COVID Ward Model of Care Update

Employee Forum | 6 October 2020

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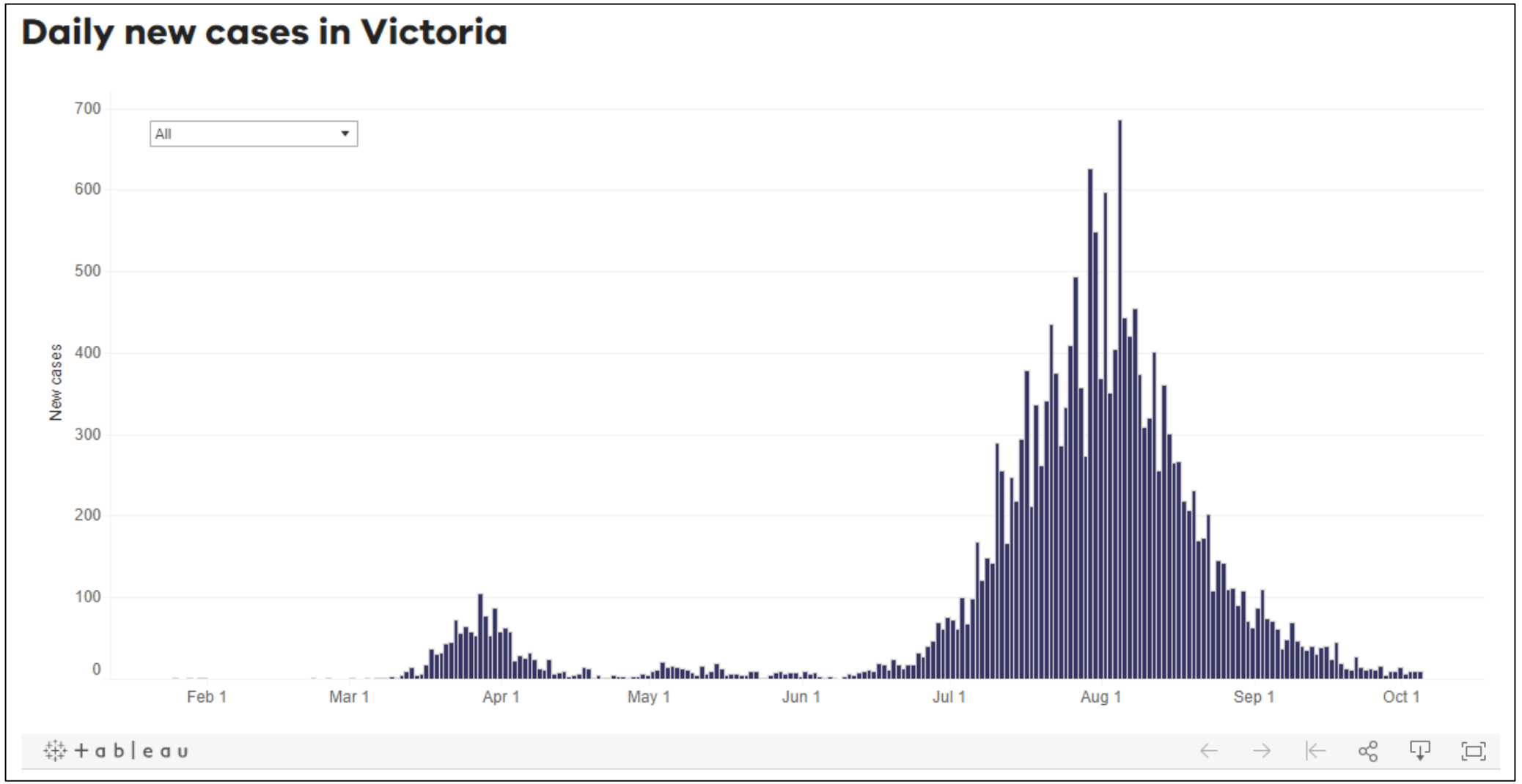
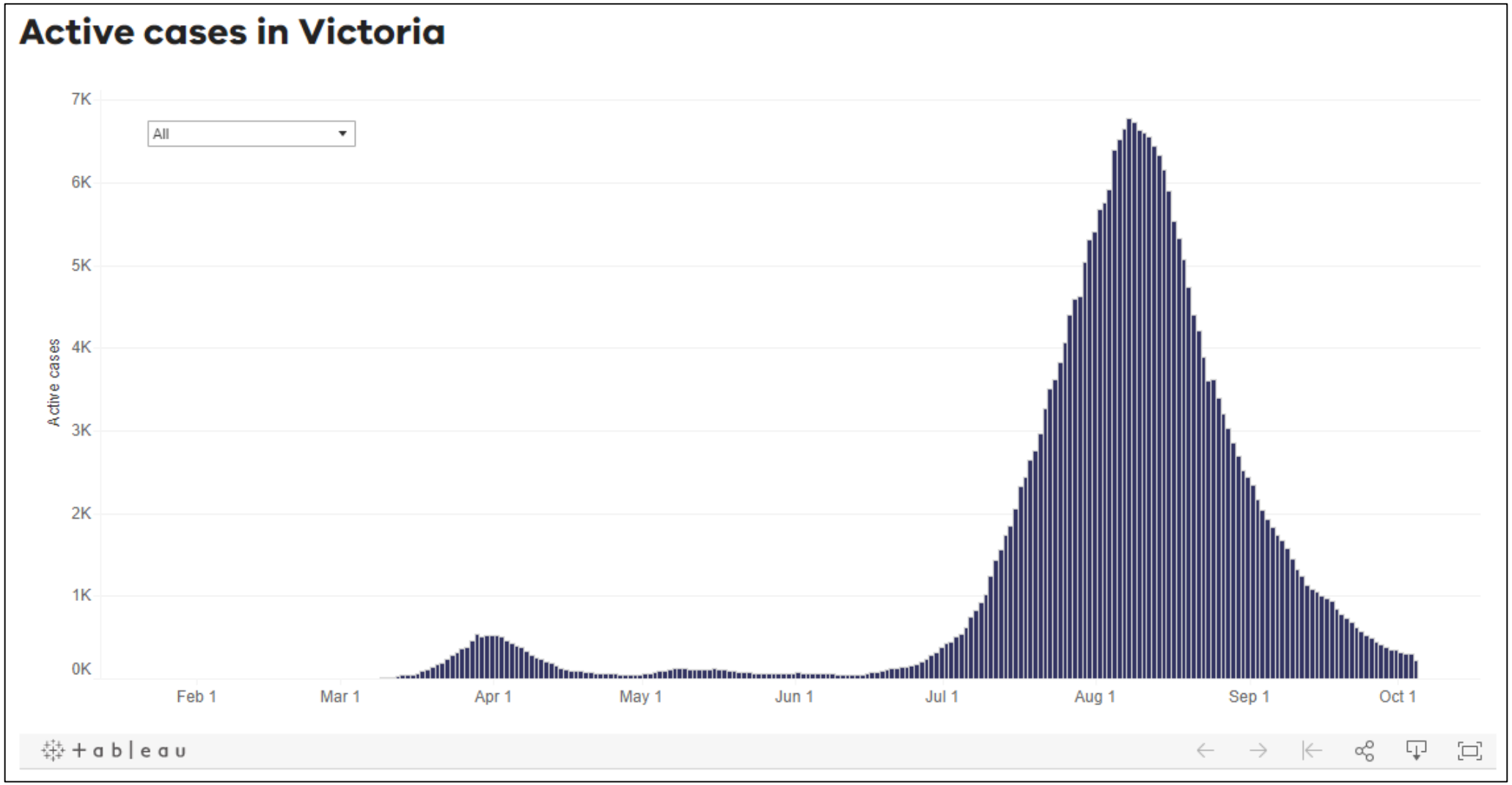
Monash Health

Victoria is seeing a reduction in new daily cases of COVID-19



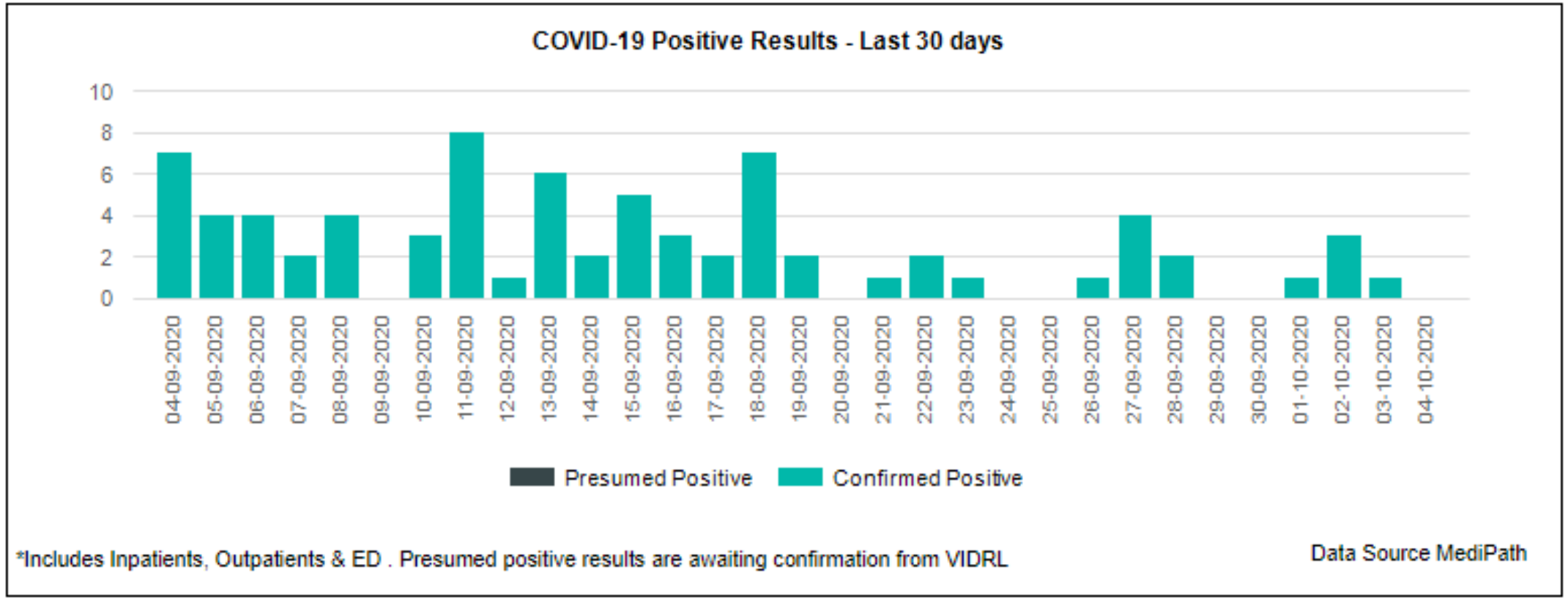
Source: www.dhhs.vic.gov.au/victorian-coronavirus-covid-19-data, 5/10/20

There is a corresponding reduction in active cases in the community



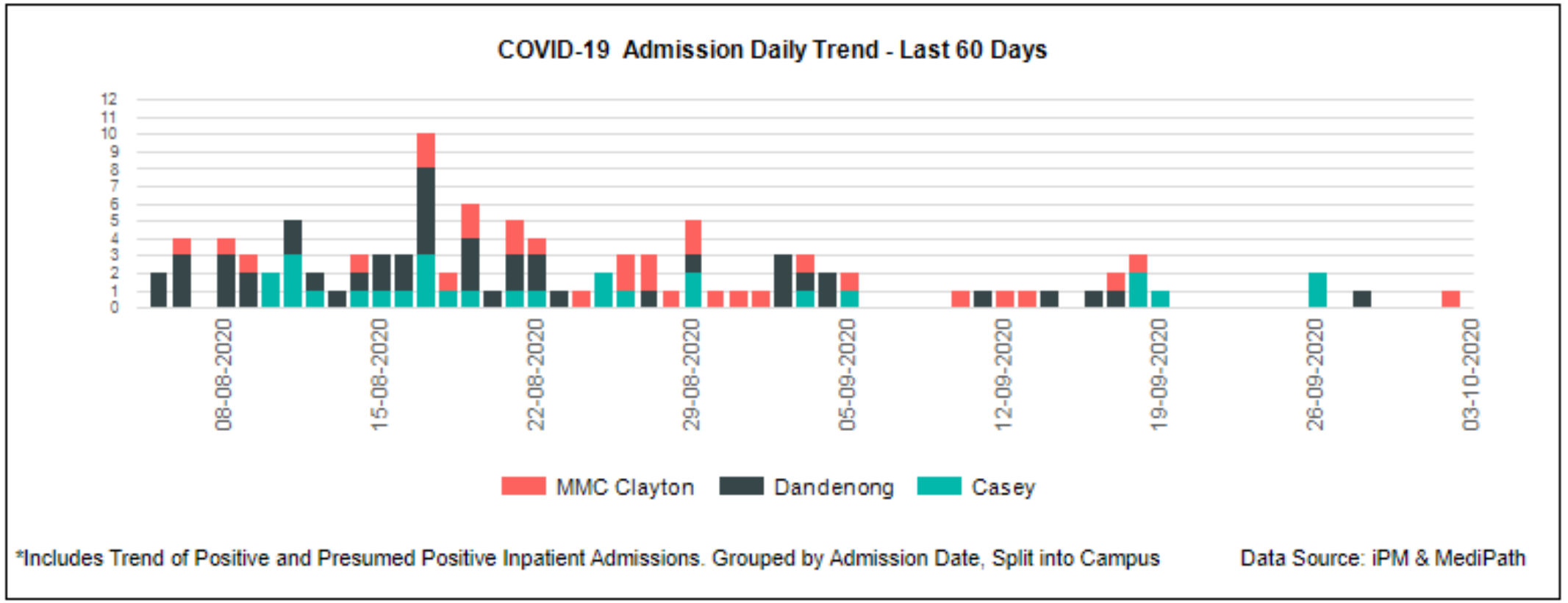
Source: www.dhhs.vic.gov.au/victorian-coronavirus-covid-19-data, 5/10/20

Monash Health screening clinics have seen a reduction in positive results over the past month



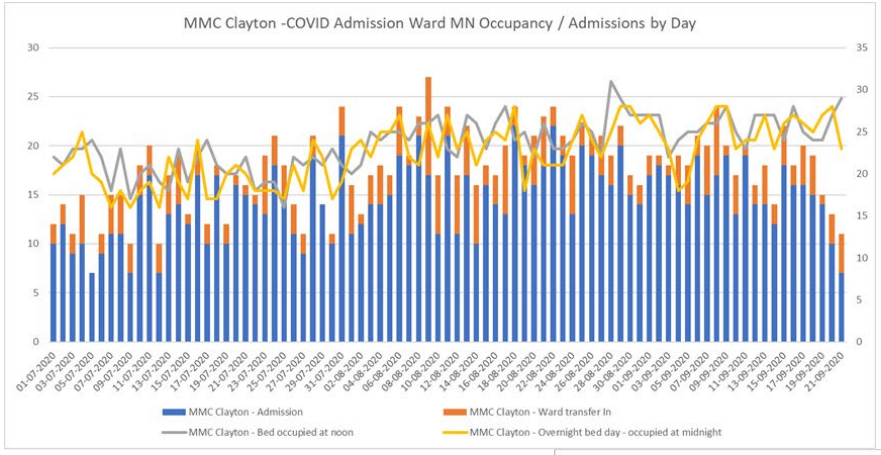
Source: BI portal, COVID monitoring report, 5/10/20

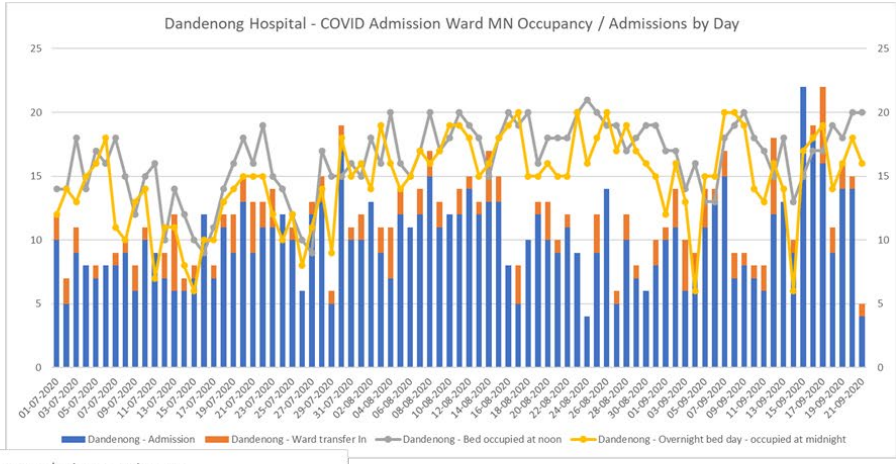
We have also seen a reduction in COVID admissions over the past 2 months

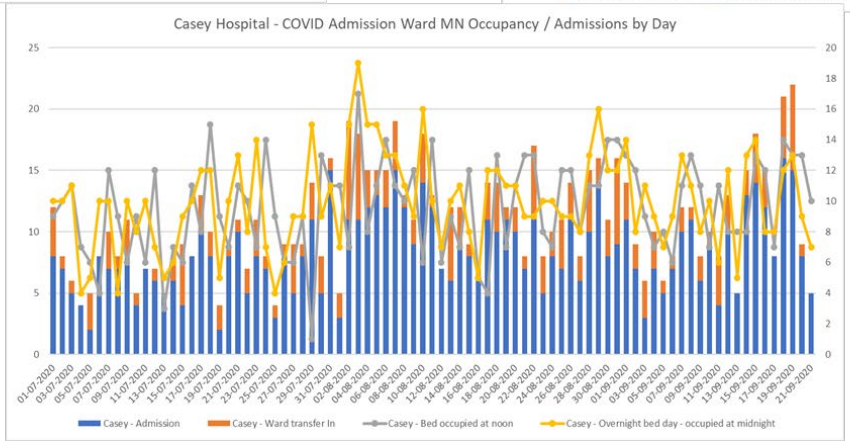


Source: BI portal, COVID monitoring report, 5/10/20

We are observing high numbers of Suspected COVID patients through our admission wards and this will continue







! Only **1%** of >5,000 patients screened for COVID have returned a positive result

Low number of HCW infections associated with identifiable risk factors

- Care of a patient not recognized as COVID
  - Elderly, deterioration on ward, MET calls
- Care of patient with high care requirements
  - Nursing home residents/physically combative
- Close contact of an unrecognized positive employee
  - Staff areas, tearooms, less PPE

Risk factors **do not** include ICU, theatre, ED and COVID Admission wards

Our current Model of Care is not sustainable long term

Additional Gen Med teams stood up at each site

39 employees redeployed to date (19 units impacted)

Significant roster gaps with increased elective demand

Risk of burnout for employees on COVID Admission wards

Multiple bed moves adversely impacts progression of care

Our principles continue to inform our evolving COVID-19 Model of Care

1. The safety and wellbeing of our **employees** is paramount

   PPE education / training

2. We will **protect** our non-COVID inpatients from transmission, especially our most vulnerable patient cohorts (immunocompromised and elderly)

   Cohorting avoid mixing of patients and clinical teams

   The plan moving forward:
   - Managing patients swabbed for COVID using current PPE approach in usual care wards to improve continuity of care and reduce delirium burden
   - Maintain cohorting of COVID positive patients

3. We will equip our employees with the **resources** they need to provide care (PPE, IT systems, equipment, training, psychosocial support)

   PPE education / training, Well being resources

4. Where demand exceeds our capacity to provide care, care will be prioritised based on **agreed clinical policies**

   Reduce non-essential care to provide capacity for COVID surge and Prioritisation of Care

We can predict suspected COVID activity through our current inpatient wards if we transition to our pre COVID admission model

Ward	Specialty Unit	Average Daily SCOVID Bed Day Utilisation	Average Daily Admissions
SW2 / W2 / SW4 / W4	General Medicine / Endocrinology	12.3	8.9
W3	General Surgery Vascular Surgery	1.1	0.9
SW3	Orthopaedic Surgery	0.7	0.6
N1	Plastic Surgery / ENT Surgery / OMF Surgery / Gynaecology	0.9	0.7
N3	Gastroenterology / Colorectal Surgery	0.4	0.4
Maternity	Obstetrics	0.0	0.0
	Total Daily Bed Requirement	**15.3**	**11.4**

Source: BI portal, FY20/21 Admission Ward LOS / admission data YTD, 22 September 2020

Monash Health proposes revisions to our Model of Care to optimise

	Status	Details
Admission / Management Wards 	Updated	Cease Admission Wards, swabbed COVID patients admitted to home ward Medical and Surgical COVID Management wards for confirmed +ve cases at each site
ED and ICU wards 	No change	
Personal Protective Equipment (PPE) 	No change	Maintain current PPE practices as per MH policy
PPE Coach / Advisor / Concierge 	Updated	Individualised resourcing dependent on suspected-COVID admission demand
MET Call / Code Blue 	No change	Follow procedures in the updated flowcharts published on 29 September
Pre-operative screening 	No change	Maintain current pre-operative screening

Our infection prevention principles will be applied to the revised Model of Care

1. Utilise single rooms where available
2. Develop shared bathroom model as appropriate
3. Dedicated staff on a shift / ward (NS) as appropriate
4. Appropriate level of PPE utilised for each patient as per MH policy
5. Individualise PPE coach / advisor / concierge support allocation per ward configuration based on demand
   - Resource embedded in workforce profile for wards with high suspected COVID demand
   - Roving teams in areas with low suspected COVID demand

Next steps

1. Engage with each ward in partnership with Infection Prevention to develop local plans based on predicted demand
   - Review ward and staffing configuration for SCOVID demand (high risk staff)
   - Determine PPE training requirements
   - Assess PPE coach / concierge requirements based on predicted suspected COVID demand
     - Dedicated PPE resource in workforce profile vs Roving PPE team
   - Review equipment requirements
   - Ensure clear signage for identification of patient categories
2. Review individual site bed plans
3. Develop comprehensive Communication Plan
4. Complete CIS and undertake Union Briefing – Wednesday 7 October 2020
5. Proposed Go-Live date TBC pending ward readiness and workforce resourcing