UnitingCare

Hospitals

COVID 19 Pandemic Plan

Proudly representing
Blue Care | Lifeline | ARRCS | The Wesley Hospital | Buderim Private Hospital
St Stephen's Hospital | St Andrew's War Memorial Hospital

Contents

1. Introduction

1.1 Background

The novel coronavirus outbreak represents a significant risk to UnitingCare. It has the potential to cause high levels of morbidity and mortality and to disrupt our community socially and economically.

Viral respiratory diseases have the greatest potential to cause pandemics and the key threat of new pandemic virus strains lies at the human–animal interface. (Australian Government Department of Health 2020). Coronavirus (COVID 19) is a respiratory illness caused by a new virus that has not previously been identified in humans.

COVID–19 is spread from person to person most likely through:

- Close contact with an infectious person
- Contact with droplets from an infected person's cough or sneeze; or
- Touching objects or surfaces (such as door knobs or tables) contaminated by cough or sneeze droplets from a person with confirmation COVID 19 Infection, and then touching your mouth or face

Possible risk factors for progressing to severe illness include, but are not limited to:

- older age
- underlying chronic medical conditions such as:
    - lung disease
    - cancer
    - heart failure
    - cerebrovascular disease
    - renal disease
    - liver disease
    - diabetes and immunocompromising conditions

The Communicable Disease Network Australia Guidelines National Guidelines for Public Health Units summarises interim recommendations for surveillance, case definitions, infection control, and laboratory testing and contact management for coronavirus disease (COVID 19).

The *Queensland Whole-of-Government Pandemic Plan*, the *Australian Health Sector Emergency Response Plan for Novel Coronavirus* and the Australian Government Department of Health Operational Plan for People with Disability are designed to guide the Australian health and community service sector response. The UnitingCare Pandemic Plan has been developed in the context of the Australian Health Sector Emergency Response Plan for Novel Coronavirus and has been informed by detailed scenario planning (**Appendix 1**) within UnitingCare. This document supplements the UnitingCare Pandemic Plan by outlining the practical implementation of the response at the operational level specifically for Hospitals.

1.2 Purpose

The purpose of this document is to outline the operating instructions for UnitingCare Hospitals team members in response to the COVID 19 pandemic. It will remain a fluid document and be updated as changes come to hand. Please refer to the version control to ensure you are referring to the correct version of this operating instruction, printed copies will be uncontrolled.

This document should be read in conjunction with the UnitingCare Pandemic Plan for a copy of the plan please email: Business.Continuity@ucareqld.com.au.

1.3 Guiding principles

These operating instructions must be delivered in line with the principles as set out in the UnitingCare Pandemic Plan. The UnitingCare Pandemic Plan guiding principles of this plan's approach include:

- Minimise transmissibility, morbidity and mortality;
- Minimise the burden on/ support care / service delivery systems; and the use of existing systems and governance mechanisms to ensure continuity of services and ensuring the safety of our clients and staff, particularly our most vulnerable clients;
- An agile and flexible approach (a "can do" attitude) that can be scaled and varied to meet the needs experienced across the UnitingCare service streams and business units at the time;
- A pragmatic and resourceful approach to maintain service provision, revenue and manage labour costs wherever possible while also ensuring effective stewardship of resources required to ensure safety of our clients and staff;
- Evidence-based decision making;
- Strong linkages with emergency response arrangements;
- Clear strategic approaches to the collection of monitoring data; and
- An emphasis on communication and collaboration activities across the service streams and business support services as a key tool in management of the response.

1.4 Scope

This plan does not include:

- Strategic crisis management arrangements as outlined in the UnitingCare Crisis Management Plan
- Whole of UnitingCare pandemic response arrangements as outlined in the UnitingCare Pandemic Plan
- Site specific hospital outbreak response procedures outlined in hospital pandemic plans and procedures
- Restoration activities for a loss of services that are covered in Group and Service Business Continuity Plans
- Emergency response procedures covered in Fire and Evacuation Plans (FEP).

1.5 Related documents

- UnitingCare Crisis and Incident Management Policy
- UnitingCare Crisis Management Plan
- UnitingCare Business Continuity Management Policy
- UnitingCare Business Continuity Management Manual
- UnitingCare Pandemic Plan

1.6 Key references

Please continue to follow the updates provided by the Federal Government and Queensland Health which are reiterated by the CEO - https://www.unitingcareqld.com.au/COVID 19.

On this UnitingCare micro Website (or site) staff members will be able to access the key requirements which apply to all members of the community (Community Guidance) as set out by the Federal Government and Queensland Health. The site contains directions and guidance provided by UnitingCare in response to COVID 19 and advice relating to the delivery of UnitingCare services deemed to be essential services.

As the requirements change regularly it is both important to monitor this site carefully.

In additional, key Government Departments and Professional Bodies are publishing guidance and requirements for various funded service areas which are deemed essential services. Key sites are as follows:

- Commonwealth Department of health - https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-COVID 19-advice-for-the-health-and-aged-care-sector
- Queensland Health - https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-COVID 19
- Australian College of Nursing - https://www.acn.edu.au/COVID 19-workforce-solutions
- Australian College of Nursing - https://www.acn.edu.au/COVID 19-resources
- Royal Australasian College of Surgeons - https://www.surgeons.org/news/news/COVID 19-update-17-april
- Australian Society of Anaesthetists - https://asa.org.au/COVID 19-updates/
- Australian and New Zealand College of Anaesthetists - http://www.anzca.edu.au/front-page-news/COVID 19-impact-on-anzca
- College of Intensive Care of Australia and New Zealand - https://cicm.org.au/Resources/Coronavirus
- Centre for Disease Control and Prevention (USA) - https://www.cdc.gov/coronavirus/2019-nCoV/index.html

1.7 Exercise, maintenance and review

This document will be exercised, maintained and reviewed on an annual basis in accordance with the UnitingCare Business Continuity Management Policy and Manual.

Debriefing should be conducted within 14 days of the declaration to stand down and/or returning to normal business. Refer to the Business Continuity Management Manual regarding debriefing and for Post Event Report Templates.

1.8 Governance

- All quality standards, regulations and measures must be maintained as per usual.
- Existing reporting must be maintained (see Reporting Document for COVID 19, UCQDOX Child and Family Open folder – COVID 19 resources)
- Complete Client spreadsheet as soon as there is a suspected or confirmed case of COVID 19.
- Complete Staff table for P&C as soon as there is a suspected or confirmed case of COVID 19.
- Report all confirmed cases for staff or clients on Riskman

- Monday.com is the online task management system utilised by the COVID 19 Operational Team, all key actions for Hospitals and other service streams in the Operational Team are recorded in Monday.com with updates by 3.30pm each day by Operational Team members. The actions are prioritised and risks identified in Monday.com, with a daily COVID 19 snapshot provided to Crisis Management Team (CMT) and Operations Team members plus Hospital General Managers (GM) each morning.
- The Risk and Assurance Team maintain a tactical risk profile, which is updated from Monday.com risks and distributed daily, with feeds into the Enterprise Risk profile for Pandemic Risk, maintained by the Risk and Assurance team.
- The Group Executive (GE) Hospitals will coordinate regular meetings with GM's Hospitals and other key stakeholders to maintain oversight of individual hospital and group hospital pandemic response. Currently these are held daily via Skype for Business and documented.
- The GE Hospitals and Hospital Executive teams will coordinate regular meetings with Queensland Health key stakeholders. Currently these are held weekly in relation to Surgery Connect and ad hoc in relation to other Pandemic response planning.

1.9 Document information

Version	**Date**	**Amendment**	**Author**
1.0	March 2020	Initial draft	Chris Foley
Document location:		*UCQ Intranet*	
Document Owner:		*GE Hospitals*	*Michael Krieg*
Authorised by:		*GE Hospitals*	*Approved 20 May 2020*
Distribution:		*Buderim Private Hospital* *St Andrews Hospital* *St Stephens Hospital* *The Wesley Hospital*	

2. Authority to activate

The GE Hospitals or the Director or appointed delegate are authorised to activate this plan. The triggers to activate this plan will be:

- activation of the UnitingCare Pandemic Plan;
- declaration of a pandemic by the World Health Organisation (WHO);
- advice from a credible source that sustained community transmission of a novel virus with pandemic potential has occurred; or
- notification from the Australian, State or Territory Government Department of Health of the emergence of a novel virus with pandemic potential in Australia or overseas.

3. Roles and responsibilities

Where possible, during a pandemic the business as usual management process and hierarchy structures and reporting should be maintained unless the matter is pandemic response related.

Entity	Roles and responsibilities
UnitingCare Crisis Management Team (CMT)	• Strategic management and decision-making authority • Direct and track recovery progress and associated costs • Analyse risks and consequences • Represent service stream operational groups and recovery teams and report progress, as agreed • Internal and external communication lead
UnitingCare Operations Team	• Lead by Director Clinical Governance (as the Hospital representative also) • Provide Subject Matter Expert advice and support in accordance with the business capability they deliver • Execute and coordinate the response on behalf of the CMT • Perform additional tasks as directed by the nominated Operations Team Lead or CMT Controller

4. Communications

Communications across the hospitals shall be maintained either through telephone calls, Workplace Chat or through the corporate preferred method – Skype for Business. If you do not have access to Skype for Business, please log s service desk request. Instructions for using skype for business have been provided in the COVID 19 website. https://www.unitingcareqld.com.au/COVID 19

All communications across the organisation in relation to COVID 19 require approval as per the process at **Appendix 1.** Staff are not to design COVID 19 communication material or guidance for their team or wider organisation. Should communication be required please speak to your line manager who will ensure the COVID 19 Operational Team works with you through the approval process.

Each hospital will provide internal communications regularly to all staff and to targeted key stakeholders, such as Visiting Medical Practitioners, Volunteers etc.

The below table outlines the communication and reporting processes during a pandemic:

Queensland Health	State legislation sets out the responsibilities for reporting and managing outbreaks of communicable diseases. Their aim is to improve infectious disease control through improved disease notification procedures. Services are responsible for becoming familiar with and adhering to the relevant State legislation. Specific reporting requirements for confirmed cases involves contacting Queensland Health through the state Public Health Unit (PHU). Alternatively, if a hospital is contacted by Queensland Health, any requests for information or assistances should be communicated through to the UnitingCare Operations Team Hospital Representative.
Funding bodies and regulators	Government funding bodies and regulators have contractual and legislative reporting requirements for critical incidents, including outbreaks during a pandemic. Where the funding body or regulatory request is part of the services business as usual process, the service is to respond accordingly. Where a service receives a request from a funding body or regulator around

	the pandemic and/or reporting mechanisms, they should escalate the request through to the UnitingCare Operations Team Hospital representative.
Media Spokesperson	Identified by the UnitingCare Crisis Management Team as the appointed media point of contact in addition to the Head of Corporate Affairs.
The UnitingCare Operations Team	Coordinates and approves all pandemic communications across external (customer and other stakeholders) and internal (staff and volunteer) for all business channels.
UnitingCare Intranet Site unitingcareqld.com.au/COVID 19	A UnitingCare Micro Site provides the central point of truth for all information and resources as it relates to the pandemic.
Riskman	Staff Incidents are to be recorded in the Riskman system and managed in accordance with UC policy.

5. Infection Control

As per the Federal Government and Queensland Health directions, infection control measures are to be adhered to. These include but are not limited to the following:

5.1 Effective hand washing and hygiene

Continue to use effective hand washing and hygiene techniques as outlined by the World Health Organisation and Queensland Health. All staff are to complete the Infection Control mandatory training and refresher programs made available by each hospital.

5.2 Common area cleaning

- Common areas are to be cleaned using disinfectant wipes, soap and water or another detergent followed by liquid disinfectant can be used if disinfectant wipes are not available.
- Clean and disinfect high touch surfaces (including floors) every few hours
- Ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with WHS Toolbox Talk: http://intranet/services/PeopleServices/whws/default.aspx

5.3 Social distancing

- Staff and Clients are reminded that they must maintain the following physical (social) distancing: 2.00m indoors and 1.5m outdoors.
- Children, young people and adult clients are to be provided with easy to follow information regarding social distancing.

5.4 Personal Protection Equipment

- Unnecessary use of PPE should be avoided.
- Strategies to reduce the use of PPE should not reduce the safety of our workers, and PPE should always be available to be used by those who require it.

- Consideration can be given to using alternative products and reuse of gowns may be considered for use in areas that currently use single use items. See PPE Matrix for guidelines - https://www.unitingcareqld.com.au/COVID 19.
- PPE should only be worn by hospital staff where they are supporting a patient that is either suspected of or confirmed of being infected with COVID 19. Or as part of business as usual i.e. personal care, dressing wounds etc.

The PPE Levels Matrix provides a guide as to the type of PPE required at different stages of outbreak. The development of the PPE Matrix has been informed by UnitingCare Hospital infection control staff and the Queensland Health PPE guidelines. Please go to the UnitingCare COVID 19 microsite for the update PPE Levels for hospitals. https://www.unitingcareqld.com.au/COVID 19.

5.5 Stockpile of PPE

In order to ensure staff have access to the correct PPE should a patient be tested positive for COVID 19, staff will be provided with appropriate PPE from the business as usual allocated supply of PPE for each hospital and supplemented by PPE available through UnitingCare stockpile of PPE. This stockpile is being continuously monitored and added to with central Procurement Team working exclusively on this initiative. Any requests for additional PPE for hospitals are to be made through the Hospital Executive to the COVID 19 Operations Team Leader, who will liaise with the Procurement Team to access appropriate type and quantity of PPR from the Tingalpa Warehouse.

5.6 Influenza vaccination

Staff are strongly encouraged to have an influenza vaccination. This will be communicated directly with each hospital. Those with a genuine medical reason for declining will need to provide a medical certificate.

Access is available through on-site clinics, visiting General Practitioner's and accessing a pharmacy. Those that nominate to visit a General Practitioner will be reimbursed the vaccine fee only, not the General Practitioner fee.

6. Guidance for management of suspected or confirmed case

- Resources for health care professionals for COVID 19 - https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/novel-coronavirus-qld-clinicians/resources-for-clinicians
- Information for clinicians for COVID 19 - https://www.health.gov.au/sites/default/files/documents/2020/03/coronavirus-COVID 19-information-for-clinicians.pdf
- Screening tool for COVID 19 - https://www.health.qld.gov.au/__data/assets/pdf_file/0029/948314/COVID 19-clinical-screening-assessment.pdf
- Recommendations for use of PPE during hospital care of people with COVID 19 - https://www.health.gov.au/resources/publications/interim-recommendations-for-the-use-of-personal-protective-equipment-ppe-during-hospital-care-of-people-with-coronavirus-disease-2019-COVID 19
- PPE statement from State-wide Infection Clinical Network (Clinical Excellence Qld) - https://www.health.qld.gov.au/__data/assets/pdf_file/0036/954747/ppe-statement.pdf
- Guidance on laboratory testing for COVID 19 - https://www.health.gov.au/sites/default/files/documents/2020/04/phln-guidance-on-laboratory-testing-for-sars-cov-2-the-virus-that-causes-COVID 19_1.pdf

- Training for healthcare workers for COVID 19 - https://www.health.gov.au/resources/apps-and-tools/COVID 19-infection-control-training

7. COVID 19 related staff leave

Any staff required to take leave for suspected or confirmed COVID 19 is required to be reported by their manager to People Advisory as soon as practicable as being notified locally.

The information can be sent via email: peopleadvisory@ucareqld.com.au or alternatively, you can contact People Advisory on 1300 136 757 (option 2) and a team member will walk you through the questions.

This information is entered into a UC centralised excel spreadsheet and is analysed and reported daily into the "Daily COVID 19 snapshot" which is circulated to all members of the Crisis Management Team and COVID 19 Operational Teams.

Completed by	**Completion Date**
Business Unit/Service	
Employee Number	
Employment Status	
Employee's First Name	
Employee's Surname	
Employee's Mobile Phone Contact Number	
Employee's Position Title	
Employee's Direct Manager	
Employee's Direct Manager Email	
Employee's Direct Manager Contact Number	
Facility / Site / Location	
Brief History Background	
Initial Step (e.g. Social Isolation/Testing, Pending)	
Date of Test	
Date results received	
Work Arrangement (e.g. Leave, Work from Home, N/A)	

Self-Quarantine Commencement Date and Time	
Planned Self-Quarantine End Date	
Actual End Date	
Cleared to Return?	
Leave Type (e.g. Annual, Personal, Long Service Leave etc.)	
Leave Start Date	
Leave End Date	
Outcome (e.g. Returned to Work, All Clear)	
Outcome Date	
Comments	

8. Finance and supply

The UnitingCare Operations Team will conduct financial and revenue modelling which includes establishing a process to understand the financial implications related to the pandemic. The processes for reporting revenue losses or purchasing additional items to support our clients and staff through this time have been updated. These updates will also create opportunities for service streams to better respond to the events and identify funding opportunities or changes that are required.

A pandemic expense is a typical purchase or increase in expenditure that your service would not have otherwise incurred prior to the pandemic commencing.

Similarly, pandemic revenue loss refers to the financial impact of any fee-for-service that has been reduced or terminated outside of normal cancellation trends. This may include reduced site hours or service provisioning, and the cancellation of activities or events.

For expenses that will be invoiced and paid for through the normal accounts payable process, please note that specific cost centres, sub-codes and service classifications will be created to capture pandemic related expenses (as per below purchases through accounts payable). With the exception of the following – ALL other aspects of financial code dimensions remain unchanged:

Finance System(s)	Service Stream	Chosen Solution	Code #	Code Name
AX09 Basware	ACCS Retirement Living	One *sub-code* to be used across the service. For example: XXXX (main account) – XX (region) – XXX (centre) – XX (cost centre) – **COVID19 (sub code)**	COVID19	Not applicable.

Ensure that the correct cost centres, sub-codes and service classifications have been captured during the invoice coding and approval process.

8.1 Procurement

During a pandemic, the supply stream will be severely impacted. Procurement of items such as Personal Protective Equipment (PPE) will be coordinated through the Operations Team. The points of contact for the Operations Team are as follows:

- Christine Foley – Operations Team Leader
- Karen Perkins – Operations Team

Hospital Executive teams will communicate the purchasing requirements to the COVID 19 Operations Team and with the Procurement Team. Acquisition of items will be in large quantities and these items (and their cost) will be distributed to your respective area accordingly.

8.2 Other pandemic related expenditure

The UnitingCare Operations Team will develop an online tool to clearly capture pandemic related expenditure that does not follow the processes mentioned above. This includes purchases made with petty cash and/or procurement cards. This process will be in addition to complying with normal process such as Promaster and petty cash reconciliation where it is mandated that transaction descriptions include the identified title, for example: “pandemic expense”. UnitingCare Business Units should update the online tool on a daily basis. The online tool can be found at: https://form.jotform.com/200768340889870 It should take no longer than approximately 5 minutes to complete.

8.3 Supply chain management

Existing channels for ordering products are to be leveraged in the first instance using the current procurement process.

Hospital PPE and key clinical consumables are provided as a stock take from each hospital Supply Manager daily (Monday to Friday) to COVID 19 Operations Team (Procurement) for reconciliation onto daily summary of stock available at hospitals, in Stockpile and on back order. This daily summary is emailed to Hospital GM’s, GE Hospitals and COVID 19 Operations Team each morning as an update. The CMT is provided with a weekly update on PPE access and use.

9. Workforce management

Existing employment and management legislation, industrial relations agreements, policies and practices in relation to salaries, wages and conditions continue to apply and are enforceable, unless varied through appropriate processes. Particular care should be taken to ensure meal breaks, shift changes and rest periods continue to be observed, to offset the risk of fatigue compromising the quality of services.

People and Culture have conducted staff profiling utilising the Better Impact application to inform workforce planning decisions during a pandemic.

9.1 Flexible work arrangements and worksites

Working from home arrangements for staff must be prior-approved by the staff member's executive. Information for working from home can be found at: https://www.unitingcareqld.com.au/COVID 19

Resources to support staff working from home will be available from the above listed website however staff are reminded to print these resources prior to working from home as the microsite can only be accessed through Citrix.

Home sites should be secure, appropriate and kept separate from daily living. Managers and staff should have established timings for regular contact both individually and collectively by email, phone or conference call and maintain appropriate work process.

During a global pandemic it is likely that the UnitingCare My Service Desk will be impacted. For this reason, staff will be reminded that the My Service Desk team should only be contacted for widespread, high impact, critical urgency. All other requests are to be logged via My Service Desk Portal.

All managers and leaders are to keep track of any hardware assets that staffs take home for remote working during the pandemic period.

9.2 Leave management

Leave resources will be available through the established https://www.unitingcareqld.com.au/COVID 19 website:

- Leave Management Guide
- Leave Decision Tree
- Community and Residential Staff Factsheets.

9.3 Support mechanisms

The following mechanisms are in place to support UnitingCare during and outside of a pandemic:

- Our Chaplains: missionteam@ucareqld.com.au
- Staff Assistance Programs: Benestar 1300 360 364
- Lifeline: 13 11 14.

9.4 Education and Training

In addition to the standard infection control training conducted, during a pandemic staff will be required to complete the online training packages developed as they relate to infection control practices, hygiene, and Personal Protective Equipment (PPE).

9.5 Facilities and Maintenance

There will be no change to existing business as usual facilities and maintenance contracting and services at this stage.

Maintenance and Facilities contractors will maintain the applicable physical distance as per their own company guidelines. Please ensure all contractors to site understand the requirements and all details (name, company, contact number, time and date) for each contractor on site is recorded should contract tracing be required.

9.6 Mail Distribution

There will be no change to the way that mail is distributed across each site at this stage.

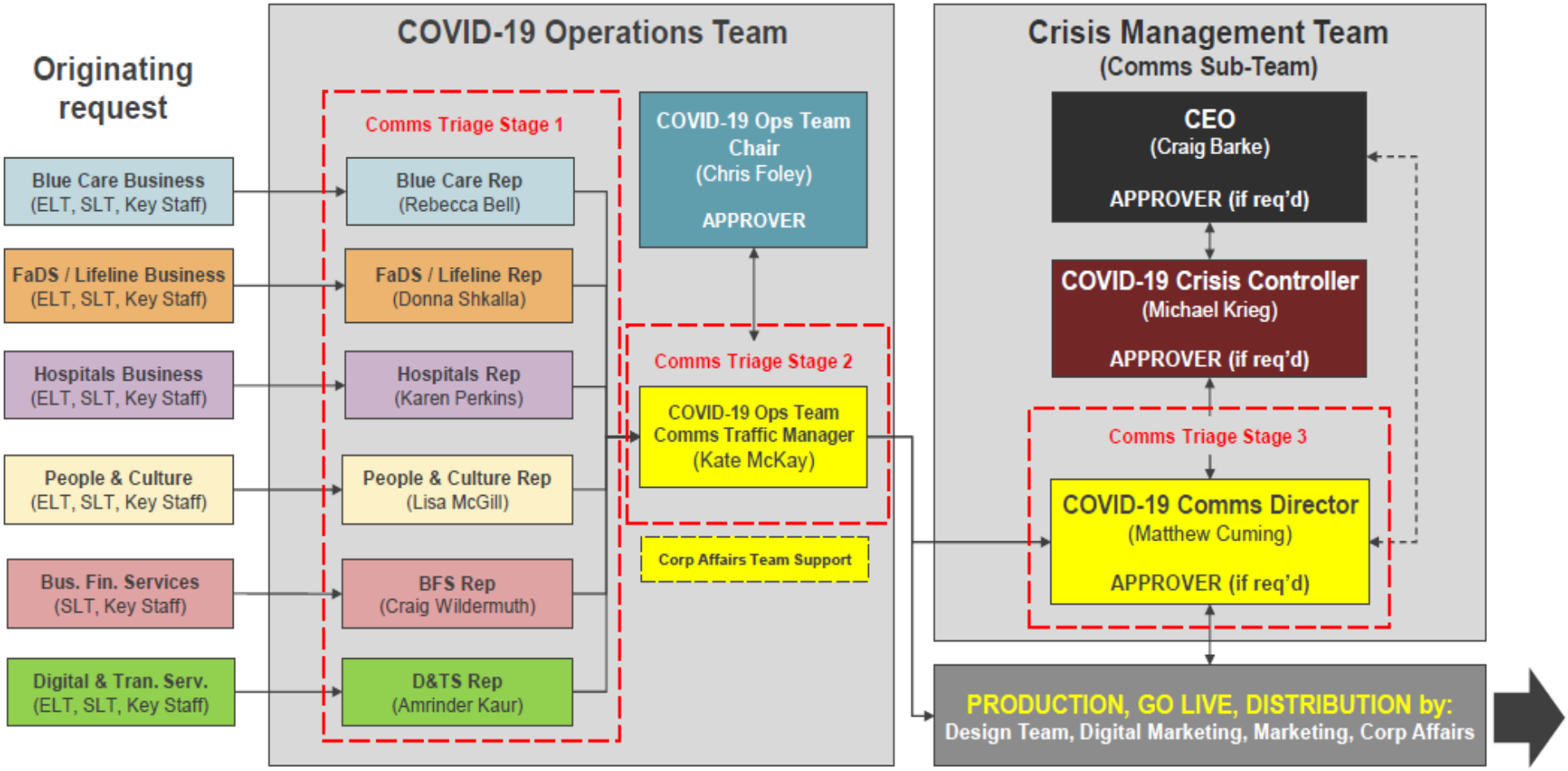
Where a staff member distributes the mail - Maintain BAU (including physical distancing).

Appendix 1: Communication framework

COVID-19 Crisis Communication Development & Approval Process

UnitingCare

Applies to all COVID-19 external (customer and stakeholder) and internal (employee and volunteer) communications



Appendix 2: Scenario Planning

The hospitals scenarios are broken into two response scenarios, one for the Metropolitan hospitals and one for the Regional hospitals. The two Metropolitan Hospitals will be operating under the Queensland Health Metro North Hospitals and Health Services area, Buderim Private Hospital will be operating under the Queensland Health Sunshine Coast Hospitals and Health services area, and St. Stephen's Hospital will be operating under the Wide Bay Hospitals and Health Services area. In summary, each scenario is based on the following mitigation. Planning is based on moving through the scenarios. Hospital Services **has no active cases at 22/04/2020.**

Coordinated overall response to COVID 19

Domain	Ongoing response
Governance	• Central COVID-19 team, led by Chris Foley, coordinating response across hospitals in the UCH network • This team has extensive representation from both clinical and non-clinical staff, and will continue to guide UCH's cross-stream response as the situation evolves further
Communication	• Hospital GMs are communicating daily to Michael Krieg – expected to notify UCQ leadership when first patients with COVID-19 present to UCH, and in the event that staff are affected by COVID-19 (infected or in isolation) • Hospital GMs are communicating plans to care staff and VMOs • Corporate affairs have developed internal and external communication plans for UCQ • Aged Care and FADs are ensuring ongoing coordination between staff, families, residents, and regulators
Regulatory compliance and accreditation	• It will be important for all staff to document COVID-19 patient interactions, to ensure we can account for the impacts of COVID on UCH and patients • Heightened requirement for proportionate risk based regulatory response. Therefore will need to maintain comprehensive logic and documentation behind our decision processes.

Domain	Ongoing response
Protecting the vulnerable	• A clear understanding of our client group and who is considered vulnerable. • Adequate PPE stock and staff are competent in use. • Utilise existing infection control policy and procedures where suitable plus additional COVID advice. • Identifying advanced health directives and EPOA where available.
Leadership and Culture	• Leadership to will be required to be agile, flexible, pragmatic and resourceful. • Will need to ensure the right skills and alternative models of service delivery are available. • Reassurance to staff and clients that UCQ is prepared for the continuing of our care services
Staff support/workforce planning	• A clear understanding of our staff skills, knowledge and talents and to leverage these in an unknown market • To have a workforce continuity plan which is flexible around changing scenarios including redeployment, upskilling and other workforce options should we need them. • Flexible work arrangements including work from home scenarios are to be planned for, taking into account OH& S issues and technology impacts.

Domain	Ongoing response
Supply chain and Finance	• Identify potential supply issues and working closely with supplies to maintain critical consumables and therapeutic goods. • Undertake financial modelling of mild, moderate and severe scenarios. • To review and amend current business continuity plans relevant for possible unfolding of known scenarios. • Logistics of stockpiling and distribution of limited resources to areas of greatest needs within the organisations.
Coordination and planning	• Executive meet regularly with good record keeping of meeting decisions, outcomes and actions • The CMT, ops team and UCQ executive are monitoring federal and state advice and other key advisorys to maintain situational awareness and response. • Ops team responds to escalating risk and tests assumptions to ensure the organisation is prepared to respond to changing scenarios that impact on the ability to maintain capacity to provide services • There is a plan for possible suspension of non essential services in consultation with staff and clients. This plan is able to be appropriately communicated.

Planning the response around potential scenarios

	Mild: Limited national spread, quick recovery	Moderate: Largest metro areas impacted	Severe: Generalised spread
Degree and rate of spread	Case growth limited to a few clusters (urban areas), and isolated cases in other areas. **Total cases < 5k**	Several major areas of disease (major cities) with less impact in other areas. Disease plateaus within ~2 months. **Total cases – 5k – 500k**	Case transmission is not contained, accelerating in the near term, and continuing over an extended period. **Reaches 500k – 10M cases** before plateauing
Severity of disease	Most cases are identified early, limiting severity of disease. Optimal clinical care limits mortality to ~0.5%	Despite significant acceleration in cases, well-prepared hospitals address higher volume and maintain mortality rate at ~0.5%	Health systems challenged by case growth; mortality remains at ~0.5%, but heavily impacted areas drive pockets of mortality over 1.5%
Affected regions	Cases are concentrated in 305 limited clusters; major metro areas with extensive international flight connectivity are at greatest risk	All major cities see cases in the thousands to low hundreds of thousands. Cases are limited in rural areas	Widespread throughout country, with all major cities experiencing a minimum 2 month quarantine, with some areas of extended quarantine

Scenario 1: Regional Hospital

COVID 19 may represent opportunities for UCQ to expand some services, particularly surgery (mild scenario situation).

Scenario: COVID 19 outbreak is able to be contained within the public healthcare system, with patients predominantly presenting to public fever clinics and managed in public hospitals. Federal Government decision to only perform Category 1 or Urgent Category 2 Elective Surgery in public and private hospitals resulting in 40-50% bed occupancy in private hospitals while awaiting Qld Health agreement and planning to be put in place.

	Impacts	Mitigation
Clinical operations	• Initial low occupancy with Federal directive to reduce elective surgery until QH agreement executed. • Surgical and medical case load is likely to be of a private and public mix with potentially an increase occupancy level across the facilities once Surgery Connect commences • Expect no or low numbers of Covid19 patients	• Where possible, select case types that are likely to result in greater revenue for UCQs, balanced against patients' clinical need (as per current process) • Increase staff education to prepare for COVID19 cases and also maximise mandatory training • Consider opportunities to share resources across service streams to ensure adequate training/service preparation
Workforce	• Surgeons may have varying availabilities, and cases of varying resource-intensity; • Lower theatre utilisation may lead to decreased demands on theatre staff and VMP loss of income.	• Potential opportunity to manage medical workforce to support change in casemix and activity • Optimisation of staff rostering will be required • Management of staff leave and training will be required
Supply chain	• Slightly increased or augmented demand for surgical supplies, and PPE depending on case mix; • Inability to source PPE required for Covid19 response.	• Sourcing of supplies through existing channels as needed; • Access UCQ stockpile based on clinical priority.
Patients	• Decreased numbers of patients due to Federal directive to reduce elective surgery and while waiting for QH agreement execution • Requirement to admit and manage COVID19 patients within existing hospital environments	• Regular and effective communication with GPs and VMPs to ensure maximise admissions of patients within QH agreement • Engage with QH to maximise uptake of Surgery Connect agreement

Taking Care Further

Scenario 2: Regional Hospital

We could continue to provide most clinical services even if some COVID 19 patients were managed in UnitingCare Hospitals (moderate scenario situation).

Scenario: Public facilities are reaching capacity managing patients with COVID 19, or some community transmission of COVID 19 occurs (through infection from staff or visiting family members).

	Impacts	Mitigation
Clinical operations	• Increasing risk of non-COVID patients and staff being exposed to COVID-19 patients presenting to the ED • Likely to stretch ward bed occupancy, with increased patient care needs and additional workhours • Increased pressure on critical care services • Surgery Connect case load is unknown	• Screen for COVID symptoms, identify and move these patients through ED as quickly as possible • Maximise Surgery Connect agreement to manage patient occupancy and case loads
Workforce	• Higher pressure on staff to discharge patients • Greater requirements for home-based care to facilitate discharges • Challenges with medical workforce funding based on QH agreement terms	• May need discharge staff to assist with ACAT assessments • Need to consider patient flow requirements to manage beds. Utilise hospital in the home where possible.
Supply chain	• Slightly increased or augmented demand for surgical supplies, and PPE depending on case mix; • Inability to source PPE required for Covid19 response	• Sourcing of supplies through existing channels as needed; • Access UCQ stockpile based on clinical priority.
Patients	• Patients attending some service areas may be particularly vulnerable • Patients may need to be discharged with some ongoing care needs (e.g. rehabilitation)	• Screen treatment centre patients for symptoms of COVID-19, and redirect accordingly • Reduce risk of aerosolization in day-to-day cares and procedures, e.g. spacers instead of nebulisers where possible, Operating Theatre

Scenario 3: Regional Hospital

Queensland Health hospitals at capacity and COVID 19 patients required to be admitted to UnitingCare Hospitals which may create significant pressure and necessitate major changes to clinical service provision (severe scenario situation).

Scenario: COVID 19 infections are sufficiently prevalent that a high burden of UCH inpatients have COVID 19, stretching capacity for ward-based and ICU care

	Impacts	Mitigation
Clinical operations	• Potential for ED to be rapidly overwhelmed by cases • Significant pressure on wards to provide higher level care. • Some care services for non-COVID patients may need to be deprioritised or reconsidered • Medical patients will comprise a much higher proportion of patients than under business as usual	• ED and ICU maybe rapidly overcome by cases. • Rationing of treatment may need to be instigated. • Consider cohorting of COVID-19 patients requiring care, separate cohorting of high-risk patients (e.g. oncology, maternity) • Consider revenue implications of fewer surgical patients.
Workforce	• Likely to result in significant staffing gaps due to sick leave/fatigue in both clinical and non-clinical service areas, worsened if school closures occur • High demand for clinicians with high-level skills (airway management, care of ventilated patients)	• Consider alternative workforce pools • Redeploy ED, CCU and experienced ward-based staff to ICU as able and as needed • Higher utilisation of mission staff for pastoral and psychological support
Supply chain	• Significantly increased need for PPE to protect staff and non-COVID patients with limited supply • Move to alternative supplies and multiuse	• Secure supply of PPE at central warehouse to ration and prioritise limited stock. • Implement strategies to prevent leakage of resources
Patients	• Potential need to prioritise limited resources among patients, or make difficult care decisions • Psychosocial impact of widespread COVID-19	• All care decisions to be lead by clinicians and care team • Pastoral care on-hand to assist clinicians, patients and their families

Scenario 4: Metropolitan Hospital

COVID 19 patients admitted into TWH / SAWMH via Emergency Centres or suspected / confirmed cases managed as inpatients (mild scenario situation)

Scenario: COVID 19 outbreak is able to be contained within the public healthcare system, however Metro North Hospital and Health Service expect UC hospitals to manage any patients presenting with COVID 19 or inpatients suspected or confirmed as COVID 19. Private hospitals will be undertaking surgical caseloads and hospitals should be prepared for a ramp up in occupancy levels or surgical or medical patients directed to them through the Surgery Connect process.

	Impacts	Mitigation
Clinical operations	• Initial low occupancy in hospitals following Federal directive to reduce elective surgery until QH agreement executed. • Surgical and medical case load is likely to be of a private and public mix with potentially an increase occupancy level across the facilities once Surgery Connect commences	• Where possible, select case types that are likely to result in greater revenue for UCQs, balanced against patients' clinical need (as per current process) • Increase staff education to prepare for COVID19 cases and also maximise mandatory training • Consider opportunities to share resources across service streams to ensure adequate training/service preparation
Workforce	• Surgeons may have varying availabilities, and cases of varying resource-intensity • Low staff utilisation initially until QH agreement executed	• Potential opportunity to manage medical workforce to support change in casemix and activity • Optimisation of staff rostering will be required • Management of staff leave and training will be required
Supply chain	• PPE supply chain critical in conserving where possible and acquiring stockpile centrally	• Sourcing of supplies through existing channels as needed • Access UCQ stockpile based on clinical priority
Patients	• Decreased numbers of patients due to Federal directive to reduce elective surgery and while waiting for QH agreement execution • Requirement to admit and manage COVID19 patients within existing hospital environments	• Regular and effective communication with GPs and VMPs to ensure maximise admissions of patients within QH agreement • Engage with QH to maximise uptake of Surgery Connect agreement

Scenario 5: Metropolitan Hospital

We could continue to provide most clinical services even if some COVID 19 patients were managed in UnitingCare Hospitals (moderate scenario situation).

Scenario: Public facilities are reaching capacity and patients with COVID 19 are admitted to UnitingCare Hospitals, or some community transmission of COVID 19 occurs (through infection from staff or visiting family members).

	Impacts	Mitigation
Clinical operations	• Increasing risk of non-COVID patients and staff being exposed to COVID-19 patients presenting to the ED • Likely to stretch ward bed occupancy, with increased patient care needs and additional workhours • Increased pressure on critical care services, particularly ICU beds • Bed pressure may result in the need to reduce surgery	• Screen for COVID symptoms, identify and move these patients through ED as quickly as possible • Consider alternative solutions for patient housing, including hotels with low occupancy for management of patients with lower care needs • Theatres prioritise day surgeries and cases least to need ICU admission in the post-operative period
Workforce	• Higher pressure on staff to discharge patients • Greater requirements for home-based care to facilitate discharges • Challenges with medical workforce funding based on QH agreement terms	• May need discharge staff to assist with ACAT assessments • Need to consider patient flow requirements to mange beds. Utilise hospital in the home where possible. • Optimise surgical casemix to reduce pressure on ward and ICU beds where possible
Supply chain	• Slightly increased or augmented demand for surgical supplies, and PPE depending on case mix; • Inability to source PPE required for Covid19 response	• Sourcing of supplies through existing channels as needed; • Access UCQ stockpile based on clinical priority.
Patients	• Patients attending some service areas may be particularly vulnerable • Non-COVID patients will be at risk of hospital-acquired infection from increasing numbers of COVID patients • Patients may need to be discharged with some ongoing care needs (e.g. rehabilitation)	• Screen treatment centre patients for symptoms of COVID-19, and redirect accordingly • Reduce risk of aerosolization in day-to-day cares and surgery, e.g. spacers instead of nebulisers where possible

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Scenario 6: Metropolitan Hospital

A high burden of COVID 19 patients in UnitingCare Hospitals may create significant pressure, and necessitate major changes to clinical service provision (severe scenario situation).

Scenario: COVID 19 infections are sufficiently prevalent that a high burden of UCH inpatients have COVID 19, stretching capacity for ward-based and ICU care

	Impacts	Mitigation
Clinical operations	• Potential for ED to be rapidly overwhelmed by cases • Significant pressure on wards to provide higher level care. • Some care services for non-COVID patients may need to be deprioritised or reconsidered • Medical patients will comprise a much higher proportion of patients than under business as usual	• ED and ICU maybe rapidly overcome by cases. • Rationing of treatment may need to be instigated. • Consider cohorting of COVID-19 patients requiring care, separate cohorting of high-risk patients (e.g. oncology, maternity) • Consider revenue implications of fewer surgical patients.
Workforce	• Likely to result in significant staffing gaps due to sick leave/fatigue in both clinical and non-clinical service areas, worsened if school closures occur • High demand for clinicians with high-level skills (airway management, care of ventilated patients)	• Consider alternative workforce pools • Redeploy ED, CCU and experienced ward-based staff to ICU as able and as needed • Higher utilisation of mission staff for pastoral and psychological support
Supply chain	• Significantly increased need for PPE to protect staff and non-COVID patients with limited supply • Move to alternative supplies and multiuse	• Secure supply of PPE at central warehouse to ration and prioritise limited stock. • Implement strategies to prevent leakage of resources
Patients	• Potential need to prioritise limited resources among patients, or make difficult care decisions • Psychosocial impact of widespread COVID-19	• All care decisions to be lead by clinicians and care team • Pastoral care on-hand to assist clinicians, patients and their families

Appendix 3: Service Leader Preparation Checklist

Key Questions for Consideration	Comments – Check when Completed
Has the patient been isolated? Have appropriate care actions been taken?	
Have the people who have been in immediate contact with the COVID 19 positive patient been asked to self-isolate?	
Have you notified you direct line manager? (Your direct line manager will forward this to your Hospital Executive, Group Executive Hospitals and COVID 19 Operations Manager	
Have you reported to the relevant Department (e.g. Public Health Unit)?	
Has Queensland Heath contacted you to discuss contact tracing? Do you have the rosters and patient information at hand to support this contract tracing activity?	
Have all staff and patients been notified and requested they self-isolate and monitor for symptoms (testing may need to be supported)?	
Has the staffing roster been secured?	
Is the department closed/locked down due to patients requiring self-isolation? Are family and visitors aware of the visiting arrangements and isolation requirements in the site?	
Are alternative accommodation locations required to support self-isolation?	
Do staff require alternative accommodation during the self-isolation period?	
Have staff and patients impacted been provided with access to help services including EAP, Pastoral Care and Specialist Services?	
Does the site have adequate PPE to manage the outbreak/ positive patient COVID 19 requirements?	

Appendix 4: Patient COVID 19 Positive Checklist

Key Questions for Consideration	Comments – Check when Completed
Has the patient been isolated? Have appropriate care actions been taken?	
Have the people who have been in immediate contact with the COVID 19 positive patient been asked to self-isolate?	
Have you notified you direct line manager? (Your direct line manager will forward this to your Hospital Executive, Group Executive Hospitals and COVID 19 Operations Manager	
Have you reported to the relevant Department (e.g. Public Health Unit)?	
Has Queensland Heath contacted you to discuss contact tracing? Do you have the rosters and patient information at hand to support this contract tracing activity?	
Have all staff and patients been notified and requested they self-isolate and monitor for symptoms (testing may need to be supported)?	
Has the staffing roster been secured?	
Is the department closed/locked down due to patients requiring self-isolation? Are family and visitors aware of the visiting arrangements and isolation requirements in the site?	
Are alternative accommodation locations required to support self-isolation?	
Do staff require alternative accommodation during the self-isolation period?	
Have staff and patients impacted been provided with access to help services including EAP, Pastoral Care and Specialist Services?	

Does the site have adequate PPE to manage the outbreak/ positive patient COVID 19 requirements?	

Appendix 5: Service Leader Staff COVID 19 Checklist

Key Questions for Consideration	Comments – Check when Completed
Has the staff member been isolated or taken to hospital? Have appropriate medical actions been taken (call 000 if emergency)	
Have the staff member been in immediate contact with the COVID 19 positive client and other staff? Have staff been asked to self-isolate, have clients been notified to self-isolate?	
Have you notified you direct line manager? (Your direct line manager will forward this to your Hospital Executive, Group Executive Hospitals and COVID 19 Operations Manager	
Have you reported to the relevant People and Culture? Has the staff member been advised of their leave and support services available?	
Has Queensland Heath contacted you to discuss contact tracing? Do you have the rosters and client information at hand to support this contract tracing activity?	
Has the staffing roster been secured if multiple staff are required to self-isolate/ill?	
Are family and visitors aware of the visiting arrangements and isolation requirements in the site if the site is impacted?	
Are alternative accommodation locations required to support staff's self-isolation?	
Have staff impacted been provided with access to help services including EAP, Pastoral Care and Community Recovery Hotline?	
Has the site have adequate PPE to manage the outbreak/COVID 19 response?	

Appendix 6: UnitingCare planning across response stages

Initial Action Stage

Category	Activity	✓
Minimise transmission	Isolation of confirmed cases	
	Quarantine of close contacts and suspected cases	
	Case and contact management	
Resources HR & Stockpile	Provide available PPE as appropriate	
	Organise delivery points of use utilising Supply Distribution Centre	
	Prioritise resources based on needs	
	Maintain staff, equipment, management systems	
	Deploy stockpile items from Distribution Centre	
	Monitor health, residential and disability system capacity	
	Identify and engage surge staff	
	Consider needs for additional support to systems in remote communities;	
	Maintain essential system activities.	
	Maintain essential system activities	
Clinical care	Manage cases and contacts	
	Encourage voluntary isolation of cases and quarantine of close contacts and suspected cases	

	Monitor and support needs of at-risk groups (when identified)	
	Encourage advance planning directives of hospital facilities	
	System to prepare for potential need to engage surge staff	
	Consider strategies to reduce routine hospital demand such as different models of healthcare provision;	
	Develop and disseminate triage algorithm	
	Develop cohort strategy	
	Support outbreak investigation and management in residential care facilities, schools and other institutions;	
	Consider the need to implement alternative models of care to minimise the burden on the health system for example, fever clinics.	
Infection control	Confirm with frontline staff the application of standard infection control strategies (or provide alternate advice if appropriate)	
	Provide advice to staff, their clients and families on respiratory hygiene and hand-washing	
Identification	Conduct contact tracing (where need is identified)	
	Confirm identification of at-risk groups	
	Analyse and report trends in data	
	Maintain case notification system	
	Monitor sustainability of surveillance systems	

Targeted Action Stage

Category	**Activity**	✓

Minimising transmission	Supporting isolation of identified cases and quarantine of suspected cases and close contacts	
	Ongoing case and contact management, as required	
Resources HR & Stockpile	Monitor health system capacity and establish triggers and thresholds for when capacity will be overwhelmed	
	Services will implement surge staff arrangements as needed (and where possible)	
	Health services will prioritise services to best meet demand for acute care	
	State and territory health departments will undertake urgent assessment and coordination of available specialist equipment based on outbreak predictions and geographic spread	
	Maintain staff, equipment, management systems	
	Provide PPE and/or vaccines (if available) as appropriate to healthcare workers and other approved stakeholders as deemed necessary	
	Provide additional support to health systems in remote communities as needed (and where possible)	
Clinical care	Isolation of confirmed cases	
	Encourage voluntary quarantine of close contacts and suspected cases	
	Triage and cohort patients, as necessary	
	Manage contacts as agreed by CDNA	
	Support outbreak investigation and management in hospitals	
	Consider using different strategies to treat mild cases where resources are overwhelmed	
	New models of care may be instituted to manage novel coronavirus patients, for example: innovative methods for contact tracing and diagnostic testing (call centres, at-home specimen collection etc.) home based care, which may require contingency community services support (potentially telephone support)	

	fever clinics staffed predominantly by nurses via management protocols, with onsite or telephone medical support	
	Adjustment of ICU staffing ratios and opening of new ICU beds or negative pressure rooms, where available	
Infection control	Isolation of confirmed cases, and quarantine of repatriated nationals and approved foreign nationals as required	
	Encourage voluntary quarantine of close contacts and suspected cases	
	Continue application of agreed infection control strategies appropriate to increasing knowledge of transmissibility	
	Continue to provide advice to the public on respiratory hygiene and hand-washing	

Stand-down Stage

Individual activities will be regularly assessed and stood down when they no longer contribute to the outbreak response. The **trigger** for the move into the Stand-down stage will occur when advice from Federal and State Departments indicates that the outbreak has reached a level where it can be managed under normal healthcare arrangements. Stand-down activities will focus on**:**

- supporting and maintaining quality care;
- ceasing activities that are no longer needed, and transitioning activities to normal business or interim arrangements;
- monitoring for a second wave of the outbreak;
- monitoring for the development of resistance to any pharmaceutical measures, if any are being used;
- communication activities to support the return from emergency response to normal business services; and
- evaluating systems and revising plans and procedures.

The UnitingCare Crisis Controller will stand-down the pandemic response based on the advice from subject matter experts and in alignment with Australian Government stand-down measures.

Category	**Activity**	✓
Resources (stockpile)	Assess the status of stockpiles and equipment (PPE and antivirals, if used)	

	Review processes and policies	
	Replenish stocks as appropriate	
	Update plans and protocols in line with lessons observed	
Resources (HR)	Implement interim arrangements if required	
	Support any resources that are depleted, in order to meet remaining demand	
Clinical care	Implement interim arrangements if required	
	Transition triage and cohorting systems	
	Resume elective procedures (hospitals)	
	Resume non-urgent work (primary and secondary care)	
	Review processes and policies	
	Update plans and protocols in line with lessons observed	
	Monitor for a second wave or change in the virus	
Legislation	Prepare and action any legislative instruments required to return legislative powers to normal.	
Surveillance	Monitor for a second wave or change in the virus	
	Review processes and policies	
	Update surveillance plans in line with lessons observed	