

SDMS Number: P20/339

THS Hospitals – North

COVID-19

Escalation Management Plan

May 2022

Version 5.0

# Version Control

| **Version Number** | **Creation Date** | **Description of Change** |
| --- | --- | --- |
| 1.0 | 3 April 2020 | Approved by the Secretary- Department of Health |
| 2.0 | 6 June 2020 | Approved by the Secretary, DoH |
| 3.0 | 19 November 2020 | Approved by the Secretary, DoH |
| 4.0 | 11 November 2021 | Updated standard sections across all Regional Plans and changes associated with vaccination and COVID-19 variants |
| 4.0 | 7 December 2021 | Approved by the Secretary DoH |
| 4.1 | 16 December 2021 | Update references to multiple employment consistent with the COVID-19 DoH Workers in High-Risk Settings with External Employment Policy. |
| 5.0 | 6 April 2022 | Updated Introduction and Internal Communications Methods  Update to Triggers and Actions across escalation Levels 1, 2, 3 and 4  ICU Surge Capacity and LGH ICU beds staffed  Update to Escalation Level Responses and LGH Bed Capacity for Levels 1, 2 and 3  Renumbering of Appendices 7 to 11  Updates to Appendices 1, 2, 3, 4, 5 and 11  Appendix 12 – Winter Strategy 2022 added |
| 5.0 | 13 May 2022 | Approved by Secretary - Department of Health |

We acknowledge and respect Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we work and live, and pay respect to Elders past and present. For around 40 000 years, Aboriginal people have lived on lutruwita/Tasmania, within strong and resilient communities. We acknowledge that as we work to strengthen resilience against COVID-19 across Tasmania.

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# Abbreviations

|  |  |
| --- | --- |
|  |  |
| 3R  4K  6D | Secondary COVID-19 Ward  Paediatric Ward  Medical Ward with Negative Pressure Room |
| ACAT | Aged Care Assessment Team |
| AMU  ARI | Acute Medical Unit  Acute Respiratory Infection |
| ATEOC | Ambulance Tasmania Emergency Operations Centre |
| BCP | Business Continuity Plan |
| CDC | Centres for Disease Control and Prevention |
| CDNA | Communicable Disease Network Australia |
| CNC | Clinical Nurse Consultant |
| ComRRS | Community Rapid Response Service |
| DNA’s | Did Not Attends |
| DoH | Department of Health |
| DPU  ECC | Day Procedure Unit  Emergency Coordination Centre |
| ED | Emergency Department |
| EDMS  EMU | Executive Director Medical Services  Emergency Management Unit |
| EOC | Emergency Operation Centres |
| GP | General Practitioner |
| HALT  HDU | Hospital Aged Care Liaison Team  High Dependency Unit |
| ICU | Intensive Care Unit |
| ID  ILI  IOC  IPCU | Infectious Disease  Influenza Like Illness  Integrated Operations Centre  Infection Protection and Control Unit |
| JLG  LGH  MCH  NCCU  ND  NDIS | John L. Grove Unit  Launceston General Hospital  Mersey Community Hospital  Northern Coronary Care Unit  Nursing Director  National Disability Insurance Services |
| NHMRC | National Health and Medical Research Council |
| NWRH  OPS | North West Regional Hospital  Outpatient Department |
| PACU  PFU | Post-Operative Care Unit  Patient Flow Unit |
| PHEOC | Public Health Emergency Operations Centre |
| PMI | Patient Master Index |
| PPE  PTAS | Personal Protective Equipment  Patient Travel Assistance Scheme |
| RHC  RHEMT-N | Regional Health Commander  Regional Health Emergency Management Team – North |
| RHH | Royal Hobart Hospital |
| SARS-CoV-2 | Severe Acute Respiratory Syndrome Coronavirus 2 |
| SCC | State Control Centre |
| SoNG  SSSU  TBP | Series of National Guidelines  Short Stay Surgical Unit  Transmission-Based Precautions |
| TEMA | Tasmanian Emergency Management Arrangements |
| 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%[[1]](#footnote-1) per cent. A small number of people experience long term effects from the disease known as   
‘long-COVID-19 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[[2]](#footnote-2).

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.

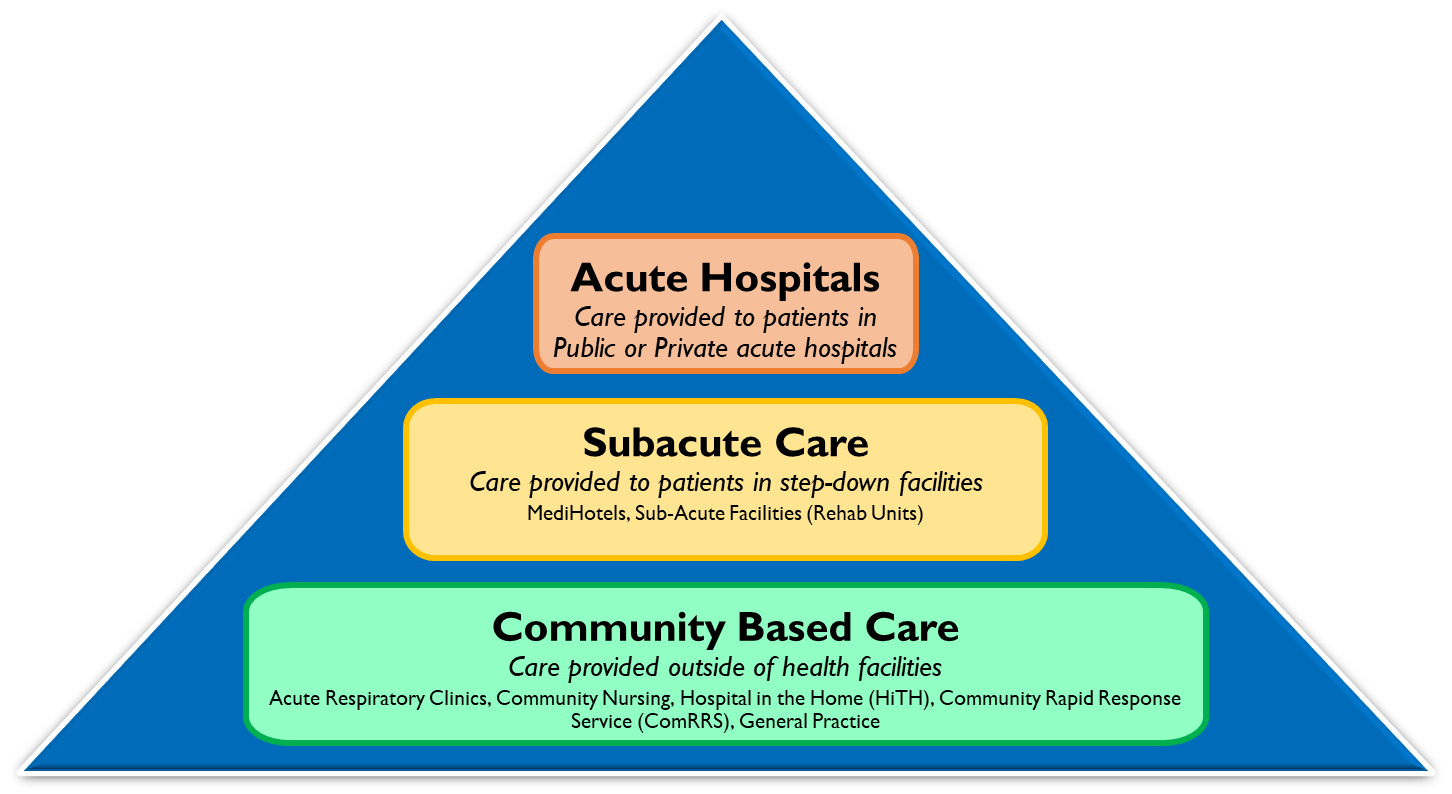
As the pandemic unfolds, SARS CoV-2 has become more divergent, and a number of these divergent strains have been designated as variants of concerns (VoC) by the World Health Organisation and in Australia by the Communicable Diseases Genomic Network. A variant of concern contains mutations that impact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

The short infectious period and high transmissibility of SARS CoV-2 place significant burden on public health resources and contract tracing. The newer variants are 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)[[3]](#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 – Commissioner of Police– in close liaison with Secretary of the Department of Health and Director of Public Health.

The THS Hospitals - North 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 THS- North 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 Hospitals North 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 Hospitals North command, control and coordination arrangements for COVID-19.
* Outline the actions that the Hospitals North region will undertake to prevent disease transmission between staff, patients and visitors.
* Clarify the roles and responsibilities across the Hospitals North and partners for the response to and recovery from a COVID-19 pandemic.
* Assist all sites and campuses of the Hospitals North to manage COVID-19 effectively including management of outbreaks.
* Outline the 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 provide communications to local stakeholders with frequency dependent upon escalation level.

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 Hospitals North 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)[[4]](#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[[5]](#footnote-5),[[6]](#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 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.
* 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.

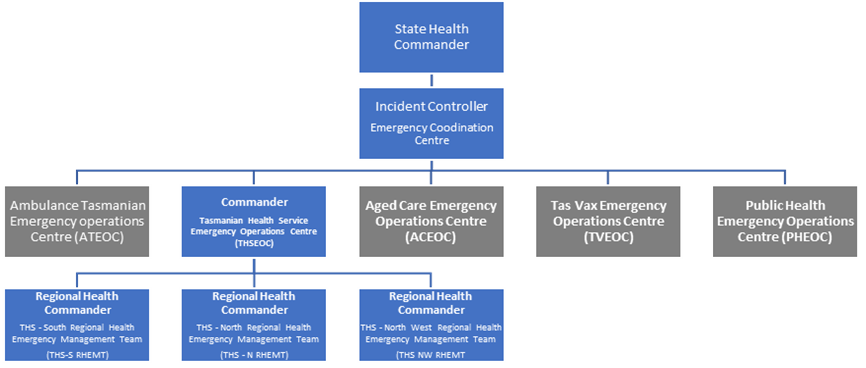
**Ambulance Tasmania Emergency Operations Centre (ATEOC):** responsible for the coordination and management of Ambulance Tasmania COVID-19 response operations and consequence management.

**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-19 vaccine rollout. THS Operating Model

**THS Operating Model:**

The below model outlines the operating model for the Department of Health, with THS COVID-19 Response elements in blue.



## 

## **Hospitals North Local Response**

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

The RHEMT-N supports progression of the actions outlined in the plan: identify risks, develop mitigation strategies and escalate as appropriate.

The membership of the RHEMT-N includes:

* Regional Health Commander / Executive Director Medical Services
* Chief Executive Hospitals North/North West
* Executive Director of Nursing
* Director of Operations
* Director Allied Health
* Nursing Director Pandemic Response
* Nursing Director - Women’s & Children’s Services
* Clinical Director - Women’s & Children’s Services
* Nursing Director – Northern Cancer Service
* Nursing Director – Critical & Acute Inpatient Services
* Clinical Director – Department of Medicine
* Nursing Director – Integrated Operations
* Nursing Director – Surgical & Perioperative Services
* Clinical Director – Surgical & Perioperative Services
* Nursing Director – Sub Acute & Ambulatory Care Services
* Nursing Director – Primary Health North
* Staff Specialist – Infectious Diseases Physician
* Director - Corporate Services
* Nurse Manager – Infection Prevention and Control Unit
* Manager ICT THS/Hospitals North
* Manager – House Services / Medical Orderlies / Security Services
* Emergency Management Coordinator
* Community Engagement and Communications Officer
* Northern Region GP Liaison
* Pharmacy Site Manager
* Human Resource Manager
* WH&S Advisor

**External Stakeholders**

External stakeholders are invited to join the RHEMT-N membership at increased escalation levels as determined by the Regional Health Commander to ensure a cohesive approach. This includes representation from:

* Calvary Private Hospital
* Ambulance Tasmania
* Tasmania Police
* Regional Emergency Management Committee
* Department of Health ECC Representative

The current objectives and priorities of the RHEMT-N are:

* Implementation of THS-N incident management arrangements
* Coordination of the implementation of departmental surge management plans
* Effective human resource management
* Effective engagement of THS partners
* Development of a logistics plan
* Development of internal communications plan
* Ongoing review of Infection Control Measures

The RHEMT-N is supported by five key subgroups:

* Operations & Planning (COVID-19 Operational Working Group)
* Clinical Planning
* Planning
* Logistics
* Communications and Media

The RHEMT-N has responsibility for nine District Hospitals, some of which include onsite Residential Aged Care Facilities which are subject to Commonwealth Government legislation. These facilities 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-N 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. | | | | |

# The triggers on their own do not mean an automatic change in level of response, however they are designed to allow the RHEMT-N to consider the need for an escalation in response.

\* Awaiting transfer to LGH

**Detailed Actions at each Level**

|  |  |
| --- | --- |
| **Level 1 Response-**  **‘Business as Usual’** | Level 1 is the Response ‘Business as Usual’ (BAU) Phase, which involves maintaining business continuity.  Facility   * Identify and prepare dedicated clinical spaces and equipment to treat infected patients in Emergency Department (ED), dedicated COVID-19 inpatient beds in wards and Intensive Care Unit (ICU), as well as the Community Case Management Facility (CCMF) and an outpatient HOT Clinic for consultations and treatments. * Ongoing review and implementation of COVID-19 Safety Plans[[7]](#footnote-7) * Screening for all staff and visitors as per THS EOC direction. * Visitor Restrictions as per THS EOC direction. * Arrange appropriate and consistent signage at entrances, screening desks, reception and waiting areas. * Ensure hand and respiratory hygiene stations at all entrances, reception areas, screening desks and common areas. * Maintain physical distancing practices in the workplace – monitor meetings, education sessions, workspace allocation and meal break areas. * Prepare to increase cleaning services for terminal cleans and frequent touch areas. * Review scheduled maintenance, capital works and regular deliveries to sites and assess if essential for these to continue if escalate to Level 2 response. * Prepare for Level 2 - closure of hospital kiosk and volunteer programs (excluding chaplaincy) depending on contained cases versus community/other transmission.   Staffing   * Plan and quantify staffing, additional resources and equipment requirements enabling an imminent Level 2 Response. * Provide regular information and education sessions to staff on latest variant of COVID-19 including transmission, signs and symptoms and risk minimisation reminding staff of their individual responsibility for monitoring their own health status and to isolate, get tested and not to come to work if experiencing any respiratory symptoms or feeling unwell. * Identify staff who meet the Vulnerable Persons criteria and plan alternative duties or working from home arrangements (risk assessment based) preparing for Level 2 response. * Ensure students are not located in COVID-19 suspected/positive zones unless by agreement with training institutions and compliance with Public Health directions. * Ensure 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 staff wellness strategies for physical and mental health. * Ensure district, primary health and subacute facilities have access to the education and training and are establishing processes to support the acute services in a Level 2 phase.   Patient Flow   * Comply with *Hospitals North COVID-19 Patient Transfer Guideline[[8]](#footnote-8)* for transfer of inpatients to RACF’s and other facilities. * Continue with business as usual in line with the Launceston General Hospital Escalation Management Plan.   PPE and Staff Training   * Continue education on PPE use, donning and doffing, competency assessment and auditing program– mandatory for all staff and repeated annually. * Review stock at least monthly and order additional supplies and equipment as required including PPE, hand hygiene products, cleaning and pharmacy supplies to ensure prepared for Level 2 response. * Plan and implement staff training to increase local contact tracing capacity.   Screening, Testing and Vaccination   * Staff to access off-site COVID-19 PCR testing locations[[9]](#footnote-9) operated by the ECC and encouragement of high levels of early PCR / RAT testing where the person meets epidemiological criteria or is symptomatic. * Screening stations at entry points to health services as per THS EOC directions.[[10]](#footnote-10) * Promote, encourage and facilitate all staff to obtain Commonwealth recommended doses of COVID-19 vaccination.[[11]](#footnote-11) * Ensure non COVID-19 vaccination (Influenza/Pneumovax and other respiratory vaccination) has been promoted.   Meeting Frequency and Communications   * Weekly THS EOC and weekly DoH ECC meetings. * RHEMT-N and COVID-19 Operational Working Group meetings if required. * Statewide PPE Working Party meetings as required. * Weekly PPE meeting to review supply issues and PPE availability. * Ensure regular communication and dissemination of information on emergency status and preparedness and containment strategies to all staff. * Weekly PPE meeting to review supply issues and PPE availability. * All meetings and gatherings to comply with physical distancing requirements.   De-escalation from Level 2 to Level 1occurs in accordance with agreed trigger points and RHEMT-N endorsement. |
| **Level 2 Response**  **‘Activation’** | Level 2 is the Response ‘Activation’ Phase, involving an operationalisation of some plans and actions in preparation for an escalation to Level 3.  Facility   * Limit access to hospital by closing some public entrances. * Visitor Restrictions – as per STHS EOC directions (in accordance with Public Health Directions). * Ensure all staff and visitors adhere to current Public Health Direction and/or THS policy for screening. * Enact use of COVID-19 mitigation equipment to treat COVID-19 positive patients. * All staff complete the Tasmanian Health Screening Tool questionnaire prior to entering the hospital each day. * Review outpatient department services with Telehealth clinics preferred. If to continue, confirm appropriate scheduling is in place to ensure physical distancing is maintained and risk reduction measures are in place. * Regular briefing to ECC re LGH capacity for ongoing emergency surgery. * Review all scheduled regular maintenance, contractor visits and delivery of goods to the site are deemed essential. * Review and update all ward/departmental COVID-19 Safety Plans.     Patient Flow   * Maximise non COVID-19 bed capacity within the LGH and District Hospitals with appropriate separation of COVID-19 and non COVID-19 patients and through transfer of appropriate non COVID-19 patients to alternate facilities (Private and District Hospitals provided demand does not relate to an outbreak). * Consider ‘Criteria led discharge’ of non-infected patients (wherever possible). * Consider relocation to alternative COVID-19 treatment locations (District Hospitals, private hospital, or Community Nursing). Ensure ID Physician and Public Health advice and any testing requirements are adhered to as part of discharge process. * Review LGH bed capacity management plan for COVID-19 patients. * Prepare for preservation of surgical and medical capability through engagement with private hospitals and day procedure facilities. * Prepare for continuation of medical activity only available in public sector (e.g., Interventional cardiology). * Consider NW COVID-19 patients requiring Critical Care or imminent ventilatory support. * Plan for potential repurposing of Transit Lounge when in Level 3. * Consider/prepare 3R for transition to secondary COVID-19 ward.   Staffing   * Planned staffing, rostering and management of additional resources and equipment requirements enabling an anticipated/imminent Level 3 Response. * Implement working from home arrangements when necessary and if required for non-clinical staff. * Allocate alternative duties or working from home arrangements for identified vulnerable staff[[12]](#footnote-12) as per ECC direction. * Ensure adequate, and appropriately trained, cleaning staff available to conduct terminal cleans and increase cleaning of frequent touch point areas and confirm ability to resource an imminent escalation to Level 3. * Ensure regular communication and sharing of updated information with all Hospitals North staff. * Ensure students are not located in COVID-19 suspected/positive zones unless by agreement with training institutions and compliance with Public Health directions.   Infection Prevention Control   * Acute Medical Unit activated as dedicated COVID-19 Adult Ward (secondary COVID-19 Ward is 3R); ED, ICU and Obstetric and Paediatric Wards mixed model with designated COVID-19 and non COVID-19 beds/zones. * Continue ongoing training and education on IPC and PPE practices, conduct competency assessments and complete site audits.   Meeting Frequency and Communications   * Weekly – Twice weekly THS EOC and DoH ECC meetings as required. * Weekly – Twice weekly RHEMT-N meetings as required. * Weekly – Twice weekly COVID-19 Operational Working Group meetings as required. * Communiques (via REACH) and sharing of updated information with all THS-N staff after each RHEMT-N meeting. Stakeholder briefings, memorandums, staff forums as required. * All meetings and gatherings to comply with physical distancing requirements – with preference to use TEAMS meetings. * Daily CCMF toolbox meetings chaired by Regional Health Commander (RHC) – this incorporates representatives from all areas with current COVID-19 inpatients, Nursing Director, Integrated Operations, Nurse Manager, Infection Prevention Control Unit, Infectious Diseases Physicians and Nursing Director, Pandemic Response. * Weekly PPE meeting to review supply issues and PPE availability. |
| **Level 3 Response** | Level 3 is the Response Phase, involving activation of strategies and actions to respond to an increase in COVID-19 presentations and inpatients that require treatment and/or increased numbers of furloughed staff.  **Escalation to Level 3 requires THS RHC approval.**  Facility   * Ongoing bed capacity management of COVID-19 dedicated areas. * Visitor Restrictions as per THS EOC directions unless by approved exemption. * Restrict access to clinical areas of hospitals to essential staff only - visitors and non-essential staff to be excluded. * Reduce elective activity in line with demand and capacity management. * All non-essential outpatient services and visiting health services to be suspended to minimise exposure, contain community transmission and ensure effective use of resources. Telehealth clinics to continue for identified specialties subject to staffing availability. * Maintain closure of hospital kiosk and remaining volunteer programs. * Planning for escalation Level 4 response.   Patient Flow   * Maximise non COVID-19 bed capacity within the LGH and District Hospitals with appropriate separation of COVID-19 and non COVID-19 patients and through transfer of appropriate non COVID-19 patients to alternate facilities (Private and District Hospitals provided demand does not relate to an outbreak). * Continue to outsource as much elective surgical/medical activity as possible to Private Hospitals and day procedure centres. Testing and screening of all admissions and transfers as per THS EOC direction. * Use alternative Critical Care areas to increase capacity for non-COVID-19 ventilated patients i.e., PACU and HDU. * Acute Medical Unit continues to be used for high acuity patients admitted with confirmed COVID-19. * Ward 3R to be activated for lower acuity COVID-19 positive patients and those de-isolated patients within 28 days of previous COVID-19 infection. * Obstetric and Paediatric Wards enact further zoning to receive increased numbers of COVID-19 patients. * Ensure capacity for NW COVID-19 patients requiring Critical Care or imminent ventilatory support. * Re-purpose Transit Lounge. * Utilise all district hospital capacity available.   Staffing   * Reallocate appropriately prepared clinical staff as required to COVID-19 * 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. * Staff working in clinical areas who wear N95/P2 masks should have completed fit-testing and have completed PPE training. * Conduct regular auditing of IPC practices and PPE donning and doffing. * Access State Emergency Medical Stockpile (Pandemic stock) as necessary.   Meeting Frequency and Communications   * Continue to ensure regular dissemination of communiques via REACH to all Hospitals North staff. * Minimum thrice weekly RHEMT-N Meetings. * Minimum twice weekly COVID-19 Operational Working Group. * Attendance at all scheduled THS EOC, THS ECC meetings. * Invite Private Hospital and other external stakeholder representatives on  RHEMT-N. * Regular briefing to ECC re LGH capacity for ongoing emergency surgery. * Ensure representation at all Emergency Operation Centre meetings and dissemination of information out to stakeholders.   Plan for anticipated / imminent Level 4 Response. |
| **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 to Level 4 requires approval from the State Health Commander.   * Move to whole of State System Response. * RHEMT-N provides seven day per week support.   Facility   * Facility to be closed to all visitors unless by exemption granted under Public Health directions by the Regional Health Commander or delegate. * Closure of elective services as required and notify the general public and clients of any cessation of services. * Follow Outbreak Management Plan if relevant situation. * Increase capacity utilising temporary health facilities such as field hospitals if deployed under statewide response.   Patient Flow   * Maximise non COVID-19 bed capacity within the LGH and District Hospitals with appropriate separation of COVID-19 and non COVID-19 patients and through transfer of appropriate non COVID-19 patients to alternate facilities (Private and District Hospitals provided demand does not relate to an outbreak). * Testing and screening of all admissions and transfers as per THS EOC direction. * Prepare for receipt of COVID-19 patients from other regions and/or facilities as directed through the ECC and THS EOC.   Staffing   * Seek assistance from external health care providers. * Staff testing in line with Public Health and THS EOC direction.   Meeting Frequency and Communications   * Daily Clinical Stakeholder Briefings, THS EOC (weekdays), THS ECC (weekdays) and as required. * Maintain communication and sharing of information with all staff members in collaboration with ECC. * Closure of service notification via ECC/Health Commander and Media Outlets to be coordinated centrally.   Notify the public and clients of cessation of local services. |

# Summary of COVID-19 Statewide Surge Capacity

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **South** | **North** | **North West** | **Statewide** |
| COVID-19 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 | 50 | 25 | 0 | 75 |
| Capacity to manage COVID-19 positive patients in the community3 |  |  |  | 2 500 |

1. These numbers may vary based on input variables factors, including workforce availability.
2. Planned capital works may temporarily affect these numbers.
3. Work is currently underway to develop a model of care for the management of COVID-19 positive patients in the community. This number is indicative based on the number of monitoring devices currently purchased. MOC work will continue which will impact final model capacity.

**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 | 11 | 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

Hospitals North staff can refer to Unit Level Action Plans for more detailed information on the actions required at each escalation level.

Visit [Coronavirus disease (COVID-19)](https://www.coronavirus.tas.gov.au/) for Current Situation.

## Level 1 Responses - Business as Usual

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| **Level 1 Response - ‘Business as Usual’** |
| * Maintain business continuity in line with THS Escalation Principles (‘Business as Usual’). * Plan and quantify staffing, additional resources and equipment requirements enabling an imminent Level 2 Response, including development of a reserve staff register. * Watching brief on current situation including Public Health Directions restrictions and testing. * Identification and training of staff to deploy for contact tracing. * Review and amend Outbreak Management Plans and other Pandemic related documents. * Regular Training on COVID-19 Code Blue, COVID-19 Intubations, Donning & Doffing, fit testing and checking. * Monitor mandatory COVID-19 staff and contractor (essential visitors) vaccination requirements. * Other measures detailed under Level 1 Business as Usual * PPE to be worn by staff and visitors as per THS EOC/Public Health state directions. * Patient screening and testing for ED presentations, outpatient and elective surgery as directed by THS EOC/Public Health. |

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# LGH Bed Capacity Plan – Level 1

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Ward/Department** | **Trigger/s** | **Beds Available for COVID-19 positive patients** | **Business as Usual** | **Comments** |
| ***Ward 6D*** | 1-2 ward admissions | \*2 negative pressure rooms | Continues for remaining beds |  |
| ***Acute Medical Unit*** | >2 ward admissions | 16 beds | Until decant | If Ward 6D beds deemed not required  When required to decant non COVID-19 patients transferred to other LGH wards, Calvary Medical Ward or District Hospitals. |
| ***Medical Wards (3D, 4D, 5D)*** |  |  | Continues |  |
| ***Ward 3R*** |  | 26 | Continues | Can be activated within 24 hours or utilised for patients de-isolated within last 28 days |
| ***Subacute*** |  |  | Continues |  |
| ***Surgical Wards (5A, 5B)*** |  | \*2 negative pressure  Works in planning phase (awaiting works in April 2022). | Continues |  |
| ***Ward 4B*** | Women in labour | 2 negative pressure rooms | Continues for remaining beds | Air purifiers to be used in non-negative pressure rooms. |
| ***Ward 4O*** |  |  | Continues |  |
| ***Ward 4N*** |  | \*1 negative pressure room | Continues | To be used for  COVID-19 positive newborn who has been separated from Mother. |
| ***Ward 4K*** | >1 paediatric/adolescent patients  6 pts: | 2 negative pressure rooms  Patients move into zoning plan will require installation of hording - 7 beds available.  Rezoning and separation of adolescent area from 4K - 17 beds will become available for paediatrics and postnatal women if unable to D/C home; This occurs in preparation for Level 2 Response. | Continues for remaining beds | Air purifiers to be used in non-negative pressure rooms. |
| ***Emergency Department*** |  | 2 negative pressure isolation rooms.  EDOT and plaster room with air purifiers and/or McMonty hood.  Plus cubicle 37/38 as overflow. | Continues for remaining beds | Suspected COVID-19 patients to be managed with transmission-based precautions. |
| ***Intensive Care Unit*** |  | 2 negative pressure rooms = 4 beds available. | Continues for remaining beds |  |
| ***Day Procedure Unit*** |  |  | Continues | COVID-19 positive endoscopy patients to ORS. |
| ***Short Stay Surgical Unit*** |  |  | Continues |  |
| ***Operating Theatres/Recovery*** |  |  | Continues |  |
| ***Transit Lounge*** |  |  | Continues |  |
| ***Angiography Suite*** |  |  | Continues | Known / Suspected COVID-19 positive patients managed per Angio plan. |

**NOTE**: Close Contacts will be managed in alternate rooms, capacity permitting

|  |  |
| --- | --- |
| **Emergency Department Capacity/Planning**   |  | | --- | | * All non-ED staff to enter ED via waiting room entrance or the NEU entrance (back of department) where possible (consider radiographers/ ICU/ Food services/ cleaners). * Confirmed COVID-19 patients to be prioritised for negative pressure rooms (ISO 1 and 2) and single rooms (Plaster, EDOT) or 37 / 38 if possible with the use of air purifiers and McMonty Hoods. * Any patient who requires resuscitation to be managed in resus regardless of COVID-19 status. * Suspected COVID-19 patients to be managed with transmission-based precautions throughout the department in cubicles. * Segregated waiting areas for patients with COVID-19 and respiratory symptoms where possible. * Patient screening to occur at time of triage, clerking to occur as usual process. Screening at triage to allow for early identification of suspect COVID-19 (s-COVID-19) and re-direction to COVID-19 cubicles if available. Ambulance triage from side window triage location. * Security to screen staff and visitors. * All ED presentations to be RAT tested either by ED or AT. * PCR testing for patients with risk factors for COVID-19 (symptoms and/or household contacts) and/or who are being admitted. * Three resus bays remain unchanged. * Fast Track remains in Fast Track. * All staff to don N95/P2 masks and protective eyewear as minimum PPE. * Staff preparedness, training and simulation activities in ED continue. * Communication with AT re. triage of patients with acute respiratory illness in ambulance. * Ambulance Tasmania (AT) to pre-notify known COVID-19 presentations, and triage staff to complete pre-notification form inclusive of FULL name, DOB, address to allow pre-clerking. * AMU / Ward 6D to take confirmed COVID-19 cases directly from community wherever possible. * Inpatient teams and outpatient departments to visit ED for assessments / consults. * ED avoidance strategies to be considered for high risk groups e.g., oncology patients. * Identified showering and change facilities for staff pre/post shift. * Plan to redeploy vulnerable staff to non COVID-19 areas. | |
| **Intensive Care Capacity**   * Establish State-wide Critical Care Network to enable 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 * Review and maintain ICU Capacity Surge Plan to provide a staged increase in ICU capacity supported by additional equipment purchases. * Continued upskill of non-ICU trained nurses and anaesthetists in critical care management of patients. * Prepare for rapid transition to Level 2. |
| Level 2 Responses – Activation Phase  |  | | --- | | **Level 2 Response – ‘Activation Phase’** |   **Inpatient ward reconfiguration**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Ward/Department** | **Trigger/s** | **Beds Available for COVID-19 positive patients** | **Business as Usual** | **Comments** | | ***Ward 6D*** | When COVID-19 positive patients discharged negative pressure rooms are to convert back to non COVID-19 beds **AND** AMU stood up as COVID-19 ward. | *Zero* | Resumes | Negative pressure rooms may be used for COVID-19 positive patients on an as needs basis. | | ***Ward 3R*** | AMU at 50% capacity commence stand up as second COVID-19 positive ward. | 26 |  | Non COVID-19 Patients decanted to John L. Grove, other LGH wards, Calvary Medical Ward or District Hospitals). | | ***Acute Medical Unit*** | >2 ward admissions | 16 |  |  | | ***Medical Wards***  ***(3D, 4D, 5D, 6D)*** |  |  | Accept 3R patients if appropriate to assist with decant of 3R |  | | ***Subacute (John L Grove)*** |  |  | Continues | Decant appropriate patients from John L Grove to enable capacity for transfer of medically stable non  COVID-19 patients from 3R. | | ***Surgical Wards (5A, 5B)*** |  |  | Elective surgery continues with appropriate pre checks  Continue to admit non COVID-19 admissions to surgical beds including non-surgical patients. | Prepare PACU to receive ICU non COVID-19 cases in escalation level 3.  Accept 3R patients if appropriate to assist with decant of 3R | | ***Ward 4B*** | Women in labour | 2 negative pressure rooms | Continues for remaining beds | Air purifiers to be used in non-negative pressure rooms. | | ***Ward 4O*** |  |  | Continues | Air purifiers to be used in non-negative pressure rooms. | | ***Ward 4N*** |  | 1 negative pressure room | Continues |  | | ***Ward 4K*** | 2 -6 paediatric/adolescent patients  6+ patients: | 2 negative pressure rooms  7 beds available  17 beds will become available for paediatrics and postnatal women if unable to D/C home. | Continues for remaining beds  Patients move into zoning plan will require installation of hording.  Rezoning and separation of adolescent area from 4K. | Air purifiers to be used in non-negative pressure rooms. | | ***Emergency Department*** | 4 patients  All single rooms are being utilised. | 2 negative pressure isolation rooms  EDOT and plaster room with air purifiers and/or McMonty hood.  Plus cubicle 37/38 as overflow |  |  | | ***Intensive Care Unit*** |  | 2 negative pressure rooms = 4 beds | Up to 4 COVID-19 positive patients. | Enact the ICU Statewide Surge Capacity Plan. \* | | ***Day Procedure Unit*** |  |  | Continues elective and emergency cases. | COVID-19 positive endoscopy patients to ORS. | | ***Short Stay Surgical Unit*** |  |  | Continue to support non COVID-19 elective and emergency surgical patients |  | | ***Operating Theatres/PACU*** |  |  | Reduce elective surgery cases as required.  Support SCOVID/COVID-19 positive cases including Obstetric and endoscopy patients in dedicated theatres. |  | | ***Transit Lounge*** |  |  | Continues |  | | ***Angiography Suite*** |  |  | Continues | Known / Suspected  COVID-19 positive patients managed per Angio plan. | | ***Calvary – St Luke’s*** |  |  | 6 | Overflow / decant beds available from 18/10/2021 | | ***Calvary – St Vincent’s*** |  |  | 14 | Overflow / decant beds available from 1/11/21 | | ***Calvary – surge*** |  |  | 5 | Negotiated on an as-needs basis. |   **NOTE**: Close Contacts will be managed in alternate rooms, capacity permitting  **General Ward Configuration**  **AMU to become a COVID-19 Dedicated Ward** *(Trigger for reconfiguration: 2 admitted COVID-19 patients in Ward 6D negative pressure rooms, COVID-19 Positive/Suspect patients in AMU)*  **AMU Preparedness**   * Activate processes for stores delivery, catering, pharmacy, rubbish collection and radiology including a dedicated X-ray machine to remain on the AMU. * Deactivate Pathology Chute. * Unnecessary furniture, books and equipment removed. * Set Up Donning and Doffing areas. * NUM and CNE to be relocated external to AMU. * Establish intubation trolley. * AMU patients decanted to other wards and or discharged as deemed appropriate. * Activate Clerical processes for admission and discharge. * AMU has capacity to accommodate dialysis patients. * Activate Internal Code Blue and MET call procedures established for COVID-19 ward. * Continuing education and training of staff regarding COVID-19 Management of patients including PPE procedures. * Review staffing model and determine staffing levels. Identify external staffing room and set up.   **Women’s and Children’s Services**  Obstetric Cases   * COVID-19 positive pregnant women to be managed as per all adults if not in labour. * COVID-19 positive mothers in labour will be delivered in Room 4 or Room 0 in Ward 4B. * Caesarean section will be performed in COVID-19 theatre with early notification to the ORS. * COVID-19 positive mothers to remain with babies given detrimental effects of separation of feeding and bonding.   Suspect / Confirmed COVID-19 Paediatric Admissions   * Children with ILI will be treated as suspect COVID-19 cases until proven otherwise. * A flexible cut-off of 14 years has been established for AMU admission. * All other children will be admitted to ward 4K isolation rooms. * All COVID-19 positive children will be managed under contact and airborne precautions. * Children should only be admitted if absolutely necessary for clinical reasons. * Suspected / confirmed cases should be placed in negative pressure isolation rooms with contact and airborne precautions. * Patients to be allocated two dedicated nurses using appropriate transmission-based precautions. * Only one carer for each child and should remain the sole carer throughout the admission where possible. * Exit / entry of staff to rooms to be recorded. * COVID-19 positive and non COVID-19 staff separation arrangements finalised.   **Outpatients**  QV and Paediatric outpatients to be reduced with some telehealth appointments. |
| **Emergency Department Capacity/Planning**   |  | | --- | | * All non-ED staff to enter ED via waiting room entrance or the NEU entrance (back of department) where possible (consider radiographers/ ICU/ Food services/ cleaners). * Confirmed COVID-19 patients to be prioritised for negative pressure rooms (ISO 1 and 2) and single rooms (Plaster, EDOT) or 37 / 38 if possible, with the use of air purifiers and McMonty Hoods. * Any patient who requires resuscitation to be managed in resus regardless of COVID-19 status. * Suspected COVID-19 patients to be managed with transmission-based precautions throughout the department in cubicles. * Segregated waiting areas for patients with COVID-19 and respiratory symptoms where possible. * Patient screening to occur at time of triage, clerking to occur as usual process. Screening at triage to allow for early identification of suspect COVID-19 (s-COVID-19) and re-direction to COVID-19 cubicles if available. Ambulance triage from side window triage location. * Security to screen staff and visitors. * All ED presentations to be RAT tested either by ED or AT. * PCR testing for patients with risk factors for COVID-19 (symptoms and/or household contacts) and/or who are being admitted. * Three resus bays remain unchanged. * Fast Track remains in Fast Track. * All staff to don N95/P2 masks and protective eyewear as minimum PPE. * Staff preparedness, training and simulation activities in ED continue. * Communication with AT re. triage of patients with acute respiratory illness in ambulance. * Ambulance Tasmania (AT) to pre-notify known COVID-19 presentations, and triage staff to complete pre-notification form inclusive of FULL name, DOB, address to allow pre-clerking. * AMU / Ward 6D to take confirmed COVID-19 cases directly from community wherever possible. * Inpatient teams and outpatient departments to visit ED for assessments / consults. * ED avoidance strategies to be considered for high risk groups e.g., oncology patients. * Identified showering and change facilities for staff pre/post shift. * Plan to redeploy vulnerable staff to non COVID-19 areas. * Stable COVID-19 positive cases may begin to be managed in the main department if no single rooms are available. * Rooms 8 and 9 may also be prioritised for COVID-19 positive patients if they are not required for mental health presentations. Should this occur and rooms 8/9 are required for mental health and patient safety then the COVID-19 positive may be moved to another appropriate space in the department. * Cubicles 37 and 38 in fast track to also be used. * Redirection where appropriate of non urgent ED patients to GP / Urgent Care Centre. * Ongoing staff training and support. * Minimise numbers of inpatient team members entering ED. * Minimise numbers of staff required to enter. | |
| **Surgical Services Response**   * Use three theatres to support at risk and suspect/confirmed COVID-19 patients * Review endoscopy sessions with a focus on maintaining urgent cases and in particular colonoscopy maintenance. * Maintain Elective Surgery. Review and act on any state-wide or national directives to restrict services to Cat 1 and Cat 2 as required. * Update upskilled theatre nurses and anaesthetists in critical care management of ICU patients in recovery beds. * Maintain COVID-19 Safety plans in outpatient clinics to maintain optimal safe throughput, moving to phone reviews and telehealth where possible. * Implement COVID-19 cancellation reason code in iPM for reporting purposes. * Day prior screening phone call to all patients with booked appointments and elective surgery/endoscopy appointments- advising of COVID-19 restrictions as per current public Health advice with patients advised to call admissions or clinics if they are showing fever or other COVID-19 signs and symptoms. * Use COVID-19 specific surgery postponement letter for patients and GPs. * Where able/necessary, increase outsourced elective surgery to Calvary Healthcare Private Hospitals. * Follow up of patients with rapid discharge home with phone review i.e., advice when sutures or clips are to be removed, dressing changes and any ongoing follow up - GP or otherwise. |
| **Outpatient Services Response**   * Review current outpatient bookings and provide appointment via Telehealth or telephone consultation if clinically appropriate. * Review all outpatient appointment patient cancellations and Did Not Attends to ensure urgent cases are not missed and are clinically reviewed. * Implement COVID-19 cancellation reason code in iPM for reporting purposes. * Send text message to all patients with booked appointments- advising to call OPD if they are showing signs of flu or fever. * Use COVID-19 specific appointment postponement letter for patient and GP. * Review Outpatient Website COVID-19 information to align with Health Pathways information. * Patient Screening at reception. If any risks are identified, Nursing review will consider cancellation or postponement of appointment. * Environmental control to support physical distancing. * Consider postponing of Category 2 and 3 patients not suitable for Telehealth or telephone. |
| **Equipment, Supplies and Consumables (PPE)**   * Determine what equipment is available. * Weekly review & monitoring of stock / orders / delivery dates. * Setup of additional storage spaces. COVID-19 and Non COVID-19 areas. * Access Statewide Emergency Management Supply (SEMS) as required * 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-19 / non COVID-19 areas, patients and families. |
| **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.   * Provide local assistance to implement the statewide COVID-19 @ Home program to support patients to manage their care at home. * Stand up of Coach House Community Case Management Facility as directed by ECC. * Increase in ComRRS to assist in self-isolation and follow-up. * Working with Public Health Services and Primary Health 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. * Reviewing district site/community nursing roles/capacity. * Alternative models of care e.g., COVID-19 @ Home program * GP clinic consultation to reduce ED non COVID-19 presentations. * Alerting community nurses to existing self-isolated patients. * ED avoidance strategies for post operative surgical patients. |
| **Hospital Infection Control Measures**  These measures are aimed at reducing unnecessary movement of people into the hospital. These strategies are part of COVID-19 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 all clinical areas. * Amendment to visitor policy and communication across organisation and community regarding this change. Subject to Public Health advice. * Establish consistent patient/visitor information and signage across all facilities. * Staff training and compliance with PPE. * Staff allocated to either COVID-19 or non COVID-19 areas. * Environmental separation of COVID-19 positive and non COVID-19 patients across all clinical areas. * Non-essential access ceased. * Any essential contractors screened. * Consider cafeteria reduced seating capacity – permission of staff only. * Consider cashless payments only. * Screening staff to wear P2 / N95 Respirator and Eye Protection. * Implement additional contact tracing staff resources as required. |
| **Staff management and planning**   * Vulnerable staff - identified and management plan. * 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 – not located in COVID-19 suspected/positive zones. * Adherence to mandatory COVID-19 vaccination direction. * HR input required re. redeployment, recruitment, leave. * Review and consider closure of higher risk volunteer programs. * Enact LGH COVID-19 Nursing Workforce Surge Capacity Plan.   **Staff Recruitment**   * Plan to recruit above establishment numbers to enable prompt response to escalation. |
| **Communication Management**   * Communiques (via REACH) and sharing of updated information with all Hospitals North staff after each RHEMT-N meeting. As required, stakeholder briefings, memorandums, staff forums. * Daily CCMF toolbox meetings – this incorporates representatives from all areas with current COVID-19 inpatients. * Individual unit-based action plans and training. |
| **Private Hospitals**   * Advise Private Hospitals of Escalation Level. * Invite delegate to THS-N EOC meeting as key stakeholder in the event of escalation. * Commence joint preparations for private hospitals to accept public patients. * Meetings with Private Hospitals where necessary. |
| **Interhospital Transfers**   * Liaise with Ambulance Tas and current transport providers, between NW hospitals, aged care facilities, District Hospitals and RHH. * Comply with screening processes at each site prior to transferring a patient to the LGH based on current Public Health Advice. |

# Level 3 Response

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| **Level 3 Response** |
| **Testing, Screening and Assessment**  **COVID-19 Respiratory Clinics**   * ECC to establish additional respiratory clinics in line with Public Health testing strategy. * Increase Health Care Worker testing capability as required. |
| **Bed Capacity Planning**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Ward/Department** | **Trigger/s** | **Beds Available for COVID-19 positive patients** | **Business as Usual** | **Comments** | | ***Ward 6D*** | Discharge of  COVID-19 positive patients  **AND**  AMU stood up as COVID-19 ward | Zero | Resumes | Negative pressure rooms may be used for COVID-19 positive patients on an as needs basis. | | ***Acute Medical Unit*** | >2 ward admissions | 16 (full COVID-19 ward for high acuity patients) |  |  | | ***Ward 3R*** | AMU at 100% capacity | 26 bed COVID-19 ward |  | Patients decanted to John L. Grove, other LGH wards, Calvary Medical Ward or District Hospitals). | | ***Medical Wards***  ***(3D, 4D, 5D, 6D)*** |  |  | Continues |  | | ***Subacute (John L Grove)*** | Conversion of Ward 3R to COVID-19 ward |  | Inpatient criteria changes to receive medically stable: **-**non COVID-19 medical patient with appropriate GOALS of Care.  - Rehab patients  - Nursing Home placements  - Palliative Care patients |  | | ***Surgical Wards (5A, 5B)*** |  |  | Elective surgery reduced to clinically most urgent patient cohort.  Admit non COVID-19 admissions including medical patients.  Reduce Acute Pain Services to Mon-Fri model to preserve staff. | Maximise all outsourcing of elective cases. | | ***Ward 4B*** | Women in labour > 2 | 2 negative pressure rooms | Continues for remaining beds | Air purifiers to be used in non-negative pressure rooms with COVID-19 positive women. | | ***Ward 4O*** |  |  | Continues | Air purifiers to be used in non-negative pressure rooms with COVID-19 positive women. | | ***Ward 4N*** |  | 1 negative pressure room | Continues |  | | ***Ward 4K*** | 2-6 Paediatric/adolescent patients  6+ patients | 2 negative pressure rooms  Pts move into zoning plan will require installation of hording - 7 beds available.  17 beds will become available for paediatrics and postnatal women if unable to discharge home. | Continues for remaining beds  Rezoning and separation of adolescent area from 4K - | Air purifiers to be used in non-negative pressure rooms with COVID-19 positive women. | | ***Intensive Care Unit*** | >3 COVID-19 positive patients | 2 negative pressure rooms (4 beds) + whole of ICU 18 – 21 beds total (depending on utilisation of shared negative pressure beds). |  | MET Teams: COVID-19 and non-COVID-19  Statewide ICU Surge Capacity Plan in place \* | | ***Day Procedure Unit*** |  |  | Endoscopy reduced to the most urgent/emergency cases only + other urgent non COVID-19 pts | COVID-19 positive endoscopy patients to ORS | | ***Short Stay Surgical Unit*** |  |  | Continues |  | | ***Operating Theatres/PACU*** | 3 theatres allocated for COVID-19 positive patients |  | PACU to receive up to 8 non COVID-19 ICU pts | Prepare PACU to receive ICU non COVID-19 cases up to 8 beds  Intensivists overseeing medical care  ICU Nurses overseeing Anaesthetic Nurses.  PACU Governance shared DoS / DoM | | ***Transit Lounge*** |  |  | Repurpose as required |  | | ***Ward 3D \*General Medical (Non-COVID-19 specific)*** |  |  | 12 |  | | ***Calvary – St Luke’s*** |  |  | 6 | Overflow / decant beds available from 18/10/21 | | ***Calvary – St Vincent’s*** |  |  | 14 | Overflow / decant beds available from 1/11/21 | | ***Calvary - Surge*** |  |  | 5 | Negotiated on as needs basis. |   **NOTE**: Close Contacts will be managed in alternate rooms capacity permitting  \* Redeploy appropriately prepared clinic staff toAMU/3R/ED/ICU  \* THS – Intensive Care Surge Capacity Plan in response to COVID-19 Pandemic |
| |  | | --- | | **Emergency Department Capacity**  Review service model daily to ensure safest service continuity option across Northern region.   * All non-ED staff to enter ED via waiting room entrance or the NEU entrance (back of department) where possible (consider radiographers/ ICU/ Food services/ cleaners). * Confirmed COVID-19 patients to be prioritised for negative pressure rooms (ISO 1 and 2) and single rooms (Plaster, EDOT) or 37/8 if possible with the use of air purifiers and McMonty Hoods. * Any patient who requires resuscitation to be managed in resus regardless of COVID-19 status. * Suspected COVID-19 patients to be managed with transmission-based precautions throughout the department in cubicles. * Segregated waiting areas for patients with COVID-19 and respiratory symptoms where possible. * Patient screening to occur at time of triage, clerking to occur as usual process. Screening at triage to allow for early identification of suspect COVID-19 (s-COVID-19) and re-direction to COVID-19 cubicles if available. Ambulance triage from side window triage location. * Security to screen staff and visitors. * All ED presentations to be RAT tested either by ED or AT. * PCR testing for patients with risk factors for COVID-19 (symptoms and/or household contacts) and/or who are being admitted. * Three resus bays remain unchanged. * Fast Track remains in Fast Track. * All staff to don N95/P2 masks and protective eyewear as minimum PPE. * Staff preparedness, training and simulation activities in ED continue. * Communication with AT re. triage of patients with acute respiratory illness in ambulance. * Ambulance Tasmania (AT) to pre-notify known COVID-19 presentations, and triage staff to complete pre-notification form inclusive of FULL name, DOB, address to allow pre-clerking. * AMU/6D/Ward 3R to take confirmed COVID-19 cases directly from community wherever possible. * Inpatient teams and outpatient departments to visit ED for assessments / consults. * ED avoidance strategies to be considered for highrisk groups e.g., oncology patients. * Identified showering and change facilities for staff pre/post shift. * Plan to redeploy vulnerable staff to non COVID-19 areas. * Stable COVID-19 positive cases may begin to be managed in the main department if no single rooms are available. * Rooms 8 and 9 may also be prioritised for COVID-19 positive patients if they are not required for mental health presentations. Should this occur and rooms 8/9 are required for mental health and patient safety then the COVID-19 positive may be moved to another appropriate space in the department. * Cubicles 37 and 38 in fast track to also be used. * Redirection where appropriate of non urgent ED patients to GP / Urgent Care Centre. * Ongoing staff training and support. * Minimise numbers of inpatient team members entering ED. * Minimise numbers of staff required to enter. * Three resuscitation bays remain unchanged – COVID-19 patients will be resuscitated appropriately with staff in full PPE for Contact and Airborne precautions, utilising air purifiers and McMonty Hoods   All ED Staff to wear P2 / N95 masks and eyewear. Full contact and airborne PPE to be worn for all known and suspected COVID-19 patients. | |
| **Intensive Care Capacity**   * First four COVID-19 patients to be managed in the isolation rooms. * Communication between Tasmanian Critical Care Departments continues. * Communication with PACU continues in preparation for possible decant. * Once >4 COVID-19 patients admitted the whole of ICU becomes a COVID-19 unit to admit COVID-19 patients only. * 20 bed capacity for COVID-19 patients on ICU (can have 2 patients in each isolation room). * All staff will be in PPE with external donning and doffing areas with “spotters” to ensure safe PPE use. There will be separate entry and exit sites to the ICU COVID-19 zone. * Isolation rooms will be used for high aerosol procedures if available (paediatric humidified oxygen, tracheostomy insertion, bronchoscopy, extubation). * 16 bed capacity in PACU becomes the non COVID-19 ICU/HDU non COVID-19 area with ICU rounds to provide clinical oversight. To be governed by Department of Surgery and staffed by Anaesthetic staff with ICU Medical staff inreach. * MET teams to split into COVID-19 and non COVID-19 units. * Restrict movement of external staff into the unit. * External intubation team staffed by anaesthetists. * Staffing if >10 ICU patients: two ICU consultants in day handover to single consultant overnight. Two teams of consultant and registrar RMO. Post morning round, one consultant will review recovery patients via MS Teams with anaesthetist supervising recovery. Theatre to confirm recovery staffing model for non COVID-19 patients. One ICU consultant will attend daily for paper discussion of problems. ICU registrars in conjunction with anaesthetic registrars will assist staff recovery. * Nursing staff requirements to be confirmed. |
| **Inpatient Ward Reconfiguration**   * Medical staff will be allocated to COVID-19 and non COVID-19 areas according to need, clinical expertise and personal circumstances.   **AMU & Ward 3R Plans**   * AMU managed as a COVID-19 ONLY ward – no visitors or non-essential staff access. * Ward 6D will not admit COVID-19 patients when AMU is operational as a COVID-19 ward. * Ward 3R will be stood up to receive COVID-19 patients when AMU is at 50% capacity. * Staff to arrive in plain clothes, change into supplied scrubs. * Donning and doffing areas with “spotters” will be activated for AMU and Ward 3R. * Suspect and confirmed COVID-19 patients with high acuity to be admitted AMU. Ward 3R will receive patients with lower acuity care requirements. * Portable X-ray housed in procedure room in the AMU to be used once in lockdown.   **Women’s and Children’s Services**   * Health screening must be performed on all women and their partners prior to entry to LGH. * Women and or their partners that have a RED screening result will be met at the QV Entrance and escorted to COVID-19 zone in 4B for obstetric assessment. Those women not in labour will be transferred to suitable COVID-19 ward in LGH.   **Rest of Hospital Plan**   * Inpatient medical and surgical wards to prepare to rapidly decant to district and private hospitals according to a step-wise decant plan if needed. |
| **Surgical Services Response**  **Ward Plan**   * Dependent on surgical ward occupancy, Surgical Nursing staff will be redeployed to support other areas according to need, clinical expertise and personal circumstances. * Outbreak management plan well established.   **Operating Room Suite Plan**   * Review all elective surgery, case by case prioritisation of elective Cat 1 urgent cases. * Outsource as much elective activity as possible. * COVID-19 positive Surgical cases including Caesarean sections/ Endoscopy allocated to appropriate theatre.   **Outpatient Plan**   * All face-to-face clinics will be cancelled except high priority clinics. Continue Telehealth clinics as able. This will be determined by clinical appropriateness and staffing availability. * Orthopaedic Clinic used to support ED fast track patient cohort as directed by ED plan (DoM Governance). |
| **Outpatient Services Response**   * To ease pressure from ED, ensure that all specialities still have access to Outpatient services in a skeleton staff model. * Communication to GPs / patients re. reduced service. * Redeploy nursing staff to ward areas if/when necessary and able to maintain clinic safe staffing levels. * Ensure redeployed staff fully trained in PPE donning / doffing. * Use available environmental capacity for ward overflow and additional needs. |
| **Equipment, Supplies and Consumables (PPE)**   * Daily reviews of equipment / stock. * Ensure adequate stock of essential PPE stock / hand gel etc on Wards. * As per level 2 response |
| **Hospital Avoidance Measures**   * Provide local assistance to implement the statewide COVID-19 @ Home program to support patients to manage their care at home. * Stand up of Coach House Community Case Management Facility as directed by ECC. * Increase in ComRRS to assist in self-isolation and follow-up. * Working with Public Health Services and Primary Health 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. * Reviewing district site/community nursing roles/capacity. * Alternative models of care e.g., COVID-19 @ Home program * GP clinic consultation to reduce ED non COVID-19 presentations. * Alerting community nurses to existing self-isolated patients. * ED avoidance strategies for post operative surgical patients. * Telehealth Expansion |
| **Hospital Infection Control Measures**   * Appropriate visitor policy as per Public Health advice and THS EOC approved Visitor Policy. * 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 all clinical areas. * Amendment to visitor policy and communication across organisation and community regarding this change. Subject to Public Health advice. * Establish consistent patient/visitor information and signage across all facilities. * Staff training and compliance with PPE. * Staff allocated to either COVID-19 or non COVID-19 areas. * Environmental separation of COVID-19 positive and non COVID-19 patients across all clinical areas. * Non-essential access ceased. * Any essential contractors screened. * Consider cafeteria reduced seating capacity – permission of staff only. * Consider cashless payments only. * ED staff and Facility Entrance screening staff to wear P2 / N95 Respirator and Eye Protection. * Implement additional contact tracing staff resources as required. |
| **Interhospital Transfers**   * As per Level 2 response – dependent on Ambulance Tas/private capacity to transfer patients to NW hospitals, RACFs, District Hospitals and RHH. * Compliance with Patient Transfer Protocol and Policy for transfer of inpatients to RCF’s and other facilities. * Use patient screening tool to safely direct patients to inpatient beds avoiding the ED wherever possible. |
| **Staff and Workforce**   * Monitor Physical Distancing Measures * Manage vulnerable staff members in accordance with national and state guidelines. * Enhance critical care training. * Emotional health and wellbeing awareness and support for staff. * 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. * Student programs reviewed and reduced accordingly. * Enact LGH COVID-19 Nursing Workforce Surge Capacity Plan. |
| **Private Hospitals**   * Use private hospitals as per Commonwealth National Partnership Agreement and purchasing agreements. * Private Hospital representative to participate in RHEMT-N meetings. |

# Level 4 Response

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| **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 new 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:   * Wards 5A, 5B, 5D, 3D, 6D, 4D, John L. Grove Centre to decant to private health facilities and District Hospitals as appropriate. * Establish field hospital/s   Response for Level 4 beyond is managed as a State-wide response, with the surge capacity of all hospitals utilised to meet both COVID-19 and non COVID-19 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: [What you can do | Coronavirus disease (COVID-19)](https://www.coronavirus.tas.gov.au/keeping-yourself-safe/what-you-can-do).

The [Infection Control Management for Suspected or Confirmed COVID-19 Hospitals North](https://cm.health.local/pandp/showdoc.aspx?recnum=P20/604) guideline 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:

[COVID-19 Coronavirus](https://doh.health.tas.gov.au/intranet/human_resources/work_health_safety_and_wellbeing/worker_wellbeing_and_support/covid-19_coronavirus)

[COVID-19 Staff Information | DHHS and THS Intranet (health.tas.gov.au)](https://doh.health.tas.gov.au/intranet/covid-19_staff_information)

[Employee Assistance Program (EAP) | DHHS and THS Intranet (health.tas.gov.au)](https://doh.health.tas.gov.au/intranet/human_resources/work_health_safety_and_wellbeing/worker_wellbeing_and_support/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)

[Working from home (COVID-19) | DHHS and THS Intranet (health.tas.gov.au)](https://doh.health.tas.gov.au/intranet/human_resources/employment/working_from_home/working_from_home_covid-19)

**Testing**

Notwithstanding the Public Health Testing Strategy, where a Health Care Worker seeks a COVID-19 test (symptomatic or asymptomatic) they are able to walk in for a PCR appointment at the Public Health Launceston Testing Clinic and/or obtain a RAT test via the Public Health website. ([Request a Rapid Antigen Test Kit (health.tas.gov.au)](https://forms.health.tas.gov.au/220306333551040).

**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 COVID-19, 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 also undertake training through THEO that relates to infection control, hand hygiene and PPE.  The training can be found at:

[THEO - Tasmania Health Education Online (dhhs.tas.gov.au)](https://theo.dhhs.tas.gov.au/)

[Course: THS North Mandatory COVID-19 PPE Training (dhhs.tas.gov.au)](https://theo.dhhs.tas.gov.au/course/view.php?id=1323)

[Course: THS Hand Hygiene (dhhs.tas.gov.au)](https://theo.dhhs.tas.gov.au/course/view.php?id=1568)

[Course: Covid19 Education Courses (dhhs.tas.gov.au)](https://theo.dhhs.tas.gov.au/course/view.php?id=1217)

[COVID19 eLearning: Infection Control Training - COVID19 (dhhs.tas.gov.au)](https://theo.dhhs.tas.gov.au/mod/scorm/view.php?id=18199)

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

* Asks a ‘PPE Buddy’ to review their PPE use and/or to observe them next time they use PPE
* Asks a colleague or nurse working in a clinical area to observe them as they use PPE and invite them to guide their practice
* Contact the LGH Infection Prevention and Control Unit on 6777 6669 and discuss any questions that they may about PPE.

**Dual and Multiple 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.

Dual 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
* LGH COVID-19 Nursing and Midwifery Workforce Surge Capacity Plan
* 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-19 Training**

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

[Course: THS North Mandatory COVID-19 PPE Training (dhhs.tas.gov.au)](https://theo.dhhs.tas.gov.au/course/view.php?id=1323)

**Appendix 3: Infection Prevention**

Hospitals North will follow existing protocols and guidelines to minimise transmission and protect staff, patients and the community.

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 [Infection Control Management for Suspected or Confirmed COVID-19 Hospitals North](https://cm.health.local/pandp/showdoc.aspx?recnum=P20/604) 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 [Infection Control Management for Suspected or Confirmed COVID-19 Hospitals North](https://cm.health.local/pandp/showdoc.aspx?recnum=P20/604) guideline. Precautions will be maintained until the patient meets Public Health Service clearance criteria and has been formally de-isolated by the daily COVID-19 management meetings.

**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 [Infection Control Management for Suspected or Confirmed COVID-19 Hospitals North](https://cm.health.local/pandp/showdoc.aspx?recnum=P20/604) guideline. This includes, at minimum, the following PPE:

* P2/N95 respirator
* 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 respirators) 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 respirators. Fit-checking involves a quick check each time the respirators is put on, to ensure that the respirators 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 respirators 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 respirators, all staff should undertake training through THEO. The training can be found at:

[Mask Fit Training face to face (dhhs.tas.gov.au)](https://theo.dhhs.tas.gov.au/enrol/index.php?id=1407)

THS/Hospital North Fit Testing Guideline provides information and guidance to employees and employers regarding the THS/Hospital North Fit Testing Program for healthcare workers that require the use of disposable particulate filter respirators (PFR) (e.g., P2 or N95 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:

[Personal Protective Equipment demonstration videos | Tasmanian Department of Health](https://www.health.tas.gov.au/health-topics/infection-prevention-and-control/healthcare-worker-education/personal-protective-equipment-demonstration-videos)

THS-North Fit Testing (P2 / N95 mask) guideline (<https://cm.health.local/pandp/showdoc.aspx?recnum=P21/163>)

**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 Hospitals North COVID-19 Patient Transferguideline **(**<https://cm.health.local/pandp/showdoc.aspx?recnum=P22/69> **)** when transferring suspected or confirmed COVID-19 patients between clinical areas of the Launceston General Hospital. This applies to Paediatric and Adult patients.

**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 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 minimum standards will be 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.

Regional Emergency Management Teams are in the process of auditing COVID-19 Safe Work Plans.

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 occurred.

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, e.g. norovirus gastroenteritis, 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 (<https://cm.health.local/pandp/showdoc.aspx?recnum=P20/281> )
* Outbreak Management -THS North Protocol (<https://cm.health.local/pandp/showdoc.aspx?recnum=P2010/0278-001> )

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.
* 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)[1] 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.

Contact tracing for COVID-19 within Hospitals North is overseen by the Infection Prevention and Control Unit with additional staffing resources sourced as required. COVID-19 specific contact tracing is outlined in the [Infection Control Management for Suspected or Confirmed COVID-19 Hospitals North](https://cm.health.local/pandp/showdoc.aspx?recnum=P20/604) guideline and the Hospitals North Outbreak Management Protocol.

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

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-19 ward, avoiding the Emergency Department.

This Hospitals North COVID-19 Patient Transfer guideline (<https://cm.health.local/pandp/showdoc.aspx?recnum=P22/69> **)** 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-19 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 COVID-19 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 use 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 Positive COVID-19 Cases in the Community**

Work is currently underway to revise and plan for 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 and Community Case Management Facilities across Tasmania.

**Community Rapid Response Program**

The Community Rapid Response (CommRRs) provides acute care for patients in their home, including residential aged care facilities.  ComRRS program works in conjunction with local General Practitioners to manage care for clients in their homes removing the need for patients to attend the Emergency Department.

**Appendix 7: 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 increase 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-19 Control Centre.

**Appendix 8 – 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 9 – Pharmaceutical Supply**

Tasmanian Health Service Statewide Hospital Pharmacy has:

* Increased medication stock holdings of all relevant medications to 12 weeks stock on hand.
* Determined specific COVID-19 medication requirements to maintain a strategic stockholding based on forecasting & actual usage

The strategic stockholding of COVID-19 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-19 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 10 – 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.
* 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

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 – Fit Testing**

**THS-N Fit Testing Program**

THS-North Fit Testing (P2/N95 mask) guideline (<https://cm.health.local/pandp/showdoc.aspx?recnum=P21/163>)

**Rationale**

A risk management approach has been adopted within the THS for the provision of fit testing to healthcare workers with priority to be given to staff who are likely to require P2/N95 respirators to be donned during their employment.

A facial fit test is a validated method of matching a respirator to an individual and verifies whether a specific type, model and size of mask is likely to provide an adequate seal for individuals.

**Type of Fit Testing**

Disposable particulate filter respirators (PFR) (e.g., P2 or N95 respirators) are close fitting respirators worn by individuals to provide respiratory protection

Hospitals North will use Quantitative Fit Testing of these respirators to employees. It is an outsourced service facilitated by an accredited Occupational Hygienist.

This will involve an objective measurement of the leakage of particles from inside the person’s respirators using a Porta Count™ instrument to measure a numerical indicator called the ‘fit factor’, the ratio of ambient generated salt particles detected on either side of the wearer’s respirators.

This QNFT will be undertaken by a competent fit test operator with the THS-N program outsourced for the THS-N.

**Frequency**

Fit testing is not mandatory in THS but strongly recommended for staff working in identified high-risk areas.

Sessions are conducted on site at regular intervals throughout the year.

**Appendix 12 – Winter Strategy 2022**

**THS COVID-19 Winter Planning Support**

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

* Increased COVID-19 and Influenza vaccination access particularly for vulnerable cohorts.
* Increased levels of community testing to detect COVID-19 and Influenza 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-19 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 e.g., 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 20), has been established to respond to COVID-19 and will be maintained across winter 2022 to meet both COVID-19 and non COVID-19 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 including Influenza and RSV 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-1)
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-2)
3. [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)
4. [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)
5. Department of Health COVID-19 Emergency Coordination Centre Operating Guidelines, 9 March 2020 [↑](#footnote-ref-5)
6. [COVID-19 Emergency Coordination Centre | DHHS and THS Intranet (health.tas.gov.au)](https://www.health.tas.gov.au/intranet/ecc) [↑](#footnote-ref-6)
7. [Workplace COVID plan (coronavirus.tas.gov.au)](https://www.coronavirus.tas.gov.au/__data/assets/pdf_file/0023/91238/Workplace-COVID-Plan-No.-2-18-Dec-20.pdf) [↑](#footnote-ref-7)
8. To access guideline, go to the DoH Tasmania Strategic Documents Management System, <https://cm.health.local/PandP/showdoc.aspx?recnum=P22/69> [↑](#footnote-ref-8)
9. [Testing for COVID-19 | Coronavirus disease (COVID-19)](https://www.coronavirus.tas.gov.au/keeping-yourself-safe/testing-for-covid19) currently Dowling St., Launceston [↑](#footnote-ref-9)
10. [DoH Health Screening](https://screening.health.tas.gov.au/) [↑](#footnote-ref-10)
11. [Vaccination information | Coronavirus disease (COVID-19)](https://www.coronavirus.tas.gov.au/vaccination-information/covid-19-vaccination) [↑](#footnote-ref-11)
12. Front line Health Care and Aged Care workers will be required to provide evidence of COVID-19 vaccination from October 2021 [↑](#footnote-ref-12)