TARANAKI
District Health Board

Taranaki DHB Hospital Escalation Framework Principles <u>in relation to COVID-19</u>

- Hospitals focusing on maintaining business as able, within staff & facility resourcing.
- Hospital wide approach, but with flexibility at a service level due to variations in capacity and demand across the Hospital and Specialist Services
- No specific need for split teams/rosters due to hospital wide vaccination status (*noting that H&S risk assessment of individuals still apply)*
- Managing non-urgent work via virtual and telehealth for as long as possible.
- Have options of telehealth for patients identifying as non-vaccinated wishing to have a virtual appointment.
- Staff surveillance testing using Rapid Antigen Tests (RATS) and quick on-site rapid PCR test to reduce unnecessary staff 'stand down time' – in line with MOH risk assessment & categorization framework.
- Specific risk assessment and procedures relating to exposure events of staff to Covid-19.
- Continuous cycle of maintaining and updating Covid-19 skills, information, resources - including scenario exercises for management of a COVID-19 suspected case in the Emergency Department, Wards, Theatres, ICU/HDU. As well as up to date PPE training and FIT testing.
- Redeployment plans and activation triggers in place to respond to escalating demand within the hospital or community Covid-19 environment.
- Established clinical pathways both within and outside the hospital facility, including confirmed outsourcing agreements.

- Daily operations for <u>ALL AREAS</u> include the following:
    - Screening questions, streaming of patients and swabbing as per standard operating procedures (SOPs) for the area are required for all hospital visitors and patients.
    - Identified streaming pathways for COVID-19 suspected and positive cases in all relevant areas. Including areas such as Emergency departments physically triaging in a designated area for those yellow and orange patients.
    - Clear Standard operating procedures for management of covid-19 patients as they transition through the facility and into the community.
    - Clear standard operating procedures to maintain staff safety and wellbeing in a COVID-19 setting
    - Additional directorate specific Escalation Framework to guide service responses and activities
    - An understanding that capacity and demand is impacted as a result of COVID-19 environment beyond patient numbers due to: isolation of beds/wards, re- allocation of staff to support the Covid-19 surge or community response, staff stand down time or sickness or availability of consumables.
    - Management and direction from the COVID 19 directorate
    - Regular updated communications regarding the COVID 19 situation within the hospital and community
    - Ability to stand up additional facilities to respond to the covid-19 environment – including outbuildings, isolation, covid-19 specific facilities and negative pressure environments.
    - Visitors are encouraged as risk assessment and hospital escalation status allows.
    - Care in the community is coordinated through the Covid-19 Hub in the Community Health Integrations Centre (CHIC) in collaboration with all primary/community health providers and iwi.

Taranaki DHB Hospital Escalation Framework

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Hospital Escalation Framework - Directorate Response Activities

Note: This escalation framework is not exclusive to COVID-19 and could be used for other pandemic related scenarios.

Hospital Escalation Status	Medical and Acute	Surgical and Planned Care	South Taranaki Rural Health Services - Hawera	Women and Children	Allied Health and Community	Mental Health and Addictions	**Support Services** (Security, cleaning, IT, facilities, HR, Admin and Engineering)	**COVID Directorate** (Care in the Community/Testing/ vaccination/ resilience/ emergency response)
Status -Green – Readiness ***COVID OMICRON TRIGGER/TIPPING POINT: Omicron is being contained and managed in the community. Workforce numbers not noticeably impacted.*** • Demand starts to impact capacity. • Risk environment is minimal for patients and staff. • Minor adjustments in service delivery and operational management required. • A focus is on managing hospital volumes and patient flow. • Monitoring of any community impact in place. • Planning for escalation to Phase 2 activated. • Business as able managed at unit management level. MOPs level communication. • Visitor policy risk assessment is applied to any impacted areas – with policy adjusted as infection, prevention control (IPC) advises.	• Focus is maintaining efficient acute patient flow. • Maintain ability to instigate, if necessary, a dedicated isolation (e.g. COVID-19) ward. • Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients	• Focus is maintaining efficient throughput for planned care. • Covid-19 capable theatre available. • Maintain engagement with Southern Cross for assistance with urgent, lower complexity cases. • Review patients on waiting lists by urgency and prioritise accordingly.	• Focus is maintaining efficient acute patient flow. • Focus on prevention of admission and utilising community models of care. • Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients	• Staffing to meet acuity • Flex within directorate if needed. • Have the ability to instigate, if necessary, a dedicated isolation (e.g. COVID-19) area. • Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients	• Focus on prevention of admission and supported discharging models. • Focus is on maintain acute and planned patient flow • Patients for discharge soon are priorities for all AHST services • Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients	• Staffing to meet acuity • Flex within directorate if needed. • Have the ability to instigate, if necessary, a dedicated isolation (e.g. COVID-19) area. • Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients	• Security remains in place for screening questions • Support services are activated as needed and coordinated though the emergency response lead and IOC. • Facility and Clinical Equipment coordinator ensures readiness and maintenance of clinical equipment and negative pressure equipment	• Hospital response is coordinated from the hospital lead in collaboration with other directorate leads including responding to any needs identified in the community. • Care in the Community/Testing/ vaccination/ resilience/ emergency response is managed by GM Covid-19 and Covid-19 operational lead.
Status - Yellow - Action **COVID OMICRON TRIGGERS/TIPPING POINTS: Community spread of Omicron. workforce impacted less than 15%.** • Demand significantly outstrips capacity. • Risk environment is moderate for patients and staff • Moderate adjustments in service delivery and operational management required. • A focus on reducing hospital volumes and supporting high demand services. • Monitoring of community impact maintained. • Planning for escalation to phase 3 activated • Business as able managed at unit and service management level. • Hospital wide communication strategy initiated • Stand up operational/ directorate level group as needed • Visitor policy risk assessment is applied to any impacted areas – with policy adjusted as infection, prevention control (IPC) advises.	• Activate Emergency Department triaging in a physically separate setting and provide Emergency Department services with prioritisation on high acuity medical and trauma care. Provide advice in non-contact settings where possible. • Manage outpatient referrals to ensure clinical and equity risk is understood and managed. • Activate Early Supported Discharge, aggressive discharge and step-down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers) • Engage across other DHBs to appropriately discharge out of area patients back to domicile hospital or other setting (to be considered in conjunction with current Hospital Alert Level at other DHBs)	• Acute surgery to operate as staffing and facilities allow, with priority on trauma cases • Planned Care surgery and other interventions to be prioritised based on urgency & resource availability (e.g. ICU **not** required) • Manage outpatient referrals to ensure clinical and equity risk is understood and managed. • Consider any planning for additional for ICU/HDU capacity. • Covid-19 capable theatre available. • Outsourcing with Southern Cross for urgent, lower complexity cases.	• Activate Emergency Department triaging in a physically separate setting and provide Emergency Department services with prioritisation on high acuity medical and trauma care. Provide advice in non-contact settings where possible. • STRHGP Acute care service to manage primary appropriate patients redirected from Hawera ED and support COVID-19 positive patient assessment for non-COVID related illness or injury. • Manage outpatient referrals to ensure clinical and equity risk is understood and managed.	• Utilise staff redeployment and staffing to acuity if child health or maternal are the main impacted area. • Redeployment within directorate as able to support directorate response. • Manage outpatient referrals to ensure clinical and equity risk is understood and managed. • Collaborate with community/private providers where agreements are in place to manage waitlists and plan for phase 3 • Maintain and further develop the provision of outpatient activity via telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever clinically appropriate and acceptable for patients	• Focus on prevention of admission and supported discharging models. • Patients for discharge soon are priorities for all AHST services • Redeployment within directorate as able to support hospital response. • Manage outpatient and community referrals to ensure clinical and equity risk is understood and managed. • Collaborate with community/private providers where agreements are in place to manage waitlists and plan for phase 3 • Continue use of telehealth where appropriate to reduce risk of community spread	• Whai ora presenting to ED for crisis assessment to be redirected to MHAS. • Consider redirection of any medically unwell patients to acute ward, if capacity issue within MHAS. • Redeployment within directorate as able to support directorate response. • Consider virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows	• Security remains in place for screening questions • Support services are activated as needed and coordinated though the emergency response lead and IOC. • Engineering engage in oxygen and environment activity to support escalating situation • • Cleaning and Orderly services will initiate a reduction of service provision to all non-clinical/non urgent areas and focus on clinical services.	• Hospital response is coordinated from the hospital lead in collaboration with other directorate leads. • Redeployment of staff to support surge capacity is requested by Covid-19 directorate including resource required to support the community response. This is coordinated in collaboration with Integrated Operations centres (IOC) • Care in the Community/Testing/ vaccination/ resilience/ emergency response is managed by GM Covid-19 and Covid-19 operational lead.
Status – Orange - Critical Hospital **COVID OMICRON TRIGGERS/ TIPPING POINTS: Widespread community spread of Omicron. Hospital workforce impacted less than 30%** • Demand critically outstrips capacity. • Risk environment is high for patients and staff. • Substantial adjustments in service delivery and operational management required. • A focus on reducing hospital services where necessary to support the hospital and community response required to reduce risk. • Monitoring of community impact maintained. • Business as able managed at service and directorate management level. • Hospital wide communication strategy continued • Operational/ directorate level group continued with escalation to an IMT or emergency response as the situation requires. • Planning for de-escalation commences. • Visitor policy risk assessment is applied to any impacted areas – with policy adjusted as infection, prevention control (IPC) advises.	• Emergency Department services limited to high acuity medical and trauma care. • Manage outpatient referrals to ensure clinical and equity risk is understood and managed • Only accept Immediate/urgent outpatient referrals, but ensure clinical risk is understood and managed • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows • Activate palliative care alternative end of life services for non-COVID-19 patients	• Continue acute surgery as staffing and capacity allows, prioritising non-deferrable, life-saving surgery • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows • Dedicated Covid-19. capable theatre available • Redeployment of staff as required to areas of high need. • Activate plans for additional ICU/HDU capacity as required, including regional support. • Continue to outsource to Southern Cross based on priority as able.	• Emergency Department services limited to high acuity medical and trauma care. • STRHGP Acute care service to manage primary appropriate patients redirected from Hawera ED and support COVID-19 positive patient assessment for non-COVID related illness or injury. • Manage outpatient referrals to ensure clinical and equity risk is understood and managed • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows	• Utilise staff redeployment from other areas to support staffing to acuity if child health or maternal are the main impacted area. • Increase specialist cover to support clinical decision making and flow if child health or maternity is the main area of impact • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows	• Priority patients only – focusing on high risk and need areas and patients. • Maximise community response • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows • Utilise clinical skills to support wider hospital response including offering 7 day coverage as able.	• Whai ora presenting to ED for crisis assessment to be redirected to MHAS. • Consider redirection of any medically unwell patients to acute ward, if capacity issue within MH.AS • Utilise staff redeployment from other areas to support staffing to acuity if MHAS is the main impacted area. • Continue with virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows	• Wellbeing check on clinical and support teams • Administration services sustained and non critical staff deployed to sustain essential clinical services (booking, OPD, Ward Admin) • Cleaning and Orderly services would <u>immediately</u> initiate a reduction of service provision to all non-clinical/non urgent areas and focus on clinical service support •	• Hospital response is coordinated from the hospital lead in collaboration with other directorate leads including the IOC. • Redeployment of staff to support capacity is requested by Covid-19 directorate including resource required to support the community response. This is coordinated in collaboration with Integrated Operations centres (IOC) • Care in the Community/Testing/ vaccination/ resilience/ emergency response is managed by GM Covid-19 and Covid-19 operational lead.

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Escalation during Critical Status - Health System Response

Escalation Status	Medical and Acute And Urgent Care Providers	Surgical and Planned Care And Southern Cross	South Taranaki Rural Health Services	Women and Children LMCs and relevant NGOs	Allied Health and Community And ARC facilities and all relevant NGOs	Mental Health and Addictions Acute, community and NGO	Hospital Site support Services (Security, Cleaning, Orderlies, Facilities, Admin and Engineering)	Hospital Site Business Support (Procurement, Contracts, Finance, IT, Human Resources)	COVID Directorate (Care in the Community including Maori Health providers and Primary Care. And Testing/ vaccination/ resilience/ emergency response)
Status – Red - Critical Health System. **<u>Minimal Health Services Only</u>** **COVID OMICRON TRIGGERS/ TIPPING POINTS: Widespread community spread of Omicron. Hospital workforce impacted more than 30%** Demand critically outstrips capacity across the health system. Risk environment is high for patients and staff across system Radical adjustments in service delivery and operational management required. A focus on reducing hospital services wherever possible to support the hospital <u>and</u> community critical service response Minimal services in hospital only Hospital wide communication strategy continued Full sector emergency planning coordinated through ELT Planning for de-escalation commences. Asymptomatic visitors only considered through risk assessment.	• Emergency Department services limited to high acuity medical and trauma care. • Manage outpatient referrals to ensure clinical and equity risk is understood and managed • Only accept Immediate/urgent outpatient referrals, but ensure clinical risk is understood and managed • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows • Activate palliative care alternative end of life services for non-COVID-19 patients	• Continue acute surgery as staffing and capacity allows, prioritising non-deferrable, life-saving surgery • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows • Theatre manages all patients under orange or red streams (all theatres Covid-19 ready) • Redeployment of staff as required to areas of high need. • Activate plans for additional ICU/HDU capacity as required, including regional support. • Outsource to Southern Cross based on priority if possible.	• Emergency Department services limited to high acuity medical and trauma care. • STRHGP Acute care service to manage primary appropriate patients redirected from Hawera ED and support COVID-19 positive patient assessment for non-COVID related illness or injury. • Manage outpatient referrals to ensure clinical and equity risk is understood and managed • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows	• Utilise staff redeployment from other areas to support staffing to acuity if child health or maternal are the main impacted area. • Increase specialist cover to support clinical decision making and flow if child health or maternity is the main area of impact • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows	• Priority patients only – focusing on high risk and need areas and patients. • Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows • Utilise clinical skills to support wider hospital response across 7 days as able. * Community facing services and response are co-ordinated as the "Care in the Community Response"	• Urgent Medical Attention (e.g. Detox) • Whai ora requiring urgent medical intervention should present to ED first. • Mental Health Assessment/Review Whai ora that would normally present to ED should be redirected to Te Puna Wiaora with a phone call to the Coordinator to clarify specifics of where person should be seen i.e. Rimu or Meeting Room 1 • Consider redirection of any medically unwell TPW whai ora to acute hospital ward , if capacity issue within MHAS • Consider staff redeployment,12-hour shifts, to maintain critical services • Consider additional security support for restraint capability. • All non-essential service delivery to stop. • Consider flow of information in and out of the service (admin team) • Continue with virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows.	• Wellbeing check on clinical and support teams • Administration services sustained and non-critical staff deployed to sustain essential clinical services (booking, OPD, Ward Admin) * Security staffing at such levels to maintain controlled entry and security support to Base & Hawera Hospitals and critical support service developed as part of an emergency response (e.g. field hospitals, Vaccination centres, testing centres). * Patient services (orderly, cleaning and telephone services) maintained recognising there may be an increased demand on staff for services at a minimum service delivery level. * Engineering staffing to be maintained at levels to maintain critical functions of the hospital including electrical, HVAC, nurse call systems, security systems, Chillers, water and mechanical services.	• Continue to link with national / regional procurement or supply agencies, to support clinical teams and maintenance of supply chain • Administration services sustained and non-critical staff deployed to sustain essential clinical services (booking, OPD, Ward Admin) • Prioritise contract / work requests to urgent only, as staffing allows, ensuring financial and/or clinical impact risks are understood and managed (includes maintenance of ICT systems and clinical equipment) • Continue to support community testing activity, through procurement, storage and provision of additional supplies as necessary	• Hospital response is coordinated from the hospital lead in collaboration with other directorate leads including the IOC. • Redeployment of staff to support capacity is requested by Covid-19 directorate including resource required to support the community response. This is coordinated in collaboration with Integrated Operations centres (IOC) • Care in the Community/Testing/ vaccination/ resilience/ emergency response is managed by GM Covid-19 and Covid-19 operational lead.