Vulnerable Cohort Plan

Royal Adelaide Hospital

COVID-19

V1.0 – 30 September 2020

Government of South Australia

Health
Central Adelaide
Local Health Network

This plan is a specific hazard sub-plan (COVID-19) to the CALHN Disaster Resilience Response Plan – Human Disease annex and should be read in conjunction with the said Plan.

Document Ownership & History

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File Location: [DRU to insert file location link – final/latest copy]

Next review due: January 2021

Plan exercised: [insert day/month/year]

Approval Date	Version	Who approved (New/Revised Version)	Reason for Change
30/09/20	V1.0	CALHN COVID IMT	FINAL

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1. INTRODUCTION

Scope

1.1. This plan applies across a range of RAH based services when preparing for, responding to and recovering from a confirmed 'vulnerable cohort' - COVID-19.

Purpose

1.2. The purpose of this plan is to clearly outline the roles, responsibilities and operational functions when preparing for, responding to and recovering from a vulnerable cohort (COVID-19) incident that will impact the services or sites of CALHN.

1.3. This plan may be implemented in part or whole subject to the nature, complexity and scale of the incident being responded to.

1.4. Plan activation shall be undertaken in accordance with the CALHN COVID Incident Management Team (IMT), site and local unit/service requirements and/or existing OWIs.

Objectives

1.5. The core objectives of this plan and its arrangements are;

- 1.5.1. Provide a timely and safe response to manage the presentation of vulnerable cohort COVID-19 positive cases.
- 1.5.2. Provide an initial location for COVID-19 positive, "well" patients to be managed in a timely way arising from established vulnerable cohort populations.
- 1.5.3. Preserve and protect the provision of key service delivery by CALHN services and sites especially as the primary receiving site,
- 1.5.4. Ensure consistency and alignment with the CALHN disaster resilience arrangements and the relevant SA Health strategies.

Assumptions

The assumptions below form the framework upon which this plan is based;

1.6. The Vulnerable Cohort scope includes:

- 1.6.1. Indigenous (Aboriginal) communities
- 1.6.2. Residential Aged Care Facility (RACF) residents
- 1.6.3. Mental health patients incapable of self-isolation
- 1.6.4. Homeless / rough sleepers
- 1.6.5. Custody and Corrections, including forensic cases

1.7. Applies to all patients that are highly probable or confirmed positive patients.

1.8. RAH may have to manage a first wave of vulnerable cohort patients

- 1.8.1. Single vulnerable cohort response of up to 20 or
- 1.8.2. 2 separate vulnerable cohorts of up to 10,

1.9. CALHN assumes that once the above thresholds are met, that additional, extraordinary and alternate resources are implemented by the State Control Centre - Health.

1.9.1. This would then see RAH revert to only managing acutely unwell COVID positive cases.

1.10. Vulnerable cohort patients may present RAH ED unannounced.

1.11. In the early phases of known cohorts, the patients may be COVID-19 positive and well (not requiring any significant care needs).

1.12. One positive patient could rapidly transition into multiple patients in a short time period.

1.13. External notification may occur to CALHN via any of the following mechanisms;

1.13.1. State Control Centre – Health and/or State Health Commander

1.13.2. Communicable Diseases Control Branch

1.13.3. Health Rapid Response Team – Forward (Site) Commander

1.13.4. SA Ambulance Service – Emergency Operations Centre (EOC)

1.13.5. SA Prison Health Service

1.14. External notification may be received by any of the following CALHN mechanisms;

1.14.1. Executive Director – Operations

1.14.2. Executive On-Call

1.14.3. RAH Emergency Department via

1.14.3.1. Duty Emergency Physician or Senior ED Registrar

1.14.3.2. Government Radio Network (GRN) radio

1.14.4. Infectious Disease team

1.15. CALHN will receive advanced notice of known cohort cases and all transfers will be via SAAS with correct PPE protocols enacted, (Health Rapid Response Teams (HRRT) are likely to have been deployed to an external site to manage.

1.16. Infectious Diseases (ID) Unit & Infection Prevention Control Unit (IPCU) staff requires notification 24/7

1.17. The optimal pathway will be a direct admission of a COVID -19 Positive patient into in-patient capacity in reserve available at RAH 24/7.

1.18. RAH ED will have capacity to accept several patients at short notice and will be able to create additional internal capacity to accommodate subsequent arrivals at the frequency required.

1.19. RAH Patient Flow will prioritise bed allocation to this group of patients.

1.20. Receiving COVID-19 wards have the same capacity to take patients 24/7.

1.21. A staged rate of transfer will be enacted wherever clinically safe to do so. - stable, well patients.

1.22. Stable (well) COVID-19 positive patients can be admitted directly to the COVID -19 Ward 24/7 and do not need to go to ED first.

1.22.1. The above assumption will hold up in situations of multiple staged, stable admissions.

1.23. Dept. for Correctional Services – Any COVID positive prisoner will be transported by SAAS to the RAH. This will be subject to discussion between the Dept. for Correctional Services and the HRRT Forward Commander on a case by case basis.

1.24. Residential Care Facility – Any COVID positive resident will be transported by SAAS to RAH, (metropolitan / urban fringe areas only).

1.25. Indigenous (Aboriginal) communities – Any COVID positive resident will be transported by SAAS to RAH.

1.26. Homeless / rough sleeper – Any COVID positive rough sleeper will be transported by SAAS to RAH, (metropolitan / urban fringe areas only).

1.27. Mental Health - Any COVID positive consumer will be transported by SAAS to RAH, (metropolitan / urban fringe areas only).

Related plans & arrangements

This section looks at existing plans and arrangements that support the response to a COVID-19 incident.

1.28. SA Health – Health Rapid Response Plan
1.29. SA Health - Aboriginal Communities COVID-19 Health Action Plan
1.30. SA Health – State Integrated Inpatient Plan
1.31. SA Health – South Australian strategy for responding to COVID-19 in residential aged care facilities – V1.2 – 7 September 2020
1.32. SA Prison Health Service – COVID positive patient management guidelines
1.33. CALHN Human Disease Annex – COVID-19
1.34. CALHN (RAH) Decant Plan – V2
1.35. CALHN Incident Management Framework
1.36. CALHN Mental Health Decant Plan
1.37. CALHN COVID-19 (SARS-COV-2) - Management Guide
1.38. RAH ED COVID-19 Response Plan
1.39. Major Incident Notification OWI
1.40. Activation of the Network Command Centre OWI

Plan activation

1.41. This plan **WILL** be activated upon direction from the Network (COVID) Commander, Executive on-call or Duty Emergency Physician.
1.42. This plan can be activated separate to, or in conjunction with other COVID-19 related plans.

2. GOVERNANCE & ASSURANCE

CALHN

2.1. CALHN disaster resilience governance is overseen by the CALHN Disaster Resilience Committee.
2.2. This plan will be monitored by the CALHN Incident Management Team, supported by the Disaster Resilience Unit.
2.3. The Network is supported in all aspects of the comprehensive (Prevention, Preparedness, Response and Recovery – PPRR) approach by the CALHN Disaster Resilience Unit.
2.4. Each business area / service is responsible for identifying and addressing specific, local COVID-19 issues in accordance with this plan, where relevant.
2.5. CALHN is led by the Network Commander during incident activations.

Plan review

2.6. This plan shall be reviewed by the plan author and owner at regular intervals and when directed.

Plan exercise

2.7. This plan shall be exercised by the plan author, plan owner or the Disaster Resilience Unit with key staff at practicable intervals; especially where any changes to the plan occurs.

2.8. Following the completion of an exercise, the plan author, owner or other nominated delegate shall complete and submit an 'exercise summary form'.

2.9. The exercise summary form (template found here) shall be sent to the CALHN Disaster Resilience Unit (DRU) mailbox – here, post each exercise.

3. ROLE & RESPONSIBILITY

Unit / Service Lead

3.1. The Executive Director – Operations, along with the Network (COVID) Commander is responsible for this Plan.

3.2. They are responsible for having overall responsibility for the unit/service-, preparedness, response and recovery approach to any COVID-19 event that requires activation of this Plan.

Plan role(s)

3.3. The list below outlines the key incident related roles that are identified within this plan, if relevant

- 3.3.1. Network COVID Commander (and IMT)
- 3.3.2. CALHN Executive on-call
- 3.3.3. Duty Emergency Physician
- 3.3.4. Infectious Disease Registrar & IPCU personnel
- 3.3.5. Duty Intensivist
- 3.3.6. CALHN Patient Flow Coordinator / After Hours Coordinator
- 3.3.7. General Med / 102 Registrar
- 3.3.8. Spotless Duty Manager
- 3.3.9. CALHN Communications Team

Program / Service Incident Lead

3.4. The CALHN Incident Management Framework identifies that each program shall nominate a "Program /Service Incident Lead".

3.5. They are responsible for having overall responsibility for the Program-wide, preparedness, response and recovery approach to any significant extreme weather event that requires activation of this Plan.

3.6. They shall form part of an Operations Section of the IMT, where required.

3.7. For this plan, it is acknowledged that Acute and Urgent Care have oversight of a large amount of the resources that are required to support the initial response to a vulnerable cohort response.

Network (COVID) Commander

3.8. The Network (COVID) Commander is responsible for ensuring that all relevant plans are developed and maintained.

3.9. The Network (COVID) Commander is responsible for ensuring that all relevant plans are enacted, as required.

3.10. They shall be responsible for ensuring a Local Health Network (LHN) wide, preparedness, response and recovery approach to any significant COVID-19 event that requires activation of related plans.

3.11. They shall lead the Network Incident Command Centre (NICC), in the event of activation.

Disaster Resilience Unit

3.12. The CALHN DRU is responsible for maintaining a central repository of all COVID-19 plans.

3.13. The DRU shall support the broader organisational wide preparedness, response and recovery activities as required.

3.14. The DRU shall support CALHN programs with planning and plan development.

4. DEFINITIONS

Definitions

4.1. This annex should be read with the SA Health – Disaster Resilience Glossary for definition of terms/acronyms.

Human Disease:

4.2. Any impairment of normal physiological function affecting all or part of an organism, especially a specific pathological change caused by infection, stress etc., producing characteristic symptoms, illness or sickness in general detected in humans

Epidemic:

4.3. An outbreak or unusually high occurrence of a disease or illness in a population or area (Australian Health Management Plan for Pandemic Influenza AHMPPI). In the context of the State Human Disease Hazard Plan reference is made to: "human disease/s that have the potential to cause harm to people, the environment, or economy of South Australia to an extent which could overwhelm the capacity of existing health response resources."

Pandemic:

4.4. A pandemic is the worldwide spread of a new disease. A pandemic occurs when a new virus emerges and spreads around the world, and most people do not have immunity. Viruses that have caused past pandemics typically originated from animal viruses.

COVID-19:

4.5. Coronavirus disease 2019: The name of the disease caused by the virus SARS-CoV-2, as agreed by the World Health Organization, the World Organization for Animal Health and the Food and Agriculture Organization of the United Nations.

SARS-CoV-2:

4.6. Severe acute respiratory syndrome coronavirus 2: The formal name of the coronavirus that causes COVID-19, as determined by the International Committee on Taxonomy of Viruses. Previously, this coronavirus was commonly known as 'novel coronavirus 2019 (2019-nCoV)'.

Confirmed Case:

4.7. A person who tests positive to a validated specific SARS-CoV-2 nucleic acid test or has the virus identified by electron microscopy or viral culture.

Suspect Case:

4.8. This is a dynamic determination based on advice developed by AHPPC and documented in the COVID SoNG.

CoSTAT Matrix – triggers

4.9. Below is the current CoSTAT matrix phases and triggers.

Incident Response Synchronisation Matrix - PHASES & TRIGGERS *(taken from V4.1 – 10 August 2020)*

CoSTAT	AHMPPI DESCRIPTION	TRIGGER POINT	LEADERSHIP	DECISION BY
1	Standby	• Nil in-patient COVID Cases in SA • 2 - 3 cases of community transmission • State Human Disease / Public health declaration (Public Health Act) • State Emergency Management Declaration (Emergency Management Act)	Heightened organisational awareness / Consider Incident management & Command arrangements	ED - Operations or CALHN (COVID) Network Commander
2	Initial Response	• 1 - 15 admitted in-patients (COVID / General wards) AND/OR • Analysis of community transmission, indicating significant community exposure / cluster • 1 x Confirmed COVID positive ICU case from community transmission • Jurisdictional intelligence indicating high burden / load • Impact of deployment of SA / CALHN personnel to other jurisdictions	Incident management & Command arrangements	CALHN (COVID) Network Commander & Incident Management Team (IMT)
3	*(Enhanced)* Initial Response	• Sustained and/or escalating cases via community transmission AND/OR • >16 admitted COVID-19 inpatients in RAH OR • 3+ positive COVID ICU admissions	Incident management & Command arrangements	CALHN Command Centre and State Control Centre – Health (SCC-H) operations
4	Targeted Response	• >24 COVID-19 ICU patients OR • >64 COVID-19 inpatients general ward RAH OR • 3+ consecutive days of ED presentations >290	Incident management & Command arrangements	CALHN Incident Command Centre and State Control Centre – Health (SCC-H) operations
5	*(Sustained)* Targeted Response	• COVID-19 ICU patients exceed RAH capacity OR • COVID-19 GenMed/102 patients exceed RAH capacity OR • Workforce no longer capable of staffing all COVID-19 beds at normal ratios	Incident management & Command arrangements	State Disaster arrangements

BEFORE AND DURING THE INCIDENT

5. PREVENTION

5.1. Novel human disease incidents (endemics and pandemics) will occur and are unable to be prevented by the Hazard Leader or SA Health, including CALHN.

5.2. SA Health as Human Disease Hazard Leader;

5.2.1. The State Emergency Management Plan (SEMP) has assigned SA Health the role of Human Disease Hazard Leader.

5.2.2. The role of Hazard Leader is described in Part 2 of the SEMP.

6. PREPAREDNESS

6.1. This section will largely focus on preparing for a COVID-19 event.

6.2. This is largely what CoSTAT 1 activities relate to.

COVID-19 - Preparedness activities

6.3. Preparedness activities largely relate to existing business as usual activities and other local, specific unit COVID related plans.

6.4. CALHN shall ensure that contemporary copies of existing state plans are maintained to ensure awareness of expectations of CALHN / RAH during a COVID response.

6.5. CALHN IMT shall ensure that they monitor situational intelligence, looking for emerging cases and/or clusters.

6.6. Emergency Department clinical personnel are to ensure heightened awareness of high risk factors including symptoms and epidemiological criteria.

6.7. CALHN shall ensure that there is COVID in-patient capacity maintained and an early trigger to develop additional capacity should caseload require.

6.8. All clinical teams should be alert to any symptomatic cases that arise from vulnerable cohorts and ensure that there is an early, timely internal escalation/notification.

7. RESPONSE

7.1. Any vulnerable cohort response will see a shift to CoSTAT 2 (or greater).

7.2. A response to a vulnerable cohort incident may be triggered by the following;

7.2.1. Unknown – symptomatic/unwell patient presentation(s) to RAH ED from one of the identified vulnerable cohorts identified in Section 1.6 AND have a high risk history (epidemiological criteria / case definition).

- The above would be an internal trigger for this plan.

7.2.2. Known – re-location of known positive, vulnerable patient(s), likely coordinated by the Health Rapid Response Team (HRRT) to the RAH.

7.2.3. These may be well and/or asymptomatic or may be unwell/symptomatic.

- The above would be an external trigger for this plan.

General principles

7.3. Any community, vulnerable cohort incident will be contained on site and managed by the SA Health – Health Rapid Response Team.

7.3.1. This means that it's expected that both advance notice will be provided to CALHN, and

7.3.2. Staged, staggered in-bound arrivals of cases to the RAH ED.

7.4. The two known exceptions to the above are;

7.4.1. Residential Aged Care Sector cases, and/or

7.4.2. Where the clinical condition warrants a time-dependant transfer.

7.5. RAH shall maintain a capability and capacity to receive and manage in-bound vulnerable cohort cases, up to 20 cases COVID-19 positive well in a 12 hour period.

Management of unknown cases

7.6. Under CoSTAT 1, RAH ED will triage the arrival of all patients in accordance with their symptoms and history (epidemiological criteria / case definition).

7.7. These patients will be managed as per CALHN OWI5409, including a COVID-19 and respiratory surveillance swab.

7.8. RAH ED will advise Infectious Disease and IPCU of highly probably cases and a decision made as to whom shall advise Communicable Disease Control Branch (CDCB).

7.9. COVID GenXpert (RAPID) tests are used in selected cases, in accordance with SA Pathology guidelines.

7.10. Any patient that is found to be positive shall be moved to either 6GG (or other RAH COVID in-patient area) if stable, or ICU if unwell and requiring additional support.

7.11. Where vulnerable cohort patient is determined to be positive, this shall initiate an alerting / notification process, both internal and external notifications.

7.12. It's assumed that once identified, this will then in turn trigger a geographical vulnerable cohort response, as led by SA Health – Health Rapid Response Team (HRRT).

7.13. Any 'unknown' scenario will progress through to a 'known' scenario, once the State Control Centre – Health is advised.

Management of known cases

7.14. This relates to identified highly probable / confirmed positive cases within a vulnerable cohort outside of the hospital environment.

7.15. SA Health will lead the response to any geographical case/cluster within a vulnerable cohort population, in accordance with various state and sector plans.

7.16. In these cases, it is expected that RAH will be the primary receiving site for cohorting and will be initially capable to receive;

7.16.1. One vulnerable cluster cohort of up to 20 patients, or

7.16.2. Two vulnerable clusters cohorts of up 10 patients each.

7.17. It is expected that when the thresholds above are reached, that State Health Command will initiate extraordinary, alternate arrangements.

7.18. RAH is likely to receive advance notice of patients (including COVID well) being transferred by SAAS.

7.19. Receiving COVID positive patients will see CALHN shift from CoSTAT 1 to either CoSTAT 2 or 3, potentially in a short space of time (<48 hours)

Alerting

7.20. Where vulnerable cohort patient(s) is determined to be positive as an in-patient at RAH, this shall initiate an alerting / notification process, both internal and external stakeholders.

7.21. For known/identified cases, the treating physician / team is likely to be made aware of the positive status of their patient directly.

7.22. Where Infectious Disease / IPCU becomes aware from SA Pathology or Communicable Disease Control Branch (CDCB), they shall advise the treating Medical team within 30 mins.

7.23. The PRIORITY of any holder of the above information – COVID positive AND originates from a vulnerable cohort,

7.23.1. Inform Patient Flow / After Hours Coordinator **within 30 mins**.

7.24. Once advised, the Patient Flow team / After Hours Coordinator is to **immediately** notify the Executive Director – Operations (in hours) or Executive On-call (after hours).

7.25. Patient Flow / After Hours Coordinator shall contact the Spotless Duty Manager and advise of current situation within 30 mins.

7.26. The Executive Director – Operations will liaise with the RAH Emergency Department - Duty Emergency Physician and determine what intelligence is known about the vulnerable cohort incident.

7.27. The Executive Director – Operations shall advise the Network (COVID) Commander as soon as practicable.

7.27.1. If RAH is to receive > 6 patients in a 12 hour period or additional extraordinary capacity is required to be created, then the COVID IMT shall be recalled, (minimum, 90 min recall).

7.28. The Executive Director – Operations shall initiate a Major Incident Notification List message via Switchboard (33# or 7074 3333) and state "Major Incident – ALERT – COVID response".

7.29. If it is anticipated or known that moderate numbers are likely to be arriving at RAH, placing significant pressure on existing capacity and resources, then the Executive Director – Operations shall initiate a Major Incident Notification List message via

Switchboard (33# or 7074 3333) and state "Major Incident – STANDBY – COVID response".

7.30. If the arrival numbers and/or time frame is likely to overwhelm the RAH, then a "Code Brown – COVID - Major Incident – ACTIVATION" should be called and the IMT recalled and NICC established.

Originator	Recipient	Time frame (from notification)
Clinical personnel *(source of information)*	RAH Patient Flow / After Hours Coordinator	< 30 mins
Patient Flow / After Hours Coordinator	Executive Director – Operations *(in hours)* Executive on-call *(after hours)*	< 10 mins
Patient Flow / After Hours Coordinator	Spotless Duty Manager	(Likely surge only) < 10 mins
Executive on-call *(after hours)*	Executive Director – Operations	< 10 mins
Executive Director – Operations	Network COVID Commander	< 30 mins

Notification

7.31. Upon being alerted, the Executive Director – Operations shall inform the Network (COVID) Commander within 30 mins.

7.32. The Executive Director – Operations and Network (COVID) Commander shall determine what requirement (if any) there is to recall the COVID Incident Management Team.

7.33. Any requirement to 'recall/assemble' the IMT shall be done via Switchboard (33# or RAH external emergency number – 7074 3333) and ask them to message the "COVID Hotkey".

7.33.1. The message should identify the NICC activation and the time of the first NICC briefing.

7.33.2. IMT personnel shall SMS their acknowledgement of this message to the Network COVID Commander.

Actions

7.34. Royal Adelaide Hospital shall prepare to receive multiple persons from a vulnerable cohort until confirmed otherwise.

7.35. RAH Emergency Department, General Medicine (102), Infectious Disease / IPCU, Intensive Care and Spotless shall initiate local surge arrangements. (Its assumed that

up to 20 persons may be transferred to the RAH **BEFORE** the State Control Centre – Health will implement alternate, extraordinary inpatient measures).

7.36. Ensure that 6GG and 6GA are prepared to receive patients.

7.37. Ensure that additional capacity is created commensurate with the intelligence of potential and/or actual incoming cases.

7.38. There are state-wide plans for managing the geographical, cluster responses for the vulnerable cohorts as identified in this plan.

7.39. Residential Aged Care Facility – The affected RACF will appoint an Outbreak Coordinator and will liaise directly with the RAH Duty Emergency Physician on 0401 718 961 (RAH ED COVID Consultant).

7.39.1. In most cases (and preferred), the HRRT Forward Commander will coordinate site activities, including transfer/transport of positive cases to RAH.

7.40. Custodial / Corrections – The affected custodial site will liaise with CDCB and work with the HRRT – Forward Commander to arrange the transfer of positive cases to RAH.

7.40.1. The HRRT Forward Commander will coordinate site activities, including transfer/transport of positive cases to RAH.

7.40.2. SA Prison Health Service plan outlines the arrangements for managing COVID probable and positive cases on site prior to their re-location to the RAH.

7.40.3. There is no expectation at this time that there will be any requirement for security related lockdowns at RAH to support this strategy.

7.40.4. It's anticipated that custodial officers will accompany each transfer.

7.40.5. It's expected that this will be determined by the HRRT Forward Commander.

7.41. Indigenous (Aboriginal) Communities – The affected community / lands will identify an Aboriginal Community Controlled Health Service (ACCHS) liaison, which will liaise with CDCB and work with the HRRT – Forward Commander to arrange the transfer of positive cases to RAH.

7.41.1. The HRRT Forward Commander will coordinate site activities, including transfer/transport of positive cases to RAH.

7.41.2. Owing to the rural and remote localities, there is expected to be moderate lead time to prepare suitable in-patient space.

7.41.3. SA Health – Aboriginal Communities plan outlines the arrangements for managing COVID probable and positive cases in their communities prior to their re-location to the RAH.

7.42. Rough Sleepers / Homeless – TBA

7.43. Mental Health –

7.43.1. Any medically unwell mental health patients will be transferred to the COVID positive inpatient area.

7.43.2. Mental Health have a staged approach to manage COVID well, mental health patients, as outlined on page 11 of the CALHN Mental Health Clinical Program Plan (May 2020).

AFTER THE INCIDENT

8. RECOVERY

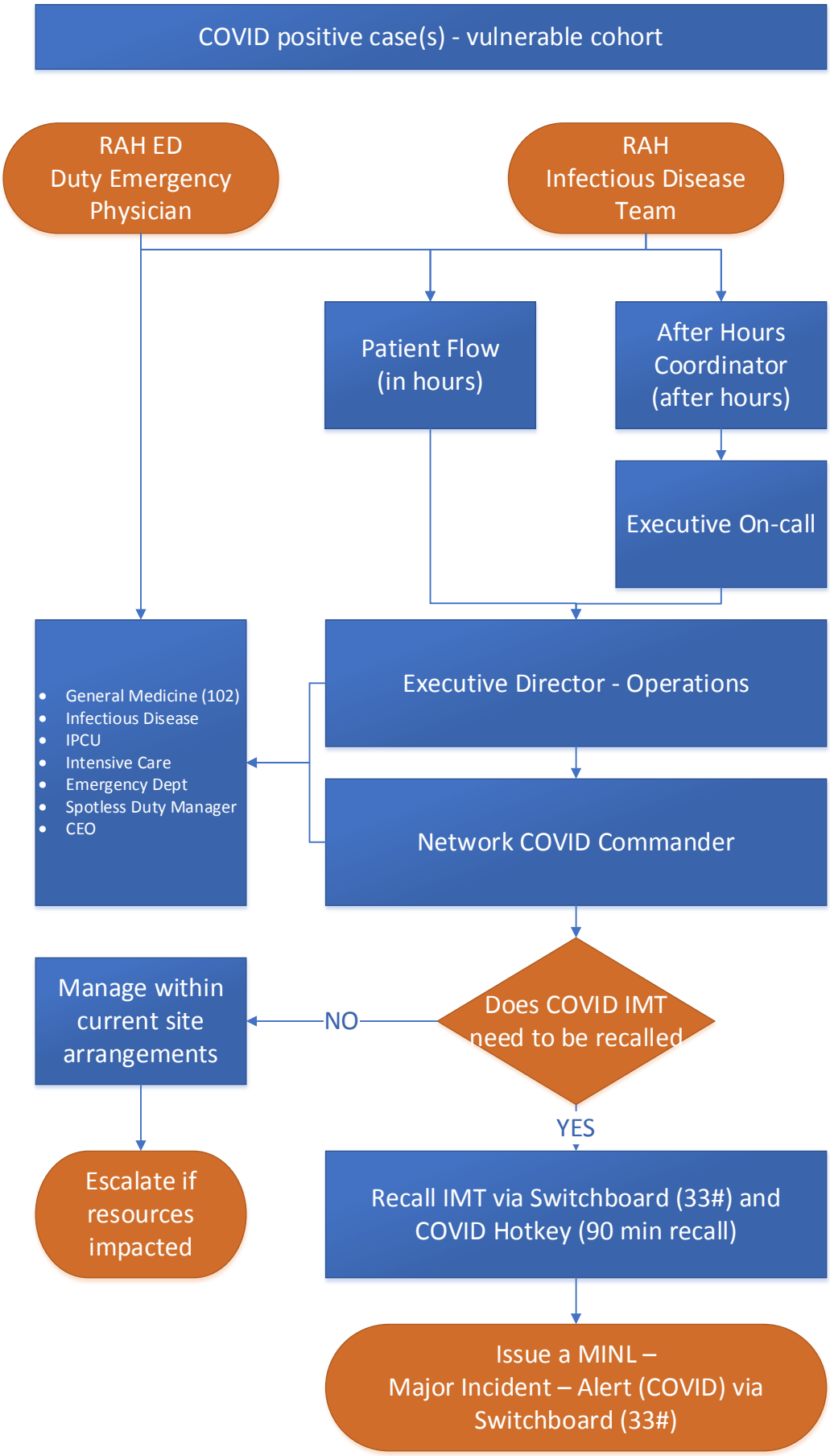
8.1. This shall relate to a return to CoSTAT 1 in the first instance.
  8.1.1. This shall be considered as CoSTAT 1, but COVID ready.
8.2. Longer term, formal incident recovery from COVID-19 is not expected for 1-3 years.
8.3. The Network Commander will determine any scaling back or cessation of incident related activities.
8.4. The CALHN COVID IMT will advise of changes to the CoSTAT levels via the formal Gate Review processes.
8.5. This will be done through the Network Commander to the Program/Service Incident Leads in the first instance.
8.6. As a part of the enduring CoSTAT 1 operations, there will be a distinct shift of responsibilities from incident management to normal line / business management.
8.7. Longer term, the Clinical Program Delivery Managers shall be responsible for monitoring the recovery impacts on their respective services and reporting to the Executive Director – Operations.

9. DEBRIEF / LEARNINGS

9.1. Following any escalation of the COVID CoSTAT matrix, the Network Commander and the Manager, Disaster Resilience Unit will determine whether a debrief is required in accordance with the CALHN Disaster Resilience Strategy.
9.2. Local debriefs (each plan) are encouraged.
9.3. The CALHN Incident / Exercise Debrief Guidelines shall be used as the methodology for both local (quick) post-incident capture and whole of Network (comprehensive) debriefs.
9.4. An action plan shall be developed, identifying respective owners and timelines for corrective action/follow up.
9.5. The CALHN Disaster Resilience Committee shall monitor progress of any actions.

10. APPENDIX

APPENDIX 1 – Alerting / notification pathway



APPENDIX 2 – Key Responsibilities

Initial intelligence source

To collate the following (minimum) information;

- Type of vulnerable cohort site (Corrections, Indigenous, RACF etc)?
- Physical Location(s) – suburb?
- Number of suspected / confirmed positive cases?
- Number of unwell (vulnerable) close contacts at the site?
- Anticipated number of persons requiring transfer to RAH?
- What transport mediums likely to be used?
- Any known care requirements of positive cases?
- Estimated time of departure (ETD) & arrival (ETA)?
- Is the SA Health – Health Rapid Response Team onsite?
    - If so, who is the Forward Commander and their contact number?

RAH ED – Duty Emergency Physician

- Collate and assess known intelligence
- Initiate alerting of key personnel
- Ensure that local capacity is available to manage initial in-bound transfers
- Implement COVID positive pathway/OWI5409

General Medicine (102)

- Collate and assess known intelligence
- Implement COVID positive pathway

Infectious Disease / IPCU

- Collate and assess known intelligence
- Implement COVID positive pathway / OWI5409

Patient Flow / After Hours Coordinator

- Collate and assess known intelligence
- Initiate alerting of key personnel
- Determine current capacity (beds and staffing)
- Identify additional resources, as required

Intensive Care

- Collate and assess known intelligence
- Implement COVID positive pathway / OWI5409

Spotless Duty Manager

- Collate and assess known intelligence
- Support the clinical and non-clinical service delivery as required, this involve;
    - Patient movements
    - Additional consumables, including PPE
    - Opening up additional COVID positive bed space, including pandemic handling
    - Additional cleaning requirements, including increased waste management
    - Media management, facility access and traffic management

Executive On-call

- Collate and assess known intelligence
- Initiate alerting of key personnel
- Ensure sufficient local resources exist to support response
- Alert SA Media / CALHN Communications

Executive Director – Operations / Network (COVID) Commander

- Collate and assess known intelligence
- Initiate alerting of key personnel, including briefing the CEO
- Ensure sufficient local resources exist to support response
- Determine whether site leadership/resources can manage response in the short, or whether activation of the COVID IMT is required.
- Liaise with SCC-H, HRRT – Forward Commander and/or CDCB as to information updates
- Be available for any media engagement / pressers as required.

APPENDIX 3 – Major Incident Messaging

Authorised persons to initiate an ALERT or STANDBY include;

- Duty Emergency Physician (DEP),
- After Hours Coordinator / Patient Flow Lead
- Executive on-call,
- Executive Director – Operations
- Network(COVID) Commander
- Manager, Disaster Resilience

Authorised persons to initiate ACTIVATION include;

- Executive on-call,
- Executive Director – Operations
- Network(COVID) Commander
- Manager, Disaster Resilience

Major Incident – ALERT – COVID

1) Upon being notified that RAH is to receive vulnerable cohort patients then a MINL shall be issued via Switchboard (33# or 7074 3333) and an ALERT message issued

Major Incident – STANDBY – COVID

2) If it is anticipated or known that moderate numbers are likely to be arriving at RAH, placing significant pressure on existing capacity and resources, then a MINL shall be issued via Switchboard (33# or 7074 3333) and an STANDBY message issued

Major Incident – ACTIVATION – COVID

3) If the arrival numbers and/or time frame is likely to overwhelm the RAH, then a MINL shall be issued via Switchboard (33# or 7074 3333) and an ACTIVATION message issued and the IMT recalled and NICC established.
4) In addition, the RAH ED Leadership Hub shall be activated and a RAH ED Commander and Deputy Commander appointed.

APPENDIX 4 – Vulnerable Cohort Aide Memoir - 1

[…insert here…]