacity of up to 25 beds, including 3 isolation rooms)   + COVID ICU will be all bed spaces in existing DCCM location (1D/H) – capacity of 23 beds * 24 ventilators on site and 16 transport ventilators. * 39 bedside ventilators in total (some stored offsite). * Transport ventilators will be utilised for a greater than standard 48-hour period.   + In addition to the ICU ventilation, THS South has the following in ED:   + • 5 Hamilton (+ 5 on order) transport ventilators operational.   + • 3 Oxylog transport ventilators operational   + • 3 Oxylog transport ventilators with Biomed (repairs) * Facilitate the onboarding of appropriate staff to enable the full use of ventilator capacity   Note: It requires approx. 100 FTE for 15 ventilated ICU beds at safe workforce standard levels.   * + Once ICU staffing support is exhausted draw upon general nursing staff, supported by ICU experienced nurses (2-3 patients with general nurse, supported by ICU nurse) Facilitate other equipment requirements including beds, infusion pumps, monitors, renal replacement machines). |
| **Inpatient ward reconfiguration with commissioning of K Block**  **Operationalise dedicated COVID-19 Ward**   * The establishment of an COVID-19 Isolation Ward will be achieved through transferring non-COVID-19 positive Ward K10W patients to a number of surgical wards * Capacity up to 18 beds (non-cohorting), or 32 beds (cohorting) * If K10W capacity is exceeded COVID patients will be housed in Ward K10E and then overflow to K9 wards * As per Business Continuity Sub Plans, only critical services will continue to be provided at Level 3. This includes:   + Renal Dialysis   + Oncology   + STEMI and Category 1 PCI and cardiac devices   + Acute Stoke   + Ambulatory Care Service   **Women’s and Children’s Services**   * COVID-19 area to be established in maternity, paediatrics ward and NPICU when capacity exceeded in dedicated COVID ward areas * COVID-19 positive mothers to remain with babies unless NPICU care required, due to the detrimental effects of separation for feeding and bonding * COVID areas clearly separate from non COVID patients in Paediatrics, Maternity and NPICU in K Block WACS area |
| **Surgical Services Response**   * Dedicated Theatres 8 and 9 for COVID-19 positive patients (Independent air circulation and Negative Pressure) * Patient transfer directly into theatre, recover in the theatre and transfer directly back to inpatient K-Block (COVID-19) ward using droplet transmission-based precautions * Comply with the number of air exchanges required (as published by CDC) before theatre can be cleaned and utilised again * Review all elective surgery and non-surgical procedures * Case by case consideration of Category 1 elective urgent cases * Reduced activity will allow for theatre staff to be redeployed to required area * HPH Surgical beds to be utilised for urgent elective surgery on non-COVID patients * Transfer urgent cardiothoracic and neurosurgical cases to Calvary Health Care * Recovery area used for non COVID ICU expansion. |
| **Outpatient Services Response**  Postpone or transition to telehealth all outpatient appointments with the exception of services focussed on admission avoidance, life sustaining medication, critical assessments supporting primary care/General Practice, cancer therapies, and maternity services.   * Continue to utilise and expand telehealth services where appropriate. |
| **Hospital Avoidance Measures**   * Telehealth Expansion * Community nursing continuing as an essential service * Community based options:   + COVID@Home   + Hospital in the home (HiTH)   + CommRS   + Expanded GP -consultant advice services * Expand Community Case Management capacity for mildly unwell COVID patients and those with circumstances which make it difficult to self-isolate. |
| **Hospital Infection Control Measures**   * No visitors (exemption to be provided by Chief Executive/Regional Health Commander only) or as per Public Health Directive or internal policy |
| **Hospital Transfers**  **Intrahospital Transfers**   * Decision to transfer patient to level 6 facility from level 4 and 5 facilities will be made on an individual basis. Current State-wide services delivered from the THS-S are:   + Burns   + Cardiothoracic   + Neurosurgery   + Major trauma   + Endovascular Clot Retrieval   + Paediatric Surgery   + Vascular Surgery   **Interstate Transfer patient**   * Transfer to other states for medical emergencies or care negotiated at a case by case level. Including, but not limited to:   + Organ Donation   + Stroke / Neurosurgical Intervention   + Major Spinal Cord Injury   + Paediatric / NICU transfers   + Oncology interstate treatment   + Major Burns |
| **Staff and Workforce**   * Audit compliance with Physical Distancing Measures * Manage vulnerable staff members in accordance with national and state guidelines * Enhance critical care training * Implement strategies to increase workforce capacity * Ensure staff returning to work following isolation or quarantine comply with the agreed return to work process * Implement strategies to manage staff illness and presenteeism * Implement strategies to increase workforce capacity * Enable workforce wellness and support program |
| **Private Hospitals**   * Private Hospitals invited to participate in the RHEMT * Non- respiratory ED presentations to be diverted to private ED’s * Utilise private hospitals as per Commonwealth National Partnership Agreement and purchasing agreements |

## Level 4 Response

|  |
| --- |
| **Level 4 Response** |
|  |
| Level 4 response will be activated upon level 3 response capacity being exceeded. This will normally occur when a facility/region reaches capacity to receive or manage patients which has been caused by patient numbers or staffing shortages. Once a facility reaches level 4, non-essential staff movement between wards and departments must cease.  Strategies to be considered if level 4 is reached include:   * Reconfiguration of the planned occupancy of K Block. * K10 West expands into K10 East – becoming a 39-bed (non-cohorting) / 64-bed (cohorting) COVID -19 ward * K10 East ceases to accept admissions and patients awaiting discharge * K9 becomes a further expansion for COVID -19 capacity * K8 remains as surgical and NPICU allows for appropriate social distancing * K7 Maternity COVID and Non COVID sections * K6 Paediatric COVID and Non COVID sections (Paediatric 26 bed COVID unit, adolescents18 bedded Non COVID unit) * K5 remains as CSSD * K4 (previously expansion of non-COVID ICU) becomes expansion of COVID ICU capacity, with deep clean of Main ICU to become a 23-bedded Non COVID ICU * K3 & K2 will be either COVID or Non COVID depending on numbers and 3J capacity for Mental Health * 2A & 6A allows further expansion of COVID -19 expansion wards. * Surgical NON COVID capacity will largely be through the private hospitals   Response for Level 4 beyond this point is managed by a State-wide response, with the surge capacity of all hospitals utilised to meet to meet both COVID and non-COVID patient demand. |

**Appendix1: Staff and Workforce**

**Staff Health and Wellbeing**

Staff have a responsibility to help prevent the spread of COVID-19 and all respiratory illnesses. Staff are directed to the COVID-19 website for up to date to date information on how to prevent the spread and protect themselves. The website can be located at: <https://www.coronavirus.tas.gov.au/keeping-yourself-safe/what-you-can-do>

[Healthcare Worker IPC Requirements during Coronavirus Disease 2019 (COVID-19) Pandemic](http://gormpr-cm01/pandp/showdoc.aspx?recnum=P20/438) guidelines should be read in conjunction with Safe Workplaces (COVID-19 Response) and COVID-19 safety plans to minimise the risk of COVID-19 transmission in the workplace.

A focus on the care and protection of staff is essential for staff wellbeing, to ensure a safe, sustainable workforce and to maintain high quality clinical care. It is recognised that health care workers will likely have an increased workload with a heightened anxiety both at work and at home.

It is important to be aware of staff physical and mental wellbeing. This pandemic is physically and mentally challenging for all staff and it is vital that they feel supported and cared for throughout. Communication across departments, hospitals and the wider community will be vital to ensuring maintenance of staff safety and quality of care. Staff support can be provided at a state-wide, regional and individual department levels.

Mental Health and Employee Assistance and Wellbeing resources are available at:

<http://www.dhhs.tas.gov.au/intranet/covid-19_staff_information>

<http://www.dhhs.tas.gov.au/intranet/corporate/human_resources/work_health_safety_and_wellbeing/worker_wellbeing_and_support/EAP> – Employee Assistance Program (EAP)

**Vulnerable Staff Members**

ANZICS COVID 19 guidelines recommend vulnerable staff should not enter the COVID-19 isolation area. This includes staff who are pregnant, have significant chronic respiratory illnesses or are immunosuppressed.

The international experience is that mortality is higher in older patients, particularly those with comorbidities related to cardiovascular disease, diabetes mellitus, chronic respiratory diseases, hypertension and malignancy. Staff member risk decisions should be made on a case by case basis by the unit director with the support of the local occupational health and safety unit. We recommend that vulnerable staff be reallocated to other roles and not enter COVID-19 areas.



[Australian Health Protection Principal Committee (AHPPC) advice to National Cabinet](https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-advice-to-national-cabinet-on-30-march-2020)

[Employee in Vulnerable Groups Declaration](https://www.dhhs.tas.gov.au/intranet/corporate/human_resources/employment/hours/working_from_home/working_from_home_covid-19/Employee_in_Vulnerable_Groups_Declaration_COVID-19.docx)

**Testing**

Notwithstanding the Public Health Testing Strategy, where a Health Care Worker seeks a COVID19 test (symptomatic or asymptomatic) they are able to contact the Central Hub and utilise dedicated Health Care Worker appointments to obtain a test.

**Return to Work**

This section will be updated based on Public Health advice in relation to vaccinated healthcare workers.

Where a Health Care Worker has tested positive for COVID19, clearance of Health Care Workers to return to work is to be based on Public Health advice.

It is important that staff feel both safe and confident to return to the workplace and their role.

To support this, Health Care Workers must undertake training through THEO that relates to infection control, hand hygiene and PPE.  The training can be found at:

<https://theo.dhhs.tas.gov.au/course/view.php?id=1197>

Correct use of PPE is a skill that requires practice. To ensure that staff understanding of the appropriate use of PPE is optimal it is recommended that the HCW:

* ask a ‘PPE Buddy’ to review their PPE use and/or to observe them next time they use PPE
* ask a colleague or nurse working in a clinical area to observe them as they utilise PPE and invite them to guide their practice
* contact the RHH Infection Prevention and Control Unit on 6166 8658 and discuss any questions that they may about PPE.

**Dual Employment and Staff Movements**

Currently there are many clinical staff within Tasmanian who are employed across a number of health facilities both in and across the public and private sector. In addition, staff within facilities can work across many wards and Departments.

Multiple employment will be managed from a risk perspective and in accordance with the escalation level under THS Escalation Management Plans and outbreak Management Plans.

The [COVID-19 DoH Workers in High-Risk Settings with External Employment Policy](http://gormpr-cm01/PandP/showdoc.aspx?recnum=P21/499) provides a mechanism to rapidly identify DoH staff working in defined DoH high-risk settings that are also working at other (private) hospitals, health and/or aged care facilities, to expedite the timely assessment of whether restrictions on additional external employment is required to minimise the risk of COVID-19 transmission.

**Increasing Workforce Capacity**

The following strategies will be used throughout all levels of escalation to increase workforce capacity to address workforce shortages resulting from COVID-19:

* Department of Health Register of Health Professionals Agency (Medical, Nursing, Allied Health)
* Australian Health Practitioner Regulation Register of Practitioners
* Utilising the student workforce across all disciplines
* Accessing the recently retired workforce, including through sub-register arrangements
* Redeployment options for clinical staff in non-clinical roles, and
* Identifying staff with previous ICU experience.

Accessing the Register:



**Appendix 2: Training**

**Enhanced Critical Care Training**

In order to support the nursing workforce to respond to the COVID-19 crisis, the Australian Government Department of Health is sponsoring access to SURGE – Critical Care courses. SURGE – Critical Care provides education for Registered Nurses on the necessary minimum knowledge and skills required to work in High Dependency or Critical Care settings, such as Intensive Care Units (ICU).

Critical to quality outcomes in Australian and New Zealand ICUs is availability of experienced Intensive Care staff trained to provide high-quality care for critically ill patients. The THS does not currently have adequate levels of staff to operationalised the additional ventilators purchased to meet possible increases in COVID 19 demand. Regions are currently staffed for 28 public ICU beds. To facilitate additional ICU workforce capacity an ICU workforce working group has been established with State-wide ICU representatives. A Workforce Training Proposal was submitted, and in January 2021 the Tasmanian Department of Health approved the release of funding to enable operational areas to deliver additional clinical ICU training programs. These programs will increase the number of appropriately trained staff to work in ICU to operationalise the State-wide ICU surge capacity plan. The programs are presently being conducted in all regions.

THS delivers a number of critical care training programs including the RHH Introduction to Critical Care Program and UTAS Post Graduate Critical Care. These programs will continue to be delivered subject to workforce shortages.

Additional training has been provided to pharmacists through the Society of Hospital Pharmacists, in order to increase the number of trained ICU pharmacists.

**COVID Training**

All staff should undertake training through THEO that relates to infection control, hand hygiene and PPE. The training can be found at:

<https://theo.dhhs.tas.gov.au/course/view.php?id=1197>

**Appendix 3: Infection Prevention**

Staff of **THS South** will follow existing protocols and guidelines to minimise transmission and protect staff, patients and the community.

[Tasmanian Health Service South Guideline Infection Control Management During COVID-19 Pandemic.](https://cm.health.local/pandp/showdoc.aspx?recnum=P20/175)

Infection prevention and control practices are a two-tiered system comprising ‘Standard Precautions’ and ‘Transmission-Based Precautions’ which minimise the risk of transmission of infectious agents to patients/clients, staff, contractors, students, volunteers and visitors.

Patients with suspected COVID-19 will be managed under standard and transmission-based contact, droplet and airborne precautions in accordance with the Hospitals South Infection Control Management During COVID-19 Pandemic Guideline. Precautions will be maintained until both the Respiratory PCR and SARS-CoV2 PCRs are negative, **AND** expiry of any quarantine period as prescribed by Public Health Services..

Patients with confirmed COVID-19 will be managed under standard and transmission-based contact, droplet and airborne precautions in accordance with the Hospitals South Infection Control Management During COVID-19 Pandemic Guideline. Precautions will be maintained until clearance has been guided by Public Health Services.

**Standard precautions**

Standard precautions including meticulous hand hygiene (5 Moments) are to be followed for all patients.

Staff should always observe cough etiquette and respiratory hygiene. Patients/clients are to be instructed in appropriate cough etiquette and respiratory hygiene and supported and encouraged to adopt these strategies.

Soiled linen and waste may also represent a risk for transmission. Management of these items if to be in accordance with established guidelines and protocols

Environmental hygiene is recognised as a key component to minimise the risk of transmission. Schedules for cleaning will be implemented in accordance with relevant documents, including Statewide and local protocols and guidelines

**Transmission-Based Precautions**

Transmission-Based Precautions (TBP) are used in addition to Standard Precautions and are a combination of measures used to prevent transmission of specific infectious agents that may not be contained by Standard Precautions alone. Transmission-Based Precautions are applied to patients/clients suspected or confirmed to be colonised or infected with agents transmitted by the contact, droplet or airborne routes.

**Suspected or confirmed COVID-19 case Personal Protective Equipment (PPE)**

Patients with suspected or confirmed COVID-19 are to be managed in accordance with the Hospitals South Infection Control Management During COVID-19 Pandemic Guideline. This includes, at minimum, the following PPE:

* P2/N95 mask
* Approved protective eyewear or face shield
* Long-sleeved fluid impervious gown and
* Medical examination gloves

The sequence for putting on (donning) and removing (doffing) PPE is designed to reduce the risk of contamination to staff. All staff caring for patients with COVID-19 are required to be trained in the correct use of PPE. Staff are encouraged to have a PPE ‘buddy’ to support correct donning and doffing of PPE. A PPE ‘buddy’ can be any person who is familiar with and confident in the use of the required PPE. Doors signs will be displayed in agreed prominent locations both inside and outside the patient room, including in the anteroom where available, to act as a guide to consistent practices.

**Fit-Check/Fit-Test**

As legislated within the Tasmanian WHS Regulations, managers and supervisors must ensure that PPE (including P2/N95 masks) is appropriately selected for use to minimise risk to employee health and safety.

Managers and supervisors have a responsibility to ensure that:

* PPE is suitable, having regard to the nature of the work and any hazard associated with the work; and
* PPE is of suitable size and fit; reasonably comfortable for the employee who is to use or wear it; and
* staff have been provided with information, training and instruction regarding its proper use.

Fit-checking is the minimum standard at the point of use for healthcare workers using P2/N95 masks. Fit-checking involves a quick check each time the mask is put on, to ensure that the mask is properly applied, that a good seal is achieved over the bridge of the nose and mouth that and there are no gaps between the mask and face. No clinical activity should be undertaken until a satisfactory fit has been achieved via the fit-check process.

To support staff in the safe and correct use of PPE, including P2/N95 masks, all staff should undertake training through THEO. The training can be found at:

<https://theo.dhhs.tas.gov.au/course/view.php?id=1197>

THS/Hospital South Fit Testing Guideline provides information and guidance to employees and employers regarding the THS/Hospital South Fit Testing Program for healthcare workers that require the use of disposable particulate filter respirators (PFR) (e.g. P2 or N95 masks or respirators) for transmission-based infection control precautions.

To support staff in the safe and correct use of PPE, including P2/N95 masks, the following resources are available:

[Tasmanian Public Health Service PPE Demonstration Video](http://www.dhhs.tas.gov.au/publichealth/tasmanian_infection_prevention_and_control_unit/healthcare_worker_education/proper_use_of_personal_protective_equipment)

[P2 (N95) Mask Fit Checking (fact sheet)](https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/infection-prevention/transmission-precautions/p2n95-mask)

THS South Fit Testing Guideline provides information and guidance to employees and employers regarding the THS/Hospital South Fit Testing Program for healthcare workers that require the use of disposable particulate filter respirators (PFR) (e.g. P2 or N95 masks or respirators) for transmission-based infection control precautions.

**Intra-hospital Transfer**

If transfer outside of the room is essential, the patient should wear a surgical mask during transfer and follow respiratory hygiene and cough etiquette. If patient transfer requires the use of the lift, then no other patient or other staff (i.e. not acutely attending to the patient) should occupy the lift.

All staff attending should wear the following PPE:

* P2/N95
* Face shield or goggles
* Long-sleeved gown
* Disposable non-sterile glove

Staff are to comply with the [**Transfer of Suspected or Confirmed COVID-19 Adult and Paediatric Patients within The Royal Hobart Hospital**](http://gormpr-cm01/pandp/showdoc.aspx?recnum=P20/172)guidelines when transferring suspected or confirmed COVID-19 patients between clinical areas of the Royal Hobart Hospital. This applies to Paediatric and Adult patients, with separate guidelines for newborn patients transfers.

**Physical Distancing Measures**

Physical distancing is another strategy which will be adopted in conjunction with infection prevention and control measures to stop or slow the spread of infectious diseases. It means reduced contact between people.

Physical distancing is important because COVID-19 is spread by close contact with an infected person, or by contact with droplets or aerosolised particles from an infected person's respiratory tract.

In the context of COVID-19 physical distancing is defined as 1.5 metres or greater physical separation. Ensuring appropriate physical distancing measures for staff, patients, visitors and others who may enter healthcare settings is essential across all escalation measures. However, as the situation escalates, additional physical distancing measures will be put in place.

The COVID-19 Safe Workplaces Framework supports businesses and workplaces in Tasmania to continue to operate, or reopen, while protecting Tasmania's health and safety during the COVID-19 pandemic.

The Framework is made up of three key parts:

* Minimum standards to manage the ongoing risk of COVID-19 in workplaces. These have been established as a new regulation in the Work Health and Safety Regulations.
* COVID-19 Safe Workplace Guidelines to provide more detail on how sectors and workplaces can meet the minimum standards.
* COVID-19 Safety Plans to outline how each workplace complies with the minimum standards.

Safe Work Plans are in place in all areas and will need to be maintained and reviewed as the Pandemic progresses.

More information on the COVID-19 Safe Workplaces Framework can be located at:

<https://worksafe.tas.gov.au/topics/Health-and-Safety/safety-alerts/coronavirus/covid-safe-workplaces-framework>

**Reporting COVID-19 related Safety Events**

It is necessary to track related events to support accurate and consistent reporting. All related events should contain COVID-19 in the event description. This will assist the organisation to easily identify and investigate events where a patient or staff member has been exposed to the coronavirus in the health care setting or a break in Infection Control practice has occurrent.

All COVID-19 related SRLS incidents will be reviewed on a regular basis by key stakeholders, with improvement actions and escalation of issues as relevant.

Please see link below for details on reporting SRLS COVID 19 incidents including WHS exposure.

<http://www.dhhs.tas.gov.au/intranet/ths/patient_safety_service/images_and_files/SRLS_Update_-_Reporting_COVID-19_related_Safety_Events_Factsheet.pdf>

**Appendix 4: Outbreak Management**

Outbreaks of transmissible infectious pathogens in healthcare facilities have the capacity to cause significant disruption to service delivery and can pose a risk to healthcare workers, patients and visitors. The early detection and appropriate management of transmissible infectious pathogens is critical to minimise the impact of these events.

Relevant frameworks and supporting documents include:

* [COVID-19 Case and outbreak management framework for Tasmanian Settings](https://cm.health.local/pandp/showdoc.aspx?recnum=P20/586)
* [Tasmanian Health Service: Outbreak Management Plan](file:///C:\Users\sayre\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\Y3OB1GJ9\•%09https:\cm.health.local\pandp\showdoc.aspx%3frecnum=P20\281)

These documents clearly describe:

* THS command, control and coordination arrangements and alignment with the Tasmanian Emergency Management Arrangements (TEMA) and Tasmanian Health Action Plan for Pandemic Influenza (THAPPI)
* Roles and responsibilities, and
* Broad strategies for the mitigation, preparedness for, response to and recovery from an outbreak in THS facilities and services, within the broader Tasmanian and national emergency management arrangements.

**Contact Tracing**

The World Health Organization (WHO)characterises Contact Tracing as the process of identifying, assessing and managing people who have been exposed to a disease in order to prevent onward transmission. To assist in timely identification of close contacts and to support the implementation of control measures, such as quarantine, for close contacts, contact tracing capacity will be in place in each region of the THS.

Local guidelines will be in place to provide a framework for contact tracing within the Tasmanian Health Service (THS) when a case of COVID-19 is detected in a THS service or facility. Staff within the THS regions will be trained in contact tracing to support this activity in the event of an outbreak. Hospitals South have a COVID-19 Contact Tracing Guideline, this document will be maintained to meet requirements in consultation with Public Health Services.

**Appendix 5: COVID-19 Patient Transfers Between Hospitals**

All THS staff must comply with the practice detailed herein. This includes junior and senior medical staff, nursing staff, and bed management staff involved in coordinating the transfer, acceptance and admission of adult and paediatric patients that are either confirmed, probable or suspect cases of COVID-19, as per Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units (COVID-19 SoNG) (hereafter referred to as COVID-19 patients).

Admission to Hospital should occur with minimal transfer locations. Cases in the community requiring admission should do directly to the COVID ward, avoiding the Emergency Department.

This COVID-19 Patient Transfer Protocol should be read in conjunction with other relevant THS patient transfer protocols, including clinical condition specific protocols.

The Private Hospitals in Hobart are designated as COVID free hospitals at escalation levels 1-3

**Overarching criteria for transfer**

Medical Goals of Care (MGOC) for each patient should guide the decision on whether a transfer should occur. MGOC for COVID-19 patients are to be developed in line with protocols in place in each THS region.

Transfers of COVID-19 patients with a MGOC A are to be approved, with transfer occurring in line with the process outlined in section 3.

Transfers of COVID-19 patients with a MGOC other than A are through agreement of transferring and receiving clinicians, with transfer occurring in line with the process outlined in Section 3 of the protocol.

This requirement recognises the increased risk in transferring COVID-19 patients.

The transfer destination is based on clinical need and the nearest required clinical service. ICU bed availability will not be taken into consideration unless there is a choice of hospitals providing the required clinical service that can be reached within a clinically appropriate timeframe.

**Intra-hospital Transfer**

**See Appendix 3**

**Appendix 6: Hospital Avoidance Measures**

**Private Hospital Utilisation**

The National Partnership Agreement for COVID19 provides funding viability for private hospital and that states will enter into agreements with private hospitals requiring that private hospitals accept patients as directed by states.

The National Partnership Agreement has been signed and is in effect. The NPA allows the state to utilise the following bed capacity to respond to COVID 19.

|  |  |
| --- | --- |
| **Hospital** | **Bed Capacity** |
| Hobart Private Hospital | 71 |
| Calvary North (two hospitals) | 65 |
| Calvary South (two hospitals) | 80 (+ 11 ICU) |
| North West Private Hospital | 12 |

**Management of COVID-19 Cases in the Community**

This should be undertaken as per the Model of Care for Management of Positive COVID-19 Cases in the Community. This model outlines the clinical care arrangements and public health requirements for positive COVID-19 clients to be managed in the community including home isolation with COVID@Home support and Community Case Management Facilities across Tasmania.

**Hospital in the Home (South)**

The Hospital in the Home (HITH) provides acute care for inpatients in their home, including Residential aged care facilities.  HITH is a joint initiative of the Community Rapid Response Services ComRRS) and the General Medical Unit at the RHH.  The HITH ward opened with 4 beds on 20 April 2020 and increased to 12 beds by 1 July 2020.

Patients can be admitted and transferred to HITH from the Emergency Department or transferred to HITH during an admission to another ward. Patients must be referred by a medical consultant who identifies that the admitted patient care required is suitable to be delivered in the patient’s home. To be eligible for the HTIH you must:

1. Meet the criteria of an admitted patient
2. Be eight years or older
3. Be clinically stable
4. Have appropriate support to be managed safely at home
5. Consent to receiving their acute care at home
6. Should not be suitable for non-admitted alternatives for care (e.g. ComRRS, OPAT, Specialist Palliative Care, ACC, Community Nursing, Primary Care)
7. Live in a 30-minute radius of the Glenorchy Health Centre
8. Have a place of residence that is safe (for patient and staff), accessible for crisis care and with adequate communication facilities and access to transportation.

More information on the HITH program can be found at: <http://www.dhhs.tas.gov.au/intranet/stho/ceo/group_director_clinical_operations/seo/projects/hith>

**Appendix 8: Clinical Support Strategies**

**Ambulance Tasmanian Deployment Clinical Assistance Team (DCAT)**

The DCAT is intended to:

* support Tasmanian hospitals in caring for critically unwell and injured patients in case of overwhelming surge or staffing shortages due to illness, and
* facilitate timely medical retrieval of critically ill cases between facilities in order to level clinical demand across the state.

**Partnership with Private Hospital**

Tasmania has established private sector viability guarantee agreements with Private Health facilities. This may support patient transfers or reallocation of services to facilitate Tasmania’s response to increased demand pressure due to the COVID 19 pandemic.

**AusMAT - Australian Defence Force**

The Australian Defense Force (ADF) AusMAT have the expertise, knowledge and experience in Disaster Management to aid and support communities in need. The decision to engage the ADF support is through consultation and communication between the Commonwealth and State Governments, and will be coordinated via the COVID Control Centre.

**Appendix 9 – Increased ICU Capability**

The Statewide [THS - Intensive Care Surge Capacity Plan](https://cm.health.local/pandp/showdoc.aspx?recnum=P20/341) outlines how ICU capability will be increased.

**Appendix 10 – Pharmaceutical Supply**

Tasmanian Health Service Statewide Hospital Pharmacy has:

* Increased medication stock holdings of all relevent medications to 12 weeks stock on hand.
* Determined specific COVID medication requirements to maintain a strategic stockholding based on forecasting & actual usage

The strategic stockholding of COVID medication is based on 80 patients requiring ICU admission and ventilation for a period of 11 days (mean length of stay).

The strategic stock hold of COVID medication is maintained separate to the medications that are supplied for elective surgery.  This ensures the ability to rapidly respond to an escalation in the volume of cases requiring ICU admission and ventilation.

**Appendix 11 – Access to State Emergency Medical Stockpile (SEMS) Personal Protective Equipment (PPE)**

The SEMS has been established to increase the capacity of the Department of Health (DoH) to respond to Tasmanian public health system demands for PPE.

The SEMS will be utilised :

* when there are shortages of PPE in the Tasmanian public health system, either due to:
* increased usage resulting from an outbreak, epidemic or pandemic; or
* a disruption in the supply chain (e.g. manufacturing issues or goods have been lost in transit).
* for the supply of PPE to State, Australian Government and contracted agencies engaged in border control activities, from point of entry into Tasmania to release from hotel quarantine;
* for the supply of PPE to Government agencies engaged in the control of ports receiving freight; and
* for the emergency supply of PPE to private residential aged care service providers.

In the event that SEMS product volumes are insufficient or assessed as likely to be insufficient to address PPE demands, the DoH will request access to the Australian Government’s National Medical Stockpile, through the Tasmanian Chief Medical Officer.

Requests for the emergency supply of PPE to private residential aged care service providers will be managed through the DoH’s Emergency Coordination Centre / Aged Care Emergency Operations Centre in partnership with the Australian Government.

Requests to the DoH and subsequent need to draw on the SEMS for other purposes, will be considered on a case by case basis and the authority to draw upon the SEMS in these instances will be provided by the Secretary.

**Table 1: PPE Products in the SEMS**

|  |
| --- |
| Description |
| **Masks** |
| Surgical masks |
| N95/P2 Respirator suitable for surgical use |
| **Gowns** |
| Impervious gowns |
| Surgical gowns |
| Chemotherapy gowns |
| **Gloves** |
| Long-cuff examination gloves |
| Examination gloves |
| Sterile surgical gloves |
| **Other Items** |
| Eye Protection – frames and lenses |
| Eye Protection – goggles |
| Face shields |
| Aprons |
| Coveralls |
| Hospital grade hand sanitiser |
| Surgical caps |
| Shoe covers |
| Thermometers |
| Thermometer probes |
| Wipes |

**Storage**

The SEMS is stored under a contractual arrangement with Tasmanian Storage and Logistics, Rokeby. The Director Finance and Procurement is responsible for approving changes to the storage location.

**Access and Requests**

The Statewide Supply Manager is responsible for assessing the request in the first instance.

Requests to access SEMS PPE must be made using standard form available from the following email: [dfp@ths.tas.gov.au](mailto:dfp@ths.tas.gov.au)

Internal (Tasmanian Health Service) requests should only be made following consultation with the relevant local Supply Team and confirmation from them that there is no “business as usual” stock of the required PPE items.

The following information must be provided:

* requesting area
* reason for request
* products and quantities required
* cost centre
* location(s) for delivery
* timeframe for delivery
* risk(s) if request is not approved, and
* details of the staff member making the request.

**Appendix 11 - Winter Strategy**

**THS COVID-19 Winter Planning Support**

The Department of Health will lead a heightened response for the 2022 winter period which includes:

* Increased COVID and Influenza vaccination access particularly for vulnerable cohorts
* Increased levels of community testing to detect influenza and COVID and ensure timely and accurate treatment
* Increased hospital avoidance and primary care support through alternate care pathways including:
  + COVID@Home+ supporting Primary Care Practitioners
  + GP-Led Respiratory Clinics
  + Case Management Facilities
  + Government Managed Accommodation Facilities
* Continuing to build and maintain COVID and influenza medication treatment stockpiles and increase availability, including through pre-positioning.

[Winter Strategy | Tasmanian Department of Health](https://www.health.tas.gov.au/about/what-we-do/strategic-programs-and-initiatives/winter-strategy)

COVID-19 prevention and management strategies implemented throughout the THS during the pandemic support flu prevention and winter management strategies for staff, visitors and patients in THS hospitals and facilities eg physical distancing, mask wearing, hand hygiene.

**Hospital Bed Capacity**

Expanded hospital bed capacity, as described in the above Summary of COVID-19 Statewide Surge Capacity (page 21), has been established to respond to COVID-19 and will be maintained across winter 2022 to meet both COVID and non-COVID demand, including Influenza admissions. Monitoring of bed closures will occur to ensure safe staffing levels and maximum availability. Staff absence will be monitored daily to inform response.

Each region has its own patient access and flow processes in place to manage daily and seasonal demand and oversee patient access and flow improvements.

**Outbreak Management Planning**

Each region has an up-to-date facility Outbreak Management Plan that provides staff information on measures to implement to interrupt transmission of outbreak agents as quickly as possible and prevent additional cases, particularly outbreaks of gastrointestinal or respiratory pathogens. This document references both COVID-19 and influenza.

**Screening**

All staff, patients and visitors must complete electronic screening questions to assess the risk of exposure to other staff, patients and visitors of contracting COVID-19. This screening tool can be modified to include additional flu related questions if required. The current question set would not permit entry to facilities of persons with flu-like symptoms.

**Testing**

PCR testing of hospital inpatients for COVID-19 will also include testing for other respiratory illnesses if indicated.

**Vaccination**

All staff and volunteers are offered influenza vaccines and are strongly encouraged to participate in this program. Vaccination rates will be monitored with appropriate targets set for staff. Vaccination will be mandatory for THS staff working in residential aged care facilities.

**Respiratory Safe Behaviour Target**

COVID-19 safety behaviours including respiratory and hand hygiene and physical distancing can all be applied to influenza-like illness.

Signage throughout facilities related to COVID-19 will remind staff, visitors and patients to adhere to these behaviours.

1. [COVID-19 Mortality | Australian Bureau of Statistics (abs.gov.au)](https://www.abs.gov.au/articles/covid-19-mortality-0#deaths-due-to-covid-19-in-australia) as at 31/8/20 [↑](#footnote-ref-2)
2. [Department of Health | Coronavirus Disease 2019 (COVID-19)](https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm) [↑](#footnote-ref-3)
3. [Tasmanian Emergency Management Arrangements Issue 1 (d2kpbjo3hey01t.cloudfront.net)](https://d2kpbjo3hey01t.cloudfront.net/uploads/2020/02/DPFEM-TEMA-Issue1-13-Feb-2020-DIGITAL-ART.pdf) [↑](#footnote-ref-4)
4. Department of Health COVID-19 Emergency Coordination Centre Operating Guidelines, 9 March 2020 [↑](#footnote-ref-5)
5. [COVID-19 Emergency Coordination Centre | DHHS and THS Intranet (health.tas.gov.au)](https://www.health.tas.gov.au/intranet/ecc) [↑](#footnote-ref-6)