Questions and Answers with Auckland IPC teams.

Q.1
If there is a next time, what would you do differently in terms of hospital IPC or recommend to other hospitals facing what you have faced?

A.1

1. Resource more staff! Even if you don't have additional qualified IPC staff I would strengthen the link nurse system so they could be seconded into the team – just to carry on BAU.
2. If we had enough staff I would create a role to do non-COVID work and rotate the team through that to allow for time away from the high pressures of the COVID stream.
3. Involve the educators early so they can pick up some of the PPE training that's required.
4. Form two bubbles within the IPC team to protect the team in the event of an exposure. Currently most of the team would be stood down if one of the team members became positive.
5. Get your online education updated now so that staff at least have some baseline knowledge.
6. Our IT team have been very supportive and have provided us with some great time saving reports and tools – unfortunately you don't know what you'll need until you're in the thick of it, but a good relationship has definitely helped!
7. Have a plan for asymptomatic staff screening from the get go – it helps to relay anxiety.

<u>Other useful information under Q.1</u>

- There are so many things we would have completed last year in hindsight and unfortunately they are the things that we could never action by ourselves.
- Not having a voice or even an invite at times to IMT meetings has been a struggle. It is extremely important that IPC have a seat at the IMT table. We thankfully have a very tight knit relationship with our ID and microbiology teams and this helped to a certain degree.
- Having a COVID ward model plan in place. Have a good supply of:
  - PPE - all the necessary equipment (e.g. scrubs, Bioquell tent, extra respiratory machines and related equipment,
  - phones or intercoms in each patient room to aid communication),
  - pre-printed signage in order for COVID wards to be stood up at very little notice.
  - Don/doff PPE training (will you train PPE spotters?) for all staff and education of the 'red zone/orange zone/green zone process.
- Ensure each service has a COVID plan:
  - Tea room separation,
  - bubbles within each service,
  - staff to staff transmission plan,
  - overflow COVID plan, and
  - overflow ICU plan etc
- Consider exposure event plans:
  - aged residual care outbreak plan,
  - mental health plan,
  - obstetric plan,
  - triage system in ED,
  - transfer route for COVID confirmed pts,
  - visitor screening and policy,
  - security plan, resus/CPR policy,
  - plan for family admissions (e.g. obstetric patients/babies on adult COVID respiratory wards).
- Having additional negative pressure capacity works actioned last year would have prepared us much better for this year's escalation phase and into the border reopening

phase. I would highly recommend other IPC teams meet with their air technicians/ engineers to gain an understanding of the current ventilation process for each clinical area in your hospital (including maps) and make the necessary adjustments NOW if you can.

- Having a robust plan in place for asymptomatic staff testing last year would have helped us a lot this year. So something to consider for you all especially as we head towards the border reopening.
- Having community facing staff and high risk area staff continuously wear N95 masks and eye protection meant that we would have avoided multiple staff stand downs (especially in ED, birthing unit, and community). This is now common practice, and as exposure events pop up outside of the high risk areas the question is often asked, shouldn't all staff be wearing N95 masks to avoid further massive staff stand downs? Certainly some services have already instigated this themselves.
- Issues with no clear direction from HR and occupational health about what to do with unvaccinated staff is ongoing, and continues to cause significant problems.

Q. 2

How can the NZ IPC community provide more support to Auckland?

Having IPC Nurse Specialists come from other parts of the country to support the MIFs supported us hugely, so we could concentrate on our local COVID response. Without this, we would have been seconded to the MIFS ourselves and it would have left our stretched team on the ground even more stretched, so I would just like to thank all of you who helped with this.

The majority of COVID+ patients are from our CMH catchment, however our region has an agreed collegial approach, where we share patients across each DHB, and we are very thankful for this. Whilst it has been an extremely exhausting past 18 months for IPC in our region, one good thing is we have had a lot of experience and learnings through managing COVID+ patients (1,826 cases in this region and counting), so there has been plenty of opportunity for our processes to improve.

We would be happy to help with any queries you might have over the coming months as we move to border reopening. Our greatest challenge now is with Delta transmission occurring in a particularly challenging cohort of patients.

Thanks to Rachael Hart and Sandi Gamon for above abridged notes from their interview.

Carolyn Clissold, 13/10/21