Infection Control Guidelines for the Management of Coronavirus (MERS, SARS, SARS-CoV-2 or Novel Coronavirus)

**Purpose**

This procedure provides recommendations regarding best practice for prevention of transmission whilst caring for or managing patients with suspected or confirmed Coronavirus including Middle Eastern Respiratory Syndrome (MERS) Coronavirus, Severe Acute Respiratory Syndrome (SARS), and any Novel Coronaviruses (Emerging diseases) in Children’s Health Queensland (CHQ).

**Scope**

This procedure applies to all Children's Health Queensland staff, healthcare students, consultants and contractors.

**Procedure**

The incubation period for coronavirus is 2-14 days, most commonly five days. Human to human transmission of coronavirus has been demonstrated internationally with frequent transmission within households and healthcare settings. Novel coronaviruses have the potential to cause significant outbreaks. Public health updates should be monitored and will guide testing and case definitions.

**Heightened degree of awareness**

Early recognition is critical for preventing transmission of a coronavirus. Healthcare workers must recognise possible cases and follow correct infection prevention and control precautions.

Screening will take place to aid early identification and appropriate risk stratification for personal protective equipment (PPE) and patient placement.
Screening

Prior to receiving clinical services, patients / families currently must be screened to assess their risk of SARS CoV-2. The flow sheet for All COVID-19 screening outside of emergency will guide initial requirements in elective admission, community services, outpatients and home visits.

Screening for MERS-CoV relies on epidemiological criteria and includes a history of travel from the Middle East or exposure contact. (https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-mers-gen-info-prof.htm#tested).

Entry to hospital

- Screening stations have been established at all open entrances to the hospital including the car park. These are manned by a Nurse and Security Guard.
- The screening includes Exposure Criteria questions relating to COVID-19 including travel, quarantine orders, contact with a COVID case and respiratory symptoms as well as performing a temperature check. If a visitor answers yes to any Exposure Criteria questions, the screening station nurse will escort the patient and family to a single room at their destination within the hospital, or to the Emergency department (ED) if more appropriate.
- Staff running these stations are working under the Screening Controls for CHQ-PROC-64712 Visitation and Access during COVID-19 Pandemic Period

Inpatients

A more detailed process flow for families and visitors attending the Queensland Children’s Hospital (QCH) can be seen here COVID-19 Risk screening flowchart (Inpatient/Outpatient) and gives reference to risk stratification and PPE requirements.

Emergency Department

A mandatory COVID-19 precautions flag has been added to the Triage Assessment in ieMR. The flag will allow for the appropriate management and streaming of suspected or confirmed COVID-19 patients to be initiated as they arrive in the ED. Please refer to ALL COVID-19 Screening in Emergency (Triage) checklist and flowsheet. Triage staff are to identify if high risk or low risk COVID and document in the presenting complaint triage assessment box. Staff within emergency are then required to complete the ieMR checklist within 60 minutes. Please refer to COVID-19 Risk Screening flowchart (Emergency Department) for information on flow and screening in Emergency.
Community based services

Community based services should use the flow sheet for All COVID-19 screening outside of emergency to risk assess families.

Any at risk / symptomatic child / family should be referred to 13HEALTH, their GP or ED for medical review as appropriate for the situation.

The family should be advised to immediately isolate. Staff can then arrange follow up appointments based on the situation and family's preference ensuring safety for both family and staff members.

If a face-to-face presentation cannot be delayed, please follow the PPE recommendations outlined in COVID-19 Personal Protection Equipment (PPE) Requirements - Outpatients Department, Emergency Department and Community.

Case definition

The case definition is based on current local and international data regarding the clinical course and epidemiology of COVID-19 or MERS. Health authorities are constantly monitoring the spectrum of clinical symptoms and nature of illness. Using a 14-day exposure period will cover the duration of the incubation period in the vast majority of cases. For current MERS case definitions see https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-mers-cov-info-clphp.htm.

Confirmed case COVID-19

Most up to date case definitions are found at: https://www.health.gov.au/news/announcements/coronavirus-covid-19-cdna-guidelines

A person who tests positive to a validated specific SARS-CoV-2 nucleic acid test or; has the virus isolated in cell culture with PCR confirmation or; undergoes seroconversion or; has a significant rise in SARS-CoV-2 neutralising or; IgG antibody level.

Probable case

A person who has detection of SARS-CoV-2 neutralising or IgG antibody AND has had a compatible clinical illness AND meets one or more of the epidemiological criteria outlined in the suspect case definition (see below).

Suspect case

Clinical and public health judgement should be used to determine the need for testing in hospitalised patients and patients who do not meet the clinical or epidemiological criteria.

A person who meets the following clinical AND epidemiological criteria:

Clinical Criteria

Fever (≥38°C)\textsuperscript{1} or history of fever (e.g. night sweats, chills) OR acute respiratory infection (e.g. cough, shortness of breath, sore throat, loss of taste or smell).

Epidemiological criteria

i. In the 14 days prior to illness onset:

Close contact (refer to Contact definition below) with a confirmed or probable case

International or interstate travel

\textsuperscript{1} Fever is defined as a temperature of 38°C or higher.
Passengers and crew who have travelled on a cruise ship  
Healthcare, aged or residential care workers and staff with direct patient contact  
People who have lived in or travelled through a geographically localised area with elevated risk of community transmission, as defined by public health authorities  
ii. Hospitalised patients, where no other clinical focus of infection or alternate explanation of the patient’s illness is evident.

**Additional notes**  
- It is recommended that temperature is measured using a tympanic, oral or other thermometer proven to consistently and accurately represent peripheral body temperature.  
- Other reported symptoms of COVID-19 include: loss of smell, loss of taste, runny nose, muscle pain, joint pain, diarrhoea, nausea/vomiting and loss of appetite. Clinical and public health judgement should be used to determine if individuals with sudden and unexplained onset of one or more of these other symptoms should be considered suspect cases.  
- For further information on geographically localised areas with elevated risk of community transmission, refer to the Department of Health website.

**Contact Definition**

**Close contact definition**  
A close contact is defined as requiring:  
- face-to-face contact in any setting with a confirmed or probable case, for greater than 15 minutes cumulative over the course of a week, in the period extending from 48 hours before onset of symptoms in the confirmed or probable case, or  
- sharing of a closed space with a confirmed or probable case for a prolonged period (e.g. more than 2 hours) in the period extending from 48 hours before onset of symptoms in the confirmed or probable case.

**Testing**

- Novel Coronavirus (2019-ncOV)  
- CDNA Guidelines Middle Eastern Respiratory Syndrome Coronavirus (MERS-CoV)  
- CDNA National Guidelines for Public Health Units  

Testing for SARS-CoV-2 to find cases of COVID-19 and minimise onward transmission is directed by the Series of National Guidelines and the Australian National Disease Surveillance Plan. Testing can be defined into essential, enhanced and expanded testing as per the following.

**Essential testing**  
Essential testing is for patients who fulfil both clinical criteria [fever (≥37.5°C) or history of fever (e.g. night sweats, chills) **OR** acute respiratory illness] **AND** epidemiological criteria:  
- Close contact; international, interstate or cruise travel  
- Health, aged or residential care worker with patient contact  
- Travelled through hot spot(s) or admitted hospital patients with no other cause for their infection evident
Patients who undergo essential testing are managed as suspect cases of COVID-19 whilst awaiting test results and should be managed as per the “high risk” stratification for PPE requirements.

**Public Health Alerts**

**Enhanced testing**

Enhanced testing is for patients who fulfil clinical criteria only:

- fever (≥37.5°C) or history of fever (e.g. night sweats, chills)
  
  **OR**

- acute respiratory illness (e.g. cough, shortness of breath, sore throat, cough, shortness of breath

- acute fatigue/myalgia/arthralgia

- loss of smell, loss of taste

Testing beyond the suspect case definition should be undertaken on persons with: fever (≥37.5°C) or history of fever (e.g. night sweats, chills) or loss of smell or loss of taste, where no other clinical focus of infection or alternate explanation of the patient’s illness is evident, **OR** acute respiratory infection (e.g. cough, shortness of breath, sore throat)

Patients undergoing enhanced testing are NOT a suspect case of COVID-19 and can be considered ‘low risk’ for COVID-19 for hospital PPE requirements.

**Who should be tested?**

- Anyone with any of the following COVID-19 symptoms, no matter how mild:
  - fever or history of fever
  - sore throat, rhinorrhoea
  - cough, shortness of breath
  - acute fatigue/myalgia/arthralgia
  - loss of smell, loss of taste

- People in quarantine, in accordance with current quarantine protocols. This is to ensure they are not infectious when they are released from quarantine

- Contacts of confirmed or suspect cases.

**Isolation during testing period**

Patients who have undergone essential testing (i.e. fulfil both clinical and epidemiological criteria for testing) require isolation. They should be treated as a suspected case and the appropriate PPE worn for “high risk” patients. See the PPE flow chart [COVID-19 Personal Protection Equipment flowchart](#)

Place appropriate signage on room and advise parents appropriately.

**Laboratory testing for coronavirus**

All testing for SARS-CoV-2 is performed by collecting upper respiratory (nasopharyngeal swabs). Please see [Appendix 6](#) for how to perform the collection.
Transmission based precautions when collecting specimens for SARS-CoV-2.

- When collecting respiratory specimens, transmission-based precautions should be observed whether or not respiratory symptoms are present.
- For most patients with mild illness in the community, collection of upper respiratory specimens (i.e. nasopharyngeal) is a low risk procedure and can be performed using Contact and Droplet with eye protection precautions.

Perform hand hygiene before donning gown (or apron if low risk), gloves, eye protection (goggles or face shield), and surgical mask.

To collect combined nasopharyngeal/nasal swabs, stand slightly to the side of the patient to avoid exposure to respiratory secretions, should the patient cough or sneeze.

At completion of consultation, remove personal protective equipment (PPE) and perform hand hygiene, wipe any contacted/contaminated surfaces with Clinell wipes.

Note that, for droplet precautions, the room does not need to be left empty after sample collection.

NB: See donning and doffing instructional video in TEACHQ+ or the staff SARS-CoV-2 portal for guidance.

- Collection of upper respiratory specimens is not generally regarded as aerosol-generating, but airborne precautions should be used for collection of specimens from severely symptomatic patients. If the patient has severe symptoms suggestive of pneumonia, e.g. fever and breathing difficulty, then airborne plus precautions should be observed.

Perform hand hygiene before donning disposable gown, gloves, eye protection (goggles or face shield), and P2 / N95 mask/respirator.

Collection in a room with negative pressure air-handling where available.

Please refer to COVID-19 Personal Protection Equipment Flowchart for inpatient PPE and OPD/ED Personal Protection Equipment requirements for OPD, ED and testing centre.

**ALERT**
Please note prescription glasses are not sufficient protective eye wear. Goggles or a face shield are required to be used over the prescription glasses.

Infection prevention precautions

Notification of suspected or confirmed coronavirus patients is mandatory

Promptly alert key facility staff about suspected or confirmed coronavirus patients including:

- Infectious diseases consultant on call
- Infection control staff (Infection Management and Prevention Service – IMPS)
- Executive Director Medical Services on call
- Nursing Director on call
- Patient Flow Unit
- Clinical laboratory
- Staff caring for the patient
- Hospital and Health Service Public Health Physician Metro South 07 3176 4000
- Hospital operational staff manager (Medirest - cleaning, security and porterage services)
Please see Appendix 1 for QCH role description and communication requirement in the event of coronavirus.

---

ALERT
For new and emerging respiratory viruses please refer to the Department of Health for the most up to date information.

---

Confirmed or suspect cases must be placed immediately in a negative pressure or single room and contact and droplet with eye protection precautions PPE be worn by all staff until the patient meets the appropriate release from isolation criteria.

### Patient placement and personal protection

<table>
<thead>
<tr>
<th>All confirmed or suspected coronaviruses.</th>
<th>ED</th>
<th>Ward admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Place a surgical or procedural mask on the patient and parent upon entry into the Emergency Department. Place patient in a room, with negative pressure air-handling (if available).</td>
<td>Patient and parent should already have surgical or procedural masks in situ, if not place a surgical mask on each. Place patient in a room, with negative pressure air-handling (if available).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Novel coronavirus (SARS-CoV-2– COVID-19)</th>
<th>ED</th>
<th>Ward admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use contact, droplet with eye protection transmission precautions including a disposable fluid resistant gown, gloves, surgical mask, and eye protection while reviewing the patient Airborne plus precautions, i.e. a P2/N95 mask and eye protection must also be used while collecting specimens from a symptomatic patient in a negative pressure room if available.</td>
<td>Mild to moderate disease: Use contact, droplet with eye protection transmission precautions including a disposable fluid resistant gown, gloves, surgical mask, and eye protection while reviewing the patient Severe disease or AGP: Airborne plus precautions, i.e. a P2/N95 mask and eye protection</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MERS and SARS</th>
<th>ED</th>
<th>Ward admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use contact, droplet with eye protection plus Airborne plus precautions, i.e. a P2/N95 mask, including a disposable fluid resistant gown, gloves, and eye protection while reviewing the patient</td>
<td>Use contact, droplet with eye protection plus Airborne plus precautions, i.e. a P2/N95 mask, including a disposable fluid resistant gown, gloves, and eye protection while reviewing the patient</td>
<td></td>
</tr>
</tbody>
</table>

### Room allocation and PPE for patients with suspected or confirmed coronavirus

High risk patients as per the risk matrix COVID-19 Personal Protective Equipment Flowchart should be placed in a single room containing a private bathroom and an anteroom with a negative pressure air handling system when available. Contact and Droplet with eye protection should be used for all routine cares and airborne plus for all aerosol generating procedures (AGP).

The room allocation for high risk patients should follow the DisMap (i.e. admit to 9A or 9B negative pressure first then single rooms).

If a patient is considered low risk asymptomatic of respiratory symptoms and have undergone enhanced or expanded testing for COVID, they should be placed in a single room in the applicable ward for their specialty. Their PPE requirements will depend on the presence of fever or respiratory symptoms (see risk matrix COVID-19 Personal Protective Equipment Flowchart).
Patients requiring a surgical bed

Under the current pandemic plan there are no allocated surgical pandemic wards. If a patient presents to QCH and is COVID-19 positive or risk stratified as high risk COVID-19 and requires a surgical admission they are to be allocated to a negative pressure or single room in one of the pandemic allocated clinical areas: 9A, 9B, 10A or PICU. If there is a critical clinical requirement for a surgical bed, please discuss with IMPS during business hours 3068 4145 or the Infectious Diseases doctor on-call who can be contacted through switch.

---

**ALERT**

Confirmed COVID positive children must be admitted to allocated clinical areas only (9A, 9B, 10A, PICU) and must not be admitted to surgical wards (4B/C, 5D)

High risk COVID-19 children must be admitted to allocated clinical areas only (9A, 9B, 10A, PICU) and cannot be admitted to single rooms on surgical wards (4B/C, 5D) without IMPS approval.

---

**Signage**

- Add the [Stop Poster](#) sign to the door to ensure that all staff/visitors report to the nurse before entering the room.
- For high risk patients, provide precaution signage directing staff to use [Contact and Droplet with Eye Protection Precautions](#) with an [Airborne Plus](#) for [Aerosol Generating Procedures (AGP)](#).
- For high risk patients in PICU, Airborne Plus PPE should be worn at all times.
- For low risk patients with acute respiratory symptoms, provide signage advising to use droplet and contact precautions for routine cares and droplet, contact and eye protection for AGPs.
- Provide signage on alternative access doors (other than ante-room access door) to advise staff to only enter/exit via the anteroom.

---

**Staff log**

- All staff that enter the room of a high risk or confirmed COVID-19 patient should be added to the staff log, this needs to be sent daily to chq_imps@health.qld.gov.au
- Please add a patient sticker on the back of the log.
- Ensure the log is accessible to all staff who enter the room in a timely manner.
- See [Appendix 2](#) for [Staff Personnel Log Sheet](#)

---

**Personal protective equipment**

Personal protective equipment (PPE) is one of the key elements of preventing the spread of communicable diseases including coronavirus to healthcare workers (HCW), families and other hospital staff.

Compliance with processes for donning and doffing PPE is critical to staff safety.

- Please see [Appendix 3](#) for how to fit check an N95/P2 mask and [Donning and Doffing of PPE](#) poster.
- For how to don and doff the [3M1860](#) and general donning and doffing can be viewed on the [staff portal](#).
- To review which mask to use when please view [COVID-19 Masks and Uses](#) and which PPE to wear [COVID-19 Personal Protection Equipment Chart Guide](#).
General principles in relation to PPE

- HCWs must have received training and instruction on the donning and removing process and must have practiced these.
- PPE must remain in place and be worn correctly for the duration of exposure to potentially contaminated areas.
- PPE must not be adjusted during patient care.
- The removal of used PPE is a high-risk process that requires a structured and systematic procedure (doffing), HCWs must follow this step by step guide.
- HCWs must be given sufficient time to DON (on) and DOFF (remove) PPE correctly without disturbances.

PPE supply

- CHQ have implemented a PPE stewardship and stock control system to monitor PPE supplies. [CHQ-WI-63323- Personal Protective Equipment (PPE) Rationalisation within CHQ-COVID-19](#)
- Additional supplies of PPE can be obtained from the pandemic PPE supply storage Level B3 Lift-well IMPS Storage Area – access via porterage / security services. See Appendix 4 for Pandemic stock location.

Please advise IMPS [chq_imps@health.qld.gov.au](mailto:chq_imps@health.qld.gov.au) if you use this so it can be replenished.

Afterhours this can be obtained through the Patient Flow Nurse Manager in the QCH Operations Centre.

PPE sequence (pandemic respiratory infections)

Contact, Droplet precautions with Eye Protection with Airborne Plus precautions required for management of aerosol generating procedures.

Before any CHQ staff member can don PPE to enter a patient room with Airborne Plus OR Contact and Droplet with Eye Protection Precautions in place, the following steps must be taken:

- Face must be clean shaven, hair tied back
- All objects removed from pockets and uniform (eg: pens, phone, ID badge, jewellery)
- Complete cover of all skin surfaces / hair is not required (unlike Ebola PPE as below)
- Have an observer to check correct application of N95/P2 mask prior to room entry.
- Completion of written PPE checklist not mandatory.
- Ensure you write your name on the Staff Personnel Log sheet on the door for high risk or confirmed COVID-19 cases.
- Hand hygiene should be undertaken in accordance with the “5 moments for hand hygiene.”
- Gloves should be changed if they become torn or heavily contaminated
- Double gloving is not required
- Gloves should be changed before an ANTT procedure
- Gowns should be changed if they become soiled
- DO NOT THROW AWAY GOGGLES
- These must be cleaned and disinfected using a disinfectant wipe (e.g. Clinell Universal) after each use by the person who wore them and prior to re-use.
- Patient notes / charts should be kept outside the patient room
In the Anteroom Room | Before Leaving Patient Room | After Leaving Patient Room (In Anteroom)
--- | --- | ---
- Perform HH  
- Put on gown  
- Put on N95/P2 mask and perform fit check. A surgical mask can be worn if not performing AGP.  
- Put on eyewear/face shield  
- Put on gloves, ensure the gloves go over the cuffs of the gown. | - Dispose of gloves  
- Perform HH  
- Dispose of eyewear/face shield *  
- Perform HH  
- Dispose of gown  
- Perform HH | - Perform Hand Hygiene (as you have touched the door handle)  
- Dispose of Mask  
- Perform HH

*Gown can be removed before eye protection if desired. Either option is safe and acceptable.

### Aerosol generating procedures (AGP)

**Table 1:** Aerosol generating procedures in paediatrics (with highest risk procedures listed first)

<table>
<thead>
<tr>
<th>High Risk of Generating Aerosols</th>
<th>Potential risk of generating aerosols</th>
<th>Low risk for generating aerosols</th>
</tr>
</thead>
</table>
| Insertion or removal of endotracheal tube  
Intentional or inadvertent disconnection/reconnection of closed ventilator circuit  
High frequency oscillatory ventilation  
Open oropharyngeal or tracheal suctioning  
Bronchoscopy/BAL  
Nasendoscopy  
Tracheostomy change/open suction  
Intercostal catheter insertion  
Thoracic surgery that involves entering the lung  
Surgery with exposure of respiratory mucosa  
Invasive dental surgery  
High flow nasal oxygen | Manual or non-invasive ventilation (CPAP, BiPAP)  
Collection of induced sputum  
Transoesophageal echocardiography  
Nebulised medication  
PEP and oscillating PEP devices  
BubblePEP  
Manual hyperinflation  
Positioning/gravity assisted drainage techniques and manual techniques (eg expiratory vibrations, percussion, manual assisted cough, intra/extra pulmonary high frequency oscillation devices)  
Positive pressure devices/PEP techniques  
Air enema reduction of intussusception | Nitrous oxide  
Removal of nasal foreign body  
Insertion of a nasogastric tube  
Respiratory function tests  
Prolonged and high volume sound stimulation exercises  
Nasal application of barium  
High intensity exercise  
Coughing  
Sneezing  
Collection of a nasopharyngeal swab |

- Some procedures may be more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking or breathing.
- Previous advice to use airborne precautions for care of patients with severe coughing has been withdrawn because:
  - viral load does not necessarily correlate with clinical condition
  - coughing generates droplets, predominantly
surgical masks provide adequate protection.

- **AGPs** should be avoided where possible. If AGPs can’t be avoided, a combination of measures should be used to reduce exposures when performing these on suspected or confirmed Coronavirus patients:
  - Only perform AGPs when medically necessary
  - Limit the number of HCWs present during the procedure to those essential for patient care and support
  - Conduct the procedures in negative pressure rooms
  - Conduct environmental cleaning following these procedures as described in the environmental cleaning section
  - If a negative pressure room is not possible, the room should be left empty for 30 minutes post with the door closed.

Please refer to COVID-19 Personal Protection Equipment Flowchart for inpatient PPE and PPE and COVID-19 Personal Protection Equipment (PPE) Requirements for OPD and ED. Assessment and Clinical Procedures.

The minimum number of carers for the child, and no visitors should be present.

---

**ALERT**

IMPS and ID do not need to approve the use of an **AGP** to provide care to a patient. If clinically indicated following appropriate risk assessment, the procedure should be undertaken with the use of appropriate PPE as per the COVID-19 Personal Protection Equipment flowchart.

---

**Patient care equipment**

Patient-care devices (e.g. electronic thermometers, sphygmomanometers, glucometers, hoists, pat slides) may transmit Coronavirus when shared between patients.

Where possible, all equipment required for patient care should be dedicated for the use of an individual patient or disposable equipment (e.g. tourniquets) used for the duration of the admission.

If equipment cannot be dedicated to the patient for the duration of illness it should be thoroughly cleaned and disinfected using Clinell wipes before returned to CELS / used by other patients.

---

**ALERT**

Tourniquets must be single use for any infectious patients. Re-usable tourniquets are not to be used on any infectious patient.

---

**Designated wards / units at Queensland Children’s Hospital**

The following wards / units have suitable patient accommodation (single room with ensuite, anteroom and negative pressure) **AND** staff trained in pandemic management and PPE donning and removal / doffing:

- Emergency Department (ED)
- Paediatric Intensive Care Unit (PICU)
- 9a inpatient ward.
- 9b inpatient ward
- 10a inpatient ward

See **Appendix 5** - List of negative rooms within Queensland Children’s hospital.
Environmental controls
Rooms should be cleaned as an orange clean. Refer to Cleaning Matrix

Environmental cleaning and disinfection

Equipment cleaning
All equipment is to be wiped down by staff in PPE before being released from the room and into the hallway where it can be wiped down again with Clinell wipes by staff wearing gloves and a white apron.

Before leaving the room the staff member needs to follow the doffing procedure both in the room and anteroom before performing the second clean.

Medirest can then attend to room clean.

Routine cleaning
Further advice is available for in the work instructions for Cleaning and Waste removal

- Medirest Cleaning and Waste Removal (PICU) - COVID-19 and
- Medirest Cleaning and Waste Removal (Emergency and Ward) - COVID-19

Daily cleaning tasks of the patient care environment should be undertaken as per usual isolation precaution requirements i.e. daily and discharge orange clean as per Cleaning Matrix and Contact and Droplet with Eye Protections.

- Ask a nurse to observe/check your PPE before entering room if you are not familiar with the process.
- Cleaning staff must also follow the advice regarding hair ties, being clean shaven, having no nail polish or fake nails and not carrying any extra objects (e.g. pens, phone, ID badge) into the room. Every cleaner who enters the patient room must also write their name on the list health care worker personnel log. Please ask nursing staff for this list.
- Do not leave door open and ajar while cleaning.

Final disinfectant clean / discharge / transfer clean

- Prior to cleaning the room, all of the patient’s personal effects and privacy curtains if present, should be removed for laundering
- Handle used textiles and fabrics with minimum agitation to avoid contamination of air, surfaces and persons.
- The room and all patient care equipment remaining in the room should be physically cleaned and disinfected.
- All furniture, patient equipment items, horizontal surfaces, frequently touched surfaces (e.g. light switches and call buttons) and bathroom / toilet / shower area should be thoroughly cleaned and disinfected
- All consumables that are unable to be cleaned should be discarded.

Linen

- No special requirements are required for the removal of linen for suspected or confirmed COVID-19 patients.
Air circulation times in negative pressure rooms

ED: 30 minutes
PICU: 30 minutes
9a: 40 minutes
9b Bed 10: 60 Minutes
Theatre 14: 40 Minutes.

Cohorting

Confirmed cases

Cohorting of confirmed cases of a pandemic organism must only be undertaken following consultation with local experts, such as infectious diseases physicians and IMPS. Where practicable, managing patients with mild illness in their own home is the preferred approach rather than cohorting patients.

Cohorting patients who are infected with a pandemic organism confines their care to one area and prevents contact with other patients.

The following principles apply when making decisions about patient placement:

- Unrelated COVID patients must be in a single room and must not be cohorted. Cohorting places families and caregivers at significant risk.
- Siblings can be cohorted, however 1.5 meters must be maintained between each person. This is taking into account the risk of other pathogens.
- Confirmed cases of the confirmed pandemic organism take priority over other conditions requiring contact and droplet precautions. Consult with the IMPS for other diseases/presentations requiring isolation.
- Prioritise patients who have severe pneumonia symptoms for placement in single rooms with negative pressure air handling.
- Care should be taken to ensure that confirmed pandemic organism cases co-infected with influenza are not cohorted.

**ALERT**

Unrelated COVID patients must be in a single room and must not be cohorted. Siblings may be cohorted, however 1.5 meter spacing is required between patients.

Suspected cases

The decision to cohort suspected cases needs to be taken following consultation with local experts, such as infectious diseases physicians and IMPS. Cohorting suspected cases is not recommended.

See applicable DisMAP for applicable plans for each area for patient placement. DisMAP can be located in CHQ-PROC-63326 – Respiratory Pandemic Sub Plan.

Visitors/family

Family members and visitors should be limited to those essential for patient support. During pandemic respiratory outbreaks ensure Public Heath Directives are enforced and any exemptions are sought as required.

The following principles should be followed in relation to visitors who enter the patient care area:
• Visitors should be screened for symptoms of acute respiratory illness before entering the facility.
• Parents are to remain in the patient room unless required to leave or go home.
• Meals should be delivered.
• Parent / carer to wear a surgical or procedural mask when exiting the patient room and to wear a mask while in the hospital facility.
• For transfer of patient routes, please refer CHQ-PROC-63005- Transport of high risk or confirmed patients with pandemic respiratory infections (MERS, SARS, SARS-CoV-2 or Novel Coronavirus, Pandemic influenza) Staff resources.
• Support the parent to understand the risk of transmission and the use of infection prevention measures such as PPE and respiratory hygiene.
• Parents and carers should not visit other patients or other areas of the hospital including lounges and / or food / cafeteria / common areas. A log of all visitors who enter the patient room should be maintained.
• Visitors should not be allowed to be present during AGPs. For young children who may find procedures distressing, one caregiver may remain in the room for AGPs if necessary.
• Visitors should report any signs or symptoms of acute illness for a period for up to 14 days after the last known exposure to the patient.
• Refer to CHQ-PROC-64712- Visitation and access during COVID-19 pandemic period.
• Please refer to Appendix 7 for visitors who have a quarantine order.

---

**ALERT**

Carers of patients who are suspected or confirmed cases of COVID-19 must remain in the patient’s room at all times. When they leave the hospital, they must go directly to their vehicle and wear a mask when entering and leaving the hospital.

---

**Restrictions when crossing the border**

Information about border restrictions please visit Latest updates – Coronavirus (COVID-19)

**Patient care consideration**

**Inpatient de-escalation of isolation and transmission-based precautions**

• Prior to ceasing patient isolation and transmission-based precautions for high risk children requiring ongoing hospital admission, the case should be discussed with IMPS Consultant.
• Following discussion with the IMPS consultant, a child with confirmed or probable COVID-19 may be released from inpatient isolation only if they meet all of the following criteria:
  The child has been afebrile for the previous 72 hours
  Symptoms of the COVID-19 illness have resolved for >24 hours
  The child is at least 10 days from the onset of the acute illness
  PCR testing is negative on two samples taken at least 24 hours apart at least 7 days from symptom onset
• Children with conditions that may result in viral shedding for a prolonged period of time (e.g. because of immune status and medications) should be taken into consideration.
• Children who are significantly immunocompromised must meet a higher standard to be released from isolation.
• In children with symptoms such as chronic cough the treating team should make an assessment as to whether the signs and symptoms of COVID-19 have resolved.

• A small proportion of children may have illness that has completely resolved but their respiratory specimens remain persistently PCR positive. A decision on release from isolation for these people should be made on a case-by-case basis after consultation between the treating team and IMPS.

• Faecal sampling is not recommended as a standard test, however, it may be done in discussion with IMPS for some children with gastrointestinal symptoms. For children who do have persistently positive PCR in stool after release from isolation criteria are met, further or extended precautions and exclusions should be implemented on a case-by-case basis.

• Parents of children with diarrhoea and persistently positive stool PCR should have the importance of proper hand hygiene reinforced. Soap and water should be used if possible, though alcohol hand gel may be used.

• Detailed guidance is available in the CHQ policy The Management of children with COVID-19

---

**ALERT**

ieMR alerts for positive SARS-CoV-2 can only be removed by IMPS. If you feel your patient fits criteria and can be removed from precautions please contact IMPS 3068 4145.

---

**Staffing allocation**

• We recommend senior staff members are allocated to patients with suspected or confirmed COVID-19.

• Please limit the number of staff entering the room.

• COVID patients should be allocated dedicated HCWs to minimise the risk of transmission and exposure to other patients and HCWs.

• Key wards / department identified to accommodate patients with a pandemic related illness should have ongoing training of nursing staff in pandemic management and pandemic PPE donning and doffing to equip this cohort in pandemic response and management (i.e. ED, PICU, wards 9a).

• As it is not feasible to train all staff who may be required to provide patient care services in these departments, the ward / department nurse holds a pivotal role in ensuring all staff attending the patient undertake correct PPE donning and doffing and other procedures vital to prevent transmission of infection such as decontamination of equipment between patients.

• Only allocate staff to undertake environmental cleaning, and disinfection of equipment who are competent in donning and doffing standard, airborne and contact precautions PPE i.e. operational services staff.

• Staff rosters should include adequate numbers of staff to avoid staff fatigue. Wearing a P2/N95 respirator can be tolerated for only limited periods - regular breaks are required.

Certain health conditions may preclude HCWs from providing direct care for Coronavirus patients and should be taken into consideration when allocating staff. These may include:

• Medical conditions that could affect their ability to exit the room quickly and safely, or may require another HCW to enter the room to provide urgent medical assistance (e.g. seizure disorder, hypoglycaemia).

• Inability to safely put on, use, or remove recommended PPE (e.g. claustrophobia, significant anxiety, body morphology or mobility issues).

• Conditions that increase the severity of illness such as diabetes, chronic lung, liver or heart disease, renal impairment, immunocompromise and cancer.

• Pregnancy is a contraindication for working in such high-risk clinical areas.
Alert
CHQ encourages all staff to review the Qld Health COVID-19 vulnerable employees guideline. If concerned or have questions please contact your line manager.

Staff monitoring

- HCWs who care for patients with High risk and confirmed COVID-19 will be recorded on a log (see Appendix 2) and kept with IMPS.
- If a HCW who has cared for a patient with suspected or confirmed Coronavirus develops any acute illness or signs or symptoms such as: fever, cough or shortness of breath they should immediately:
  - Stop work and/or not present to work
  - Notify the facility designated person i.e. Mon–Fri – CNC / CN IMPS / after-hours CNC Clinical Safety
  - Seek medical evaluation
  - Comply with work exclusion and isolation until they are no longer considered infectious to others
- Public Health and IMPS will support staff and advise them when they are cleared to return to work based on their individual circumstances.

Food services

- Non-essential staff should be restricted from entering the Coronavirus patient care area.
- Food services staff should deliver all food and beverages to the designated clean area and notify the staff caring for the patient so these should then be delivered into the patient room by staff directly caring for the patient.
- The nurse is to place the empty food tray (post meal) on to the food trolley. The nurse will wipe the tray down with Clinell Wipes prior to putting the tray on the food trolley.
- Paper plates / disposable cutlery are not required. Processing these in the normal fashion (dishwasher) is sufficient.
- Please refer to CHQ-WI-63321 – Medirest Food Services Guide – COVID-19

Management of blood products

If a septic transfusion reaction is clinically suspected in a patient with COVID-19, the patient should have a blood culture and the remaining blood component should be returned to the microbiology laboratory for sampling for microbial culture.

In this instance, the bag should be sealed to avoid leakage and contained within a clean biohazard bag before being returned to the laboratory.

Please note PICU may not have the clear biohazard bags - only the red specimen bags. Blood Bank will be able to supply the clear bags if required.

It is essential that handling is performed by staff with appropriate PPE.

This should be a two-person job as the blood component bag will need to be placed in the biohazard bag ensuring the risk of SARS-CoV-2 transmission is eliminated.

The use of pneumatic system is approved to transport this product.
Please note

Once blood bags enter the room of a COVID-19 patient, they cannot be returned to blood bank.

- Blood components should only be taken to potentially contaminated bedside clinical areas when they are definitely required for transfusion.
- Otherwise blood components should be kept on surfaces that have been cleaned and not at risk of respiratory droplet contamination.
- Hospital staff handling blood components should wear gloves where routinely required and practice the 5 moments of hand Hygiene.

Care of the deceased patient

Precautions

The risk of COVID-19 infection for personnel who handle dead bodies of persons suspected of having or confirmed to have died from COVID-19 is likely to be low. This risk is further reduced by compliance with recommended infection control procedures.

Use Contact, Droplet with Eye protection precautions. Airborne plus precautions may be required for autopsy which does not occur at QCH.

Coroner reportable deaths

A death known or suspected to most likely to be from COVID-19 will generally not need to be reported to the coroner. This is because the death is from a natural cause and the probable cause of death is known.

The fact that COVID-19 is a notifiable condition under the Public Health Act 2005 does not of itself make the death reportable to the coroner.

Doctors are encouraged to issue a cause of death certificate in these cases.

A COVID-19 death will only be reportable to the coroner if:

- the death is a death in custody or a death in care; or
- the person died as a result of the care they received or did not receive, for example, a missed diagnosis or failure to treat COVID-19.

However, a COVID-19 death will not be reportable for failure to provide health care because of inadequate resourcing in the event of an overwhelming demand for critical care services provided clinical decision making for the person is consistent with the Australian and New Zealand Intensive Care Society (ANZICS) COVID-19 Guidelines of 16 March 2020.

General enquiries about reportable deaths should be directed to the Coroners Court of Queensland during business hours on 3738 7050 (2020, Department of Justice and Attorney-General).

Care of the asymptomatic patient under quarantine

During the COVID-19 pandemic, patients may be admitted to Queensland Children’s Hospital for a reason other than a respiratory illness whilst they remain under 14-day quarantine restrictions after entering Australia from overseas or having been in close contact with a positive patient. If these patients have any possible symptoms of COVID-19, they should be managed as high-risk patients (see above).
If they do not have acute respiratory symptoms or other symptoms suggestive of COVID-19, they should be managed with droplet and contact precautions for routine cares and Airborne Plus PPE for AGP. This is to maintain a barrier when true quarantine is not possible. The child and their family member must remain in their room at all times during their stay.

Upon leaving the hospital, if their quarantine period has not ended, the child and carer should wear a mask. They should be escorted to their vehicle or taxi. If they are under hotel quarantine, the destination hotel must be called to advise them that the child and carer will be arriving soon. They must continue to wear their masks until they arrive at their hotel room or own home. The public health unit should also be advised that the patient under quarantine has returned to their hotel or own home.

Transportation of a patient

- All information about transportation of a suspected or confirmed COVID-19 patient please refer to CHQ-PROC-63005- Transport of high risk or confirmed patients with pandemic respiratory infections (MERS, SARS, SARS-CoV-2 or Novel Coronavirus, Pandemic influenza)Staff resources

Supporting documents

Authorising policy and standard/s

- Interim infection control guidelines for the management of Middle Eastern Respiratory Syndrome Coronavirus
- Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting
- Queensland Health. Management of deceased persons who are confirmed or suspected COVID-19 cases

Policies within CHQ for COVID-19

- CHQ-GDL- 63327 -The Management of children with COVID-19
- CHQ-PROC-63326 – Respiratory Pandemic sub plan
- CHQ-PROC-63326-1 Disruption and Disaster Management plan – 9A
- CHQ-PROC-64712- Visitation and access during COVID-19 pandemic-period
- CHQ-PROC-24703 -Special measures during the COVID-19 pandemic period.
- CHQ-WI-63324- Medirest cleaning and waste removal (PICU)- COVID-19
- CHQ-WI-63321 – Medirest Food Services Guide COVID-19
- CHQ-WI-63320 – Medirest Transport Guide - COVID-19
- CHQ-WI- 63319 – Medirest Cleaning and Waste Removal (Emergency and ward) -COVID-19
- CHQ-WI-63323 – Personal Protective Equipment (PPE) rationalisation within CHQ – COVID-19
- CHQ-WI- 64713 - Screening controls for visitation and access during COVID-19 pandemic period
- CHQ-PROC-64714- Overview of personal protective equipment in the COVID-19 era
Consultation

Key stakeholders who reviewed this version:
- Executive Director Medical Services.
- Director of Clinical Support
- Director of Infection Management and Prevention Service
- IMPS Committee
- A/Clinical Nurse Consultant – Infection Management and Prevention Service

Definition of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerosol generating procedures</td>
<td>Any medical procedure that can induce the production of aerosols of various sizes, including small (&lt;5 µm) particles</td>
<td>WHO ²</td>
</tr>
<tr>
<td>Cohorting</td>
<td>Placing together in the same room patients who are infected with the same pathogen and are suitable roommates</td>
<td>NHMRC ⁶</td>
</tr>
<tr>
<td>Negative pressure room</td>
<td>A single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in negative pressure rooms to minimise the transmission of infectious agents that are usually transmitted from person to person by droplet nuclei associated with coughing or aerosolisation of contaminated fluids.</td>
<td>NHMRC ⁶</td>
</tr>
<tr>
<td>Personal Protective Equipment (PPE)</td>
<td>A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, protective eyewear, face shields, and gowns.</td>
<td>NHMRC ⁶</td>
</tr>
</tbody>
</table>

Audit/evaluation strategy

<table>
<thead>
<tr>
<th>Level of risk</th>
<th>Medium (WHS – Moderate – unlikely)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy</td>
<td>Monitor for trigger incidents</td>
</tr>
<tr>
<td></td>
<td>Observation of cleaning and PPE use</td>
</tr>
<tr>
<td>Audit/review tool(s) attached</td>
<td>nil</td>
</tr>
<tr>
<td>Audit/Review date</td>
<td>As required in preparation and during pandemic responses</td>
</tr>
<tr>
<td>Review responsibility</td>
<td>IMPS CNC</td>
</tr>
<tr>
<td>Key elements Indicators / Outcomes</td>
<td>Correct use of PPE</td>
</tr>
<tr>
<td></td>
<td>Rapid and appropriate isolation/cohorting</td>
</tr>
</tbody>
</table>
# Procedure revision and approval history

<table>
<thead>
<tr>
<th>Version No.</th>
<th>Modified by</th>
<th>Amendments authorised by</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>CNC IMPS</td>
<td>EDMS</td>
<td>Executive Director Health Services</td>
</tr>
<tr>
<td>2.0</td>
<td>CNC IMPS</td>
<td>Director IMPS</td>
<td>Director of Clinical Support</td>
</tr>
<tr>
<td>3.0</td>
<td>CNC IMPS</td>
<td>Director IMPS</td>
<td>Executive Director of Clinical Services</td>
</tr>
<tr>
<td>4.0</td>
<td>CNC IMPS</td>
<td>Director IMPS</td>
<td>Executive Director of Clinical Services</td>
</tr>
<tr>
<td>5.0</td>
<td>CNC IMPS</td>
<td>Paediatric Consultant CHQ</td>
<td>Executive Director of Clinical Services (QCH)</td>
</tr>
<tr>
<td>6.0</td>
<td>CNC IMPS</td>
<td>Director IMPS</td>
<td>Executive Director of Clinical Services (QCH)</td>
</tr>
<tr>
<td>7.0</td>
<td>CNC IMPS</td>
<td>Director IMPS</td>
<td>Executive Director of Clinical Services (QCH)</td>
</tr>
<tr>
<td>8.0</td>
<td>CNC IMPS</td>
<td>Director IMPS</td>
<td>Executive Director of Clinical Services (QCH)</td>
</tr>
<tr>
<td>9.0</td>
<td>CNC IMPS</td>
<td>Director IMPS</td>
<td>Executive Director of Clinical Services (QCH)</td>
</tr>
<tr>
<td>10.0</td>
<td>CNC IMPS</td>
<td>Director IMPS</td>
<td>Executive Director of Clinical Services (QCH)</td>
</tr>
</tbody>
</table>

**Keywords**

- Infection Control, MERS, Middle Eastern Respiratory Syndrome, Coronavirus, Novel, SARS, Wuhan, suspected, confirmed, Coronavirus, 63002, COVID-19, SARS-CoV-2

**Accreditation references**

- NSQHS Standards (1-8): 3 Preventing and Controlling Healthcare Associated Infections
- ISO 9001:2015 Quality Management Systems: (4-10)
### Appendix 1: Role descriptions and communication requirements

<table>
<thead>
<tr>
<th>Role</th>
<th>Roles / responsibilities</th>
<th>Person / Role for you to contact / advise</th>
<th>Comments</th>
</tr>
</thead>
</table>
| ED triage nurse | • Screen patients to identify risk of coronavirus  
• Facilitate transfer to isolation room / orange zone ASAP  
• Place mask on patient and family members  
• Clean ED reception area of any contamination (Clinell Universal disinfectant wipes)  
• Alert NUM / flow coordinator of presentation and risk | Alert NUM / flow coordinator of presentation and risk | |
| ED nurse | • Transfer patient and carer to ED isolation room / orange zone ASAP | | |
| ED Nurse Unit Manager/ ED patient flow coordinator / Team leader | • Advise key personnel of situation  
• Ensure patient and carer transfer to isolation room / orange zone ASAP  
• Organise clinical staff to care for the patient  
• Ensure PPE, signage, is available in isolation room / orange zone anteroom  
• Ensure MET trolley / emergency equipment are readily available  
• Help organise additional supplies/ resources/ signage / information etc. including telephone interpreter service, additional PPE from B3 lift-well IMPS Storage Area  
• Ensure that clinicians don and follow PPE requirements (those staff entering the isolation room record the and details of each HCW entering, record the time of entering/exiting the patient room and any potential exposure)  
• Ensure copy of HCW register is provided to IMPS each shift to [chk.imps@health.qld.gov.au](mailto:chk.imps@health.qld.gov.au)  
• Provide reassurance and direction | Patient Flow Nurse Manager (24/7, ext. 4440) | |
| Patient Flow Manager | • Advise key personnel of situation if required  
– nursing director on call  
– Medirest executive on call  
– QCH Facilities Management  
– Coordinator | Nursing Director on-call (via switch ext. 9) | Provide support and direction |
| Nursing Director on-call (via switch ext. 9) | • Coordinate staff requirements for the next three days if possible, hospitalisation in ED/ 9a / PICU i.e. obtain sufficient staff numbers to provide patient care and staffing in consultation with NUMs / nursing directors | Medical Executive on-call (via switch) | Infectious disease consultant on call (via switch ext. 9)  
Contact during day and after hours |
<table>
<thead>
<tr>
<th>Role</th>
<th>Roles / responsibilities</th>
<th>Person / Role for you to contact / advise</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Determine need for broader communication e.g. daily operational brief / huddles, communication via clinical divisions</td>
<td>Infection Management and Prevention Service (IMPS) CNC/CN Mon – Fri daytime (ext. 4145 or via switch)</td>
<td>A/H contact CNC Clinical Safety for support</td>
</tr>
<tr>
<td>Medical Executive on-call</td>
<td>• Determine the need to contact the Chief Executive and Media / Communications</td>
<td>Chief Executive if deemed as required (via switch)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assist with organising sufficient medical staff to provide patient care</td>
<td>Media / Communication if deemed as required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Determine need for broader communication e.g. daily operational brief / huddles, communication via clinical divisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious Diseases Consultant on-call</td>
<td>• Provide advice / consultation regarding patient management</td>
<td>Public Health Unit on-call Physicians Metro South (ph 3176 4000)</td>
<td>A/H contact CNC Clinical Safety for support</td>
</tr>
<tr>
<td>(via switch). Contact during day and</td>
<td>• Advise Public Health Unit and Communicable Diseases Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>after hours</td>
<td>• Consult with IMPS nursing team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medirest porters and security</td>
<td>• Planning prior to patient transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Obtain additional pandemic PPE stock and waste disposal units from B3 lift-well – IMPS pandemic storage areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection Management and Prevention</td>
<td>• Provide advice / supervision / feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service (IMPS) CNC/CN (ext. 4145)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive if deemed as required</td>
<td>• Support patient care team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(via switch)</td>
<td>• Contribute to media communications as required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media / Communication as deemed required</td>
<td>• Coordinate media communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Facilitate communication with staff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Appendix 2: Staff personnel log

Click here for Staff personnel Log.

## Staff personnel log for suspected or confirmed high risk cases of coronavirus

<table>
<thead>
<tr>
<th>Surname</th>
<th>First name</th>
<th>Payroll No.</th>
<th>Date of contact</th>
<th>Time in room (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Email: chq_imps@health.qld.gov.au

---

![Sample Image]
Appendix 3: How to fit check a P2 / N 95 mask

Please refer to [video](#) for donning doffing and fit checking 3M1860


### Negative pressure

- The wearer inhales sharply. The mask should be drawn in to the face. If air can be drawn into the mask it will not collapse.

  **This indicates that the seal has failed.**
  You need to reposition the mask and perform the check again.

### Positive pressure

- The wearer huffs or exhales sharply. Air should not be felt leaking around the edges of the mask. This indicates that the seal is not adequate. Reposition the mask and perform the check again. The wearer should not feel any air leak between the mask and face. This is the sign of a good face - mask fit, and a successful **Fit Check.**
Appendix 4: Pandemic PPE stock location

QCH B3
Access to this area is restricted. Contact help desk for a porter with access to obtain stock.

Please note there are more quarantine waste bins available in the B3 mortuary cleaning room and cleaning storeroom.
# Appendix 5: Negative pressure rooms within QCH

<table>
<thead>
<tr>
<th>Room and Ward</th>
<th>Room Number</th>
<th>Room Description</th>
<th>AHU Location</th>
<th>Positive / Negative</th>
<th>Air exchange rates required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed 1 - Orange Zone</td>
<td>01.2.262</td>
<td>Isolation Bed 1</td>
<td>02.2.285</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Bed 2 - Orange Zone</td>
<td>01.2.265</td>
<td>Isolation Bed 2</td>
<td>02.2.285</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Bed 3 - Orange Zone</td>
<td>01.2.322</td>
<td>Isolation Bed 3</td>
<td>02.2.285</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>PICU Bed 5</td>
<td>04.1.062</td>
<td>ICU Bed 5</td>
<td>05.3.502</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 9A - Bed 20</td>
<td>09.1.001</td>
<td>Medical Ward Bed 20</td>
<td>09.2.302</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 9B - Bed 15</td>
<td>09.4.812</td>
<td>Babies Ward Bed 15</td>
<td>09.4.801</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 9A - Bed 5</td>
<td>09.3.594</td>
<td>Medical Ward Bed 5</td>
<td>09.3.523</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 9B - Bed 1</td>
<td>09.2.262</td>
<td>Babies Ward Bed 4</td>
<td>09.2.302</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 9A - Bed 11</td>
<td>09.3.514</td>
<td>Medical Ward Bed 11</td>
<td>13.1.005</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 9A - Bed 10</td>
<td>09.3.534</td>
<td>Medical Ward Bed 10</td>
<td>13.1.005</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 9A - Bed 15</td>
<td>09.1.042</td>
<td>Medical Ward Bed 15</td>
<td>13.1.005</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 10A - Bed 20</td>
<td>10.1.001</td>
<td>Surgical Ward Bed 20</td>
<td>10.2.325</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 10B - Bed 22</td>
<td>10.4.842</td>
<td>Cardiac/Oncology Ward Bed 22</td>
<td>10.4.772</td>
<td>Negative</td>
<td>y</td>
</tr>
<tr>
<td>Ward 11B - Bed 20</td>
<td>11.4.856</td>
<td>Oncology &amp; Bone Marrow Ward Bed 20</td>
<td>11.4.772</td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td>Ward 11A - Bed 5</td>
<td>11.3.581</td>
<td>Neurosciences Ward Bed 5</td>
<td>11.3.525</td>
<td>Negative</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6: Testing Information for COVID-19 (Testing Clinic)

Nasopharyngeal swab and oropharyngeal swab, Dacron or Rayon, flocked preferred

- Specimens should be collected in a single room with the door closed or in a physically separated closed area designated for suspected COVID-19 cases. (e.g. in a hospital setting).
- If this is not possible, then collect the specimens in a room with the door closed and leave the room, which should be left vacant for at least 30 minutes after specimen collection if performing an AGP only (cleaning can be performed during this time by a person wearing PPE, undertake orange clean as required refer to cleaning matrix).
- Testing clinic will be cleaned at the end of the day with an orange clean.
- Perform hand hygiene before donning gown, gloves, eye protection (goggles or face shield) and P2/N95 respirator for AGP or Surgical mask for non-AGP.
- NPA are not considered an AGP unless the patient is highly symptomatic.
- Upper respiratory tract sample collected.
- Lower respiratory tract sample if the lower tract is involved (Only specific patients, for example, an intubated patient)
- Nasopharyngeal swab collection technique
  Using a pencil grip, insert a flexible nasopharyngeal swab into one nostril in a rotating motion and gently insert it along the floor of the nasal cavity parallel to the palate until resistance is encountered, rotate gently for 10-15 seconds, then withdraw and repeat the process in the other nostril with the same swab to absorb secretions.
- Nasal wash/aspirates, collect 2-3 mL into a sterile, leak-proof, screw-top dry sterile container – only specific patients not preferred option

Testing centre is to perform Nasopharyngeal swab only.

**ALERT**

It is mandatory that all staff who performing testing have training in PPE donning and doffing and is record on Teach Q+.
Appendix 7: Visitation by family members under quarantine.

This outlines the requirements for a person who is in mandatory quarantine e.g. returned overseas traveller or from a declared hotspot and has requested that they be able to visit a patient in hospital.

The person must apply to the CHO for an exemption to visit if not a local resident. Please contact the disaster management team for further information HEOCEmergencyManagement@health.qld.gov.au.

---

**ALERT**

If an exemption is granted, parents/primary caregiver must provide consent for visitation to the patient. This must also be approved by the NUM in the applicable area.

---

Once a CHO exemption has been granted, please contact IMPS and Executive Director Clinical Services (EDCS-QCH) for approval and plan around visitation. ID consultant on call if an emergent situation that needs emergency approval. The Executive Director Clinical Services will consider the request in consultation with IMPS and members of the clinical treating team.

**IMPS** – chq_imps@health.qld.gov.au

**EDCS** – CHQ_EDCS-QCH@health.qld.gov.au

When a visit has been granted approval by IMPS and EDCS, the following risk mitigation strategies are to be followed:

When a visit has been granted approval, the following risk mitigation strategies are to be followed:

- The visitor contacts the clinical area and organises times to visit with the Nurse Unit Manager (NUM)
- The visit is to be no longer than 2 hours once a day (from arrival to departure at the hospital). Additional hours can be negotiated with IMPS and will be assessed by the risk and relation of the individual to the patient.
- They are to be met at the entrance of QCH by ward staff at arranged time and escorted directly to clinical area
- Please inform screening stations that the visitor is presenting.
- The visitor is asked by staff member all screening questions as per the CHQ-PROC-64712 Visitation and Access during COVID-10 Pandemic Period
- If visitor develops symptoms during visit, they must present to the Fever Clinic for testing, and will not be able to visit again until they no longer have symptoms, even if the COVID-19 results are negative.
- The visitor is required to wear a surgical mask during the entire visit, including during transport to and from the quarantine hotel. They can remove it to have a drink but will need to replace it immediately. The QPS / Public Health staff coordinating the visit will have issued the visitor with a mask. If the visitor does not have a surgical mask, QCH staff are to issue the visitor with a surgical mask to wear at the entrance to the hospital.
- The visitor is to complete hand hygiene on entering and exiting the hospital and clinical area
- The patient is to be in a single room and the visitor is to remain in the room for the duration of the visit – they are not to visit any other areas within the hospital (e.g. food court, clinical services)
- If the visitor needs to go to the toilet during the visit, staff are to escort them to a public bathroom. They are to return to the patient’s room immediately and they are to perform hand hygiene before and after
- Physical distancing of at least 1.5m should be maintained during visit this includes no physical contact with other family members i.e hugging.
- Visitors should clean hands immediately before and after holding hands with the patient. (Hand holding is only permitted in patients that are end of life)
- The visitor should be escorted to the designated pick up point at the completion of the visit
- During this unprecedented time, it is important to continue to show compassion to patients and visitors whilst still maintaining appropriate precautions.