Waitematā
District Health Board
Best Care for Everyone

Hospital Services
North Shore Hospital Campus
Shakespeare Road, Takapuna
Private Bag 93-503, Takapuna
Auckland 0740
Telephone: 09 489 0527

7 October 2021

Dear

Re: OIA request – ICU capacity

Thank you for your Official Information Act request received 23 August 2021 seeking information from Waitematā District Health Board (DHB) about ICU capacity since March 2020.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā is the largest and one of the most rapidly growing DHBs in the country, serving a population of around 650,000 across the North Shore, Waitakere and Rodney areas. We are the largest employer in the district, employing around 8,600 people across more than 80 locations.

In addition to providing care to our own resident population, we are the Northern Region provider of forensic mental health services and child rehabilitation services, plus the metro Auckland provider of child community dental services and community alcohol and drug services.

On 27 August, we contacted you to advise that it was necessary to extend the timeframe on our response until the end of September as our clinicians, managers and staff are concentrating on measures to manage the current COVID-19 Delta outbreak in the region.

On 1 September, we asked for clarification of this aspect of your request: **how many surgeries were rescheduled or postponed/cancelled.** You confirmed that you were seeking: **how many surgeries were rescheduled or postponed/cancelled as a result of ICU capacity/staffing**.

On 30 September, we contacted you to advise that we would provide a response in full to you by 8 October and you confirmed that you were happy with this timeframe.

In response to your request, we are able to provide the following information:

1. Since March 2020 and by each month thereafter:

- **a. the number of fully staffed/operational ICU beds available, ICU capacity**
- **b. a breakdown of all ICU staff (such as numbers of ICU nurses) and any vacancies**
- **c. and how many surgeries were rescheduled or postponed/cancelled.**

The metro Auckland DHBs' ICUs work together to support each other and manage capacity across the region. There are seven physical bed spaces allocated to ICU patients at North Shore Hospital and a combined 14 physical bed spaces for ICU and HDU patients. We are staffed for eight Registered Nurses (RN) each shift, which allows a combination of both ICU and HDU patients, based on the skill level of RN.

a. The number of fully staffed/operational ICU beds available and ICU capacity

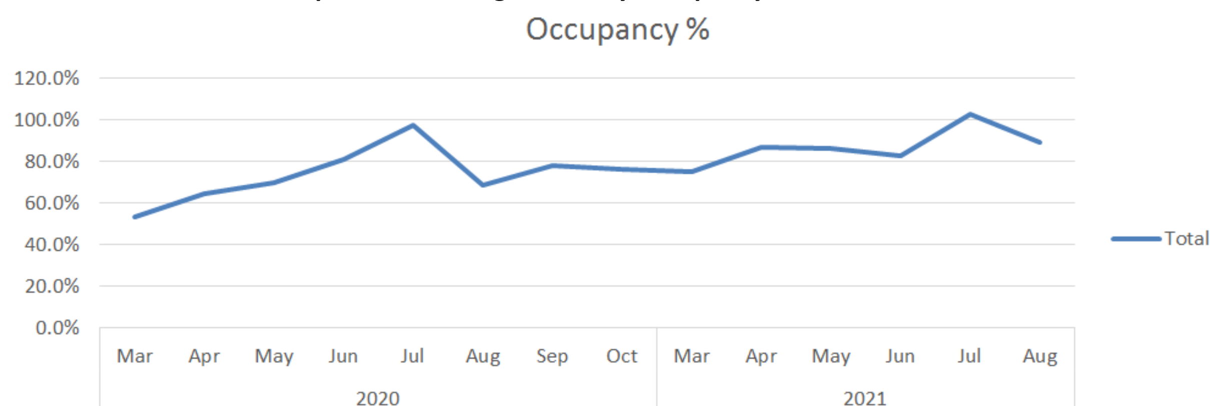
Occupancy is measured by counting the number of ICU patients as one and HDU patients as 0.5 (i.e. to account for the fact that a single nurse can look after two HDU patients) added up, divided by the number of staffed beds.

Occupancy of near, or more than, 100% is more likely during the winter months. However, these temporary peaks can be covered by managing staffing levels. Occupancy rates can also rise where a bed is used by two patients on a shift; i.e. a patient is transferred to a ward and the bed is filled straight away. The ICU database will count this as two patients being in that bed on that shift.

Other reasons for higher occupancy rates include:

- additional beds being used when an emergency patient is admitted while we await transfer of another patient to a ward bed or to another service or hospital
- if someone passes away, we may admit a patient into another physical bed space in the unit while arrangements are made with the family of the deceased.

Table 1: North Shore Hospital ICU average monthly occupancy



b. A breakdown of all ICU staff (such as numbers of ICU nurses) and any vacancies

Table 2: ICU Staffing from March 2020 to August 2021

ICU Staffing	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Specialist Medical Officers	6.18	6.18	6.58	6.81	5.80	6.50	6.25	5.84	6.30	5.41	6.39	6.38	6.64	6.47	5.68	5.81	6.08	6.61
Registrars	3.27	3.90	4.65	5.45	8.33	8.25	8.55	8.70	7.63	7.93	7.90	6.60	7.15	6.98	7.35	7.58	7.83	7.60
Senior Nurses	11.12	12.67	14.22	14.94	14.05	14.34	14.45	13.40	14.39	15.60	14.52	14.55	15.11	13.24	14.22	14.95	14.84	16.77
Registered Nurses	31.57	44.55	36.61	34.74	35.34	32.69	33.88	33.20	31.26	31.32	31.92	33.14	32.83	32.64	32.1	30.18	34.13	31.31
Internal Bureau Nurses	0.00	0.08	0.00	0.05	0.05	0.00	0.20	0.08	0.05	0.23	0.00	0.42	0.23	0.10	0.17	0.00	0.00	0.00
Health Care Assistants	2.93	4.13	3.60	3.88	3.58	3.29	3.69	3.59	3.11	3.47	3.00	3.69	3.52	3.42	3.19	2.76	3.52	3.08
Admin Clerical (Clinical)	1.15	1.26	1.30	1.14	1.33	1.34	1.35	1.59	1.14	1.13	1.16	0.85	0.83	1.11	1.24	1.07	0.95	0.98
Total FTE	**56.22**	**72.77**	**66.96**	**67.01**	**68.48**	**66.41**	**68.37**	**66.40**	**63.88**	**65.09**	**64.89**	**65.63**	**66.31**	**63.96**	**63.95**	**62.35**	**67.35**	**66.35**

Table 3: ICU Vacancies from March 2020 to August 2021*

ICU Vacancies	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
ICU																		
Specialist Medical Officers		1	1	0		0	0	0	0	0	1	1	1	1	1	1	1	1
Senior Nurses		1.9	0.9	0		0	1.6	1	1		0.5	0.8	1	1.5	4.4	4.6	3.5	3.3
Registered Nurses	0.9		0				1.9	1.9	0		2.9	5.5	1	0.9	2.9	1	3.2	2.3
Health Service Assistants			0	0		0												
Admin Clerical					1	2					0.7							0.4

*Please note that the senior nursing vacancies have largely been recruited in to and have reduced since August 2021.

c. Number of surgeries rescheduled or postponed/cancelled

Since March 2020, two surgeries have been cancelled due to staff sickness. These were unrelated to ICU capacity.

2. Since March 2020, copies of any reports, documents or briefing that include information about ICU capacity, including (but not limited) in relation to COVID-19, such as contingency plans to scale up capacity

Documents that include information about ICU capacity are attached as follows:

- **Attachment 1** - Waitematā DHB COVID-19 Readiness Framework - Hospital and Community services.
- **Attachment 2** - COVID Basics for Nurses Course Evaluation.
- **Attachment 3** - COVID-19 ICU/HDU Escalation Plan September 2020.

3. Since March 2020, copies of all correspondence with the Ministry of Health regarding critical care and ICU, in relation to COVID-19, such as confirmation of current capacity and plans to scale up capacity

Waitematā DHB has an ongoing long-term project in relation to building ICU capacity at Waitakere Hospital in order to meet the needs of the growing population in our district. Planning for this was underway before the outbreak of the COVID-19 global pandemic.

Please note that most of the attachments provided reflect a certain point-in-time when planning was in its early stages. Staffing and training issues have been addressed and, since the first Alert Level 4 lockdown, there has been significant work carried out by Waitematā DHB in our hospitals in preparation for a possible influx of patients.

Correspondence with the Ministry of Health regarding North Shore Hospital's ICU in relation to COVID-19 has been largely in relation to ensuring the required surge capacity of our ICU nursing workforce. Attachments as follows:

- **Attachment 4 –** DHB letter to CIC [Capital Investment Committee] re WTH urgent capacity, 28 April 2020.*
- **Attachment 5 –** Email: FW ICU workforce capacity, 5 May 2020
- **Attachment 6 & 6a –** Email and attachment: Write up from meeting on ICU capacity, 12 May 2020
- **Attachments 7, 7a & 7b** – Email and attachments: ICU Funding, 28 July 2020
- **Attachments 8, 8a & 8b** – Email and attachments: Summary of key themes from DHB discussions on surging the ICU workforce, 7 August 2020
- **Attachment 9** – Email: FW: ICU capacity and capability, 18 August 2020
- **Attachments 10, 10a & 10b** – Email and attachments: ICU Funding – Amendment, 13 November 2020.

*Since this letter was sent in April 2020, the Minister of Health has:

- on 28 April 2021, announced $40m funding for a new 30-bed inpatient ward at Waitakere Hospital
- set aside $20 million to add an ICU at Waitakere Hospital. This will be provided when we have completed a business case that is approved by the Minister. The business case was signed off by our Board on Wednesday, 6 October and will be submitted to the Minister's office for consideration this month.

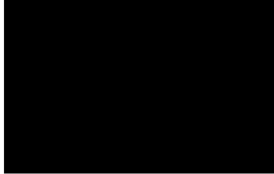
I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare.

This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely



Executive Director Hospital Services
Waitematā District Health Board

Attachment 1

Waitematā District Health Board
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COVID-19 Readiness Plan

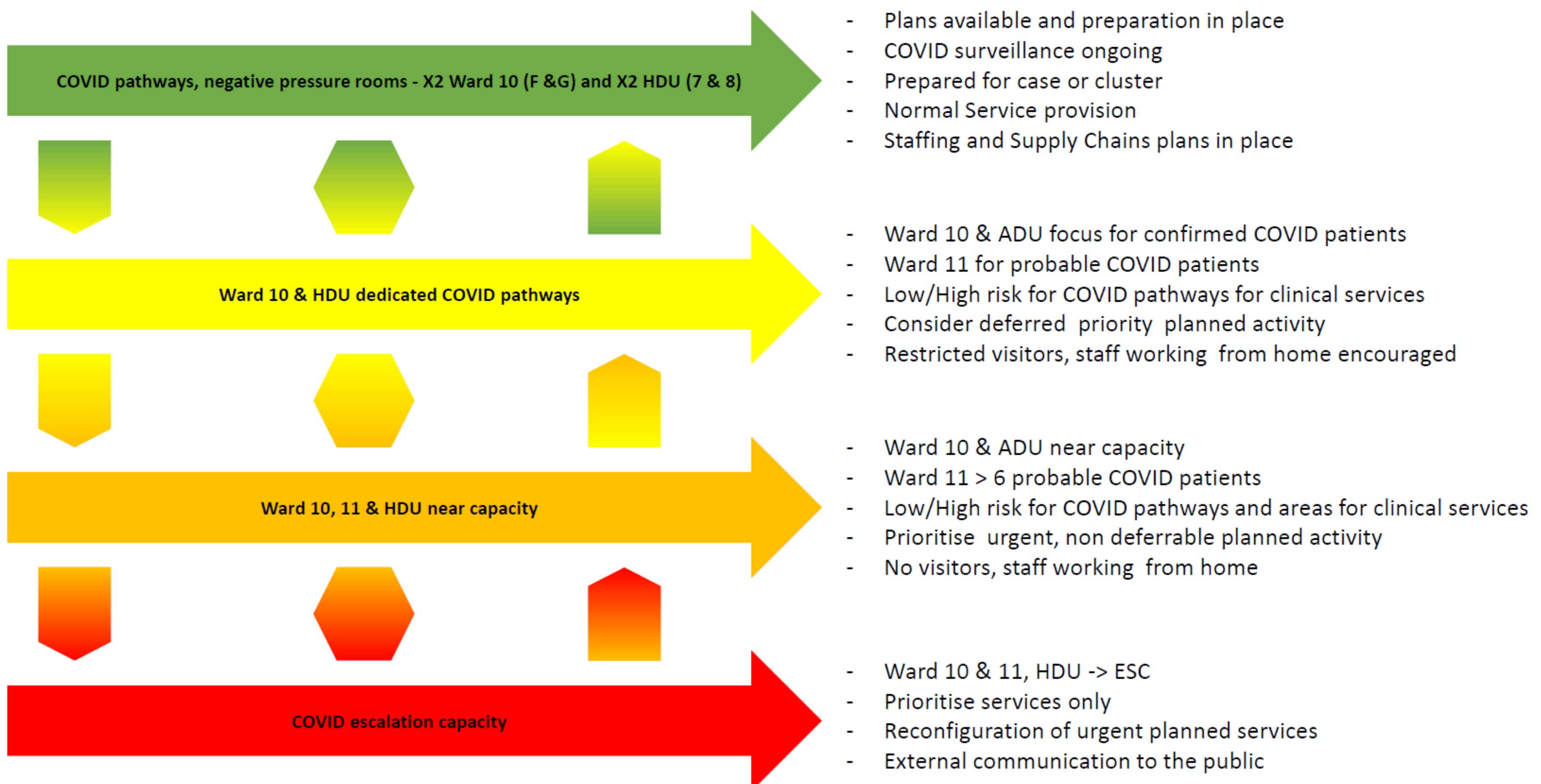
IMT Responses at various Alert Levels

Green	Light IMT with lead functions as per CIMS Model. Additional functions to be added as decided by the Incident Controller.
Yellow	Full Local and Regional IMT's as per CIMS Model. Increased Regional leadership (NRHCC, RPG) to provide oversight for matching capacity with demand. • **Hospital Triggers:** Moving to Hospital Framework Yellow: One or more local case in hospital (excludes MIQF admissions for non COVID-19 reasons) and community transmission evident. • **Clinical Technical Advisory Group (CTAG):** would be reinstated from yellow onwards and meet regularly to address clinical planning/concerns. • **Community Triggers:** Moving to Primary Care Response Framework Yellow: Any known community cases being actively investigated and managed.
Orange	Full Local and Regional IMT's as per CIMS Model. Increased Regional leadership (NRHCC, RPG) to provide oversight for matching capacity with demand. • **Hospital Triggers:** Moving to Hospital Framework Orange: Multiple local COVID-19 cases in hospital. Uncontrolled community transmission, clusters evident. • **Clinical Technical Advisory Group (CTAG):** would be reinstated from yellow onwards and meet regularly to address clinical planning/concerns. • **Community Triggers:** Moving to Primary Care Response Framework Orange: Community transmission of COVID-19 is not well controlled
Red	Full Local and Regional IMT's as per CIMS Model. Increased Regional leadership (NRHCC, RPG) to provide oversight for matching capacity with demand. • **Hospital Triggers**: Moving to Hospital Framework Red: Multiple local cases in hospital (excludes MIQF admissions for non COVID-19 reasons). Uncontrolled community transmission. • **Clinical Technical Advisory Group (CTAG):** would be reinstated from yellow onwards and meet regularly to address clinical planning/concerns. • **Community Triggers:** Moving to Primary Care Response Framework Red: There is uncontrolled community transmission of COVID-19.

Regional Bed Plan

The Northern Metropolitan Auckland Region coordinates the response to COVID-19 through the Northern Regional Health Coordination Centre (NRHCC) and the Regional Provider Capacity Planning Group oversees the day-to-day coordination, planning and response of hospital services.

WDHB COVID-19 Management Plan



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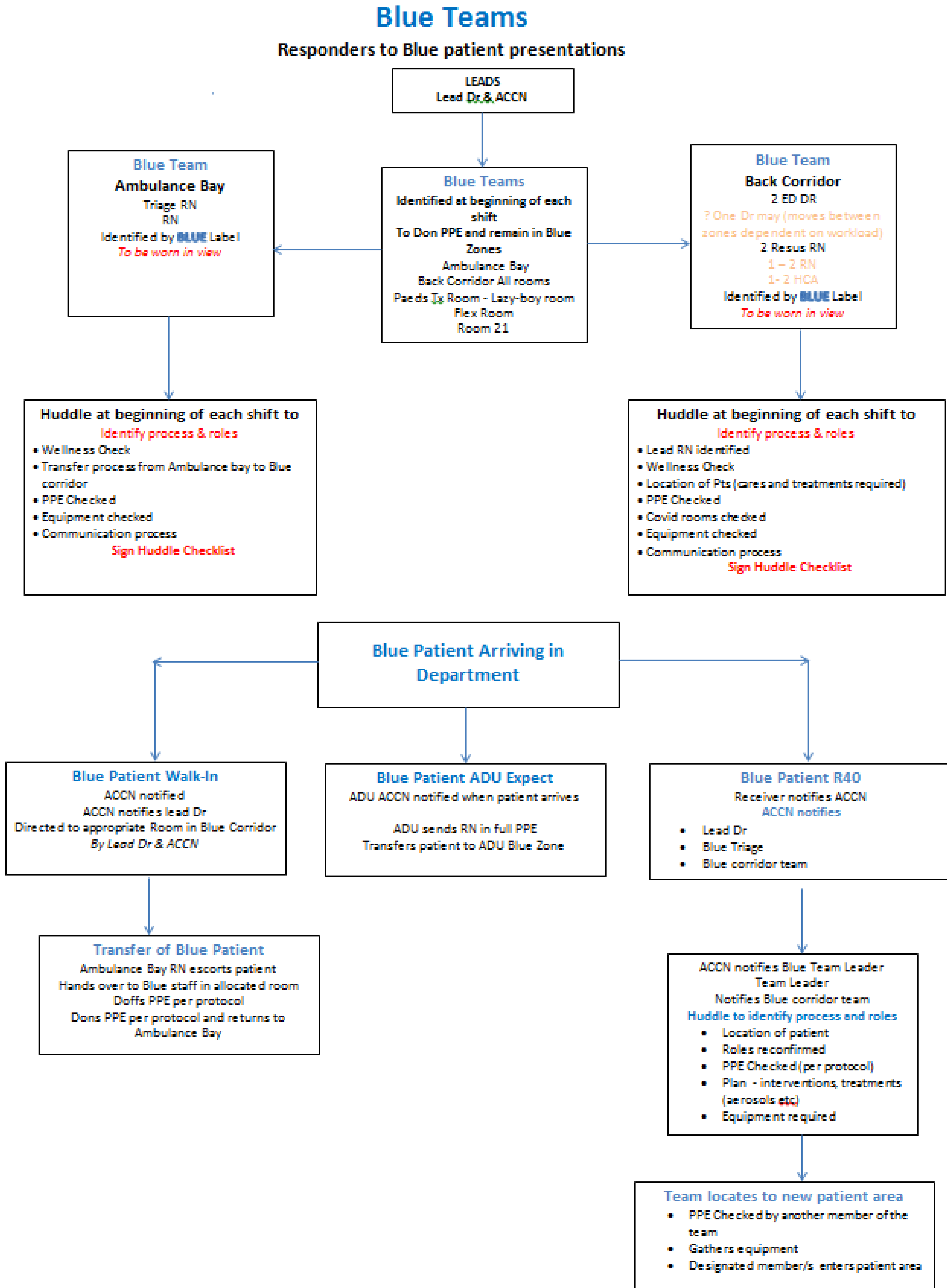
COVID-19 Readiness Plan

ED Blue Team Responders to Blue (COVID-19-positive) Patient Presentations



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COVID-19 Readiness Plan

COVID -19 WDHB NSH EMERGENCY DEPARTMENT RESPONSE FRAMEWORK

COVID-19 Emergency Department Readiness GREEN ALERT	***Trigger Status: No COVID-19 positive patients in your facility; Any cases in your community are managed and under control; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes*** • Screen patients for COVID-19 symptoms and epidemiological criteria for any Emergency Department attendance • Streaming for patients with respiratory infections /COVID risk (use of Clinical assessment tool) • Maintain ability to return, if necessary, to physically triage outside the Emergency department (Portacoms on stand –by) • Maintain a separate stream (blue) for COVID-19 suspected cases in the Emergency Department • Maintain PPE training for COVID-19 care in the Emergency Department • Follow WDHB COVID operational plan for admitting patients with suspected COVID-19
COVID-19 Emergency Department Initial Impact YELLOW ALERT	***Trigger Status (individual or cumulative): One or more COVID-19 positive patients in your facility; cases in your community are being managed; isolation capacity & ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gap*** • Continue screening and streaming patients for COVID-19 symptoms and epidemiological criteria as per Green alert • Plan for ability and immediate implementation for Emergency department triaging in physically separate settings – ie division of respiratory (Blue/Lilac)/non respiratory (White/Yellow) patients at triage • BAU nursing model (however additional resus resource for Iso rooms) • Continue a separate stream (blue) for COVID-19 suspected cases in the Emergency Department as per green alert ○ High risk COVID patients managed in negative pressure rooms (if available) or single door closed room in ED (Iso 1/Iso 2/Flex) • Preparation to open Urgent Care Community Mental health Hubs 8-4pm (to be functional if ED requires additional space for COVID-19 patient assessment. • Engage across other DHBs to appropriately transfer out of area patients back to domicile hospital or other setting (to be considered in conjunction with current hospital alert level at DHB)

COVID-19
Emergency Department
Moderate Impact
ORANGE ALERT
	Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission is not well controlled; isolation capacity and ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered
	• Separate FOH Screening process to identify those entering the acute hospital environment with COVID-19 symptoms and epidemiological criteria (staff to be provided through IMT)
	• Streaming for patients with respiratory infections /COVID risk (use of Clinical assessment tool)
	• Implement separate Emergency department triage process for respiratory/non respiratory streams
	• 'COVID Corridor' with 11 identified spaces for High Risk Blue stream patients
	    ○ Conversion of 'back corridor rooms' T1, T2,T3 as COVID spaces (appropriate nursing resource allocated)
	    ○ Conversion of Paeds Tr,1,2,3 as COVID spaces
	    ○ Paeds resus converted to adult CLOSED DOOR adult resus space
	    ○ Room 21 and Flex converted to COVID rooms
	• Paediatric diversion from NSH to WTH and Starship
	• Resus 3 converted to mixed Paeds/Adult resus area
	• Observation beds converted to acute spaces on Whiteboard
	• Modified nursing model (to staff back corridor, additional resus spaces and secondary patient screening space)
	• Modified medical model (additional Pod B spaces)
	• Urgent Care Community Mental Health Hubs extend to 8am-11pm
	• Provide Emergency department services with prioritisation on high acuity medical and trauma care
	• Confirm service level agreements for patient diversion for activation in RED
	• Plan for Forward Triage cabins and staffing arrangements for these

COVID-19 Emergency Department Severe Impact RED ALERT	***Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission uncontrolled; isolation and ICU at capacity; all available staff redeployed to critical care*** • Emergency department services limited to high acuity medical and trauma care • Activate plans as described in green, yellow and orange alert levels. • Ensure Forward Triage cabins on site and operational • Activate forward triage process • Speciality service level agreement for non-emergent patients activated • Community patient redirection • Modified nursing and medical MOC • Minimal ED observation use

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COVID-19 Readiness Plan

COVID -19 WDHB WTH EMERGENCY DEPARTMENT RESPONSE FRAMEWORK

Alert	Actions
COVID-19 Emergency Department Readiness GREEN ALERT	***Trigger Status: No COVID-19 positive patients in your facility; Any cases in your community are managed and under control; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes*** • Screen patients for COVID-19 symptoms and epidemiological criteria for any Emergency Department attendance • Streaming for patients with respiratory infections /COVID risk (use of Clinical assessment tool) • Maintain ability to return, if necessary, to physically triage outside the Emergency department (Portacoms on stand –by) • Maintain a separate stream (blue) for COVID-19 suspected cases in the Emergency Department • Maintain PPE training for COVID-19 care in the Emergency Department • Follow WDHB COVID operational plan for admitting patients with suspected COVID-19

COVID-19
Emergency Department
Initial Impact
YELLOW ALERT
	Trigger Status (individual or cumulative): One or more COVID-19 positive patients in your facility; cases in your community are being managed; isolation capacity & ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gap
	• Continue screening and streaming patients for COVID-19 symptoms and epidemiological criteria as per Green alert
	• Plan for ability and immediate implementation for Emergency department triaging in physically separate settings – ie division of respiratory (Blue/Lilac)/non respiratory (White/Yellow) patients at triage
	• BAU nursing model
	• Continue a separate stream (blue) for COVID-19 suspected cases in the Emergency Department as per green alert
	  ○ High risk COVID patients managed in negative pressure room (if available) or single door closed room in ED (Rm 22/23/27)
	  ○ Blue PPE team identified on each shift & team check-in documentation.
	• Preparation to open Urgent Care Community Mental health Hubs 8-4pm (to be functional if ED requires additional space for COVID-19 patient assessment)
	• Engage across other DHBs to appropriately transfer out of area patients back to domicile hospital or other setting (to be considered in conjunction with current hospital alert level at DHB)

Alert	Actions

COVID-19
Emergency Department
Moderate Impact
ORANGE ALERT
	Trigger Status (individual or cumulative): Multiple COVID-19 positive patients in your facility; community transmission is not well controlled; isolation capacity and ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered
	• Separate FOH Screening process to identify those entering the acute hospital environment with COVID-19 symptoms and epidemiological criteria (staff to be provided through IMT)
	• Streaming for patients with respiratory infections /COVID risk (use of Clinical assessment tool)
	• Implement separate Emergency department triage process for respiratory/non respiratory streams
	• 'COVID Spaces' with 8 identified spaces for High Risk Blue stream patients
	  ○ Consults 1-4
	  ○ Iso 22, Rm 27, 16,17
	• Conversion of sedation room to RESUS 5 Paeds RESUS/Isolation space
	• Conversion of Procedure room to RESUS 4 additional adult resus/Isolation space
	• Mental health spaces 16/17 converted to blue stream patient rooms
	• Paediatric patients from NSH diverted to WTH (and Starship where appropriate)
	• Resus 3 converted to mixed Paeds/Adult resus area
	• Observation beds converted to acute spaces on Whiteboard
	• Modified nursing model (to staff back corridor, additional resus spaces and secondary patient screening space)
	• Modified medical model (additional Pod B spaces)
	• Urgent Care Community Mental Health Hubs extend to 8am-11pm
	• Expedited MH support in ED for timely care and disposition
	• Provide Emergency department services with prioritisation on high acuity medical and trauma care
	• Confirm service level agreements for patient diversion for activation in RED
	• Plan for Forward Triage cabins and staffing arrangements for these
	• Activate delivery of forward triage cabins if RED imminent (72hr required for functional units)

Waitematā District Health Board
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COVID-19 Readiness Plan

Auckland Regional Public Health Service (ARPHS) Community Referral for COVID-19 Positive/Close Contact Patients via ED

Step	Action
1	**Auckland Regional Public Health Service (ARPHS)** contacts Emergency Department (ED) Associate **Clinical** Charge Nurse (ACCN) • **ED ACCN WTH 021 679 774** • **ED ACCN NSH 021 498 310**
2	**ARPHS** provides the following information: • Relevant patient details & clinical information • Patient's arrival time • Patient's contact details • Mode of transport (own car/Ambulance) • ARPHS contact details
3	**ED ACCN** then: • contacts patient • confirms patient's details, arrival time, transport details • gives patient arrival instructions, parking information • prepares the ED "BLUE" team for arrival • notifies Security, Duty Nurse Manager/Operations Manager for Waitemata Central
4	**Patient** arrives in hospital: • Patient remains in the car and contacts ED ACCN • ED ACCN (or nominated RN) meets the patient • Patient and visitor (x1) are given a mask • Patient and visitor are guided through to allocated ED Bed space • Patient's ED journey commences • ED ACCN notifies CNM/OM ED and DNM/OM Waitemata Central of patient's arrival • ED ACCN requests extra support/resource from Waitemata Central if applicable • ED OM/DNM Waitemata Central notifies COVID-19 Incident Management Team (IMT) of patient's arrival • If requiring admission – transfer procedure starts

Community-Facing Support Services

Allied Health (AH)
**** Blue Stream Patients ****
Adult Medical, Surgical, Orthopaedic or Maternity Patients
Blue stream patients admitted during usual work hours Monday to Friday
The relevant Clinical Leader(s) for the involved allied health discipline(s) will be alerted to any blue stream patients admitted during the week days. Referral(s) will be reviewed morning and afternoon as usual, and if essential need for allied health involvement is identified for blue stream patients the planned pathway will occur.

Blue stream patients admitted over the weekend
Physiotherapy
For admissions during the weekend **and after hours**, if deemed to require urgent Physiotherapy input, the on call respiratory Physiotherapist needs to be contacted via the operator. They will then contact their Clinical Leader (or delegate) as required. **Physiotherapy – refer Weekend On-Call policy.**

Social Work
Over the weekend the ED social worker should be alerted and will follow their normal consultation processes. They will then contact their Clinical Leader (or delegate) as required.
Link to Standard Operating Procedures

Dietetics
If patients are deemed to require dietetic input over the weekend the on-call dietitian should be contacted via the operator. They will then contact their Clinical Leader (or delegate) as required.

There is no Occupational Therapy or Speech Language Therapy service over the weekends or after-hours
Weekend or on-call referral(s) will be reviewed and if accepted the planned pathway will occur.

Maternity Social Workers
If a **blue stream** woman requires social work support, then clear discussion and planning with the Midwife Manager (or delegate) is required prior to contact. Staff will be supported by the 'runner' from the midwifery/HCA staff and auditor for donning and doffing of PPE.

Paediatric patients
Blue Stream children will not be admitted to Rangatira. Paediatric Allied Health Staff will not be requested to go to ED to look after blue stream patients in person.

READINESS PLANS FOR OUR LOCALITIES AND COMMUNITY MENTAL HEALTH

Service	Community framework level	Response
Localities (Community Services, District Nursing)	Green	Business as usual (BAU)
	Yellow	Alert Level Yellow co-ordination of community-based care delivery
	Orange	Virtual clinics only Home visits for essential care only where no other alternative Ensure correct PPE and supply chain
	Red	Virtual clinics only Ensure clinical pathway for those who can't manage at home Ensure Level 4 plans activated Ensure PPE and supply chain
Community Mental Health	Green	BAU with Ministry guidelines as instructed Initiate plan for increased COVID levels Ensure correct PPE and supply chain Utilise virtual consults as appropriate
	Yellow	Services continue BAU with Ministry guidelines as instructed Increase telehealth / phone appointments where possible Active team "bubbles" Reduce clinics as appropriate
	Orange	Increase telehealth where possible Active team 'bubbles' Reduce clinics as appropriate
	Red	Defer all clinics unless deemed acute or urgent

Attachment 2

Waitematā District Health Board
Best Care for Everyone

BASIC for Nurses – COVID-19 Response

ICU/ HDU

Scope of course

To prepare for the potential surge in ICU requirements during COVID-19 pandemic, the Critical Care community in New Zealand prepared a shortened course for units to prepare RN's redeployed to work in ICU.

The BASIC for Nurses course was developed to meet this need. Two senior nurses from NSH ICU attended the train the trainer course in Hawkes Bay. The BASIC for Nurses course is adapted specifically for COVID-19 pandemic into an 8-hour Study Day which includes theory and skill stations relevant to the knowledge/skills required during a pandemic with the focus on topics as outlined in the program in Appendix 2.

A menu of requirements was created to meet the needs of the learner / service. This included an 8 hour study day provided by the NSH ICU education team, orientation shifts with ICU level patients to refamiliarise / gain exposure to critically ill patients. The orientation period was contingent on staff availability; this was variable due to release from usual role and redeployment to other areas.

Demographic of volunteers

Ex-ICU RN's with recent experience – less than 3 years (group 1)

This group was considered to still have a solid base of ICU knowledge and skills. The assumption was that this group might need updating on changed policies and procedures. Some time was needed to recertify them in ICU specific competencies and Point of Care testing (POC). A focus on correct use of personal protective equipment (PPE) and completion of fit testing for N95 mask was prioritised. Ensuring access to all WDHB networked applications is available. All mandatory e-learning completed.

Ex- ICU RN's have left ICU more than 3 years ago (Group 2)

This group may or may not need a refresher on both ICU knowledge and skills, this was elicited by self-assessment. An offer to attend the adapted BASIC for Nurses course was extended to this group. Extra time was spent with this group to ensure competence in ventilation and continuous renal replacement therapy (CRRT). POC, PPE, fit testing and proning were focused on. In addition, a unit orientation with Health & Safety checklist, full medication test and ICU specific medication competencies needed to be completed. Ensuring access to all WDHB networked applications is available. All mandatory e-learning completed.

Anaesthetic Techs, PACU Nurses, Acute Surgical Nurses (Group 3)

This group has experience in some areas of acute/critical care but needed a comprehensive approach to look after the critical ill patient as a whole. This group required extensive orientation to new equipment, procedures and patient care of the critical ill patient. In addition, a unit orientation with Health & Safety checklist and ICU specific Medication Test and ICU specific medication competencies needed to be completed. Ensuring access to all WDHB networked applications is available. All mandatory e-learning completed.

Recruiting appropriate staff

An expression of interest was put out for RN's across the organisation for volunteers to work in ICU during the pandemic. This process was delayed by being unable to approach staff directly; we had to rely on staff answering generic emails.

This approach yielded a response from 12 RN's with varying amounts of experience and time since the had last worked clinically in an acute area. This ranged from leaving ICU within 12 months to last working clinically more than 10 years prior.

Additional collaboration between ESC and NSH PACU charge nurse managers and clinical nurse educators was undertaken to identify nurses suitable to orientate to ICU/HDU. Suitability was determined by Occupational Health Assessments and an ability to work across all shifts.

BASIC for nurses

An 8 hour study day was provided with orientation shifts to gain exposure to the following:

- Unit Orientation complete: Health & Safety Checklist
- Network Access: eVitals, ePrescribing
- POC Access: demonstrate and return -demonstration for
    - ABG machine
    - Statstrip Xpress and Statstrip Nova
- ICU specific Med Test prior to Pyxis access
    - PCA/PCEA competent
- CVAD/Arterial line maintenance
- Dressing changes: A-line, CVAD, NG-tube, ET-tube
- Nursing care of the Critical Ill Patient
- Proning process
- Documentation

In order to cover the maximum amount of topics a significant amount of pre-reading was required prior to attendance of BASIC for Nurses.

In total 48 nurses attended the BASIC for Nurses course – 12 ex-ICU nurses and 35 PACU nurses. Only 1 ex-ICU nurse completed their ICU orientation. This was due to business as usual demand requiring they remain in usual role or redeployment to areas of greater need i.e. IMT.

19 PACU nurses completed their ICU orientation. These nurses had a 2-week rotation period to ICU with between 3 – 6 shifts dependent on their current FTE. The orientating group was exposed to the mechanically ventilated and non-invasively ventilated (NIV) patients.

It is very unlikely that any nurse without prior ICU experience will be deemed competent across the spectrum of critical care after 6 shifts, however there is confidence that these RN's can function to a good standard within the ICU team model. Ongoing exposure to critical care environment is recommended to allay anxiety for these RN's.

Future planning

The ongoing demand for ICU RN's will continue while there is a global pandemic. Arguably the need for surge capacity within the ICU will always remain.

There are still a number of nurses in NSH PACU who have not completed their ICU rotation yet. Additionally ICU nurses are required to be familiar with PACU 2 as HDU patients would be decanted into PACU 2 if capacity requires. Currently HDU-only nurses (3), non-COVID nurses (4), as determined by Occupational Health will currently be considered for this orientation. PACU nurses assessed by Occupational Health as zone 3 will be prioritised to orientate to NIV. This is to achieve competency for nursing HDU patients within PACU 2.

While both PACU and ICU remain conducting business as usual a reciprocal exchange of staff is required, balanced with ensuring safe skill mix. A plan has been agreed to rotate only one nurse at a time from both units. In ICU they will have a 2-day orientation period at the bed space and then take full patient load with a predetermined ICU buddy nurse.

The acuity for ICU/HDU level COVID patients has a significant increase in the nursing hours. Sustainability of the service in order to meet this surge demand requires alternative staffing models, including additional resource. Therefore we are looking at expanding our resource group capable of looking after patients under the guidance of an ICU nurse.

The most logical group to be approached next for this training is the acute surgical ward RN. This group of nurses would need a more intense training approach as they are unfamiliar with the majority of the ICU skills and equipment. It is highly recommended that they attend the BASIC for Nurses course run by the ICU Education Team that covers a lot of ICU theory but also the nursing care skills at the skills stations. Medication test coaching will be incorporated on this day. They would then have to do all of their competencies to gain accesses, Medication Test, Unit Orientation, patient care orientation, etc.

All of the nurses who completed their orientation in ICU would need to return on a rotation basis to maintain their exposure to skills and routine of the unit.

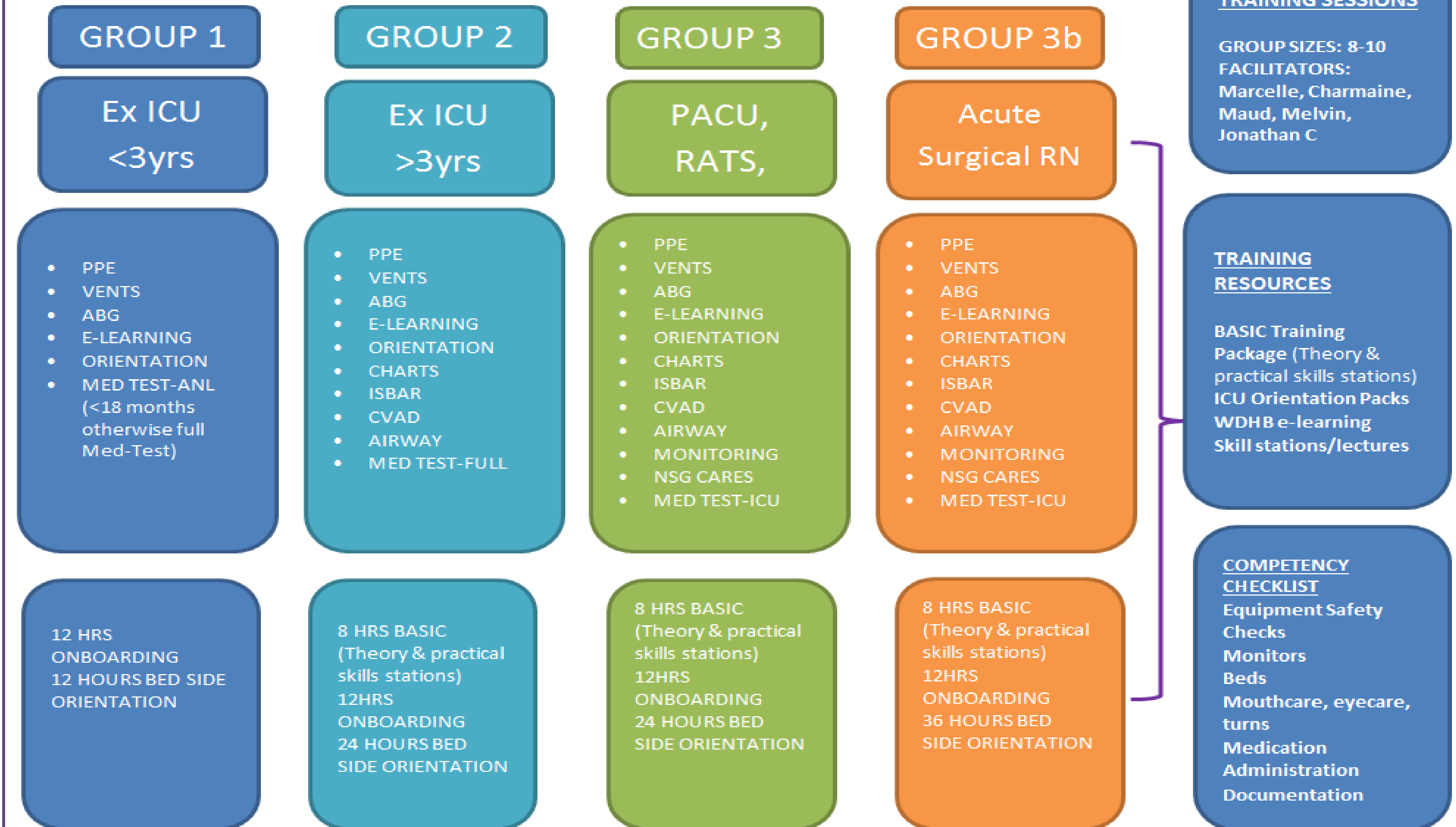
Resources for future BASIC for Nurses course

1. Venue that is capable of hosting lecture area and 4 skill stations simultaneously whilst maintaining social distancing if required.
2. Faculty of 4 is required to meet the sessions for the study day.
3. Physical resources – manikins were sourced from Waitakere SIM centre so are contingent on other bookings.

Recommendations

1. BASIC for Nurses course to be run frequently throughout the year. Initial orientation for acute surgical nurses (group 3b) into HDU to be conducted in 2 week blocks for consolidation.
2. Ongoing orientation/exposure for surgical nurses (group 3b) every 3 months of at least 1 shift in ICU/HDU.

Appendix 1:



Appendix 2:

BASIC for Nurses

Time	*Topic*	*Presenter*
0700 – 0710	Introduction	
0710 – 0730	Cardiac Physiology	
0730 – 0750	Hemodynamic Monitoring	
0750 – 0810	Neurologic Assessment	
0810 – 0830	Respiratory Physiology	
0830 – 0850	Ventilator Principles	
0850 - 0905	Tea Break	
0910 – 0930	Ventilator Modes	
0930 – 0950	Ventilator Troubleshooting	
0950 – 1010	Nursing Cares	
1010 – 1030	Communication	
	Scenarios	
1045 – 1230	Patient Assessment	
	Neurologic Assessment	
	Ventilation modes	
	NIV + Airway	
1230 – 1300	Lunch Break	
1300 - 1440	ABG	
	Ventilation troubleshooting	
	Care of intubated patient	
	Hemodynamic monitoring	
1440 – 1530	**Post test**	

COVID-19 ICU phased training plan

This model was shared on the New Zealand Critical Care **NZCCCF** for Educators by from CCDHB and then adapted to be unit specific.

COVID – 19 ICU/HDU - Escalation Plan

Contents

1. Overview 1
1.1 Associated Documents 1
2. Notification process 2
3. Phased escalation plan for ventilated patients 2
4. Escalation processes 3
4.1 First and Second patients suspected or confirmed with COVID-19 – Phase 1a. Alert level 1 - Green 3
4.2 Up to 4 respiratory patients requiring ICU/HDU – phase 1b 3
4.3 Alternative location for suspected or confirmed COVID-19 ICU patients - Phase 2 4
4.4 More than 14 ventilated patients 4
5. Workforce planning 4
5.1 Nursing 4
5.2 Medical staff 5
5.3 Training for new to ICU / returning staff 5
5.4 Alternative staffing models 5
6. ICU Coordinator actions 5
7. Transfer 5
8. Equipment 6
8.1 PPE Stocktake 6
8.2 Stocktake of consumables 6
9. Staffing and COVID-19 6
9.1 High risk staff 6
9.2 Staff allocation 7
10. Visiting 7
11. Staff from other areas 7
12. Cleaning 7
13. Appendix 1: Escalation Plan for Ventilated Patients 8
14. Appendix 2: Admission Process for Blue Stream COVID Patients to ICU/HDU 9
15. Appendix 3: Staffing Models 10
15.1 ICU level patients requiring 1:1 nursing 10
15.2 Staffing for all 4 HDU rooms used 10
15.3 Staffing Ratio 11

1. Overview

Purpose

To provide direction for all ICU staff to ensure the efficient and effective cohorting of suspected or actual COVID-19 patients within ICU/HDU.

Scope

All Waitematā DHB employees.

1.1 Associated Documents

Waitematā DHB Policy	COVID-19 IPC Management

COVID – 19 ICU/HDU - Escalation Plan

	COVID-19 Clinical Guide COVID-19 Readiness Plan Operational Plan - COVID-19 patient Standard Precautions Cleaning and Disinfection Policy
Literature	MoH Novel Coronavirus (2019-nCoV) Guidance Infection and Prevention Interim Advice for Health Professional: Novel Coronavirus (2019-nCoV) MoH (2010) Guidance for the provision of intensive care unit therapies in response to an influenza pandemic. ANZICS Guidance COVID guidance v2

2. Notification process

COVID-19 is a notifiable disease. ARPHS must be notified 09 6234600.

3. Phased escalation plan for ventilated patients

Progressions through the detailed phases below are likely to occur rapidly.

	Phase 1a – 2 patients (Alert Level 1 - Green)	**Phase 1b – 2 - 4 pts (Alert Level 2 – Yellow)**	**Phase 2 – >4 pts (Alert Level 3 – Orange)**	**Phase 3 – >14 (Alert Level 4 – Red)**
COVID suspected or confirmed patients.	HDU 7 & 8 - negative pressure rooms	HDU 7 & 8 HDU 2 & 3 – new negative pressure rooms	ESC PACU – 14	ESC PACU -14 Tower ICU/HDU - 14
Non-COVID ICU patients	Cohorted in NSH ICU (6 beds)	NSH ICU (6 beds)	NSH ICU (6 beds)	
Non-COVID HDU	HDU 1 – 5 ICU 1-6	HDU (reduced capacity only 1 space available – dependant on location of COVID patient) +/- PACU 2 (4 beds)	HDU (8 beds) +/- PACU 2 (4 beds)	PACU 2 (4 beds) for HDU & ICU
Staffing requirements				
Nursing	BAU	BAU ratio Protected “staffing bubbles” to assist with additional negative pressure rooms	BAU ratio Protected “staffing bubbles” to assist with additional negative pressure rooms Augmented / surge roster activated	3 separate rosters of RN’s Heavily augmented by PACU ESC & NSH Anaesthetic technician support All support available
Medical – SMO	BAU – 1 SMO/shift	2 SMO’s Activate 2 cell phones	ESC ICU SMO NSH ICU SMO Ana / Surg to run HDU	ESC ICU SMO NSH ICU SMO Anaesthesia SMO support Surgical SMO support
Medical – RMO	BAU – 6 RMO’s	8 RMO’s (2 on most shifts)	Attempt to find 10 RMO’s (2 on all shifts)	All support available

COVID – 19 ICU/HDU - Escalation Plan

Additional support HCA	BAU is 1/shift non rostered overnight	1 per shift	1 per site Roster night shifts	2 each shift – bureau, all support
Ward clerk	BAU	BAU	1 ward clerk each site – consider extended coverage	

Decisions to admit to ICU/HDU will remain the domain of SMO rostered for ICU. Difficult decisions will be discussed between these groups, as is usual. Consultation with wider Intensive Care Community will also be ongoing to ensure an aligned approach to ensure access to limited resources is as equitable as possible across region.

Appendix 1 – see Escalation plan for ventilated patients

4. Escalation processes

4.1 First and Second patients suspected or confirmed with COVID-19 - Phase 1a. Alert level 1 - Green

Patients will be admitted in usual ways following ICU registrar or SMO review. Notification of any actual or potential infection to ICU co-ordinator.

Patients will be admitted to the negative pressure rooms; HDU 7 or 8. The negative pressure room doors are to be kept closed and strict adherence to WDHB Contact and Droplet precautions maintained by all personnel.

Advice from infection control is that this virus spreads via droplet and aerosol. Contact and Droplet precautions are sufficient for many areas. However patients admitted to HDU will be receiving airway support and are at a higher risk of aerosol generating procedures ***so Contact and Airborne precautions are advised for all staff** in this area will be referenced throughout this document.

If aerosol generating procedures (AGP) are performed the patient must be in an airborne infection isolation room (negative pressure). AGPs include: tracheal intubation, non-invasive ventilation, tracheotomy, cardiopulmonary resuscitation, manual ventilation before intubation, bronchoscopy (and broncho-alveolar lavage) and high flow nasal oxygen.

Appendix 2 – see Admission process for blue stream patients

4.2 Up to 4 respiratory patients requiring ICU/HDU - phase 1b

When both HDU 7 & 8 are occupied with suspected or confirmed cases further COVID admissions will be into newly created negative pressure rooms HDU 2 & 3.

It will still be possible to have non-respiratory patients within HDU although beds 1 & 4 are not to be used. If both 7 & 8 are used HDU 6 will not be available.

It might be preferable to move NON-respiratory HDU patients to PACU 2.

COVID – 19 ICU/HDU - Escalation Plan

4.3 Alternative location for suspected or confirmed COVID-19 ICU patients - Phase 2

A decision may be required to isolate all respiratory patients from main hospital to limit exposure and contamination.

Alternative site for ICU is ESC PACU; this has 14 workable spaces, with capacity to further surge to 18 in theatre, with adequate electrical outlets, Oxygen and air supplies. The decision to move is made by IMT, a 24hour period is required to change the air flow within RSC, this time will allow for set up of the 14 spaces. The plan to assist with the move can be found in the ICU coordinator folder.

The ESC PACU has Schrader outlets and ICU ventilators are Puritan Bennett so an adaptor will be required, these are available for each ESC ICU bed space from clinical engineering.

The decision to open ESC ICU and Cullen ward can only be made by the IMT. The ICU SMO should contact the executive on call who will obtain approval for this.

A daily discussion between CD ICU and IMT will be required to adequately plan and initiate the move to ESC ICU.

Once IMT have approved the opening of ESC PACU as an additional ICU CNM and/or ICU Operations Manager must be contacted to initiate set up processes.

4.4 More than 14 ventilated patients

Once the 14 respiratory beds are occupied the decision to return to tower ICU may be required to meet capacity surge.
It will be unlikely that safe cohorting of non-COVID patients will occur in the same space; therefore non-COVID ICU patients will remain in PACU 2.

5. Workforce planning

5.1 Nursing

Business as usual nursing cover model for ICU is a senior RN coordinator plus 8 RNs per shift.

The ICU nursing roster will need to be augmented by ESC PACU and NSH PACU staff if we have more than 4 COVID-19 patients in ICU/HDU. This will be contingent on theatre lists being run across both sites. Oversight of nursing rosters will be done by Clinical Nurse Director Surgical Inpatient Wards.

Flexibility to increase staffed beds is available, however business as usual staffing for ICU nursing will remain at coordinator plus 8 unless otherwise directed by Clinical Nurse Director Surgical Inpatient Wards. Additional staffing for COVID-19 patients must be captured for financial tracking a record of additional staffing is to be collected by CNM ICU.

If the ESC ICU is to open, additional staffing will be required to manage 2 distinct areas. The decision to activate on call plans will be communicated by Clinical Nurse Director Surgical Inpatient Wards.

COVID – 19 ICU/HDU - Escalation Plan

5.2 Medical staff

There are 8 SMO's employed within ICU/HDU.
There are 8 registrars; additional resource is available if the surge in capacity of ICU patients eventuates.

5.3 Training for new to ICU / returning staff

ANZICS has initiated an education plan to provide support to education teams in up-skilling returning and new to ICU staff. Education materials are being shared by the intensive care community world-wide.
NSH ICU has a good plan for skill development for non-ICU nursing staff to enable them to provide assistance when surge in capacity requires.

Information on the plan can be found: **G:\ICU\ICU Management\Nurse Unit Manager\Disaster Planning\COVID-19\COVID Education**

5.4 Alternative staffing models

Pandemic precautions do not preclude normal standards of care; any decision to modify current standards will be discussed at operational level once all resources have been exhausted.

One staff member to one patient ratio **MUST** still remain. An alternative model of care will be required to meet demand;

- 3 person team comprising of ICU RN, other RN and/or Registered anaesthetic technician to care for 3 patients

6. ICU Coordinator actions

Information for the ICU coordinator to manage the unit when COVID positive patients are admitted can be found: **G:\ICU\ICU Coordinators\COVID resources 2020**

The information in this file is regularly updated by senior nursing team with evidence based information.

7. Transfer

Inter-hospital

If transfer of the patient outside the infection isolation room is necessary, the patient should wear a surgical mask while they are being transferred and follow respiratory hygiene and cough etiquette. The patient should perform hand hygiene. Health care workers transporting patients wear gloves, gown, and a N95 or surgical mask.

This process will be undertaken by a high risk transfer team comprised of anaesthetic SMO's, registrars and RAT's.

Intra-hospital transfer

Intra-hospital transfers of suspected cases, confirmed cases and persons at epidemiological risk requiring admission

- Patient to wear a surgical mask when transferring through the hospital. If the patient is accompanied by family members, the family members should also wear a surgical mask.

- Staff members transporting patients should wear gloves, gown, and a N95 or surgical mask.

8. Equipment

Equipment required by COVID patients will remain in HDU and MUST be cleaned thoroughly.

All ventilated patients will have closed suction, as per unit policy. Expiratory filters will be fitted as usual into the ventilation circuits on the inspiratory limb and bacterial filters will be fitted at the expiratory end between the expiratory valve and the expiratory limb.

An additional intubation trolley will be available for the cohorted patients and must remain on HDU side at all times.

Ventilators	6x Hamilton C6 3x Hamilton C1 1x Hamilton MR1 4x PB840 1x oxylog 4x SERVO U ventilators
Filters	2x Prismaflex (in unit) 1x Prismaflex (in renal – arrange to borrow through the Dialysis unit)
Transport Monitors	1x Phillips monitor (in equipment room)
CO2	6 x Philips cables currently Additional 7 EMA's 5 x B40 GE monitor modules
PiCCO	2 complete units
Syringe drivers	Use ICU stock – each bed space has 2 >14 bed spaces = pool stock
Infusion pumps	Use ICU stock - each bed space has 2 >14 bed spaces = pool stock
Feed pumps	Pool stock – as usual

8.1 PPE Stocktake

A daily stocktake of all PPE will be taken to ensure ordering is kept up to date and we can predict usage for the coming days, weekend use will need to be covered through these calculations as well as the orders will need to be put in on the Monday to allow for deliveries.

8.2 Stocktake of consumables

A stocktake of critical consumables will be performed dependant on the acuity of the ICU. Direction for this will come from CNM ICU to HCA. Information will be sent to procurement to track trends and pre-empt bulk ordering to manage surge in capacity.

9. Staffing and COVID-19

9.1 High risk staff

Unless there are specific, identified risks to a staff member's health, they have a duty of care for any patient on the floor as per the Nursing Council of New Zealand code of conduct, and Medical Council of New Zealand .

COVID – 19 ICU/HDU - Escalation Plan

If you believe there is a specific risk to your health you must discuss this with CNM ICU or CD and with Occupational Health. Exemptions to managing COVID patients will only be with endorsement from Occupational Health, a list is available for coordinators to ensure safe workload allocation.

9.2 Staff allocation

The allocation of staff to work in cohorted area will remain the responsibility of the off going shift coordinator, with input from other senior staff contingent of learning opportunities. The allocation must take into consideration the skill mix and support requirements for the shift.

To limit cross contamination robust infection control processes will be required to share staff between pods. The movement of staff between pods remains at the discretion of the coordinator.

Following correct use of donning PPE and maintaining good infection control principles it is safe to move between the units; however limiting access will further reduce cross contamination.

A dedicated role within the COVID staff bubble will ensure correct donning of PPE is carried out –this can be any healthcare worker as crib card to be available.

Appendix 3 describes the staffing model for up to 4 patients

10. Visiting

WDHB visitor's policy is updated regularly – please review intranet. There are specific policies for COVID positive patients; these must be adhered to fully. Dedicated visitors should be assigned on the Visitors Management App: **https://wdhb-web-apps.healthcare.huarahi.health.govt.nz/visitor/**

Visitors of those with confirmed or suspicious for COVID-19 will also require quarantine and should be encouraged to remain at home, however there will be occasions that necessitate their presence on the unit. Advice for self-quarantine can be found on Ministry of Health **website**.

11. Staff from other areas

When arranging for a consult or procedure on the cohorted unit staff must be informed where the patient is and they are in isolation for COVID-19.
Only those who will be active decision makers should enter restricted isolation area. This will be communicated to whole hospital but should any issues present please redirect to SMO on duty.
All staff must adhere to the infection control standards. If you encounter any resistance please direct to SMO on duty.
Access to ICU/HDU may be temporarily stopped for non-ICU staff.

12.Cleaning

- All equipment can be cleaned with Clinell wipes but it is recommended all cleaning is done for a minimum wet contact time of 60 seconds per item.
- Each bed space will require a level 1 clean daily and between each patient

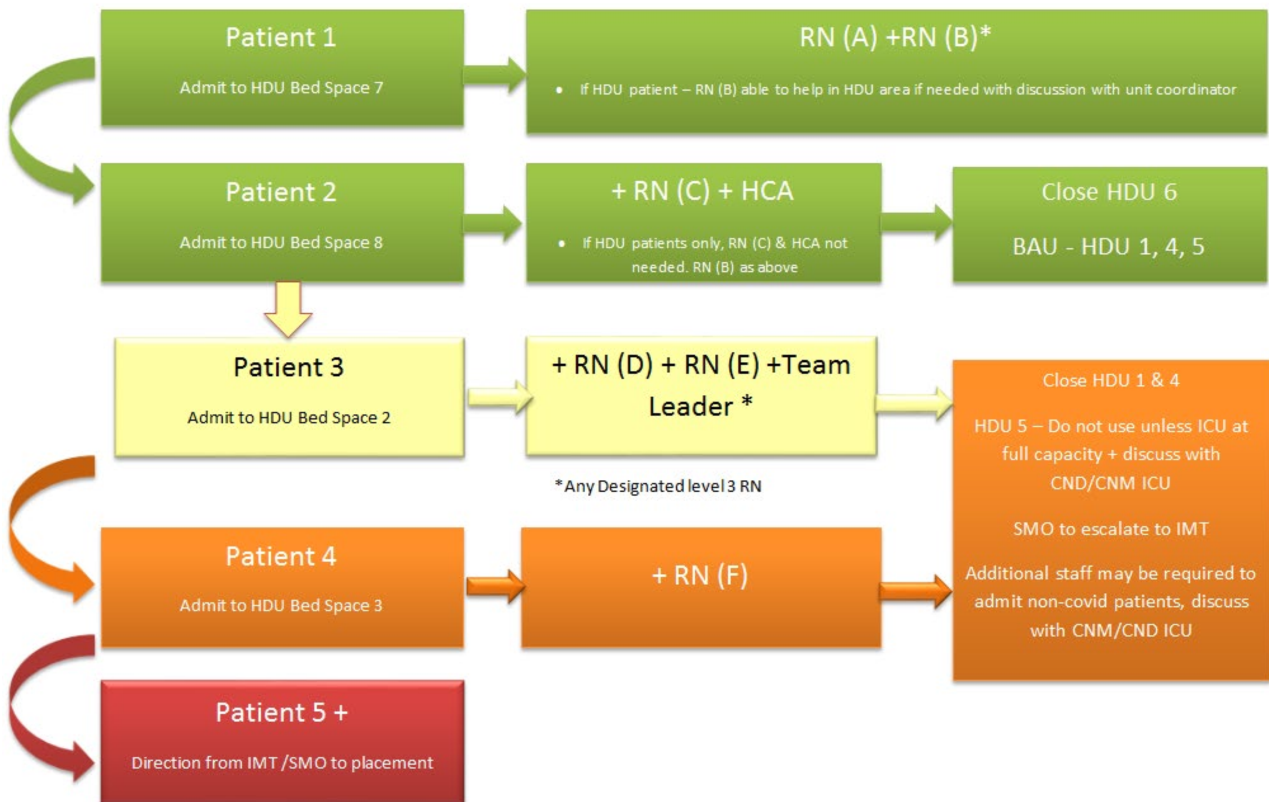
COVID – 19 ICU/HDU - Escalation Plan

13. Appendix 1: Escalation Plan for Ventilated Patients

	Phase 1a – 2 patients (Alert Level 1 - Green)	Phase 1b – 2 - 4 pts (Alert Level 2 – Yellow)	Phase 2 – >4 pts confirmed ventilated (Alert Level 3 – Orange)	Phase 3 – >14 ventilated (Alert Level 4 – Red)
COVID suspected or confirmed patients.	HDU 7 & 8 - negative pressure rooms	HDU 7 & 8, 2 & 3 – negative pressure rooms	ESC PACU – 14	ESC PACU -14 Tower ICU/HDU - 14
Non-COVID ICU patients	Cohorted in NSH ICU (6 beds)	NSH ICU (6 beds)	NSH ICU (6 beds)	
Non-COVID HDU	HDU 1 – 5 ICU 1-6	HDU (reduced capacity only 1 space available – dependant on location of COVID patient) +/- PACU 2 (4 beds)	HDU (8 beds) +/- PACU 2 (4 beds)	PACU 2 (4 beds) for HDU & ICU
Staffing requirements				
Nursing	BAU	BAU ratio Protected 'runners' to assist with additional negative pressure rooms	2 distinct rosters of RN at least 10 RN/ shift with 1 Charge Nurse each POD Augmented / surge roster activated	3 separate rosters of RN's augmented by PACU ESC & NSH Anaesthetic technician support All support available
Medical – SMO	BAU – 1 SMO/shift	2 SMO's Activate 2 cell phones	ESC ICU SMO NSH ICU SMO Ana / Surg to run HDU	ESC ICU SMO NSH ICU SMO Anaesthesia SMO support Surgical SMO support
Medical – RMO	BAU – 6 RMO's	8 RMO's (2 on most shifts)	Attempt to find 10 RMO's (2 on all shifts)	All support available
Additional support HCA	BAU is 1/shift non rostered overnight	1 per shift	1 per site Roster night shifts	2 each shift – bureau, all support
Ward clerk	BAU	BAU	1 ward clerk each site – consider extended coverage	

COVID – 19 ICU/HDU - Escalation Plan

14. Appendix 2: Admission Process for Blue Stream COVID Patients to ICU/HDU



COVID – 19 ICU/HDU - Escalation Plan

15.Appendix 3: Staffing Models

15.1 ICU level patients requiring 1:1 nursing

Staffing will be different when ICU level COVID patients are admitted. The following is meant as a guide to allow some planning for the shift and is not intended as a prescription.

- HDU 7 & 8 will require a bubble of 3 RN's to manage 2 ICU COVID patients this is to ensure safety for staff in isolation rooms, observation of correct donning and doffing procedures and timely access to equipment / medications.

This model is for 2 COVID ICU patients - HDU 7 & 8

	0700	0800	0900	1000	1100	1200
RN A	HDU 7	HDU 7	HDU 7	Break	anteroom	HDU 7
RN B	HDU 8	HDU 8	Break	Anteroom	HDU 8	HDU 8
RN C	Anteroom	Break	HDU 8	HDU 8	HDU 7	Break
Unit Coord	Ward round	Ward round	Break	HDU 7		Anteroom
HCA		Anteroom	Anteroom	Break		
	1300	1400	1500	1600	1700	1800
RN A	Break	HDU 7	HDU 7	Break	HDU 7	HDU 7
RN B	Break	HDU 8	HDU 8	HDU 8	Break	HDU8
RN C	HDU 7	Anteroom	Anteroom	Break	HDU 8	Anteroom
Unit Coord	HDU 8	Break		HDU 7	Break	
HCA	Anteroom			Anteroom	Anteroom	

*Anteroom describes RN immediately available outside isolation rooms

- Anteroom denotes time for documentation of assessment findings by primary nurse. There will be a need for RN C to cover at the end of the shift for evaluation to be documented; this should be negotiated with the COVID bubble.

Breaks:
RN A – 1000, 1300, 1600
RN B – 0900, 1300, 1700
RN C – 0800, 1200, 1600
Coord – 0900, 1400, 1700
HCA- breaks can fit in with team **BUT** there should always be a staff member allocated to Anteroom role and at least 2 RN's available in bubble.

15.2 Staffing for all 4 HDU rooms used

When HDU 2 & 3 is in use, a second bubble of 3 RN's will be required. When this happens an additional dedicated HCA and COVID Coordinator will be allocated to the COVID bubble. Overall coordination of the whole unit will be the rostered coordinator. The COVID coordinator may be a level 3 RN that has not yet completed coordinator training, they will communicate and report directly to ICU coordinator.
Essentially these two areas will form a bubble of staff; HDU 7 & 8; HDU 2 & 3. The 3 RN's assigned to these areas will work together to manage the 2 patients, spending no longer than 4 hours in full PPE.

COVID – 19 ICU/HDU - Escalation Plan

	700	800	900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900
RN A	HDU 7	HDU 7	HDU 7	BREAK	ANTE	HDU 7	BREAK	HDU 7	HDU 7	BREAK	HDU 7	HDU 7	
RN B	HDU 8	HDU 8	BREAK	HDU 8	HDU 8	HDU 8	BREAK	ANTE	HDU 8	HDU 8	BREAK	HDU 8	
RN C	ANTE	BREAK	HDU 8	HDU 7	HDU 7	BREAK	HDU 7	HDU 8	BREAK	HDU 7	HDU 8	ANTE	
RN D	HDU 2	HDU 2	HDU 2	BREAK	ANTE	HDU 2	HDU 2	BREAK	HDU 2	HDU 2	BREAK	HDU 2	
RN E	HDU 3	HDU 3	BREAK	HDU 3	HDU 3	HDU 3	BREAK	HDU 3	ANTE	BREAK	HDU 3	HDU 3	
RN F	ANTE	BREAK	HDU 3	HDU 2	HDU 2	BREAK	HDU 3	HDU 2	BREAK	HDU 3	HDU 2	ANTE	
COVID COORD		WARD ROUND	WARD ROUND	BREAK		ANTE	HDU 8	BREAK	HDU 3	ANTE	BREAK		
HCA / additional float RN		ANTE	BREAK	ANTE		BREAK	ANTE	ANTE	ANTE	BREAK	ANTE		
Actions / Turns	Huddle 0745	turns			turns extra Huddle 1150			turns			turns		

*Anteroom describes RN immediately available outside isolation rooms

Time has been allocated for the primary RN to document findings from assessment.
A staff member must be allocated to anteroom role at all times for HDU 2 & 3 as this has no visibility to main unit.
The documentation of evaluation of care should be negotiated between the RN's in each bubble.

Breaks: these are intentionally in one hour blocks to accommodate donning and doffing.

RN A – 1000, 1300, 1600
RN B – 0900, 1300, 1700
RN C – 0800, 1200, 1500
RN D – 1000, 1400, 1700
RN E – 0900, 1300, 1600
RN F – 0800, 1200, 1500
Coord – 1000, 1400, 1700
HCA / additional float RN – 0900, 1200, 1600

15.3 Staffing Ratio

Patients in total	Nurses
1 x HDU	Primary RN Secondary RN – who can assist with other patients
2 x HDU	Primary RN Secondary RN – who can assist with other patients
1 x ICU	2x RN's allocated – breaks can be covered by unit Coord or float RN from outside

Attachment 4

DHB Board Office
Waitematā DHB
Level 2, 15 Shea Terrace, Takapuna, Auckland
Private Bag 93-503, Takapuna, Auckland 1332
Telephone: 09 441 8938
Facsimile: 09 486 8924

28 April 2020

Evan Davies
Chair
Capital Investment Committee

Via email: Chris.Picard@health.govt.nz

Dear Evan

Thank you for your letter dated 23rd April 2020 regarding the outcome of the Capital Investment Committee (CIC) decisions of its meeting on 14th April 2020.

Waitematā DHB is very pleased to hear that CIC will recommend the Ministers of Health and Finance approve the DHB's request for $25m of additional Crown funding for the increase of the Importance level of the ECIB to IL4. We were also very appreciative that CIC are recommending to the joint Ministers to progress with the Central Sterile Services department. As requested in your letter, the DHB is progressing the investigation of the main tower to confirm the facilities to establish its importance level status and will advise CIC of the outcome.

Waitematā DHB is very concerned about the outcome of the Waitakere Hospital Urgent Inpatient Bed capacity project. We acknowledge that CIC endorses the project. However, the funding is not prioritised and the case must be self-funded. Waitematā DHB currently has a fully committed capital programme and is under considerably more pressure with works that have needed to be undertaken, including work brought forward, for COVID-19. Further capital requirements ahead to manage our response are also expected. The DHB's cash reserves are continuing to decline because of capital demands and it is very clear that the DHB will not be able to commence or fund the progression of the Waitakere project.

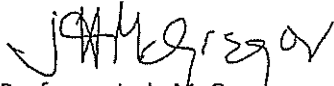
There are significant risks in not progressing with Waitakere Hospital. As the case outlines, there is urgent bed demand that will not be met, which we expect to become more pressing with the COVID-19 pandemic impacts. The local community will be particularly distressed about the decision as West Auckland has one of the highest health needs and growth in the Auckland region, if not the country. There has been political concern about the lack of progress from Cabinet ministers, local Members of Parliament, local Auckland councillors, community boards, consumer groups in West Auckland and members of the public. There is a high Māori and Pacific population in the Waitakere district, which has higher mortality rates than those in the rest of our district and this case is very important in addressing those health inequities.

When the Waitematā DHB Board considered the business case it did not put forward its preferred option which included an Intensive Care Unit (ICU), to stay within the signalled funding available. However the COVID-19 pandemic heightens its criticality. There is no high dependence beds or intensive care at Waitakere Hospital, despite having one of the busiest emergency departments in the country, as well as substantial general medicine, maternity and paediatric services - an issue of significant ongoing clinical risk. With the clear evidence of lack of ICU capacity in New Zealand,

brought to the fore with the COVID -19 crisis, the Board now believes that it is very important that an ICU be considered within the business case. The DHB has an estimated cost of $10m to add ICU capacity to the business case and would be happy to forward CIC an updated case with these extra requirements.

We are very grateful for the CIC's support of the ECIB IL4 and the CSSD cases, but we are very concerned about our inability to progress the Waitakere case, despite the overwhelming evidence of need and of the obvious inequities revealed. We therefore ask the Capital Investment Committee to urgently reconsider its decision along with receiving an updated case with ICU capacity.

Yours sincerely



Professor Judy McGregor
Chair
Waitematā District Health Board

Attachment 5

Denise Poole (WDHB)

Subject: FW: ICU workforce capacity

From: Mark Shepherd (WDHB)
Sent: Tuesday, 05 May 2020 12:05 p.m.
To: Jane.White@health.govt.nz
Cc: Kathy Briant (WDHB); Karen Hellesoe (WDHB)
Subject: RE: ICU workforce capacity

Jane
Yes happy to meet and I will ask Karen Hellesoe GM Surgery to join us.
Kathy will liaise with you. Mark

Sent from my Samsung Galaxy smartphone.

-------- Original message --------
From: Jane.White@health.govt.nz
Date: 5/05/20 10:25 AM (GMT+12:00)
To: "Mark Shepherd (WDHB)" <Mark.Shepherd@waitematadhb.govt.nz>
Subject: RE: ICU workforce capacity

Hi Mark,

As per the emails below, we would like to schedule a meeting with you to discuss ICU workforce capacity, training and models of care. Could you please let me know what your availability is like over the next couple of days and I'll organise a zoom meeting.

Kind regards,

Jane

Jane White
Programme Manager (Contractor)
Health Workforce Policy and Insights
Ministry of Health
04 907 5005

http://www.moh.govt.nz
mailto:Jane.White@health.govt.nz

From: "Joanne Gibbs (Dir Provider Services)(ADHB)" <JGibbs@adhb.govt.nz>
To: "Jane.White@health.govt.nz" <Jane.White@health.govt.nz>,
Cc: "Mark Shepherd (WDHB)" <Mark.Shepherd@waitematadhb.govt.nz>
Date: 05/05/2020 10:18 a.m.
Subject: RE: ICU workforce capacity

Hi Jane

I am the regional COO lead, but it is probably best for you to go direct to Waitematā DHB for their specific workforce capacity. Suggest you contact Mark Shepherd, COO at Waitematā.

Ngā mihi
Jo

Joanne Gibbs
Director of Provider Services
Ph: 09 307 4949 Ext: 22359| Mob: 021 192 5208

Auckland District Health Board
Level 1 | Building 37 | Auckland City Hospital
Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua*

From: Jane.White@health.govt.nz [mailto:Jane.White@health.govt.nz]
Sent: Tuesday, 05 May 2020 10:04 AM
To: Joanne Gibbs (Dir Provider Services)(ADHB) <JGibbs@adhb.govt.nz>
Subject: ICU workforce capacity

Hi Joanne,

The Health Workforce Directorate within the Ministry of Health is working with DHBs on workforce training plans to build ICU workforce capacity and capability. This follows on from the work that the ICU units and ANZICS are doing with the Ministry of Health. This will help inform advice to our Minister later this week on how we plan to work with DHBs to assess current workforce capacity, training that is being undertaken and any gaps.

Your name has been given to us by Dale and Judy McGregor. We would like to schedule a meeting with you later today or tomorrow if possible to discuss ICU numbers in the Auckland region, particularly Waitemata. We have a meeting scheduled with John Beca tomorrow to discuss ADHB ICU workforce capacity so we are hoping you will be able to help us with questions around workforce capacity at Waitemata DHB. If not, could you please provide a contact for us?

Could you please let me know what your availability is like over the couple of days and I will schedule a zoom meeting. Please could you also confirm who will be attending from your end.

Jane White
Programme Manager (Contractor)
Health Workforce Policy and Insights
Ministry of Health
04 907 5005

http://www.moh.govt.nz
mailto:Jane.White@health.govt.nz
****
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Denise Poole (WDHB)

Subject: FW: Write up from meeting on ICU capacity
Attachments: Copy of MoH meeting 6 May 2020 comment YL-CEW and KH.xlsx

From: Karen Hellesoe (WDHB)
Sent: Tuesday, 12 May 2020 7:45 a.m.
To: 'Jane.White@health.govt.nz'; Mark Shepherd (WDHB); Joy Swanink (WDHB)
Cc: Chrissie Evans Wilson (WDHB); Ywain Lawrey (WDHB)
Subject: RE: Write up from meeting on ICU capacity

Hi Jane,

Many thanks for the opportunity to meet with yourself and Anna last week.
Please find attached the write up with our added comments in red.

Regards
Karen

Karen Hellesoe
Associate General Manager Surgical and Ambulatory Services
Operations Manager Cancer Services
124 Shakespeare Rd | Takapuna 0622| Auckland
mobile : 021 419 606
www.waitematadhb.govt.nz

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From: Jane.White@health.govt.nz [mailto:Jane.White@health.govt.nz]
Sent: Wednesday, 06 May 2020 11:47 a.m.
To: Mark Shepherd (WDHB); Karen Hellesoe (WDHB); Joy Swanink (WDHB)
Subject: Write up from meeting on ICU capacity

Hi all,

Thanks for your time today. Attached is a write up of the meeting. Please take a look and add or amend anything you like. There are a few gaps so please feel free to fill these in.

I also didn't catch the name of the gentleman to the left of my screen so haven't forwarded this onto him. Please could you do so.

Thanks again.

Jane

Jane White
Programme Manager (Contractor)
Health Workforce Policy and Insights

Ministry of Health
04 907 5005

http://www.moh.govt.nz
mailto:Jane.White@health.govt.nz
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Attachment 6a

Write-up from meeting on ICU capacity - 12 May 2020

Acronyms

SMOs	Senior Medical Officers	
ANZICS	Australian and New Zealand Intensive Care Society	
BASICS course	Basic Assessment and Support in Intensive Care	
CEW	Chrissie Evans-Wilson	Project manager, Institute for Innovation and Improvement
EOI	Expressions of interest	
FTE	Full-time equivalent	
HDU	High Dependency Unit	
KH	Karen Hellesoe	Operations Manager Cancer Services
PACU	Post Anesthesia Care Unit	
PPE	Personal Protective Equipment	
RMOs	Resident Medical Officers	
RN	Registered Nurse	
YL	Ywain Lawrey	ICU Clinical Director

		Data assumptions			
Region	**DHB**	**What calculations did you make to determine the workforce numbers?**	**What assumptions did you make in determining the workforce numbers?**	**Do you have a pandemic plan in place? (Does this include a phased and tiered response?)**	**What are the staff ratios in the current model of care in use in the ICU?**
	Waitemata	CEW - Nursing FTE - Availability of space and based or projection of what staff predicted they could commit; this was returning staff, PACU staff being redeployed, current staff increasing FTE and relying on casual staff working increased hours. YL- SMO workforce; volunteers among anaesthesia for various supportive roles, e.g. ICU suppport vs HDU level. RMO's - volunteers from other departments and previously planned expansion of RMO numbers brought forward.	Part-time staff going to full time staff is included in the estimated numbers. CEW - we sought EOI from WDHB employees and staff who had recently left WDHB, not allowed to approach in formal way so relied upon personal contact.	Yes they have a phased escalation plan for what could happen over the next few months. Are in a unique position as have a small ICU with an enormous population. Also the oldest population of any DHB. Usual reliance upon being able to offload to Auckland City Hospital also threatened. This could leave them exposed in a pandemic situation. CEW/YL - Big risk is if one of the staff gets COVID-19 or is exposed. Nursing FTE is too tight. Its the confounding factors that are the big risk, with long stand down periods. Also staff not wanting to work nights and weekends.	Currently have 14 beds (6 ICUs and 8 HDUs) but not the nursing staff to manage all of these at present. WHAT ARE YOUR USUAL STAFF RATIOS? Noted that Waitakere has even less resource and to create ICU capacity there is a huge issue that hasn't been addressed in over a decade. CEW - usual staffing ratio's 8 RNs per shift. we can flex numbers of ICU and HDU capacity based on RN availability rather than space available. ICU nursing 1:1. HDU nursing 1:2 with a charge nurse.

Models of care		Workforce		
Have alternative models of care been considered for an emergency pandemic situation?	If yes, what impact would new models of care have on staffing and training requirements?	What opportunities exist to increase the capacity of the existing ICU workforce eg people working parttime who might be available to work increased hours?	Have you identified staff not currently working in ICU who have ICU experience?	Who are you planning to train or upskill - have you identified capacity in other parts of their workforce (eg theatre staff who will be under utilised when planned care is scaled back)?
New model of care based on pod team nursing. With 1 ICU nurse per ICU bed plus two additional non-ICU nurses (3 nurses altogether). Challenge is keeping distinct cohorts of pods and keeping nurses working with Covid patients separate from nurses working with non-covid patients. Really well supported by anesthestist tech nurses. Big risk if they have to use two different sites for an ICU response. Looking to increase the interface between recovering nurses, the surgical ward and HDU. CEW - ANZICS guidelines for ratios maintained throughout pandemic plan 1:1 per ICU level patient. This will be maintained but may not be an experienced ICU nurse. Intention is for teams to care for group of patient with ICU RN in each team. Use of anaesthetic technicians in teams. e.g 1 ICU nurse; 1 upskilled ward nurse; 1 anaesthetic tech to 3 patients. YL-Good regional support networks that have been tested through previous critical events. There is an agreement that if one unit is disproportionately affected then they would try to send patients to Auckland or another unit. Difficulty would be if everyone was overloaded and issues with inter-hospital transfer.	Relying on people being released from their usual roles, which is difficult as people need to get back to these roles. CEW - significant training requirement as varying experience levels. Some staff had not been in ICU for 20+ years, others have no prior experience but had trasnsferable skills (PACU staff). 8 hour study day offered with orientation shifts buddied with ICU nurse. Ongoing consolidation shifts offered but relies on release from usual place of work. significant workload for education team - not just ICU specific training but additional enhanced PPE training.	Pulling in people with previous ICU experience to increase staff to the 79 FTEs. Training PACU nurses to work in an ICU capacity - but still not the same as having an ICU nurse. Do not have enough staff to run to ICU capacity. SMOs are OK but not enough RMOs - haven't increased the number since 1998. Process is underway to grow it but waiting for recruitment process to do this. CEW - already increased FTE from many part-time staff, casual staff also working regular hours far more than usual.	Pulling support from anesthetists for SMOs. Increased liaison with PACU nurses is promising. CEW - yes that is significant resource of additional nursing FTE and SMO augmentation	Training anyone who has indicated a willingness to help. CEW - we have training for those who self identified and PACU staff who were moved by DHB to assist.

Training				
What training or upskilling have you already done?	**What training and upskilling are you planning?**	**What specific skills (eg ventilation) do you need to train for?**	**How do you plan to deliver this training (eg training programmes and/or providers)?**	**How will you ensure staff training stays current?**
Offered out the "basics" course to nurses who indicated they would be willing to help. Have trained 46 nurses to date. Training also for the small number of RMOs coming in - 8 RMOs - familiarising them with the environment. Anesthestists - providing time in the ICU. Haven't insistent on putting them through the basic course as they would work alongside an intensivist. Anesthesists are more comfortable working on other high volume work outside the ICU. CEW - BASICS course delivered, ongoing orientation / buddy shifts with ICU patients Several education sessions with anaesthetic department SMO's and RMO's.	Continuation and expansion of those already commer	CEW - Ventilation basics, medication preparation & administration, how to suction, positioning patients, orientate to equipment (continuous monitors, infusion pumps, syringe drivers, feed pumps, beds) documentation is very different in ICU.	CEW - 8 hour study day for nurses 12 hour orientation shifts	CEW - ongoing orientation/buddy shifts. Liaison between education teams (ICU and Non-ICU area) to identify gaps and provide coaching to bridge gaps

Ministry of Health
What support could the Ministry of Health provide?
Could look to provide the basic course nationally and maintain a register of who has done it. Osler application - covid preparation package could be rolled out nationally. Noted that the ICU unit is 22 years old. There is new build being developed but no plans to include an ICU within this - could the Ministry be involved in these decisions? CEW - Funding to increase nursing FTE to staff all physical beds (14). This will include additional education for staff to manage surge capability planning and maintaining training requirements. currently only 1 academic provider in North Island for ICU course - ANZICS guidelines/standards are for 50% of staff to hold this qualification our unit has far less than this. Access to the funding for the course reliant on WDHB process competing with all services accessing further education. YL- Consider support for widespread access to ICU education platforms and course such as BASICS course, Crit-iQ website, or Osler. KH Re the model of beds per 100,000 population and support WDHB to achieve closer to the national average (NZ average is 7 beds per 100,000, WDHB is currently 1.3). Consider formal training package for anaesthetists.

Attachment 7

Denise Poole (WDHB)

Subject: Funding to support DHBs to surge ICU Workforce Capacity
Attachments: Funding to Support DHBs to Surge ICU Workforce Capacity.pdf; Guidance for DHBs ICU Funding 220720.pdf

From: Peta Molloy (WDHB) **On Behalf Of** Dale Bramley (WDHB)
Sent: Tuesday, 28 July 2020 3:43 PM
To: Andrew Brant (WDHB)
Subject: FW: Funding to support DHBs to surge ICU Workforce Capacity

From: Ferila.Betham@health.govt.nz [mailto:Ferila.Betham@health.govt.nz] **On Behalf Of** Anna.Clark@health.govt.nz
Sent: Tuesday, 28 July 2020 3:24 p.m.
To: Dale Bramley (WDHB) <Dale.Bramley@waitematadhb.govt.nz>; david.meates@cdhb.govt.nz; kathryn.cook@midcentraldhb.govt.nz; Nigel Trainor (SCDHB) <ntrainor@scdhb.health.nz>; rosemary.clements@tdhb.org.nz; chris.fleming@southerndhb.govt.nz; Peter.Bramley@nmdhb.govt.nz; russell.simpson@wdhb.org.nz; Jim.Green@tdh.org.nz; Margie Apa (CMDHB) <Margie.Apa@middlemore.co.nz>; Nick Chamberlain (NDHB) <Nick.Chamberlain@northlanddhb.org.nz>; Ailsa Claire (ADHB) <AilsaC@adhb.govt.nz>; Nick.Saville-Wood@lakesdhb.govt.nz; fionnagh.dougan@ccdhb.org.nz; dale.oliff@wairarapa.dhb.org.nz; craig.climo@hawkesbaydhb.govt.nz; kevin.snee@waikatodhb.health.nz; Simon.Everitt@bopdhb.govt.nz
Subject: Funding to support DHBs to surge ICU Workforce Capacity

Good afternoon,

Please see attached letter and Guidance regarding the funding to support DHBs to surge ICU workforce capacity.

Ngā mihi, Anna

Anna Clark
Deputy Director-General | Health Workforce | Ministry of Health
E: anna.clark@health.govt.nz | M: 021 222 8915
http://www.health.govt.nz

<ATT00001.gif>

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MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
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28 July 2020

Tēnā koe

Funding to support DHBs to surge ICU workforce capacity

You will be aware that, throughout May 2020, Ministry of Health representatives met with each DHB to understand the work that had been done on surging the ICU workforce to respond to demand created by COVID-19.

One of the key challenges identified by DHBs during these discussions was a shortage of staff with ICU training and experience. While all DHBs had undertaken work to identify and train surge ICU staff, the consistent feedback was that more training needs to be done to ensure the system is best placed to respond to any future outbreaks.

Those we spoke to expressed concern about being able to access staff who had undertaken training so that they could do refresher courses to ensure their knowledge remains relevant. Some smaller DHBs also identified the lack of patients ventilated for extended periods as a barrier to providing ongoing training.

To support DHBs to build and maintain their ICU surge workforce, the Ministry has ring fenced $2 million for training. This funding can be used for:

- travel and accommodation costs incurred for DHB staff who need to travel to undertake ICU training (including refresher training); and
- wage costs incurred by DHBs to backfill staff undertaking this training (either using DHB or agency staff).

The funding will be available while we are in the Covid-19 Alert Levels. Identifying and training staff (including for refresher training) is the responsibility of your DHB.

Detail on the eligibility and process for claiming this funding is attached to this email. This information is also being provided to those in your DHB who we spoke to in May.

Any questions about this funding can be sent through to info@healthworkforce.govt.nz.

Ngā mihi

Anna Clark
Deputy Director-General
Health Workforce

Guidance for DHBs

Funding to support surging ICU workforce capacity for the Covid-19 response

Eligibility and process for claiming funding

About this funding

During May 2020, the Ministry held discussions with all 20 DHBs focusing on plans to surge their ICU workforce, ICU models of care, training undertaken and planned for the future, and areas where the Ministry could support DHBs to surge its ICU workforce capacity.

All DHBs raised the ability to release staff to undertake ICU training (including refresher training) as a key challenge to building and maintain workforce capacity.

To support DHBs to do this, the Ministry has set aside $2 million to reimburse DHBs for the costs of releasing staff for training, including costs incurred by smaller DHBs in sending non-ICU staff to larger DHBs for practical refresher training.

DHBs may claim funding to cover travel, accommodation and backfilling costs for staff attending ICU training (including refresher training and in-house training) while COVID-19 Alert Levels are in place.

This scheme will provide support for up to two days' training per staff member every six months.

Eligibility

The scheme covers:

- travel and accommodation costs incurred for DHB staff who need to travel to undertake ICU training (including refresher training); and
- wage costs incurred by DHBs to backfill staff undertaking this training (either using DHB or agency staff).

Specific costs that can be covered by the scheme include:

- For staff required to travel to receive initial or refresher training:
    - the total cost of accommodation for the eligible period;
    - a daily allowance for food, if required, which will be based on the DHB's current policies relating to meal allowances for travelling staff;
    - travel costs - this may include reimbursement of air travel, rental cars, taxis or other public transport (trains, buses)
    - Travel Management Company (TMC) transaction charges, where applicable.
- For backfilling staff who have been released for initial or refresher training:
    - wage costs for additional staff.

Please note:

- Retrospective costs for training undertaken prior to this date are not eligible for this scheme.

The process for submitting a claim

DHBs who believe they are eligible to receive reimbursement of costs incurred for ICU workforce capacity building should submit the information outlined below.

Note: the invoice must be a tax invoice:

For all claims:

- DHB details
- GST information
- Invoice number (if required)

For staff required to travel to receive initial or refresher training:

- Staff details (name, role)
- Description of accommodation provided (including number of nights of stay and accommodation provider).
- Copy of the accommodation and travel costs paid (receipt or other) attached. This may be costs paid directly to accommodation and travel providers, or through a Travel Management Company (TMC).
- In line with the coverage of this scheme, costs may include:
    - room costs, including internet – up to three nights to allow for arrival, one night between training days, and one night on completion of training if same day departure not feasible.
    - meals (receipts must be provided).
    - travel costs
    - TMC transaction charges.

For backfilling staff who have been released for initial or refresher training:

- Staff details (name, role and who they provided cover for)
- Evidence of wage costs

Claims should be emailed to **info@healthworkforce.govt.nz** with the **email subject:** ***Costs for Surging ICU Workforce Training.***

A claim form is provided in an appendix to this guide for your convenience.

Approving and processing claims

The Ministry of Health will review the application and check that all the necessary information is included. If there are any omissions, the applicant will be contacted with a request to provide the outstanding detail.

Applications for cost recovery will be approved by the Deputy Director-General Health Workforce (or their delegate).

Payment

Payments will be processed on the 20th of the month following receipt and action of the expense claims, unless otherwise identified on the DHB invoice.

Appendix I

Claim form: Costs for Surging ICU Workforce Training

Provider:

DHB		Submitted by		Date Submitted
Address		Role		
Invoice no *(invoice to accompany claim)*		Contact email and telephone no		

Staff Details: *(add extra rows if required)*

TRAINING							BACKFILLING				TOTAL COSTS
Staff Name	Role	Accom Provider	In date	Out date	Accom costs (including meals etc)	Travel and TMC charges (if applicable)	Staff Name	Role	Dates cover provided	Costs (wages)	

❒ Invoice attached ❒ Receipts attached ❒ Evidence of wage costs attached (for backfilling staff)

Claims should be emailed to ***info@healthworkforce.govt.nz*** *with the email subject:* ***Costs for Surging ICU Workforce Training***

Attachment 8

From: Ferila.Betham@health.govt.nz on behalf of Anna.Clark@health.govt.nz
Sent: Friday, 07 August 2020 11:26
To: John Beca (ADHB); Andrew.stapleton@hvdhb.govt.nz; Alex.psirides@ccdhb.govt.nz; Seton.henderson@cdhb.govt.nz; Mark Shepherd (WDHB); Craig.carr@southerndhb.govt.nz; eocplanintel@bopdhb.govt.nz; Major Disasters Only - Intelligence Manager (CMDHB); ross.freebairn@xtra.co.nz; Alan.wilson@lakesdhb.govt.nz; Lyn.horgan@midcentraldhb.govt.nz; Alex.Browne@nmdhb.govt.nz; Sarah Pickery (NDHB); rwhitticase@scdhb.health.nz; awheeler@scdhb.health.nz; Lynsey.bartlett@tdh.org.nz; Jonathan.Albrett@tdhb.org.nz; Geoff.mccracken@waikatodhb.health.nz; vicki.hookham@wairarapa.dhb.org.nz; Julie.lucas@wcdhb.health.nz; Marco.Meijer@wdhb.org.nz
Subject: RE: Summary of key themes from DHB discussions on surging the ICU workforce
Attachments: Memo on key themes from DHB ICU surge workforce meetings.pdf

Kia ora koutou

Thank you all for taking the time to speak with us in May to help understand the opportunities and the challenges in relation to surging your ICU workforce, and what role the Ministry could play in supporting DHBs in this. Attached is a summary of key themes that came out of those meetings, and the next steps for the Ministry - including the funding available to enable ICU training, which you received information on last week.

Ngā mihi, Anna

Anna Clark
Deputy Director-General | Health Workforce | Ministry of Health
E: anna.clark@health.govt.nz | M: 021 222 8915
http://www.health.govt.nz

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Attachment 8a

MINISTRY OF HEALTH
MANATŪ HAUORA

Memorandum

DHB and Ministry of Health meetings on ICU surge workforce capacity: Summary of key themes, insights and challenges

To:	DHBs CEOs and ICU Management
Copy to:	Margareth Broodkoorn and Andrew Simpson
From:	Anna Clark, Deputy Director General, Health Workforce
Date:	6 August 2020
For your:	Information

Purpose of report

1. The Ministry of Health met with ICU clinical staff across the 20 DHBs to discuss their plans for surging the ICU workforce in response to the COVID-19 pandemic. This followed on from requests for information on bed and surge capacity.
2. The Ministry was interested in understanding:
   - Models of care
   - Workforce capacity and capability
   - Training undertaken and training planned
   - How the Ministry could provide support.
3. This Memorandum provides you with a summary of the key themes, insights and challenges that were raised during these meetings. It also sets out the support the Ministry will provide to DHBs in response to the challenges identified.

DHB ICU pandemic plans

4. DHBs have all undertaken planning on how to manage ICU workforce capacity in a pandemic situation. All DHBs have ICU pandemic plans in place or under development that include phased escalation of the ICU and its workforce.
5. These plans have been approached differently, taking into account the different operating context for each DHB, including:
   - the overall demand for hospital services (some hospitals, such as Middlemore, needed to continue to provide national services such as the National Burns Unit during Alert Level 4)

- available space and opportunities to put more beds into existing ICU spaces or to extend the ICU into other areas of the hospital such as the HDU, PACU or theatre areas and the impact this has on staffing
- the ability to use staff with previous ICU experience or to train up staff to provide support in the ICU
- the availability of equipment and the ability to adapt equipment for use in the ICU, for example, anaesthetic machines.

6. DHBs have various options for expanding ICU capacity and managing infection risk including:
   - creating separate red and green zones within the ICU (this creates challenges in terms of rostering staff)
   - fitting more beds into existing ICU spaces rather than splitting across geographical areas if possible
   - moving to PACU, ED and/or theatre spaces
   - modifying anaesthetist machines as a temporary solution (no consistency in type of ICU or anaesthetist machines used).
7. Some DHBs had an ICU hot desk coordinator role to coordinate patients across the hospital and to organise flights.

ICU surge workforce capacity

8. DHBs are looking at how to surge their ICU workforce capacity as part of their pandemic planning.
9. All DHBs planned to increase the number of hours worked by having part-time staff move to fulltime hours or move to 12-hour shifts, though this would only be sustainable for a short period of time (about two weeks).

ICU nursing capacity

10. DHBs have taken several steps to boost their ICU nursing capacity. They have identified current and previous staff with ICU experience for refresher training and targeted non-ICU staff for training in basic ICU care, and have had a focus on supporting nurses to feel confident in the ICU.
11. This has included PACU nurses, theatre nurses, emergency department nurses, and medical and surgical ward nurses. Anaesthetic technicians were also a key resource for providing back-up support in the ICU. Five DHBs brought in nurses from private hospitals.
12. Small DHBs need a flexible nursing workforce with nurses being able to apply their skills in multiple ways and work across various settings.

ICU medical capacity

13. Medical support in the ICU has mainly come from Anaesthesia but also Emergency Medicine, General Medicine and outside of the DHBs, for example, General Practitioners.

14. All DHBs indicated a reliance on anaesthetists. Anaesthetists were the primary source of additional medical staff after existing ICU SMOs and ICU experienced RMOs.

15. Anaesthetists were generally only available because elective surgery stopped during the lockdown. ED doctors were also called upon if required across many of the DHBs, along with orthopaedics, surgeons and general practitioners.

16. There was a mostly positive response from Anaesthetists to involvement in pandemic planning and working in and providing back up in ICU.

Other staff brought in to support ICU workforce capacity

17. Some DHBs also looked at using allied health professionals for other cares such as proning and turning. In some DHBs ICU pharmacists and social workers were brought in to assist where possible.

18. Some DHBs looked at using physios to do proning and to provide ICU ventilation support. It was noted that physios have excellent clinical insight into the use of ventilators and some DHBs saw an opportunity to target the professional development of this cohort.

19. Physio have set up Prone turning teams, with allied health staff and other hospital staff doing proning and routine turns assistance.

Models of care

20. If current ICU capacity was exceeded, DHBs would move to a team-based model of care with one ICU nurse overseeing a pod of non-ICU nurses and allied health professionals. The intention is to free up ICU trained staff to oversee and support non-ICU staff at the bedside.

21. Staffing ratios would change depending on several factors, such as sickness, demand for ICU and demand in other parts of the hospital, and staff capability. Most DHBs would move to a ratio of one ICU nurse to three non-ICU nurses, with a smaller number prepared to move to a ratio of 1:4 or 1:5.

22. Some DHBs are also planning ways to minimise the impact of a COVID-positive staff member on the rest of the workforce, including by cohorting staff working with COVID-19 and non-COVID patients.

Training completed

23. Level 4 lockdown meant hospitals were quieter and they were able to undertake training and education sessions

24. Anaesthetists needed orientation training, mainly in the use of equipment. Training for nurses included a mixture of:

    - In-house courses run by their own educators
    - Online modified BASICS course provided by Hawke's Bay DHB
    - Massey University online course
    - Practical simulations

- Orientation shifts and buddy training.

25. Smaller DHBs have limited capacity to rotate staff and there is a challenge to upskill as patients are not generally in ICU for long periods. Some provincial DHBs sent staff to tertiary DHBs for training and to build relationships in preparation for using telehealth.
26. The aim of most DHBs was to provide enough familiarity with the equipment and enough supervision on a continuous basis, and ensure they can maintain standards within an environment requiring higher levels of intensity.

Training planned

27. All DHBs highlighted the challenges of releasing staff for initial induction/rapid orientation and ongoing upskilling, including because hospitals are now operating at full capacity. This means significant further training would likely be triggered by an increase in COVID-19 patients.
28. Most DHBs agreed that, time permitting, continual practical experience is needed along with theoretical training. Some are aiming for two to three monthly refreshers, others six months, while some had no plans for further training unless required.
29. Some DHBs are trying to incorporate ICU training as part of a nurse’s usual education hours, and in some there is ongoing liaison between education teams in the ICU and non-ICU areas to identify gaps and to provide training to bridge the gaps.
30. For the smaller DHBs, there is a challenge in providing sufficient exposure to ventilated patients when they do not have an ICU or rarely have ventilated patients.
31. Keeping private hospital staff personnel up-to-date is also a challenge for some DHBs.

Regional networks

32. All DHBS work within a regional network and some had a plan in place about how they would work together to manage a surge.
33. Generally, a centralised approach was taken with provincial or rural hospitals planning to send patients to tertiary hospitals as quickly as possible. Some of these networks had been tested through previous critical events, such as SARS, Canterbury Earthquake and the White Island eruption. Some noted they would like to better understand regional capacity.
34. Some DHBs formed Memorandums of Understanding with the private hospitals in their area.
35. A few DHBs, such as Northland and the West Coast, made good use of telehealth, with regular calls between rural DHBs and the tertiary DHB. Staffing is very tight for a small rural hospital, but they felt more comfortable because they had telehealth support.

Ministry of Health support

36. A range of areas were identified where the Ministry could provide support to surge ICU workforce capacity. The most common areas identified were:

- working with DHBs to develop a multi-disciplinary network of ICU practitioners - this would be led by DHBs and focus on setting priorities, regional contingency planning and movement of ICU staff as required
- providing a national database with up-to-date information on ICU capacity
- providing national direction around the need for refresher training and regularly releasing staff for training
- supporting and facilitate development of minimum standards for training
- funding to support the release of staff for training and for telehealth equipment
- facilitating or helping administer ICU training courses, such as the BASICS course
- addressing issues around the sustainability of student placements
- developing a strategy for increasing the number of nurses
- assisting with supporting / promoting anaesthetists to work in the ICU.

Next steps

37. The Ministry is taking a number of steps to support DHBs in response to the challenges identified.

38. The Ministry has set aside $2 million from the Covid-19 workforce funding to reimburse DHBs for the costs of releasing staff for training, including costs incurred by regional DHBs in sending non-ICU staff to tertiary DHBs for refresher training in larger and busier ICUs. This funding has been communicated to DHBs and is available while we are in the COVID-19 Alert Levels.

39. The Ministry is undertaking work to scope a multi-disciplinary network of ICU practitioners. This could be led by DHBs and help with setting priorities, regional contingency planning and movement of ICU staff if required in a localised outbreak, however further work is needed to determine the role for such a network and how it would operate (e.g. who it would be accountable to). Over the medium to long term, the Ministry will work with Directors of Nursing, Critical Care nurses within DHBs, and with the College of Critical Care Nurses, to develop a consistent ICU training framework, including a minimum standard for a nurse to work in an ICU. The Ministry will also work with the College of Anaesthetists to discuss options for ensuring that anaesthetists undertake sufficient training in the ICU so that they are more able to step in to support future pandemics or times of high need.

Attachment 9

From: Emily-Jane Willmot <Emily-Jane.Willmot@health.govt.nz>
Sent: Wednesday, 18 August 2021 11:36
To: Mark Shepherd (WDHB)
Subject: FW: ICU capacity and capability

Importance: High

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In case you wanted to know the questions I need answers to or if answering in email is easiest? See below

EJ

From: Kate Clark <Kate.Clark@health.govt.nz>
Sent: Wednesday, 18 August 2021 10:49 am
To: Brenda Wills <Brenda.Wills@health.govt.nz>; Edith Bennett <Edith.Bennett@health.govt.nz>; Nik Straugheir <Nik.Straugheir@health.govt.nz>; Emily-Jane Willmot <Emily-Jane.Willmot@health.govt.nz>; Sophie Oliff <Sophie.Oliff@health.govt.nz>
Cc: Adam Simpson <Adam.Simpson@health.govt.nz>; Jess Smaling <Jessica.Smaling@health.govt.nz>
Subject: ICU capacity and capability

Hi Brenda, Edith, Nik, EJ and Sophie

Can I please ask that you urgently (we need the information before midday) call the COOs that you are the lead contact for to get some information that relates to ICU capacity? When calling, please acknowledge to them that while on the COO call this morning we agreed this would be managed via a template from NHCC – but as we need the information with urgency, we are doing a one off call around.

I have set up a spreadsheet to record the responses in this folder.

G:\ED and Acute Demand\COVID response

The questions are:

How many ICU capable beds are there at each DHB?
What could you surge to if you need to?
Do you have the resources/workforce to surge if required?
Do you have the workforce numbers? Or if you have the workforce numbers, are they trained to use ventilators?

Can you please respond to let me know that you have got this message and are able to make the calls?

Thanks
Kate

Kate Clark | Programme Director, Acute Demand | DHB Performance and Support | 021 197 4785

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From:	Ferila Betham <Ferila.Betham@health.govt.nz> on behalf of Anna Clark <Anna.Clark@health.govt.nz>
Sent:	Friday, 13 November 2020 08:45
To:	John Beca (ADHB); Andrew.stapleton@hvdhb.govt.nz; Alex.psirides@ccdhb.govt.nz; Seton.henderson@cdhb.govt.nz; Mark Shepherd (WDHB); Craig.carr@southerndhb.govt.nz; eocplanintel@bopdhb.govt.nz; Major Disasters Only - Intelligence Manager (CMDHB); ross.freebairn@xtra.co.nz; Alan.wilson@lakesdhb.govt.nz; Lyn.horgan@midcentraldhb.govt.nzvick; Alex.Browne@nmdhb.govt.nz; Sarah Pickery (NDHB); rwhitticase@scdhb.health.nz; awheeler@scdhb.health.nz; Lynsey.bartlett@tdh.org.nz; Jonathan.Albrett@tdhb.org.nz; Geoff.mccracken@waikatodhb.health.nz; vicki.hookham@wairarapa.dhb.org.nz; Julie.lucas@wcdhb.health.nz; Marco.Meijer@wdhb.org.nz; Dale Bramley (WDHB); david.meates@cdhb.govt.nz; kathryn.cook@midcentraldhb.govt.nz; Nigel Trainor (SCDHB); rosemary.clements@tdhb.org.nz; chris.fleming@southerndhb.govt.nz; Peter.Bramley@nmdhb.govt.nz; russell.simpson@wdhb.org.nz; Jim.Green@tdh.org.nz; Margie Apa (CMDHB); Nick Chamberlain (NDHB); Ailsa Claire (ADHB); Nick.Saville-Wood@lakesdhb.govt.nz; fionnagh.dougan@ccdhb.org.nz; dale.oliff@wairarapa.dhb.org.nz; craig.climo@hawkesbaydhb.govt.nz; kevin.snee@waikatodhb.health.nz; Simon.Everitt@bopdhb.govt.nz
Subject:	ICU Funding - Amendment
Attachments:	20201112 Letter ICU Funding Amendment.pdf; 20201112 Updated Guidance document outlines.pdf

Kia ora koutou,

We previously communicated to you details on the funding support available for training towards surging your ICU workforce. Based on recent conversations with DHBs, we have expanded the criteria for the funding, which now includes the ability to include costs of nurse educator time.

The attached letter and updated guidance document outlines these changes.

Ngā mihi

Anna Clark
Deputy Director-General | Health Workforce | Ministry of Health
E: anna.clark@health.govt.nz | M: 021 222 8915
http://www.health.govt.nz

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Attachment 10a

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

12 November 2020

Tēnā koe

Expansion of the criteria for the funding to support DHBs to surge ICU workforce capacity

You will be aware that to support DHBs in their COVID-19 preparation, the Ministry had previously set aside $2 million from the COVID-19 workforce funding to reimburse DHBs for the costs of releasing staff for training to boost their ICU nursing capacity.

At the current time this funding is available to cover the following costs:

- costs of accommodation for staff required to travel to receive training;
- a daily allowance for food, if required, for travelling staff;
- travel costs;
- Travel Management Company (TMC) transaction charges, where applicable;
- wage costs for staff backfill.

Based on recent conversations with DHBs, accessing Nurse Educator time in a BAU environment would seem to be one of the biggest limiting factors to DHBs in undertaking the necessary training. As a result, we are expanding the costs which can be funded to include nurse educator time.

Funding will continue to be used to meet qualifying costs while New Zealand is in the COVID-19 Alert Levels. Retrospective costs for training undertaken prior to the initial communications of this scheme will not be eligible.

The process for applications for approval and cost recovery will remain largely unchanged from the status quo. Detail on the eligibility and process for claiming this funding is attached to this email. This information is also being provided to those in your DHB.

Any questions about this funding can be sent through to info@healthworkforce.govt.nz.

Ngā mihi

Anna Clark
Deputy Director-General
Health Workforce

Attachment 10b

Guidance for DHBs – Updated 10 November 2020

Funding to support surging ICU workforce capacity for the Covid-19 response

Eligibility and process for claiming funding

About this funding

During May 2020, the Ministry held discussions with all 20 DHBs focusing on plans to surge their ICU workforce, ICU models of care, training undertaken and planned for the future, and areas where the Ministry could support DHBs to surge its ICU workforce capacity.

All DHBs raised the ability to release staff to undertake ICU training (including refresher training) as a key challenge to building and maintain workforce capacity.

To support DHBs to do this, the Ministry has set aside $2 million to reimburse DHBs for the costs of releasing staff for training, including costs incurred by smaller DHBs in sending non-ICU staff to larger DHBs for practical refresher training.

DHBs may claim funding to cover travel, accommodation and backfilling costs for staff attending ICU training (including refresher training and in-house training), and nurse educator time to deliver the training while COVID-19 Alert Levels are in place.

This scheme will provide support for up to two days' training per staff member every six months.

Eligibility

The scheme covers:

- travel and accommodation costs incurred for DHB staff who need to travel to undertake ICU training (including refresher training);
- wage costs incurred by DHBs to backfill staff undertaking this training (either using DHB or agency staff); and
- nurse educator time to deliver the training.

Specific costs that can be covered by the scheme include:

- For staff required to travel to receive initial or refresher training:
  - the total cost of accommodation for the eligible period;
  - a daily allowance for food, if required, which will be based on the DHB's current policies relating to meal allowances for travelling staff;
  - travel costs - this may include reimbursement of air travel, rental cars, taxis or other public transport (trains, buses)
  - Travel Management Company (TMC) transaction charges, where applicable.
- For backfilling staff who have been released for initial or refresher training:
  - wage costs for additional staff.
- For Nurse Educator time to deliver the training:
  - wage costs

Please note:

- Retrospective costs for training undertaken prior to this date are not eligible for this scheme.

The process for submitting a claim

Prior to the reimbursement process, we request that an indicative 'proposal for funding' be submitted which will outline the current ICU state at the DHB, the activity to be undertaken, and the expected future state as a result of undertaking the training. A template is attached as Appendix I to help guide this proposal.

The Ministry will assess this proposal and confirm the amount we are prepared to fund. Any variances to the requested funding amount made by the Ministry will be explained to the DHB.[1]

Upon completion of the training, the DHB will submit a report identifying the increase in numbers trained as a result of this scheme, accompanied by a GST tax invoice and receipts for the reimbursement of actual costs. A list of the staff who attended the training and those who provided backfill cover will also be provided. A template for this is attached as Appendix II.

Claims should be emailed to info@healthworkforce.govt.nz with the email subject: *Costs for Surging ICU Workforce Training.*

Note: the invoice must be a tax invoice:

For all claims:

- DHB details
- GST information
- Invoice number (if required)

For staff required to travel to receive initial or refresher training:

- Staff details (name, role)
- Description of accommodation provided (including number of nights of stay and accommodation provider).
- Copy of the accommodation and travel costs paid (receipt or other) attached. This may be costs paid directly to accommodation and travel providers, or through a Travel Management Company (TMC).
- In line with the coverage of this scheme, costs may include:
    - room costs, including internet – up to three nights to allow for arrival, one night between training days, and one night on completion of training if same day departure not feasible.
    - meals (receipts must be provided).
    - travel costs
    - TMC transaction charges.

For backfilling staff who have been released for initial or refresher training:

- Staff details (name, role and who they provided cover for)

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[1] Note that funding applications will likely only be declined if the claim is for expenses not related to the ICU surge workforce training or within the eligible timeframe; or if ineligible costs are claimed.

- Evidence of wage costs

Approving and processing claims

The Ministry of Health will review the application and check that all the necessary information is included. If there are any omissions, the applicant will be contacted with a request to provide the outstanding detail.

Applications for cost recovery will be approved by the Deputy Director-General Health Workforce (or their delegate).

Payment

Payments will be processed on the 20th of the month following receipt and action of the expense claims, unless otherwise identified on the DHB invoice.

Appendix I

PROPOSAL FOR FUNDING TO SUPPORT SURGING ICU WORKFORCE CAPACITY FOR THE COVID-19 RESPONSE

CONTACT DETAILS:

DHB:

Name: **Role:**

Email: **Telephone:**

PROPOSAL SUMMARY:

Current State (what are the gaps in ICU COVID-19 surge Workforce capacity). *We recommend you consider including the number of ICU beds available and current numbers of trained staff.*

Activity to be undertaken (what training plan / modules / duration). *We recommend you consider including the numbers and roles of staff intending to participate in the training.*

Expected Future State (benefits and impacts of the training). *We recommend you consider outlining how many trained staff you would have available once the training is complete.*

COSTINGS

STAFFING – Maximum 3 days can be claimed

Role/s	Number	Hours required	Rate per hour	Total Cost	Purpose
(ie) RN	*5*	*16 per role*	*$30.00*	*$2,400.00*	*Backfill*
(ie) Nurse Educator	*2*	*8 per role*	*$45.00*	*$720.00*	*Deliver training*

TRAVEL / ACCOMMODATION - Maximum 2 nights / 3 days can be claimed

ACTIVITY	DETAILS	COSTS	TOTALS
TRAVEL			
ACCOMMODATION			
MEALS			
OTHER			

TOTAL COSTS REQUESTED: $

DATE:

MINISTRY OF HEALTH

TOTAL COSTS APPROVED: $

VARIENCE EXPLANATION:

AUTHORISED BY: Name: Role:

DATE:

DHB ADVISED: Date:

Appendix II

POST TRAINING CLAIM FORM

Date:	

ORGANISATION DETAILS

DHB:	
Address:	
Invoice No:	
Submitted by:	
Role:	
Contact Details:	

DATES TRAINING DELIVERED

From (date):	To (date):

CLAIM DETAILS

Staff Name (training attendee)	Role	Travel/Accommodation Costs (actuals)	Backfilling Costs (actuals)	Other (actuals)

❒ Invoice attached ❒ Receipts attached

Claims should be emailed to **info@healthworkforce.govt.nz** with the **email subject:** ***Costs for Surging ICU Workforce Training.***