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OIA REQUEST

Received: 10 September 2021
Due: 08 October 2021
Response Date: 08 October 2021
Subject: Covid – Te Whare Maiangiangi Policies and Procedures

In response to your request under the Official Information Act, please find our response below:

Request
I request a copy of the policies and procedures that Te Whare Maiangiangi are using to manage the risks associated with Covid19.

Response

The following documents are the current policies and procedures utilised by Te Whare Maiangiangi to manage the risk associated with COVID19 as at 15 September 2021 – Level 2 Delta.

Please note controlled documents, guidelines and procedures relating to COVID-19 and the BOPDHB response are either national or organisational procedures and relate to services and staff across the BOPDHB as well as the staff and services of Te Whare Maiangiangi.

COVID Risk Assessment for Unknown COVID Status and Case Definitions
See Appendix 1.
Case definition of COVID-19 infection definitions.

COVID-19 Testing Guidelines for DHB Health Services
See Appendix 2.

Infection Control
Interim guidance for DHB Acute Care Hospitals – See Appendix 3.

BOPDHB Visitors Policy
Policy 5.3.1 Protocol 4 - Health and Safety - Management of Volunteers and Visitors – See Appendix 4.

Policy 6.9.4 Protocol 1 - Visitors and Nominated Support Persons – Standards – See Appendix 5.

Mental Health Act Processes
Advice on compulsory assessment and treatment processes for mental health services during COVID-19 Alert Level 2 – See Appendix 6.

Personal Protective Equipment Information
MOH PPE Donning & Doffing Guidance.pdf

Cleaning
Ministry of health Cleaning instructions/ cleaning PPE – See Appendix 7.

Bay of Plenty DHB supports the open disclosure of information to assist the public understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website. Please note this response may be published on our website. Official Information Act | Bay of Plenty District Health Board | Hauora a Toi | BOPDHB

You have the right to request the Ombudsman investigate and review our response. www.ombudsman.parliament.nz or 0800 802 602.

Yours sincerely

DEBBIE BROWN
Senior Advisor Governance and Quality

Testing Guidance for the health sector

Implementing the Aotearoa New Zealand COVID-19 Testing Plan

Effective 11 September to 3 November 2021

Note: *This testing guidance is intended for the current community outbreak of COVID-19 and includes guidance for when all of New Zealand or any regions are at Alert Levels 2, 3 or 4. Specific updates may be issued with new guidance from Ministry of health in response to changing Alert Levels or nature of outbreak***,** This *Testing Guidance* will be superseded by further guidance issued by the Ministry of Health which reflects changes in outbreak status when necessary.

Key messages in this update

Testing and vaccination status

COVID-19 vaccination status of the person and their household members, and quarantine-free travel arrangements, do not change the need or decision to test for SARS-CoV-2.

Symptomatic testing

At all Alert Levels, everyone should be offered testing free of charge if they have new onset of **symptoms consistent with COVID-19 infection** .

This includes

- Elderly and children*
- contacts who develop symptoms at any time in the 14 days after exposure to a case or attendance at a location of interest
- People who meet the HIS criteria
- Those with no other obvious diagnosis
- When a test is warranted under clinical judgement
- Those recommended to by a Medical Officer of Health
- anyone who has received a vaccine within the last 48 hours and has developed one or more of the following symptoms: new respiratory symptoms, loss of smell or taste, fever of 38 degrees Celsius or higher, or muscle aches getting worse over time.

After they have been tested, they should then **stay at home** or **self-isolate** as directed until they get a negative result and have been symptom free for 24 hours.

It is particularly important with the increasing prevalence of the highly infectious Delta variant of the virus to test anyone aged 12 or older who is symptomatic during the spring months when colds and flu are still prevalent to ensure a COVID-19 outbreak does not spread undetected.

* At Alert level 1: symptomatic children under the age of 12 years may be excused from testing if they do not meet any of the following:

- subject to a Border Order or Section 70 notice**.
- close or casual plus contacts of confirmed COVID-19 case
- HIS criteria.
- there is no other obvious diagnosis
- when a test is warranted under clinical judgement
- it is recommended by a Medical Officer of Health.
- parents request this.

Asymptomatic people

At all Alert levels, everyone (including children and elderly) needs to be tested if they are:

- Subject to a Border order or Section 70 notice**
- Close or casual plus contacts of a confirmed COVID 19 case.
- Recommended to by a Medical Officer of Health
- Part of Alert level 4 surveillance testing for essential workers and healthcare workers
- Required to by updated guidance from the Ministry of Health.

**Unless provided with an exemption by a Medical Officer of Health or a qualified health practitioner.

Purpose

1. This Guidance is aligned with our *Aotearoa New Zealand COVID-19 Testing Plan*.
2. It is to be implemented for the period 9 September to 3 November 2021, and replaces the *COVID-19 Testing Guidance* previously in force from 8 July 2021.
3. It takes into account the current situation in Aotearoa New Zealand and globally, including current alert level and border status, local events and community factors.
4. It is intended to ensure we continue to:
   a. Implement a sufficient level of testing across Aotearoa New Zealand to ensure any cases of COVID-19 are quickly identified and managed; and
   b. Provide reassurance that the border is secure through ongoing mandatory testing.

Context

5. As of 10 September, Auckland is at Alert Level 4 and the rest of New Zealand is at Alert Level 2, in response to a now contained outbreak of the Delta variant of the virus.
6. While the whole of New Zealand was at Alert Level 4, testing numbers averaged around 30,000 a day. As of 10 September, testing numbers had averaged around 11,000 a day for the previous seven days.

The testing Plan

7. The testing approach has focus on:
   a. Testing people with symptoms of COVID-19 in all regions.

b. Testing as part of any wider case or outbreak investigation

c. testing at the border, (arrivals into New Zealand, border workers and people living and working in managed isolation and quarantine facilities).

d. Saliva testing roll out for surveillance testing of essential workers.

8. The testing approach is designed to quickly identify and manage infections in those most at risk of exposure and to to prevent undetected community spread.

9. Contact tracing and testing of asymptomatic people is used to enable rapid diagnosis and isolation of potential new cases of COVID-19.

10. There is emerging evidence that the newer variants of SARS-CoV-2 can present with less specific symptoms such as muscle aches, headaches, weakness, joint pains and abdominal pain and nausea rather than respiratory symptoms.

11. People who meet the **HIS criteria** — should be tested for COVID-19 and then self-isolate until they get a negative result,.

12. Anyone who is symptomatic should be tested as a priority, irrespective of region or other risk criteria – with the exception of children under the age of 12 years in Alert Level 1, (as noted in paragraphs 26 and 27 below).

13. Similarly, anyone who is required to be tested by the COVID-19 Public Health Response (Required Testing) Order 2020 still needs to present for their subsequent required tests., regardless of their vaccination status. They should also be tested again should they become symptomatic, even if they had a recent negative surveillance test.

14. Any border or MIQ worker who returns a a positive result from a saliva test needs to be re-tested with a PCR test using nasopharyngeal swab or combined oropharyngeal and bilateral anterior nasal swab to confirm the positive result.

15. Anyone (including children_) presenting to hospital with an acute respiratory infection, or who develops symptoms consistent with COVID-19 infection while hospitalised, should be tested for SARS-CoV-2, irrespective of region or other risk criteria.

16. Community testing needs to continue to focus on reducing barriers to testing and needs to include non-appointment-based options. To ensure that testing is equitably available for all those with symptoms, approaches should continue to be developed with Māori and Pacific communities, health leaders and health providers. DHB cultural and community liaison roles will have a key role in planning and implementing these approaches. We encourage DHBs and PHUs to seek input and advice from Māori and Pacific healthcare leaders regarding the best approach to testing for Māori and Pacific children and whānau.

17. Anyone who is required to be tested under a Section 70 notice or a Border Order must be tested, unless exempted by a qualified health practitioner or a Medical Officer of Health.

18. The local Medical Officer of Health may recommend a local change to the Testing Guidance, which may apply to an area or to specific children. For example, they may recommend testing children in a particular area who have recently travelled from an area of increased risk.

19. The decision to test or not test children should not be influenced by the vaccination status of their parents/guardians.

20. It is important to follow infection prevention and control (IPC) recommendations (in particular streaming and PPE) for those who are symptomatic regardless of whether or not they are tested for COVID-19. The experience of the last year and knowledge of the aerosol transmission of the virus have raised the bar on managing respiratory illness in healthcare settings and have shown that increased attention to IPC and ventilation can impact the incidence of a range of respiratory infections.

21. It is also important that group A streptococcal (GAS) throat infections, as well as other respiratory illnesses and illnesses which disproportionately affect Māori and Pacific communities such as measles and meningococcal disease, are considered and managed appropriately in Māori and Pacific whānau who present to primary care services or Community Testing Centres. It is also recommended that where Māori and Pacific children and young adults (3-35 years, especially those aged 4-19 years old) present with a sore throat, a throat swab is taken to identify GAS and/or empiric antibiotics are prescribed according to local guidelines.

Testing methods

22. A swab from the nasopharynx is the most effective way of detecting the presence of SARS-CoV-2 and should be taken wherever possible. Most people will tolerate this procedure, however a combined oropharyngeal and bilateral anterior nasal swab can be considered as an alternative for children and the elderly – particularly if there is concern about tissue fragility.

Testing sites

23. The Ministry will continue working with DHBs, PHUs and community health providers to support equitable access to testing for Māori and Pacific peoples, and those in hard-to-reach and rural locations.

24. In developing local approaches, lessons learned to date need to be considered, including:
    a. One size does not fit all — different approaches are needed for the different communities that require targeted testing.
    b. Clear messaging for communities is needed, including what to do while waiting for a result and the implications of a positive test for the person, their close contacts and family. This has been an area of confusion for people at times, so alignment with Ministry guidance and consistency of messaging is important.
    c. There should be clear public messaging around when and where testing is available.
    d. Public health information provided for mass events should include testing information.

25. DHBs and PHUs should ensure information in Healthpoint is kept up to date for the location of testing sites and their opening times.

Testing children

26. At any Alert Level, children should be tested if they have symptoms consistent with COVID-19. At alert level 1 those under the age of 12 may be excused from testing if they do not meet and any of the following:
    - Subject to a Border Order or Section 70 notice (unless provided with an exemption by a Medical Officer of Health or a qualified health practitioner

- They are a close or casual-plus contact of a confirmed case
- They meet the **HIS criteria**
- There is no other obvious diagnosis
- When a test is warranted under clinical judgement
- It is recommended by the medical officer of health
- Parental request

27. Children do not need to be tested if they are casual contacts unless they become symptomatic.

Further discussion regarding testing / not testing children in Alert level 1

28. The rationale for not routinely testing children under 12 years (who have no other risk factors for COVID-19) in the context of Alert Level 1 is:
    a. In the context of Alert level 1 and no other risk factors for COVID-19, there is more likely to be an alternative diagnosis explaining the symptoms.
    b. The swabbing process is relatively invasive, and this may be particularly traumatic for younger children.
    c. The difficulty of obtaining a quality swab in children can reduce the sensitivity of the test.
    d. Routine testing may be a barrier to parents presenting their children for clinical assessment in primary care settings.
    e. There is no evidence at this point in time that concern about SARS-CoV-2 variants should change the decision to test children in this context.

COVID-19 symptoms vs post-vaccination reactions

29. As the COVID-19 Pfizer/BioNTech (Comirnaty) vaccine is particularly reactogenic, it will be common for people to present with symptoms post-vaccination. Post-vaccination symptoms have generally been more pronounced after the second dose of the vaccine. The systemic reactions to the vaccines can include fatigue, headache and muscle aches and pain, which are all also common symptoms of COVID-19 infection.
30. Because vaccine effectiveness is less than 100%, COVID-19 infection should ALWAYS be considered as a possible cause of symptoms, particularly for those at higher risk of exposure.
31. When endeavouring to distinguish COVID-19 symptoms from reactions to vaccines, refer for testing anyone who presents with one or more of the following symptoms within 48 hours of receiving the first or second dose of ANY vaccine:
    a. loss of the sense of smell or taste
    b. respiratory symptoms (e.g. sore throat, cough, shortness of breath, sneezing/runny or blocked nose)
    c. generalised muscle aches which are worsening with time
    d. fever of 38 degrees Celsius or higher.
32. People with fatigue, headache, localised (not systemic) muscle aches and pain, and low-grade fever/chills in the 48 hours after any vaccination, who do not have the specific symptoms listed in

paragraph 38 above, generally do not need to be tested for COVID-19. There may be exceptions, guided by public health advice.

Other considerations

33. This *Testing Guidance* does not recommend focusing on widespread asymptomatic testing of communities, unless as part of an outbreak or case investigation. However, consideration can be given to offering asymptomatic testing to the following groups if they present to primary care:

34. Regular Surveillance testing is recommended for the following
    a. Health workers, including Aged Residential Care workers.
    b. Hospitality workers, including hotel and restaurant staff.
    c. Public-facing tourism workers.
    d. Public-facing transport workers (e.g. bus, taxi, uber, commuter train).
    e. Close or household contacts of border workers.
    f. Anyone (excluding recovered cases[1]) who has lived or worked in and exited a region that has been in Alert level 4 or an MIQ facility within the previous 14 days.

35. Key hygiene messages for all New Zealanders should stay consistent.
    a. Wash your hands regularly.
    b. Observe physical distancing.
    c. Cough and sneeze into your elbow or a tissue.
    d. Stay at home if you are unwell.
    e. Ring Healthline or your GP for advice if you are unwell.
    f. Get a test if you have any symptoms of COVID-19.

[1] A person who has recovered from COVID-19, and so is no longer infectious, will continue to have fragments of SARS-CoV-2 (the virus that causes COVID-19) in their system for up to several months beyond their infectious period. Although these fragments are neither alive nor infectious they would produce a positive result if the person had a PCR test. This is because the PCR test is designed to detect SARS-CoV-2 genetic material but cannot distinguish between alive and dead genetic material.

ALERT LEVEL 2: HEALTH AND DISABILITY SECTOR RISK ASSESSMENT FOR INTERACTIONS WITH PEOPLE OF UNKNOWN COVID-19 STATUS

This document provides guidance for a risk assessment that should be undertaken at the first point of contact with people whose COVID-19 status is unknown. Please ask the questions before contact with the person, if possible (by phone or signage); otherwise maintain physical distancing of at least 2 metres when asking them.[1] Defer care or use telemedicine where possible. Follow Standard Precautions for all care.[2] Also, refer to your organisational Infection Prevention and Control Guidance.

Clinical Criteria: Does the person have an acute respiratory infection with at least one of the following symptoms (with or without fever): new or worsening cough, fever (at least 38˚C), shortness of breath, sore throat, sneezing or runny nose, loss of sense of smell or altered sense of taste.

✓YES

✗NO

Risk Factors:

In the 14 days prior to seeking care has the person:

Had contact with a COVID-19 case **OR**

Been in attendance at a current location of interest [3] **OR**

Meets the **Higher Index for Suspicion Criteria (HIS)**[4]: Check the Ministry of Health website for updated information.

✓YES

Provide them with a medical mask to wear for source control.

Ensure they are at least 2m from others in a well ventilated space, ie single room or other space outdoors if available.

If the person needs clinical assessment or direct care wear a P2/N95 particulate respirator, eye protection, gown and gloves.

✗NO

Provide them with a medical mask to wear for source control.

Maintain 2m from others or move them into a single room.

Wear a medical mask and eye protection.

✓YES

Provide them with a medical mask to wear for source control.

Maintain 2m from others or move them into a single room.

Wear a medical mask.

Eye protection optional.

✗NO

Person to wear a face covering (their own or medical mask provided).

Wear a medical mask.

Apply Standard Precautions depending on the nature of care to be provided.

SESSIONAL MASK USE: Where possible a mask, face covering or particulate respirator can be worn continuously. Replace if it becomes damp, damaged, or at the end of a session (up to 4 hours).

1. This assessment will determine what additional IPC precautions are required.
2. Refer to Frequently Asked Questions about PPE www.health.govt.nz/ppe-health
3. Refer to MOH for contact tracing places of interest www.health.govt.nz/covid-19-contact-tracing-locations-interest#current
4. Refer to MOH case definition: www.health.govt.nz/COVID-19 case definition.

HP7716 —08 Sep 21

COVID-19

COVID-19 Infection Prevention and Control - Interim Guidance for DHB Acute Care Hospitals

10 August 2021

About this guidance

This guidance outlines the infection prevention and control (IPC) procedures for DHB acute care hospitals providing care for probable or confirmed COVID-19 patients, and those who meet the Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19[1]. This is a living document and replaces previous versions of the IPC Procedures for DHB Acute Care Hospitals and includes further advice on IPC precautions and an organisational framework for IPC preparedness for the management of COVID-19 cases. Please consult with local IPC specialist teams if further risk assessment is required for specific circumstances.

Contents

[1] Current COVID-19 case definition: www.health.govt.nz/covid19-case-definition

1. Introduction

This guidance document outlines the Infection Prevention and Control (IPC) procedures to provide a safe workplace for District Health Board (DHB) acute-care hospitals that are receiving, assessing, and caring for COVID-19 patients, and those who meet the Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19[2].

Planning and implementation strategies: to prevent and control COVID-19 should ensure;

- current Ministry of Health and DHB COVID-19 guidance is readily available and accessible in relevant areas
- early case recognition, containment, assessment, and reporting of cases occurs
- IPC control measures, including hand hygiene, appropriate use of personal protective equipment (PPE) and patient placement, are in place, along with physical distancing
- there is a process for regular audit and feedback to support continuous improvement in IPC practices
- that the practical ability to respond rapidly is supported through clearly defined links between key individuals, services and senior leadership.

This guidance is based on international guidelines and best current evidence available as the COVID-19 pandemic evolves. Some of the guidance set out in this document may need to be operationalised locally, however, the underlying principles of IPC should be adhered to.

Further updates may be made as new evidence emerges and in response to the level of community transmission in New Zealand.

Transmission-based Precautions have been the pillars upon which IPC guidance has been developed for healthcare settings when providing care for patients with suspected or confirmed COVID-19 infections. With the increasing strength of evidence for the role of aerosols in the transmission of SARS-CoV-2, we have revised this guidance document to improve the safety of healthcare workers providing care in hospital settings by mitigating the risk of exposure to small particles during patient care activities. Staff providing care for patients with suspected or confirmed SARS-CoV-2 infection should adhere to Airborne Precautions and wear a P2/N95 particulate respirator. Hospitals also need to ensure the use of effective ventilation controls, that facilitate the removal and dilution of aerosol, in clinical areas where patients with suspected or confirmed COVID-19 infections are assessed and cared for.

2. Routes of transmission

The route of transmission of SARS-CoV-2 continues to be an area of debate in the medical and scientific community. The traditional paradigm has been that respiratory viruses are transmitted by exposure to large droplets (> 5 µm) and through contact with contaminated surfaces. Close range contact with the infectious individual is required for transmission of the infectious agent. Airborne transmission via small respiratory particles, less than 5 µm, (termed aerosols) is thought to occur with only a few infectious diseases, namely measles, varicella, and laryngeal and pulmonary tuberculosis. However, scientific studies have shown that exhaled particles generated by talking, shouting, singing sneezing or coughing are predominantly small particles. These small particles can carry viable infectious viruses and bacteria[3]. The evidence that SARS-CoV-2

[2] Current COVID-19 case definition: www.health.govt.nz/covid19-case-definition

[3] Fennelly KP. Particle sizes of infectious aerosols: implications for infection control. Lancet Resp Med 2020: 8: 914-24.

is transmitted by aerosols is becoming increasingly compelling in enclosed spaces, during prolonged exposure to respiratory particles and, in settings where there is poor ventilation or air handling.

Transmission also may occur through direct and indirect contact with contaminated surfaces, or by contact with equipment used on or by the infected person (e.g. stethoscope or thermometer) but the evidence to support this is unclear[4].

Aerosol Generating Procedures (AGPs) can promote the generation of small particles (<5 µm). These fine particles remain suspended in the air for longer periods than larger particles and can be inhaled resulting in a risk of airborne transmission. The evidence supporting aerosol generation by different medical interventions is of low quality.[5] There are a number of groups looking at aerosol generation during medical interventions and the results of such studies are likely to better define the risk of aerosol generation in healthcare settings.

2.2 Infection prevention and control precautions

Standard Precautions and Transmission-based Precautions must be adhered to when managing patients with probable or confirmed COVID-19, or who meet the Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19.[6] In addition to practices carried out by health care workers when providing care, all individuals (including patients and visitors) should comply with infection control practices in health care settings. The control of spread from the source is essential to avoid transmission of COVID-19.

Standard Precautions

Standard Precautions are the basic level of IPC measures which should always be applied regardless of the infectious nature of the patient, and in the case of all probable or confirmed COVID-19 patients, or those who meet the Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19.

Key elements of Standard Precautions:

Hand hygiene – hand hygiene must be performed before every episode of direct patient care and after any activity/task or contact that potentially results in hands becoming contaminated, including before and after putting on and removing personal protective equipment (PPE), and after equipment decontamination and waste handling. https://www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/topics/hand-hygiene

- **Personal Protective Equipment (PPE)** – before use, assess the risk of exposure to blood and body fluids or contaminated surfaces before any health care activity.
- **Respiratory hygiene and cough etiquette** – this is important for source control. Make sure that the patient has access to tissues, is supported to safely dispose of the tissue after use and to perform hand hygiene.

[4] European Centre for Disease Prevention and Control. Infection prevention and control and preparedness for COVID-19 in healthcare settings. Sixth update – 9 February 2021. https://www.ecdc.europa.eu/en/publications-data/infection-prevention-and-control-and-preparedness-covid-19-healthcare-settings

[5] Assessing the evidence base for medical procedures which create a higher than usual risk of respiratory infection transmission from patient to healthcare worker, Version 1.2 14 May 2021. Antimicrobial Resistance and Healthcare Associated infection, National Services Scotland. https://hpspubsrepo.blob.core.windows.net/hps-website/nss/3055/documents/1_agp-sbar.pdf

[6] Current COVID-19 case definition: www.health.govt.nz/covid19-case-definition

- **Safe use and disposal of needles and other sharps**
- **Aseptic technique** - adhering to a set of principles to prevent infection when performing a procedure.
- **Patient care equipment** – clean, disinfect and reprocess reusable equipment between patients.
- **Appropriate cleaning and disinfection** - of environmental and other frequently touched surfaces.
- **Safe waste management:** follow regional IPC protocols for managing waste.
- **Safe handling of linen:** follow regional IPC protocols for managing used linen.

Refer to the World Health Organization (WHO) poster on standard precautions for further information, available at: https://www.who.int/docs/default-source/documents/health-topics/standard-precautions-in-health-care.pdf

Transmission-based Precautions

Transmission-based Precautions are used when Standard Precautions alone are insufficient to prevent cross transmission of an infectious agent when caring for a patient with a known or suspected infection.

Contact Precautions

Contact Precautions are used in situations where the infectious agent is transmitted via direct contact with blood or body fluids or indirectly from contact with the immediate care environment (including care equipment).

In addition to Standard Precautions, the following infection control measures should also be followed.

- The patient should be placed in a single room (with an ensuite, where possible).
- Where possible, limit the movement of the patient outside of the room.
- Appropriate PPE should be worn (gloves and fluid-resistant long sleeve gown).
- PPE should be donned before entering the room and doffed upon exiting and safely disposed of.
- Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients to other sites within the facility. Don clean PPE to assist the patient at the transport location.
- Use disposable or dedicated patient-care equipment. Avoid the use of share-patient equipment.
- Prioritise the cleaning and disinfection of these rooms.

Droplet Precautions

Droplet Precautions are used to prevent and control infection transmission over short distances of large respiratory particles, termed droplets (>5µm). If they land on the mucous membranes of the nose and mouth or conjunctivae of the eye, they can transmit infection.

In addition to Standard Precautions, the following infection control measures should be followed:

- Place a medical mask on the patient, (if they can tolerate it), for source control.
- The patient should be placed in a single room (with an ensuite, where possible).
- Appropriate PPE should be worn by healthcare workers (medical mask and eye protection upon entry into the patient room or patient space).

- Limit transport and movement of patients outside of the room unless requiring a medical procedure in another department. If transport or movement outside of the room is necessary, instruct the patient to wear a mask and follow respiratory hygiene and cough etiquette.

Airborne Precautions
Airborne Precautions are used to prevent, and control infection transmitted by small particles (<5µm) dispersed from the respiratory tract. **Refer to section 2** for modes of transmission for SARS-CoV-2.

In addition to Standard Precautions the following infection control measures should also be followed

- Place a medical mask on the patient, if they can tolerate it, for source control.
- The patient should be placed in an Airborne Infection Isolation Room (AIIR). If an AIIR is not available, place the patient in a single room that has an ensuite bathroom. The door should remain closed.
- Use PPE appropriately. The healthcare worker is to wear a P2/N95 particulate respirator that they have been fit-tested to. They should fit check it each time they wear one.
- *Refer to fit checking section in* **Role of face masks and respirators** available at: https://www.health.govt.nz/system/files/documents/pages/the_role_of_medical_masks_and_particulate_respirators_110821.pdf

Best Practice for patient placement
For patients admitted to a DHB acute-care hospital who are suspected, or confirmed COVID-19 cases, or meet the Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19[7], the implementation of Standard and Transmission-based Precautions (Contact and Airborne) are required. If available, the utilisation of an AIIR room is recommended. If there is no available AIIR room, a single room with the door closed is an acceptable option. This room should not be positively pressured to the outside corridor. A portable HEPA filtration unit, if available, may be used in this setting and it would provide an additional measure of infection prevention during the assessment of the patient.

In situations where indoor air quality may be poor, such as single rooms with less than 6 air changes per hour, internal rooms with no mechanical ventilation, rooms where windows cannot be opened to allow for air movement or where alternate strategies such as portable filtration units are not available, then consideration should be given to transfer the patient to another facility with adequate ventilation controls. In the event of needing to transfer a patient(s) to another facility, there should be pathways included in the DHB's COVID-19 pandemic preparedness planning.

If a medical procedure that generates aerosols, an aerosol generating procedure (AGP), is being undertaken, Contact and Airborne Precautions should be adhered to.

For further information refer to Frequently Asked Questions at: https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-personal-protective-equipment-central-supply/frequently-asked-questions-about-ppe-and-covid-19

3. Organisational preparedness for preventing and controlling COVID-19

Preventing transmission of SARS Cov-2 in the health care setting requires a multi-faceted approach to ensure early identification and containment measures are in place, engineering, environmental, and administrative

[7] Current COVID-19 case definition: www.health.govt.nz/covid19-case-definition

controls are established, and appropriate PPE is available. The following IPC principles can be considered as a hierarchy of controls.

3.1 Elimination of potential exposure – ensuring triage, early recognition, and source control

- Risk assessment is key to ensuring that cases meeting the Clinical and Higher Index of Suspicion (HIS) criteria are identified on entry to acute care facilities and are isolated and cared for according to IPC guidance to protect patients, visitors, and health care workers.
- Cases meeting the Clinical and Higher Index of Suspicion criteria require testing for SARS-CoV-2 and should be managed with appropriate Transmission-based Precautions and adherence to administrative controls.
- Source control is critical, including the use of medical masks where tolerated, and support for the patient to follow appropriate hand and respiratory hygiene.
- During Alert Level 3 or 4 (Community transmission occurring **or** multiple cluster outbreaks) consideration should be given to universal masking of all patients presenting to high density areas where physical distancing is not possible when awaiting triage and COVID risk assessment, e.g. Emergency Department waiting rooms.

3.2 Implementation of administrative controls

Administrative controls are policies designed to prevent and reduce the risk of exposure and transmission of COVID-19 in the acute care setting and include, but are not limited to:

- sustainable IPC infrastructures and governance
- appropriately trained personnel in IPC activities
- implementation of appropriate IPC measures (e.g. Standard Precautions for all patients)
- education of all health care workers, patients and visitors around hand hygiene and respiratory hygiene
- the safe and appropriate donning and doffing of PPE and other practices designed to prevent transmission of COVID-19
- ensuring adherence to all IPC policies and procedures for all aspects of health care
- vaccination programmes for staff and vulnerable patients
- implementing screening in high-risk areas such as emergency departments, using Standard, Contact and Airborne Precautions and appropriate triage of patients who are a probable or confirmed case of COVID-19, and those who meet the Clinical and Higher Index of Suspicion (HIS) criteria. **(Refer to Appendix 1).**

Administrative controls also include:

- the design and use of appropriate work processes and systems, including access to prompt laboratory testing
- provision and use of suitable work equipment and materials that support and enhance the efforts of health care workers to contain and control the risk of infection
- a resourced fit testing programme which ensures that appropriate staff are fit tested to available respirators at least annually.

Effective strategies need to address environmental, organisational, and individual barriers to adherence. Intervention programmes need strong leadership and the involvement of all staff at all levels. Infection

prevention does not rely solely on a functional IPC team, but also depends on hospital organisation, bed occupancy, appropriate staffing ratios, and workload. On-going workplace risk assessment for SARS-CoV-2 is required to determine the level of risk for potential occupational exposure related to role, work task and work setting.

Administrative measures specifically related to providing a safe work environment for health care workers include:

- provision of adequate education and training for health care workers
- ensuring an adequate patient-to-staff ratio
- establishing a surveillance process for acute respiratory infections potentially caused by COVID-19 virus among health care workers
- ensuring that health care workers understand the importance of promptly seeking medical care
- ensuring adequate and appropriate consumables (for example non-sterile gloves)
- monitoring health care worker compliance with Standard and Transmission-based Precautions and providing mechanisms for improvement as needed (e.g. 'buddy' systems to support correct use of PPE)
- provision of dedicated clinical and non-clinical rooms for staff working with COVID-19 patients as deemed necessary through DHB risk assessment.

3.3 Implementation of engineering and environmental controls

The control of exposure at source, including adequate ventilation systems[6,7] and effective environmental decontamination physically reduces exposure to infection.

Controls to address the infrastructure of the acute care facility aim to ensure adequate ventilation in all areas of the facility, and environmental cleaning.

Engineering controls

Engineering controls can be used to reduce or eliminate exposure of healthcare workers and other patients to infected patients. They include the use of physical barriers and dedicated pathways, remote triage areas, airborne infection isolation rooms and single patient spaces rather than shared open bays in recovery areas. Engineering controls also focus on maintaining the quality of the indoor air.

Indoor air quality in shared spaces can be improved by:

- optimising air-handling systems to provide a minimum of 6 Air Changes per Hour (ACH)
- ensuring that the system in use provides appropriate directional air movement
- providing filtration of the air through high-efficiency particulate absorbing filtration where required
- using portable HEPA filtration units in high risk areas where permanent air-handling systems are not feasible
- consider opening of windows to provide natural ventilation if mechanical ventilation is not available
- The mechanical ventilation system in use in each hospital is fit for purpose, correctly installed and regularly maintained

- The IPC Service maintaining a close working relationship with the relevant service that provides oversight for air quality.

Environmental controls

Effective cleaning and decontamination procedures are necessary to ensure removal of pathogens from the environment. There should be processes in place to ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.

Management of laundry, food services and medical waste should be in accordance with local DHB policies.

Cleaning staff providing terminal cleaning of rooms should follow recommended practices and wear the appropriate PPE for the type of room and cleaning chemicals required. Cleaning chemicals should be effective against SARS-CoV-2.

3.4 Protection of health care workers and patients using hand hygiene and personal protective equipment (PPE)

Hand Hygiene

Health care workers should follow the '5 moments for hand hygiene' before touching a patient, before any clean or aseptic procedure is performed, after exposure to body fluids, after touching a patient, and after touching a patient's surroundings. https://www.hqsc.govt.nz/our-programmes/infection-prevention-and-control/topics/hand-hygiene/

Patients should be enabled to clean their hands at key times and provided with the means to do so.

Personal Protective Equipment

Clear guidance should be provided as to the choice of PPE when caring for a probable or confirmed COVID-19 case, or those who meet Clinical and Higher Index of Suspicion (HIS) Criteria. PPE should be donned prior to any interaction with a suspected, probable or positive COVID-19 patient.
The sequence for donning and doffing PPE should be visually indicated, and a place for these activities should be designated.

- PPE donning and doffing stations should be located close to the point of use (where this does not compromise patient safety, e.g. mental health/learning disabilities) but separate from each other. If located outside a room then the two activities should not be occurring simultaneously.

Medical masks, P2/N95 particulate respirators, gowns and eye protection can be worn continuously for up to 4 hours when providing care to patients in a cohorting setting. Gloves need to be replaced between each patient encounter. Hand hygiene must be performed with change of gloves. If during continuous use the PPE becomes damp, soiled or contaminated with blood or body fluids, then all PPE, including the gown, will need to be replaced.

There are many opportunities for the transmission of SARS CoV-2 and PPE is only one, albeit an important measure, to protect health care workers and others from being exposed to the virus. The use of PPE

should be accompanied by strict adherence to national and local IPC policies and procedures, and the overarching IPC principles of hand hygiene, respiratory hygiene and cough etiquette, physical distancing, cleaning of surfaces and frequently touched items and staying home when unwell.

Regular monitoring and feedback of adherence to PPE guidance as well as support and further education for staff when needed will improve compliance, safe practice and identify gaps in PPE training and advice. Identifying barriers to safe donning and doffing of PPE and enabling workable solutions will ensure the safety of health care workers, patients and visitors is maintained.

For further information refer to: www.health.govt.nz/ppe-health

Staff caring for probable or confirmed COVID-19 patients or those who meet the Clinical and Higher Index of Suspicion (HIS) criteria

Staff assigned to care for probable or confirmed COVID-19 patients should:

- meet the occupational health policy for fitness to work in this situation and should be fully vaccinated (there should be adequate staff allocated to work in this area, with high staff to patient ratio ensured)
- follow the local procedure for documenting their details for Occupational Health follow up
- follow the guidance of their DHB for surveillance monitoring for COVID-19.

Staff who were not wearing adequate PPE for an interaction with a positive COVID-19 patient or who had a PPE breach that is considered significant by the IPC team are required to isolate at home, under the direction and monitoring of the Occupational Health team.

In March 2021, COVID-19 vaccination of all frontline healthcare workers commenced. A healthcare worker is considered to be fully vaccinated ≥ 2 weeks following the second dose of vaccine.

Vaccination is not mandatory for healthcare staff working in DHBs, therefore DHBs should work with their Occupational Health team to develop a policy to manage staff who are not vaccinated against COVID-19. For further information, refer to: https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-information-health-professionals

NOTE:
1. Fully vaccinated healthcare workers still need to follow IPC guidance including the use of PPE.
2. Patients from Quarantine Free Travel Zones (QFTZ) are to be considered 'New Zealanders' when applying the HIS criteria. https://www.miq.govt.nz/assets/MIQ-documents/operations-framework-managed-isolation-and-quarantine-facilities.pdf

4. IPC procedures for DHB acute care hospitals

The table below is for use by Infection Prevention Teams to refer to in developing IPC processes for managing patients, visitors and procedures throughout the hospital including admission from Accident and Emergency, or out-patient department.

Circumstances (Where, Who, What)	Actions and IPC measures
1. Pre-hospital interface	Primary care or ambulance service to notify the emergency department or the designated SMO at the DHB of the patient transfer to hospital.
2. Public calls to emergency departments	Refer to Healthline on 0800 538 5453.
3. Calls from community providers	Refer to Healthline on 0800 538 5453 or the local Public Health Service.
4. PPE for health care workers assessing patients	**Refer to Appendix 1** for the appropriate PPE to be worn by HCW
5. Patients presenting to Emergency Departments who are proven COVID-19 cases or who meet both the Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19	Triage and assess. Refer to **Risk assessment questions if COVID-19 status is unknown** or your local DHB COVID-19 pathway. **Refer to Appendix 1** for the appropriate PPE to be worn by HCW Patients are to wear a medical mask for source control and need to be moved to an airborne infection isolation room (AIIR), or a single room with the door closed. They should be supported to follow respiratory and hand hygiene, and cough etiquette if able.
6. Any patient(s) presenting to Emergency Departments who meet the HIS criteria only, in the absence of clinical symptoms	When interacting with patients who meet the Higher Index of Suspicion (HIS) criteria, HCWs should **Refer to Appendix 1** Patients without clinical symptoms consistent with an acute respiratory tract infection should still wear a medical mask.
7. Patients presenting to Emergency Department from Quarantine free travel zones	Patients from Quarantine Free Travel Zones (QFTZ) are to be considered as "New Zealanders" when applying the HIS criteria. If they work in an area or a role in their country of origin that meets the Ministry of Health's HIS criteria, they are managed the same as any New Zealander meeting the HIS criteria.

8. Movement of patients, who meet the Clinical criteria, or the Clinical and Higher Index of Suspicion (HIS) criteria, for COVID-19 from the Emergency Department to another department or to a ward	Each DHB should develop a patient pathway for movement of patients through their hospital starting in the Emergency Department. The movement and transport of patients should be limited to essential purposes only. Staff at the receiving department or ward should be advised that the patient meets the Clinical and HIS criteria. All health care workers involved in transferring the patient should adhere to Standard and Transmission-based Precautions **Refer to Appendix 1.** Clean PPE must be donned before transfer and it should be doffed when the transfer process is completed. If transferring the patient requires the use of a lift, as much as practically possible, the route should be clear, and the lift should be exclusively allocated for the patient and transfer staff. A designated "clean staff member", who is part of the transfer team, is recommended to operate lift buttons etc. The patient must wear a medical mask for source control, if tolerated, on transfer to and from department(s), or on transfer to a ward, and must not wait in communal areas. If possible, patients should be placed at the end of procedure or surgical lists. Medical records should not be placed on the bed during transfer (consider placing in an envelope/plastic sleeve).
9. Accompanying family/ whānau, carer or support person in the Emergency Department, <u>who meet the Clinical criteria or Clinical and Higher Index of Suspicion</u> (HIS) <u>criteria</u> for COVID-19, and who wants to remain with the patient	Ideally, in this situation, the family/whānau, carer and support person/people should be redirected to their GP or a community-based testing centre to get tested for COVID-19 and be required to self-isolate at home whilst awaiting the test result. If this situation is unavoidable, and they are required to remain with the patient in the Emergency Department during the assessment, the following actions should be undertaken to mitigate the risk: • This situation should be discussed with the senior clinical team COVID-19 response team, and the IPC service within the DHB. • The person should wear a medical mask and be supported to adhere to respiratory and hand hygiene and cough etiquette. • The person should be instructed to remain in the room/bay that the patient is in and not to leave this space unless it has been discussed with, and agreed to, by a senior member of the Emergency Department clinical team. If the patient is discharged home, the family or whānau member, carer or support person should be advised/informed to have a COVID-19 test and, self-isolate at home while awaiting the test result.

10. Accompanying family/ whānau, carer or support person who meet the <u>Clinical criteria or Clinical and Higher Index of Suspicion (HIS) criteria</u> for COVID-19, and who wants to remain with the patient following admission to the ward.	Ideally, in this situation, the family/whānau, carers and support person/people should be redirected to their GP or a community-based testing centre to get tested for COVID-19 and be required to self-isolate at home whilst awaiting the test result.
	If this situation is unavoidable, it should be discussed with the senior leadership team or COVID-19 response team, and the IPC service within the DHB, in conjunction with the local public health service, before the transfer to the ward occurs. Approval will be decided on a case-by-case basis and reviewed daily.
	
	The following additional actions should be undertaken to mitigate risk:
	
	• The person should be provided with a clean medical mask prior to leaving the Emergency Department to wear during transfer to the ward.
	• Once in the ward they should be provided with guidance about respiratory and hand hygiene, and the safe donning and doffing of a medical mask.
	• They do not need to wear a gown, gloves and eye protection in the room.
	• There should be a clear set of expectations provided to the family/whānau, carer or support person by the DHB about what they can, and cannot do, whilst in attendance. This should be provided verbally and in written form. If necessary, this may require assistance from interpreters. This will cover, but is not limited to the following:
	  ○ the person should not leave the room unless they have discussed this with the health care worker team
	  ○ testing for SARS-CoV-2 may be required, if not already done
	  ○ daily symptom check will occur
	  ○ communication with other family/whānau should be via digital means only.
	
	Food, clothing etc, can be handed to the reception area of the ward for delivering to the room.

11. Management of patients <u>meeting Higher Index of Suspicion (HIS) criteria for COVID-19</u> for an <u>unrelated medical event</u>	When interacting with patients who meet the Higher Index of Suspicion (HIS) criteria, HCWs should **Refer to Appendix 1** Standard and Transmission-based Precautions should be followed at all times until the patient is discharged or until the 14 days self-isolation period has ended; whichever is the soonest. **Refer to Appendix 1** Patient would be reviewed daily for symptoms. **Refer to Appendix 2** If they do develop symptoms they should be managed with Contact and Airborne Precautions until SARS-CoV-2 infection can be excluded. If they remain in hospital for more than 14 days after meeting the HIS criteria then, following discussion with the IPC service, they can be removed from Transmission-based Precautions.

12. Entry into room (General information across all settings)	There should be; • Clear signage on the door with instructions on the level of PPE required before entering the room • Clearly demarcated donning and doffing areas including the sequence for donning and doffing PPE. Access is limited to essential health care workers only. Local policy should guide non-essential health care workers access to the room, for example, meal delivery. Maintain a record of all people who enter the patient's room. This includes visitors and the names of accompanying family/whānau to support any future contact tracing. Ensure names of health care workers are recorded in notes, for future reference. As with any other health and safety issue identified (including blood and body fluid exposures), HCWs who experience a failure in PPE should notify their line manager and Occupational Health Department for advice.
13. Cohorting patients with confirmed COVID-19	Two or more patients with confirmed COVID-19 can be cohorted together in a multi-bedded room or bay. The decision to create cohort rooms or wards should be undertaken in discussion with senior management, COVID-19 response team, clinical microbiologists, infectious diseases physicians, and the IPC service. • Cohort areas should be separated from other patient areas with a door or physical barrier. • The cohort area should have an effective ventilation system in use. Additional ventilation equipment, such as portal HEPA filtration units, may be required. • Cohort area within a ward should be located away from high traffic areas, clearly identified, and in a safe area provided for donning and doffing PPE. • Clear signage indicating the required PPE is to be placed at the entrance of the cohort area. • Where possible only health care workers who have been assessed as competent in donning and doffing of PPE should be allocated to work in the cohort area. • A system to support correct use of PPE is recommended, e.g. a 'buddy' system. • Assigning a dedicated team of staff should be considered, along with ensuring that the staff: patient ratio is sufficient to support staff's adherence to IPC measures. • Visiting should be in accordance with national or regional Alert Level - (case by case restrictions should be part of ward policy). • All staff working in such areas should be fully vaccinated. • Patients in cohort areas should be asked to wear medical masks for source control, when able. • Movement of patients out of the cohort area should be limited. • A dedicated bathroom for cohorted patient group should be implemented.

	• Cleaning should be undertaken more frequently and, cleaning staff should be assessed as competent in donning and doffing the appropriate PPE.
14. Visitors (to patients)	Visiting should be restricted to essential visitors only and align with the COVID-19 Alert Levels range of measures. Visitors should be assessed against Clinical and Higher Index of Suspicion (HIS) criteria for COVID-19 at each visit as per the local DHB policy. If visitors meet the case definition for COVID-19, have been identified as a close contact of the case, or meet the Higher Index of Suspicion (HIS) criteria for COVID-19, they should not be visiting the hospital. Visitors should be supported to use other means of contacting the patient, such as mobile phone communication. Each DHB should develop a communication policy. Signage should be visible at the entrance to the room and guidance on the required PPE and IPC measures visitors should follow. Medical masks, hand sanitisers and waste bins should be available. There should be clear simple instructions on how to don and doff a medical mask, how to safely dispose of it and when to perform hand hygiene. Both written and verbal advice around safe practice should be provided by the IPC Service, where feasible.
15. Collection of clinical specimens	Ensure the collection, type of specimen and transport media required are followed for the receiving laboratory. **Refer to Appendix 1 for PPE requirements** For hospitalised patients, consider collecting both upper and lower respiratory tract specimens. This should be undertaken in a single room with the door closed. Refer to: https://www.health.govt.nz/system/files/documents/pages/hp7353_02_-_ppe_ipc_poster_nasopharyngeal_testing_v3.pdf
16. Diagnostic testing	See local laboratory guidance.
17. Clinical investigations and procedures	Use portable equipment wherever possible. Where this not possible, discuss with the relevant department before transferring the patient. The patient should go directly into the imaging/treatment room. The patient should wear a medical mask on transfer to and from department, and during the procedure. Contact and Airborne Precautions should be adhered to by the staff.

	Clean the equipment and the procedure room after use as per local DHB IPC guidance.
18. Handling of linen	Infectious linen should be handled as per local DHB IPC guidance.
19. Cleaning	An appropriate hospital grade disinfectant with activity against respiratory viruses, including coronavirus, or use a sodium hypochlorite solution (bleach) should be used to clean the hospital environment. Cleaning staff should be trained and updated regularly on the appropriate PPE to wear dependent on the environment. Cleaning schedules should include frequency of cleaning based on the area/s, risk and environment. On discharge of patient, a terminal clean should be done as per local DHB IPC guidance.
20. Waste	Infectious clinical and controlled waste should be disposed as per DHB IPC guidance. Large volumes of waste may be generated by frequent use of PPE; ensure regular emptying of waste to avoid over-filled bins. Used PPE may be considered Controlled Waste, however the DHB must be able to verify that the Controlled Waste is being handled in a sanitary landfill as per the Management of Health Care Waste Standard (NZS 4304: 2002).
21. Food service	Local policy should guide non-essential health care worker access to the room, including meal delivery. Standard Precautions should be used when handling used crockery and cutlery. Unopened food items or food waste is to be discarded as per local waste policy.
22. Hospitalised patient is ready for discharge	The clinical team will determine when the patient is well enough for discharge. The clinical microbiologist, infectious diseases specialist, or IPC Service should be involved in discharge planning and the Public Health Unit notified. For further information refer to COVID-19 advice for all health professionals: https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-health-professionals/covid-19-advice-all-health-professionals
23. Management of deceased patients	PPE must be worn when handling the deceased. The body should be placed in a fluid-proof body bag and once this has occurred Standard Precautions should be followed. Refer to below link for further advice. https://www.health.govt.nz/system/files/documents/pages/management-of-deaths-due-to-covid-9-information-for-funeral-directors-19082020.pdf

24. Outbreak management	If an outbreak of COVID-19 is suspected, implement the Outbreak Management Policy as per local DHB guidance, including contacting relevant departments or specialists such as the IPC service, clinical microbiologist, infectious diseases specialist and Public Health Unit.
25. Personal care considerations for patients who meets the Clinical and Higher Index of Suspicion	If assistance with personal cares are required for patients who are COVID-19 positive, the patient should wear a medical mask as appropriate and the assisting health care worker to **refer to Appendix 1** for PPE guidance.
26. Reuse of PPE	The reprocessing of single use PPE is not recommended.

5. References

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Appendix 1. Transmission-based Precautions according to Alert level.

NOTE: These IPC precautions should be followed regardless of the patients or the HCW vaccination status

Transmission-based Precautions to be followed per ALERT LEVEL				
Contact and Airborne Precautions PPE P2/N95 particulate respirator*, eye protection, long sleeve fluid resistant gown and gloves *Staff who are required to wear a P2/N95 particulate respirator should have undertaken the requisite fit testing and be trained in fit checking				
Contact and Droplet Precautions PPE Medical masks (BS or EN Standard Type IIR, or ASTM Level 1, 2 or 3), eye protection, long sleeve fluid resistant gown, and gloves				
Patient Risk Factors	**Alert Level 1**	**Alert Level 2**	**Alert Level 3**	**Alert Level 4**
	Heightened risk of importing COVID-19. Sporadic imported cases. Isolated household transmission associated with imported cases	High risk of importing COVID-19 **or** uptick in imported cases **or** uptick in household transmission **or** single or isolated cluster outbreaks	Community transmission occurring **or** multiple cluster outbreaks	Sustained and intensive transmission. Widespread outbreaks
Meets clinical <u>and</u> higher index of suspicion (HIS) criteria.				
Providing clinical care	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions
Aerosol generating procedure (AGP)	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions
Meets clinical criteria <u>only</u>				
Providing clinical care	Contact and Droplet Precautions	Contact and Droplet Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions
AGP	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions

Meets HIS criteria <u>only</u>				
Providing clinical care	Droplet Precautions	Droplet Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions
AGP	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions
Proven COVID-19 infection				
Within 14-day infectious period	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions	Contact and Airborne Precautions

Appendix 2 – Example of Daily screen for COVID-19 symptoms

Initial ward screen for COVID -19
Date: _____ Screen completed by: _____

Daily Screen:-Do you have a new fever, fatigue, body aches, cough, sore throat, headache, shortness of breath, loss of smell or taste, runny nose, sneezing, blocked nose, nausea/vomiting/ diarrhoea?

Daily Check Date		
1	No	Yes – Contact ID/ IPC team
2	No	Yes – Contact ID/ IPC team
3	No	Yes – Contact ID/ IPC team
4	No	Yes – Contact ID/ IPC team
5	No	Yes – Contact ID/ IPC team
6	No	Yes – Contact ID/ IPC team
7	No	Yes – Contact ID/ IPC team
8	No	Yes – Contact ID/ IPC team
9	No	Yes – Contact ID/ IPC team
10	No	Yes – Contact ID/ IPC team
11	No	Yes – Contact ID/ IPC team
12	No	Yes – Contact ID/ IPC team
13	No	Yes – Contact ID/ IPC team
14	No	Yes – Contact ID/ IPC team
15	No DX!	Yes – Contact ID/ IPC team

Meets Ministry of Health case definition published 16-4-2020

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI HEALTH & SAFETY PROTOCOL	HEALTH AND SAFETY - MANAGEMENT OF VOLUNTEERS & VISITORS	Policy 5.3.1 Protocol 4

STANDARD

All volunteers at the Bay of Plenty District Health Board (BOPDHB) will be under the management of an organised and recognised external provider or managed by the BOPDHB Volunteer Co-ordinator in accordance with BOPDHB Volunteer policies and protocols.

All visitors to BOPDHB workplaces (this includes regular business visitors and visitors to patients) are managed in accordance with BOPDHB policies and protocols.

STANDARDS TO BE MET

1. Volunteers

1.1. All volunteers must complete a health and safety induction/orientation programme prior to commencing volunteer work.

1.2. All volunteers shall wear a Volunteers identification badge at all times on BOPDHB work sites. This badge will be provided only on completion of the BOPDHB health and safety induction and any applicable orientation (refer policy 3.50.01 protocol 6).

2. Visitors

Excluding visitors to patients, all other visitors including company representatives are to:

2.1 Prior to visiting the hospital, contact the person they intend visiting and make an appointment with a stated time.

2.2 On arriving for the appointment, report to the designated reception area of the facility and complete the Visitors Register as a company representative stating who they are visiting and when. They are to confirm that they have read and understood the Health and Safety instructions provided by signing the appropriate form. These instructions are to be adhered to during the visit. They will then receive an official visitor's sticker which they are to wear at all times during the visit.

2.3 Attend the appointment.

2.4 On completing the appointment return to the reception, return the visitor's sticker and sign out with their signature and departure time and exit the hospital.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board Health and Safety controlled documents
- Bay of Plenty District Health Board policy 3.50.07 Volunteers
- Bay of Plenty District Health Board policy 3.50.07 protocol 1 Volunteers - Standards
- Bay of Plenty District Health Board policy 6.9.4 Visitors and Nominated Support Persons
- Bay of Plenty District Health Board policy 6.9.4 protocol 1 Visitors and Nominated Support Persons - Standards
- Bay of Plenty District Health Board policy 3.50.01 protocol 6 Staff, Contractors and Volunteer Identification (ID) Standards (Photo ID Card and Name Badge)
- Bay of Plenty District Health Board Form FM.S16.1 Staff, Contractor and Volunteer Identification and Electronic Security Access Request

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI **VISITORS PROTOCOL**	**VISITORS AND NOMINATED SUPPORT PERSONS – STANDARDS**	**Policy 6.9.4 Protocol 1**

STANDARD

Bay of Plenty District Health Board (BOPDHB) is in a pandemic situation known as COVID-19. Effective 1159 hours 7 September 2021 until further notice there is to be managed visitor access into the hospital facilities at Tauranga and Whakatane. As a Tiriti led DHB, BOPDHB affirms that this decision has been made in partnership with the Māori Health Rūnanga. Accordingly BOPDHB visitor's policy and protocol is to ensure patients have access to appropriate care, put in place rules around approved visitors in this emergency situation and to ensure that contact tracing can be facilitated should any patient, visitor or employee subsequently be diagnosed with COVID-19.

OBJECTIVE

To outline the processes to be followed by Bay of Plenty District Health Board (BOPDHB) employees for visitors to facilities.

STANDARDS TO BE MET

1. **Designated Emergency Visiting Hours and Rules**
   - 1.1. Visiting hours for both Tauranga and Whakatane Hospitals are designated as **8.00am to 8.00pm.**
   - 1.2. Alert **Level 2 Delta – Reduce** enables **managed visitors** as follows:
     - a) **Two (2) visitors at any one time** per patient, excluding high risk areas per c) d) and e) below
     - b) High risk areas – Emergency Department (ED / Intensive Care Unit (ICU) / High Dependency Unit (HDU) / Acute Care Unit (ACU) / Mental Health & Addiction Services two (2) approved visitors per patient per day. On compassionate grounds, a roster of visitors (only 2 at any one time) may be arranged for high risk areas.
     - c) Only two (2) nominated support persons may accompany any woman during labour and birth. Following birth, one (1) nominated support person at a time may visit once daily and stay as long as the woman wants
     - d) Mothers and one nominated support person per day to accompany any baby in the Special Care Baby Unit (SCBU).
     - e) Two (2) parents or guardians may be nominated to visit any hospitalised child.
     - f) Visitors will complete health screening to ensure they are well and not a COVID-19 risk.
     - g) Visitors will complete sign in requirements prior to facility entry to ensure contact traceability.
     - h) Should a patient be a confirmed or highly suspicious COVID patient then NO visitors are allowed.
     - i) In assessing requests for Māori whānau visits, Clinical Nurse Managers (CNM) / Clinical Midwife Managers (CMM) or Duty Nurse Managers (DNM) will consult with Te Pare ō Toi.
   - 1.3. At the discretion of the CNM / CMM or DNM additional visiting requests may be approved on compassionate grounds.
   - 1.4. <u>Employee Responsibilities</u>
     - a) To allow approved visitors for patients as per 1. above .
     - b) To ensure adequate information is available to visitors to make them aware of their responsibilities.

c) To ensure all clinical care is delivered in a timely manner (this may mean that visitors are asked to leave or vacate the patient space).
d) To report all unauthorised persons or inappropriate behaviour to the Shift Co-ordinator, Security or DNM immediately.
e) To monitor and implement the Visitors procedure.
f) To ensure Security is informed immediately if the behaviour from the visitor does not meet the expected standards.
g) Security – main entrance door:
- Signing in / out all visitors
- Keep record of all visitor contact details for purposes of COVID-19 traceability

h) Ensure visitors don't access the hospital facilities through entrances other than the main entrance door.

1.5. Visitor Responsibilities

a) Visitors must wear a face covering and adhere to all requests in respect to physical distancing and infection prevention and control procedures.
b) Visitors are expected to behave in a manner respectful of both the patient they are visiting, to other patients, and the facility in general. BOPDHB has a zero tolerance for any violence and / or aggression.
c) These are extraordinary circumstances. All visitors need to recognise this and follow instructions from staff to ensure everyone is kept safe.
d) Support for teams can be accessed through Security, DNMs and with Te Pare ō Toi.

2. Hospital access

2.1 Access to the Tauranga and Whakatane hospitals will be via the main entrance only.
2.2 During this COVID-19 emergency situation, the premises will be in managed visitor access.
2.3 Security staff will be stationed at the entrance and all people entering will be screened. Should it be determined that a visitor is deemed a risk they will be refused entry.
2.4 Additional support for Māori whānau can be accessed through Te Pare ō Toi.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.9.4 Visitors
- Bay of Plenty District Health Board policy 6.9.4 protocol 4 Visitors to Operating Theatre
- Bay of Plenty District Health Board policy 2.2.5 Media
- Bay of Plenty District Health Board policy 5.4.2 Smokefree
- Bay of Plenty District Health Board policy 5.4.7 Threatening Behaviour, Bullying, Harassment and Violence in the Workplace - Management
- Bay of Plenty District Health Board policy 5.5.1 Security
- Bay of Plenty District Health Board policy 5.5.3 Trespass
- Bay of Plenty District Health Board Form FM.V3.1 Visitors to Theatre – Patient Consent

Advice on compulsory assessment and treatment processes for mental health services during COVID-19 Alert Level 2

Updated 23 August 2021

This information is about compulsory assessment and treatment process under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) during the COVID-19 epidemic while at Alert Level 2. Alert Level 2 anticipates that the disease is contained, but the risk of community transmission remains. Health services are expected to operate as normally as possible but physical distancing is required.

This information is about compulsory assessment and treatment during the COVID-19 Alert Level 2 for people subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act).

The purpose of this advice is to help mental health services to continue to provide safe and effective assessment and treatment to people that respects their rights to the greatest extent possible in the circumstances. It is critical to ensure the rights of patients and proposed patients under the Mental Health Act are protected and balanced with the need to ensure patients and proposed patients receive appropriate care and treatment.

This advice may not address all situations that will arise while we are under the COVID-19 Alert Levels. Therefore, in situations where specific advice has not yet been provided and it is not possible to follow usual best practice and adhere to standard operating procedures, guidelines and policies, services will need to consider alternative approaches. When considering alternatives, services should question whether the action:

- is in the best interests of the patient
- is necessary to protect the health and safety of the patient, and others
- meets legislative requirements and aligns with the intent of the legislation
- upholds the rights of the patient and others to the maximum extent possible in the circumstances
- complies with the current COVID-19 Alert Level requirements.

This guidance is interim and may be amended as the COVID-19 alert levels evolve. This guidance should be read in conjunction with information available at health.govt.nz/covid-19 and covid19.govt.nz.

1. Use of the Mental Health Act during Alert Level 2

1.1 The Mental Health Act continues to apply during all COVID-19 alert levels. This document is intended to assist in ensuring processes under the Mental Health Act can continue as seamlessly as possible and consistently with the requirements of COVID-19 Alert Level 2.

1.2. The Mental Health Act is intended to permit compulsory mental health assessment and treatment of individuals who meet, or are reasonably believed to meet, the definition of mental disorder in the Mental Health Act. When the Mental Health Act is used it is important that the least restrictive option is used.

1.3. The Mental Health Act cannot be used to enforce assessment, treatment, or isolation for reasons unrelated to the assessment, treatment, or management of a person's mental disorder.

2. COVID-19 temporary amendments to the Mental Health Act

2.1 On 13 May 2020 the COVID-19 Response (Further Management Measures) Legislation Act 2020 was passed into law. It included a number of temporary amendments to the Mental Health Act to enable the effective operation of the Act during the COVID-19 response. Please note that these changes are temporary and apply only during the response to COVID-19 and will expire on 31 October 2021, or earlier if they are no longer necessary. The Act is available at: http://www.legislation.govt.nz/act/public/2020/0013/latest/LMS339370.html

2.2 These temporary amendments are to:

- clarify that the use of audiovisual technology is permitted for clinical assessments, examinations, and reviews of patients and proposed patients, and for judicial examinations of patients;
- clarify that Mental Health Review Tribunal reviews can be conducted using remote technology;
- clarify that district inspectors and official visitors are permitted to complete their visitation and inspection duties using remote technology, if the district inspector or official visitor is satisfied that this is appropriate (this amendment expires when the Epidemic Notice expires);
- change references to medical practitioner and health practitioner to mental health practitioner and references to medical examination to examination in certain sections to provide more clear and consistent terminology and to facilitate timely assessment of patients and better usage of the health workforce, which is likely to come under pressure during the outbreak of COVID-19.

2.3 These temporary amendments are described in the following paragraphs.

Use of audiovisual link (AVL) technology during COVID-19 response

2.4 The COVID-19 Response (Further Management Measures) Legislation Act 2020 amends the Mental Health Act to clarify that the use of AVL is permitted to access a person to exercise a power under the Act where it is not practicable for the person to be physically present. This applies to:

(a) a clinician, psychiatrist, or mental health practitioner exercising a power under this Act that requires access to a person; or

(b) a Judge, any person directed by a Judge, or a member of a Review Tribunal that is required to examine a person under this Act.

2.5 Audiovisual link (AVL) is defined as facilities that enable both audio and visual communication with the person.

2.6 Audio link only is not permitted to exercise any of these powers or perform any of these assessments.

2.7 See guidance on the use of AVL in section 3 below.

Changes to meaning of health practitioner, examination and medical certificate during COVID-19 response

2.8 The COVID-19 Response (Further Management Measures) Legislation Act modifies the existing definition of medical and health practitioners to a new defined term of 'mental health practitioner', medical examination to 'examination', and medical certificate to 'assessment certificate' for purpose of enabling timely assessment of patients and better use of the health workforce. In practice this will permit a wider range of practitioners to complete an examination and issue a certificate under section 8B regardless of which section of the Mental Health Act is used to initiate an examination under section 8B.

2.9 The meaning of "mental health practitioner" in the COVID-19 Response (Further Management Measures) Legislation Act is:

(a) a medical practitioner; or

(b) a nurse practitioner; or

(c) a registered nurse practising in mental health

'registered nurse practising in mental health' means a health practitioner who—

(a) is, or is deemed to be, registered with the Nursing Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice includes the assessment of the presence of mental disorder as defined under this Act; and

(b) holds a current practising certificate.

Modifications to section 9A

2.10 Modifications to section 9A enable duly authorised officers (in addition to Director of Area Mental Health Services) to carry out the requirements of section 9(1). In addition, "health practitioner" is modified to "mental health practitioner" in sections 9(1) and (3).

District inspector visits during COVID-19 response

2.11 The addition of section 97A permits district inspector visitations for the purposes of section 97 of the Mental Health Act to be undertaken by remote technology permitted while the epidemic notice is in force for COVID-19.

2.12 See section 10 for further guidance on district inspector visits and inquiries.

3. Assessments, examinations, and reviews of patients and proposed patients subject to the Mental Health Act, including second opinions

3.1 A greater range of activities are permitted under Alert Level 2. However, there is still a need to reduce the risk of transmitting COVID-19 through measures including physical distancing and taking extra precautions for people in the high-risk group (older people and those with existing medical conditions). Inpatient units will need to take precautions and manage visiting in a controlled way. See guidance on the Ministry of Health website at: https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-current-situation/health-and-disability-services-alert-level-2

3.2 Statutory assessments have the potential to result in restrictions on patients' rights. Timely access to services is therefore crucial to avoid unnecessarily prolonging the restrictions of rights. Experience in Alert Levels 3 and 4 has shown that some service users prefer engagement by AVL and that it has been possible to complete assessments using AVL.

3.3 As noted above, the recent COVID-19 Response (Further Management Measures) Legislation Act 2020 amends the Mental Health Act to clarify that the use of AVL is permitted where it is not practicable for the person to be physically present. This means that in-person assessment and examination is to be preferred, however, AVL can be used where this is necessary and appropriate.

3.4 Under Alert Level 2 it is expected that in-person appointments will be the usual method of engaging with patients. However, there are likely to be circumstances in which an in-person attendance is not practicable due to limitations arising under Alert Level 2. Therefore, there continues to be a need for flexibility in how assessments are carried out.

3.5 Services may use AVL where necessary to carry out Mental Health Act processes including assessment, examination, or a review of a patient or proposed patient, if in-person options are not practicable. Decisions about whether an in-person assessment is not practicable should take into account and balance the following factors.

- The preference and best interests of the patient or proposed patient
- The least restrictive manner of providing assessment and treatment
- Whether barriers to in-person attendance would prevent timely access to assessment and treatment
- The ability to maintain safety and adhere to the COVID-19 alert level requirements (such as where a person has suspected or confirmed COVID-19 infection)
- Whether the patient/proposed patient or the clinical assessor are in the high-risk group for COVID-19 (and arranging an alternative assessor would cause undue delays to the assessment)
- The effective facilitation of family/whānau engagement.

3.6 The use of AVL solely for reasons of convenience or efficiency for service providers is not acceptable.

3.7 Greater priority should be given to in-person assessments for the purposes of assessment under assessment sections 8B to 14 of the Mental Health Act as these relate to decisions that may result in a person being detained or limitations on the patient's rights.

3.8 The rationale for decisions to use AVL for should be documented and available for review by district inspectors.

3.9 Appropriate equipment should be available to ensure that assessments are conducted effectively with appropriate safeguards in terms of privacy and security.

Consent to AVL

3.10 Consent by the patient or proposed patient to conduct an assessment, examination, or review by AVL is not required, but services are encouraged to seek and document consent whenever possible.

3.11 A lack of consent does not make it unlawful to do an assessment by AVL in itself. However, it may indicate that the approach will not adequately meet the purposes behind doing the assessment (getting an accurate view of the person's mental health status and risk), which may increase the risk that the assessment could be inaccurate and the individual could be made subject to the Mental Health Act when this is inappropriate.

3.12 Where an individual is not cooperative in relation to the use of AVL, services are encouraged to think carefully about whether the use of AVL remains appropriate in the circumstances and should not use AVL unless in-person assessment is demonstrably not practicable for reasons other than just convenience for the service. Services should document the decision-making process, including recording how the interests and clinical safety of the patient were better served by an AVL assessment in the situation, and consider guidance provided by relevant professional practice standards.

3.13 Services will need to have appropriate protocols in place for conducting and documenting assessments by AVL.

3.14 Services must ensure that AVL arrangements respect the privacy of the individual, and requirements under the Health Information Privacy Code and Privacy Act 1993 are complied with.

3.15 Using AVL in mental health consultations is supported by the Royal Australian and New Zealand College of Psychiatrists, which notes that "Telepsychiatry can greatly improve access to psychiatric services for people in rural and remote areas, and in other situations where face-to-face consultations are impracticable." Resources to help implement telepsychiatry are provided on the College website at https://www.ranzcp.org/practice-education/telehealth-in-psychiatry

4. Section 9(2)(d) explanation of notice of assessment

4.1 It is mandatory for an explanation of the purpose of the assessment to take place in the presence of a support person under section 9(2)(d). An assessor must offer to organise the attendance of a support person known to the applicant, such as a family member, caregiver or friend, if such a person is available. If no such person is available, an independent person should be engaged (Justices of the Peace (JPs) are available for this purpose).

4.2 AVL may be used to fulfil the requirements of section 9(2)(d) where in-person is not practicable or if engagement by a family/whānau member or support person can be better facilitated through AVL (see section 3). If video technology is not available in the circumstance, a teleconference is also permissible.

4.3 Care must be taken to ensure that all parties can adequately participate in the interaction, and that all parties have understood the information provided.

5. Discharge of patients from inpatient units while at Alert Level 2

5.1 Services are advised to follow the guidance and protocols in place at their local District Health Board (DHB) with respect to discharge of patients from hospital generally. It is not necessary to apply different standards or protocols for mental health patients. If there is uncertainty about the discharge of a particular patient this should be escalated within local DHB management structures.

6. Court hearings under the Mental Health Act

6.1 Services should familiarise themselves with the protocols for District Court proceedings during the different COVID-19 Alert Levels which are available on the District Courts website at: https://www.courtsofnz.govt.nz/publications/announcements/covid-19/court-protocols

6.2 Services are expected to follow the directions of judges presiding in relation to the use of AVL and should assist patients to access AVL technology for participation in hearings. This includes assisting them to set up and access AVL devices, in which case proper physical distancing protocols should be complied with.

6.3 There may be times when a judge directs that aspects of a hearing other than examinations, assessments and reviews of the patient take place by audio teleconference technology. In these instances, services must follow the direction of the judge.

7. District inspector and lawyer access to patients

7.1 With respect to the ability for a district inspector or lawyer to have access to a patient, the expectation under Alert Level 2 is that such access will generally occur in person. However, meeting via AVL technology or telephone (depending on the patient's preference) will continue to be acceptable if that is the patient's preference or if an in-person meeting is not practicable or safe.

7.2 If a remote meeting is to take place, the service must ensure a process is in place to enable private and confidential conversations between a district inspector, or lawyer, and a patient. This may be accomplished by setting up an AVL or phone call in a private room that the patient can use for the purpose of the conversation.

7.3 Proper physical-distancing protocols must be maintained during in-person meetings.

8. Access to family/whānau

8.1 Every patient is entitled, at reasonable times and intervals, to receive visitors and make telephone calls. This right (section 72 of the Mental Health Act) can only be limited where the responsible clinician considers that such visits or calls would be detrimental to the patient's interests and to his or her treatment.

8.2 Under Alert Level 2, inpatient services should implement policies that allow visits from support people to the ward, with appropriate limits, controls and physical distancing protocols in place. https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-current-situation/health-and-disability-services-alert-level-2

8.3 However, AVL will remain a useful way for patients to connect with their family/whānau, especially if the circumstances make in-person visits impracticable or contrary to COVID-19 alert level restrictions, for example if the family/whānau live outside the area or are considered part of a vulnerable population.

9. Respect for cultural identity

9.1 Sections 5 and 65 of the Mental Health Act require services to ensure the powers they use when assessing and treating a patient or proposed patient are exercised in a manner that shows respect for the person's cultural identity.

9.2 It is critical for services to ensure access to necessary cultural assessments and supports is not unduly hindered by COVID-19 alert level restrictions. Cultural assessments and access to key cultural support workers or kaumātua, should be facilitated through AVL or audio teleconference technology where an in-person attendance is not practicable.

10. Inquiries and visitations by district inspectors under sections 95, 96, and 97 of the Mental Health Act

10.1 Under Alert Level 2, it is preferable that district inspectors conduct activities related to inquiries and visitations under sections 95 and 96 of the Act in person, provided that physical distancing can be maintained.

10.2 If the requirements of Alert Level 2 cannot be maintained during an in-person attendance, inquiries and visitations under sections 95 and 96 of the Mental Health Act may be met by video or audio-conference technology if the District Inspector is satisfied that they can conduct a visit using AVL means. If a district inspector requests to make a remote (AVL) inquiry or visitation the Director of Area Mental Health Services should assist in ensuring this occurs.

10.3 Services are advised to make all registers and records required by a district inspector under section 97 of the Mental Health Act accessible electronically wherever possible. This will reduce the need for district inspectors to attend in person and help reduce the movement in and out of wards.

10.4 Please note that as the provisions of sections 95 and 96 are an important protection of patient rights services **must** facilitate a visit by a District Inspector by AVL means if an in-person visit is not possible.

11. District inspectors as essential services

11.1 District inspectors have been determined to provide an essential service under the umbrella of DHB essential services and are therefore permitted to travel as needed at all alert levels to carry out their functions.

11.2 District inspectors are advised to carry their official district inspector identification with them when traveling for the purposes of district inspector activities. If a district inspector has not yet received their official identification, they are advised to carry a hard-copy of the letter of appointment to the role of district inspector. An official letter identifying them as an essential service worker during COVID-19 is not required.

12. Section 52 leave during COVID-19

12.1 The COVID-19 pandemic emergency has given cause to review the use of leave under section 52 of the Mental Health Act.

12.2 Alert Level 2 allows a continuation of leave on hospital grounds, and a cautious return to the use of leave in the community for recovery and rehabilitative purposes, where it is both safe and practicable to do so. Forensic Mental Health Services should consider leave plans on a case by case basis, balancing the risks related to COVID-19 as well as safety risks with the patient's recovery and rehabilitation needs. A blanket approach to leave eligibility will not be acceptable.

12.3 Leave plans should include details of how COVID-related requirements such as physical distancing will be maintained.

12.4 Leave outside of the region will generally continue to be restricted, unless for special circumstances (such as an emergency medical transfer or for compassionate reasons such as close family/whānau bereavements).

12.5 When considering applications for new section 52 leave, the Director of Mental Health will continue to prioritise granting applications for the purposes of urgent medical treatment, or other urgent needs/special circumstances, and where COVID-19 related concerns can be adequately managed.

12.6 However, rehabilitation leave applications will also be considered during Alert Level 2.

13. Patients currently on full section 52 overnight leave

13.1 The usual procedure requires a Special Patient on section 52 overnight leave to return to hospital to stay overnight after being out of hospital for six nights (6:1 leave category). The patient is assessed the following day and, if deemed to be safe, they are granted another period of leave for a further seven days.

13.2 In order to ensure service continuity and minimise the risk of infection for patients and staff under Alert Level 2, it is necessary to continue the approach adopted under Alert Levels 3 and 4.

13.3 Under this approach, the patient returns to the hospital[1] for a full assessment by the responsible clinician and case manager or another member of the care team. The patient should be admitted overnight when it is clinically indicated. However, the patient may return to the community on the same day, provided:

- the patient is compliant with leave conditions
- their mental state is stable
- there are no safety issues of concern, they could then be granted leave for a further period of seven days.

13.4 This approach would require the Director of Area Mental Health Services and Clinical Director of the service to think about where in the hospital, or on hospital grounds, would be the safest place for the return and assessment to take place while still maintaining physical distancing requirements.

13.5 Please note that it is not possible to dispense with the return to hospital as that would in effect give the patient a form of Ministerial Long Leave.

14. Police assistance for people with acute mental health needs

14.1 Services may call on police to assist when a person refuses to attend a health facility or other location for the purposes of mental health assessment, or if there are threats or acts of violence. As always, Police and health staff need to work together to make decisions on a case by case basis, taking into the account a person's needs and any clinical safety risks, as well as COVID-19 physical distancing requirements. Police have protocols for attending a known COVID-19 address which will apply to the assistance they are able to provide.

15. Police and duly authorised officer transport of patients and proposed patients

15.1 Services may request police assistance for transportation of a patient or proposed patient for assessment or compulsory treatment.

15.2 If the patient or proposed patient is being transported from a known COVID-19 address, or is suspected of having COVID-19, police will follow their guidance regarding contact and personal protective equipment (PPE) issued by New Zealand Police.

15.3 If a duly authorised officer (DAO) is needed, they should attend in person, unless it is not practicable to do so. See section 3 for guidance on considerations of practicability and best interest in relation to decisions about in-person or AVL attendance.

15.4 When present in person, a DAO must maintain the required physical distancing unless they have the required PPE. As a result, while DAOs typically ride in a car with police and a patient or proposed patient during transport, at this time DAOs are expected to use their own vehicle in convoy with the police transport, unless physical distancing can be maintained in the vehicle being used to transport the patient.

15.5 Where transportation is necessary for further assessment, it is important to consider the clinical safety requirements relating to transportation. DAOs must discuss with the Police such things as the person's clinical condition, the potential for violence, the need for restraint, the type of vehicle available and the distance to be travelled.

[1] Remembering that from previous Court rulings, this includes the grounds that the hospital is on.

16. Mental Health Review Tribunal hearing

16.1 The Mental Health Review Tribunal has previously developed policies for conducting hearings under Alert Levels 3 and 4 (dated 24 March 2020) and 1 and 2 (dated 4 June 2020). These are available on our website under Mental Health Review Tribunal resources. For any questions about how hearings will operate not addressed by this guidance, please contact the Tribunal secretariat on 0800 114 645 or email secretariat@mhrt.co.nz.

Robyn Shearer
Deputy Director-General
Mental Health and Addiction

John Crawshaw
Director of Mental Health and Addiction Services
Mental Health and Addiction

Cleaning Instructions – COVID-19 Droplet and Contact precautions

The COVID -19 virus is transmitted between people through respiratory droplets and contact routes.

Droplet transmission occurs when a person is in close contact (within 2m) with someone who has respiratory symptoms (e.g. coughing or sneezing).

Droplet transmission can occur when a person has contact with equipment or surfaces which have been contaminated by an infected person sneezing or coughing directly on the surface. Or by contaminated hands transferring the virus from surface to surface.

The most important steps for preventing transmission are therefore:

- **Performing hand hygiene frequently;**
- **Covering coughs and sneezes;**
- **Not touching your mouth, nose or eyes.**

The COVID virus is not a living organism, but a protein molecule (DNA) covered by a protective layer of lipid (fat). The virus is fragile, with the only protection being the thin membrane of lipid.

This membrane is destroyed by:

- Washing with detergent
- Heat – temperatures above 27C
- Alcohol – any solution greater than 65% alcohol (as in commercially prepared hand gel)
- Bleach solution (1000ppm solution – 20ml in 1L water of hospital grade bleach). Solution to be changed every 24 hours.

The virus is not impacted by cold or freezing.

DO NOT use spray solutions (e.g. bleach solution in spray bottles); DO NOT use hand soap for equipment cleaning.

When you are cleaning areas or equipment - wear PPE (surgical mask, gloves and apron) to protect yourself from inadvertently touching your face or making contact with contaminated surfaces.

Environmental clean	• In hospital – hospital cleaners follow standard procedures for patient room cleaning. • For small areas (i.e. workbench) – use cleaning wipes (detergent or detergent/ disinfectant) - wipe down area thoroughly and allow to dry. • In community (or for areas where cleaning wipes are not available) – use a container with warm water and detergent wipe down as above.
Clinical equipment*, i.e. oximetry, blood pressure cuffs *clean as per manufacturer's instructions	• Wipe down thoroughly with cleaning wipe (detergent or detergent/disinfectant) and allow to dry; • Where wipes are not available; using a clean cloth moistened in detergent and water solution wipe down item. Allow item to dry.
Patient plates and cutlery	• Standard collection processes with tray collected by staff member wearing gloves and being placed on trolley is adequate – tray is processed as per standard kitchen process.
Eye protection – goggles and face masks	• Clean after each use. • Face vison with foam strip – used by one staff member each shift (write your name on your visor); wipe down with detergent or disinfectant wipe after each use. Wipe with paper towel to dry. • Goggles or safety glasses – put on clean gloves and place eye protection in a bowl – take to the dirty utility room. Wash with detergent and water in bowl using a clean cloth to make sure all surfaces are cleaned. Rinse with water and dry with a clean towel. Return item to PPE trolley or anteroom.
Scrubs or work clothing	• If you are taking your uniform home to launder – normal laundry processes using detergent are adequate.

V1: 31-03-2020

Please refer to BOPDHB Infection Prevention and Control team for further advice (Monday to Friday); or email COVIDTAG@bopdhb.govt.nz

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI