FACT SHEET

ACCPA
Aged & Community Care Providers Association

COVID-19 Lessons Learned for Age Services Providers.

The COVID-19 pandemic is an evolving and learning experience for all. Prior to COVID-19 aged care operators would have had in place plans and processes to respond to small, facility based outbreaks of viruses such as influenza.

Responding to a pandemic requires responses on another scale and at another pace. There is very little modern precedent on which aged care providers can rely to guide them through. Learning as we tackle each circumstance is vital to ensure that all providers are as prepared as possible.

From the experience so far in aged care in Australia there are a number of lessons to reflect on that may suggest an escalation of activities based on trigger events.

All providers are working under a COVID-19 business as usual level of alertness. This reflects the broader community wide response of working to the latest AHPPC guidance regarding increased hygiene, physical distancing and COVID-19 safe working environments.

In aged care this means implementing basic alert readiness activities that reflect:

- The latest AHPPC guidance, including that which is reflected in the CDNA guidances
- State/Territory Directions for aged care and in the community
- Requirements determined by the Aged Care Quality and Safety Commission

The Government has now published new guidance on escalation activities for providers, with particular emphasis on visitation to residential care. This recognises the impact on residents of visits from loved ones and how these can be addressed in a way which balances the wellbeing of the resident with the risk of introduction of infection.

National aged care guidance – escalation tiers and aged care provider responses

Coronavirus (COVID-19) – National aged care guidance – aged care visitation guidelines

Coronavirus (COVID-19) – National aged care guidance – visitation recommended actions by tier - providers can use this checklist test their response plans against the expectations against each tier

To accompany these materials an updated Visitor Access Code has been published.

A number of points to note:

- Whilst these documents refer to pre-COVID in some instances, providers are encouraged to consider all activities in the context of living with COVID;
- The materials suggest to respond at tiers 2 and 3 – experience suggests this should be planned for well in advance during tier 1 circumstances and then enacted in subsequent tiers. It is too late when tier 2 or 3 is declared to start to plan
- Providers should identify their own trigger points for standing up and down and how this will be documented in an ongoing and dynamic risk assessment
- These should identify:
  - who will make and action decisions (and contingencies for who this would be)
  - what decision making for action will occur
  - when it should occur
  - how it will be made and communicated
- These materials are national guidance; providers should ensure they have local processes to remain up to date with the jurisdictional response and any Directions that may have been introduced which may override the national tier approach

Whilst these requirements relate to responsibilities as an aged care provider, responsibilities as an employer and under other jurisdictional Directions need to be factored into planning and response activities.

At the leadership level there is a priority to keep positive and help keep everyone motivated

- focus on gratefulness, teamwork and togetherness
- celebrate small wins – confirm their value, show your empathy
- "be seen" or at least "be heard" (i.e. don't be invisible)
- involve Board, CEO and Executive Team
- ask for ideas
- invite feedback
- recognise and reward those who go the extra mile
- share success stories
- encourage to stay home if unwell
- Be alert to and have in place mechanisms to respond to fatigue and to support the mental health of staff.

Planning and preparation

Pandemic response plans should include a trigger for escalation to the next level from the basic readiness activities, on which information on lessons learned through the experiences to date are detailed. Providers need to include in their plans triggers in the community which may require an escalation of response, as well as service level triggers which may require an adjustment to activities.

Independent reviews have noted that preparation that would previously been sufficient for infectious outbreaks for accreditation are not sufficient robust to respond to COVID-19.

- **Pandemic Alert:** AHPPC directions to citizens; general level of community alert; AHPPC directions to age services. There may be none or a small number of positive cases within the local community but there is no evidence of community transmission.
- **Community transmission:** active transmission in the community (where service is located, connected or adjacent / where staff reside); there is evidence of community transmission
- **Initial infection:** a resident, client or staff member tests positive
- **Widespread infection:** major outbreak within a facility with large numbers of residents and staff infected or a local 'hotspot' declared (per jurisdiction or by Commonwealth definition)

1. Pandemic Alert: Basic readiness activities

- Identify the hierarchy of command - with detailed information of who makes what decisions and when. Include a decision making diagram so it is obviously how roles interact and who is responsible for activities
- Need to ensure all facility staff know the pandemic plan (what it says, their role and when activities will be triggered);
- The plan should identify the senior person at the service who would
  - Take command and control (e.g. senior executive);
  - Manage communication and liaison with stakeholders and the media;
  - Manage the operational implementation of the plan (not the command and control role);
  - For ALL roles a contingency back up plan is required. The plan should identify the key handover information that would be required for all residents (noting that if regular staff are not available having a bespoke version of a handover which ensures the idiosyncracies of care which are important to an individual are capture
  - Suggest using the furloughed staff as references of information for the idiosyncrasies of care needs for residents/consumers
  - For all staff on the current situation at the service
  - For use with external agencies and for outbreak management planning (consider using a structured situation report template to ensure consistency of information is captured and then shared)
  - For all residents (noting that if regular staff are not available) have a bespoke version of a handover which ensures the idiosyncrasies of care which are important to an individual are capture
  - For all staff on the current situation at the service
  - For use with external agencies and for outbreak management planning (consider using a structured situation report template to ensure consistency of information is captured and then shared)
- Identify the clinical lead (and back up)
- Identify the Infection Prevention Control (IPC) lead (and a possible back up)

- Identify who will keep up to speed with the latest national and jurisdictional requirements and how these will be implemented and shared with all staff, residents/clients and families
- Don't assume that your facility manager will be the best person or have the capacity to take the Command and Control position – there may be someone else in your organisation who can work alongside them as a crisis manager in the event of an outbreak
- Cohort executive teams to reduce the risk of executive disruption
- Identify planned arrangement and contingency arrangements to access testing
- The plan needs to be understood, thoroughly and repeatedly,tested and agreed with all other stakeholders (inc. PHUs, hospitals, State/Territory health departments, emergency services, State/Territory response centres, local safe work organsiations, staff unions, NDIS providers, retirement living operators etc);
  - have multiple scenarios upfront when you are testing the plans – 'what if...' ;know exactly what part of the plan you are testing and identify the parts that are critical for a supply or service/activity chain not to be broken
  - Make sure the stakeholders who are involved to help e.g. Fire and rescue understand that aged care is not a hospital
  - Identify the key contacts, including out of hours contact details, for all service providers eg local inreach services, contractors delivery services and GPs
  - Ensure at all times there is clear signage of who to call in the event of a suspected or confirmed case, the order in which the calls should be made, the phone numbers, email addresses, who should make the call and how it should all be recorded. ALL staff should know that these are the steps. The sign should identify next steps particularly for when the plan needs to be implemented out of hours
- Plans should contain clarification on what roles the providers, State/Territory Health Departments, the Commonwealth and the Aged Care Quality and Safety Commission, local hospital services, WH&S authorities will play to ensure a coordinated response to a COVID-19 outbreak
- Ensure your plan includes identifying vulnerable clients and those with no formal supports, who have essential service requirements and details of their care and service schedules are readily accessible for handover, include having hard copy essential care and communication records
- Ensure you have reviewed your plans from a diversity perspective. How might your plans for communication be affected by the need to translate information into languages other than English? How might your workforce plans need to be adjusted to ensure that surge workforce staff either have a relevant language or have access to translation services? How will you ensure your contingency catering providers understand the cultural needs of your residents?
- Staff training on infection control undertaken and refreshed continuously and documented, including physical training in the donning and doffing of PPE and the establishment of super users and especially during "doffing" and when staff are tired
- PPE stocked and audited for future need – calculated so need it is anticipated for a smaller or wider outbreak
- Ensure you have adequate storage for PPE – facilities are working to around 10 sets of PPE per resident per day – and sufficient space for Donning and Doffing in specified, marked out areas. Make sure you have space and a process and a movement plan to protect designated areas.
- Documented supply chain for future PPE, noting and updating any interruptions and turnaround time for delivery
- Determine best location for PPE so that it is available promptly but securely to staff should it be needed. What do you have available to place PPE on? – e.g. over a chair, bed, table, etc – Ensure staff are aware
- Identify areas for location of ABHR Handrub and ensure that the responsibility for ensuring these are stocked is identified
- Establish a Waste Management Plan which includes clear processes for hazardous waste collection and coordination, including discussion with local suppliers. The plan should identify where waste would be stored, supply and use of rubbish collection materials and the arrangements in place with your waste collection service should you have increased need
- Staff should practice using, donning and doffing PPE prior to any outbreak and be regularly assessed for competence. A spotter/buddy role should be established, the person trained and a contingency put in place to ensure coverage across shifts.
- Modelling the use of PPE with residents so they are prepared in advance should it be deployed – this is particularly important when caring for people living with dementia as there have been cases of aggression in some facilities

- Modelling and explaining what escalation of responses to full lockdown, will work and look like to staff, residents, contractors and suppliers and families
- Determine and document what are the key services for clients and residents. Ensure this is discussed with them and their families so they are aware in advance what the impact could be
  - It can take an extra 20 minutes per resident per day due to PPE usage
  - Which 'bells and whistles' services will have to be dropped during a crisis period (including where staff numbers are depleted) to ensure the health and safety of residents is paramount, and continue to meet Aged Care Quality Standards?
  - Communicate these plans to staff and families prior to any outbreak (be alert to materials in languages other than English as required by your community)
  - Test every activity. Walk the activity to identify potential opportunities for IPC breach and document the adjustments to the activity that would need to be implemented in an an enhanced restrictions or outbreak circumstance. Ensure all staff are familiar with the revised approach
  - Calculate the time difference for every activity in a living with COVID world, and at enhanced tiers to enable workforce plans to be updated with the additional staffing requirements that will follow
  - Ensure that these changes and implications are communicated with residents, clients and their families
- Document these for each individual for whom care is delivered
- Symptom screening of staff, residents and visitors established and documentation to support (be alert to whether your local jurisdiction introduces a template for attestation)
- Ensure comprehensive information is collected for future contact tracing. If a third party supplier is used to collect this through an IT platform - test that the information can be accessed quickly and out of hours
- Consider electronic mechanisms for capturing of this information for efficiency to support the procedure and to record the compliance with it
- Identify a destruction process for records in keeping with local State requirements and the Privacy Act 1998 (Cth)
- Visitor logs for future contact tracing (name, date, contact details, duration of visit, where and to whom visit made)
- Increased cleaning including an audit of cleaning supplies and plans in place should a deep clean be provided (how if by own staff, or a contractor identified)
- Confirm cleaning materials meet the requirements of national guidance and TGA
- Confirm cleaning regimes reflect national guidance
- Twice daily for frequently touch items like light switches, hand rails, door knobs, keypads, and keyboards.
- Having a workforce management plan which anticipates how the service will respond to a loss of staff at 30%, 50% and full loss, identifying where staff will be sourced, and how, and the trigger for the need to call in the Department of Health to provide surge workforce cover
- Test the reliance of presumptions in the plan eg if staff have indicated they are available for additional hours - what these are, how can they be contacted; in what circumstances might they refuse. If your plan includes reliance on an agency make sure they know this. Test with the agency the IPC and aged care experience for any surge workforce. If there is no other option that DH surge workforce ensure this is document and this has been raised with the local state office
- Ensure for each member of staff there is documentation regarding other employment. Test with staff the willingness to work only for the home. Review rosters for the impact of such a change
- Understand your staff - whether staff have family members who may be particularly vulnerable, or live in shared accommodation with other aged/ healthcare/quarantine workers for instance so that you have a comprehensive understanding of the potential impact on availabiity.
- In the workforce plan include those staff who have capacity and would be willing to undertake additional shifts
- Have available laminated hard copy maps of the facility which identify services and residents, supply of PPE medical/surgical supplies, continence aids. Should a surge workforce be required to assume services. Have hard copy plans for the site available with pre-identified areas for cohorting, location of PPE and traffic plans marked up. Test that these work in practice
- Work out and document plans for the movement of residents and evacuation should the facility not be able to move residents within the premises or be able to cohort due to design

- Multiple site working arrangements understood and minimised where possible at tier 3 single site working should be implemented. Noting also that in non-tier 3 circumstances local orders may require this or the Commonwealth may opt to implement single site working. Ensure workforce plans are fully prepared for all staff groups for the consequences of single site working.
- Cohorting should be negotiated before any escalation of response so there is shared understanding and arrangements for any movement are documented
- Response plan developed and stress tested to a number of different scenarios – include round table planning meetings and regular reviews/ debriefs
- Contact with local support services should be undertaken prior to an outbreak to confirm planning at the interface, expectations for service delivery in the event of an outbreak and to confirm roles and responsibilities.
- Having basic and short term care plans available and up to date in paper based format so that surge workforces don't need to learn computer systems, in the event the staff are forced to leave the service and handover to staff who are unfamiliar with residents or clients. Include up to date advanced care directives
- Have prepared plans for how staff will be identified
  - for resident/clients when it may be difficult to see a member of staff due to PPE
  - for other staff, particularly identifying those who have a role in the outbreak management team or are the PPE spotter/buddy, IPC lead or clinical lead
- Include in your plan the arrangements to capture data following an outbreak to ensure there is an uninterrupted information trail for all
- Discuss with residents/clients and families what information is most important to them. Develop a personalised communication plan for each resident/client so that the information that is wanted is captured and then can be shared with the family
- Talk to families and residents about their advanced care directives – consider adding a clause to permit receiving active treatment in the case of a COVID-19 positive case (so they can still be admitted to hospital for respiratory support, for example)
- Discuss with doctors the option of having end of life medications on site, in case a resident cannot be admitted to hospital
- Ensure information is clearly documented and available for corporate issues should senior staff not be available. E.g. who to call to organise a waste collection outside of normal arrangements
- Documented logistics for calling in testing of residents (who to call) and confirmation with pathology services that testing for residents will be prioritised. Confirm in advance pathology capacity issues so that future delays can be understood and plans identified to source alternate services
- Arrangements for the transfer to hospital for early cases should be documented and shared with local hospital services. Who and how will these items be cleaned?
- Have supplies of identification wrist bands
- Determine and test the arrangements for and parameters around roles, responsibilities and expectations of the local hospital/acute health services for transfer or management in situ. Determine what arrangements for additional support the acute service would deploy
- Communication with residents (in their care plan) and families to understand their wishes and manage their expectations regarding increased visitor restrictions should responses need to escalate
- Ensure you box, label, store and log details of storage of belongings when cohorting residents, which may involve moving them temporarily to different rooms or facilities – use masking tape for simple labelling
- Establish and document a plan for the management of personal effects should a resident transfer to a hospital/other facility, return home temporarily or pass away
- Discuss and agree what off site working could be undertaken by staff who are required to isolate and are well. E.g. establish a resident/staff member/family buddy system that would work for ongoing communication
- Develop a workforce self-monitoring strategy for health and temperature screening at the start of every shift (which is documented)
- Prepare an induction pack for rapid onboarding of surge workforce. Include tailored information about residents/clients, location of plans and resources, cohorting and maps of facilities, details of processes and procedures and contact details for critical staff. Include also IPC arrangements and PPE training
- Develop transferrable skills for staff e.g. reception staff who could deliver meals to residents

- Ensure staff are aware of the resources available to them, inc mental health support
- Develop, test, share and document communication plans to include:
  - What equipment you will use (check you have enough for all the incoming calls for instance)
  - START prior to an event so there are shared expectations and understanding
  - Ensure you gather and regularly update the contact details for all families
  - How will information be shared and at what frequency information will be
  - Who will do what – which staff could be the link to families? (i.e. staff who know the residents)
  - Share with residents/clients and families what activities will need to be curtailed/stopped in the event of enhanced restrictions or an outbreak
  - From where will communication activities be coordinated and undertaken (i.e. if the facility is in lockdown)
  - Out of hours planning to be built in
  - Have your own 1800 phone number and covid@ email address with a plan to man it 24/7 by a roster of people who know the residents, to deal with family enquiries
  - Establish COVID hotlines - using an external provider if necessary
  - Consider equipping the team with smart phones or iPads to use for communication with families, and provide them with training on usage. Wherever possible roster nurses to contact families, and preferably those who know the resident/client
  - Set up virtual conference facilities such as MS teams, Skype or Zoom, to communicate with families
  - Share plans with residents particularly local advocacy services
  - Test your plans with the local advocacy service to identify areas for adjustment
  - Share plans with families (Ensure all first contact lists up to date – phone and email; Letter to families explaining that you will call first contacts and they will liaise with others
  - Share plans with stakeholders
  - Media plan – utilise LASA media templates and have tailored comms on standby (found at www.lasa.asn.au/COVID-19)
  - Consider using a small marquee for media out the front of your residency, supplying coffee and communications. Keep the media onside
  - Test your plans with your local telecoms provider including process to access additional support (e.g. additional incoming lines) particularly out of hours
  - Share plans with staff
  - Staff details up to date
  - addresses, phone, emails
  - Create display poster for donning and doffing stations, directions to PPE, medications etc, so it is clear if new staff are brought in
  - Use of social media particularly out of hours for immediacy
  - Consider what happens with family in the event of death – who, what, when, including liaison with funeral directors and arrangements for certification
  - Prepare in advance for each resident an individualised transfer plan in case of transfer to hospital with pre-populated key and critical information
  - Plan in advance with relatives and families what they would want to include in a 'go bag' in case of transfer to another room, facility or hospital. Ensure this is documented with a check in/out tickbox to ensure items are not lost in transit
  - Maintain a communications sheet per resident – who from the staff has contacted the family by date, time, and a summary of info shared
  - Include information about how the model of care may change - e.g. if hospital in the home is introduced
- Develop an Operating Manual with standard procedures across all areas of the business to hand over to contractors if staff are required to isolate

2. Community Transmission: active transmission in the community (where service is located, connected or adjacent/where staff reside)

In this scenario there is evidence of community transmission.

Basic readiness plus heightened readiness activities which reflect:

- Regular risk assessment of the local situation, recognising key trigger events which may require movement to next phase of response
- Consider precautionary use of masks (what would this mean for calculation of PPE use)
- Increased visitor restrictions documented and advertised early

- Increasing screening of residents, staff and visitors
- If staff are having a COVID-19 test or have been advised of a positive test, here are the suggested questions to assist with contact tracing:
  - Why are you being tested?
  - Direct contact – who? what contact, when, for how long? When was the direct contact; Is the direct contact unwell?
  - Signs and symptoms – what symptoms? when did they start?
  - When were you tested?
  - Where?
  - When did you work last?
  - Which wing?
  - Which residents did you assist with personal care?
  - Which residents did you assist with toileting
  - Which residents did you assist with meals
  - Which other staff did you work with?
  - Any other direct contact with residents? – what?
  - Did you use the staff room; Who was there? How long?
  - Did you go to any other parts of the home? What for?
  - Who else did you cross paths with, where, for how long? Think physios, doctors etc
- Limit/cease cross-site staff movements
  - Be alert to changing jurisdictional Directions regarding single site working and workforce planning. Consider expanding single site/ limitations on movements to include other employment (not just employment with another RACF) which – given the high level of community transmission now – would be prudent in being able to reduce the chances of COVID-19 being brought into a facility.
- If staff are in isolation but fit to work, have them on hand to advise new workers by phone, join resident and family discussions via iPad video link, etc
- Stand up increased cleaning activities
- Refresher training on infection control and PPE should become a perpetual activity overseen by the identified IPC lead
- Response plan drill 'with regularity and across all shifts' don't assume that the exec team will be on site when the call comes
- Increased cohorting
- Check-in with local support services
- Ensure that there is greater emphasis on the responsibility of RACF staff to follow Government directions around life outside work. This is again important when there is high community transmission
- Confirm arrangements for access to a surge workforce and a coordinated response from all stakeholders
- Initiate escalation activities identified in the plan
- Implement increased communication plan activities including around restrictions and requirements to staff, residents and families
- Be ready to act quickly
- Communicate clearly the possible next steps with residents, families and staff. Ensure this includes expectations and plans for dealing with visitation in line with the Visitor Access Code and State/ Territory directions. Explain how these updates will be shared
- For those families who do not have access to IT, confirm in advance their preferred method of contact and ensure this is clearly noted for the resident
- Every non staff member to sign in and out – phone number, time in, time out – important to know how long someone was on site and where they visited
- Identify vulnerable employees, communicate with them around options available and undertake a risk assessment if they are going to remain in the workplace

3. Initial infection: a resident, client or staff member tests positive

- Heightened readiness plus
- Consider if single site working arrangements for staff can be achieved
- Notify the Department of Health and State officials immediately and your public health unit if you have any confirmed COVID-19 cases of either residents/care recipients or workers in your facility, service or program report to the Department at agedcareCOVID-19cases@health.gov.au
- This notification is essential for the activation of Commonwealth support including rapid access to PPE from the National Medical Stockpile, case management, surge workforce support and supplementary pathology testing.

- If you need urgent assistance outside of normal business hours please contact the department in the relevant state on the following numbers. If the call is not immediately taken leave your name, name of the provider and a return phone number so the DH officer can return your call. Accompany your call with an email as above.
  - Victoria/Tasmania 1800 078 709
  - New South Wales / Australian Capital Territory 1800 852 649
  - South Australia 1800 288 475
  - Queensland 1800 300 125
  - Western Australia 1800 733 923
- Liaise with PHU for transfer of initial case/s to hospital
- Essential visits only (end of life/per State Directions
- Communicate arrangements during site induction with contractors/suppliers who are coming on-site
- Staff members who have been working in the vicinity of a COVID-19 positive should wear a red cap or similar – easy to identify if they go into other areas
- May need to change care approach – e.g. Showers tend to be too long and the steam makes masks ineffective after a period, so you may need to clean using adult hygiene wipes instead
- Have a PPE usage application or log - count stock every day and ensure you have trigger thresholds and forecast your needs
- Staff accommodation organised
- Staff meal and grocery service
- Emergency leave arrangements communicated with residents and families
- Some providers provide staff with mobile phones for improved communication during the crisis – in those cases its important to provide training and guidelines for usage

4. Widespread infection: major outbreak within a facility with large numbers of residents and staff infected ('hotspot' declared)

- Ensure contact is maintained with staff who are in self-isolation and/or have been diagnosed with COVID to check on welfare and progress
- Transfer out residents where possible, including healthy residents, potentially, in collaboration with PHU and State Health
- Transfer COVID-19 patients to isolation ward if this is available
- When residents return to a facility after being in hospital, it is recommended they are tested for COVID-19
- Daily register of cases/testing for residents and staff. Have a spreadsheet
- Initiate daily meetings with the Outbreak Management Team
- Initiate daily situation reports to collate single source of truth
- Provide daily updates as a minimum to all staff, residents and family contacts
- Stand up media planning
- Stand up escalation waste management plan, including liaison with waste management company on increased use
- Stand up surge workforce plan; review rostering to ensure PPE and IPC coverage as well as essential services to all residents are captured
- Stand up fatigue management plan for workforce
- Implement wrist band identification for all residents
- With reference to local Directions consider ways to reduce multi-site employment
- Establish communication with local emergency response centre

5. Home Care Specific – Planning and Prevention

- Set up COVID-19 response groups – one for planning, the other for operational tasks such as communication, contact tracing, etc
- Communicate with staff, clients and families early and on a regular basis to reduce anxiety – use as many channels as possible – website, email, facebook, phone, SMS, direct mail, posters/leaflets

- Develop specific communication strategies for CALD people, and those living with communication difficulties (e.g. hearing or visually impaired)
- Develop an Operating Manual with standard procedures across all areas of the business to hand over to contractors if staff are required to isolate
- Define what are essential services and identify different ways of delivering services where resources are limited or the time of home visits needs to be reduced
- Review all care plans
- Identify vulnerable staff – e.g. those with compromised health – and offer redeployment to non-client facing roles
- Check in with staff who would be prepared to step in, if there was a positive case in your client base, noting that some staff may not be available when it comes to it, if they are in a hot-spot where schools have closed and there are tighter restrictions on movement
- Maintain regular contact and wellness check ins (via phone or video call) with staff and clients who are in isolation or working from home
- Providers have a responsibility to ensure that all contractors are operating safely when engaged to complete work for clients
- Ensure home care workers are not only trained but have practiced donning and doffing full PPE. Ensure there is an effective disposal procedure in place and and all vehicles are stocked with adequate PPE and hand cleaning supplies and disposal procedures are established
- Review PPE protocols, stock and usage, create an emergency stockpile if possible, in case of an outbreak in your catchment area
- Review rosters to reduce multiplicity of staff visiting clients where possible
- Keep staff informed on the latest situation, at least weekly, including hotspot locations
- Set up a staffed 24/7 contact line for both consumers and care workers
- Ensure client/household infection screening questions are asked before worker arrives and again at the door
- Explore the use of CHSP funds for electronic communication devices to provide remote support, including virtual events for clients
- Support clients to feel safe by doing hand hygiene in front of them, talking about PPE and processes in place to minimise risk – also refer them to the Living Well in the Community brochure and OPAN helpline or your own support line
- Review efficacy of in-home cleaning regimes where cleaning is provided to reflect COVID-19 safe principles
- Identify how deep clean at infected locations would be provided
- Call the client before visits to check on wellness, and if unwell, identify whether planned services are essential, and if there is any additional support needed (e.g. shopping or pharmacy trips)
- Daily welfare checking for clients not receiving usual services, or those who are vulnerable
- Ancilliary services such as gardeners, tradespeople and cleaners are not generally affected by visiting restrictions, so consumers need to make their own choices and take precautions such as social distancing if and when they receive these services

6. Home Care – Dealing with a positive case or client in isolation

- Consider with every individual on a case by case basis and complete risk assessments for each case including each task to be performed
- Meet as a team to decide what the essential services are and who will deliver them
- Plan ahead for a month of services for that individual (fortnight if only in isolation as a precaution)
- Ensure adequate PPE is provided and staff are fully trained in safe procedures for donning, doffing and disposal of PPE
- Identify whether visit frequency or time in the home could be reduced, and whether some services can be delivered in a different room to the individual
- Reduce number of staff visiting – two or three maximum, with the appropriate level of qualifications and experience (e.g. level 3 workers)
- Consider sponge baths over showers, as the latter can reduce PPE effectiveness
- Schedule visits at the end of a shift so that staff can go home and shower straight afterwards without carrying any potential infection to others

7. Recovery

- Proactively manage and plan for staff to take annual leave and/or long service leave given that staff have likely not been able to take leave
- With residents, families and external providers develop individual repatriation plans for return to home
- Following internal movement of residents, implement a phased and risk informed return to normal locations
- Maintain regular communication with staff, residents/clients and their families on progress to return to a state of COVID-19 alert
- Offer trauma and grief counselling
- Review rosters for fatigue management
- Implement process to capture the data on care to ensure continuity of record keeping (particularly where hard copy records may have been used in lieu of electronic systems)
- Review individual residents and clients for clinical impact and reassess needs
- Capture lessons learned from the outbreak and review all materials to reflect any necessary changes
- Consider workforce plans for downscaling of single site working arrangements
- Socialise risk management planning approach to re-establishment of pre-outbreak activities
- Maintain vigilance regarding State/Territory Directions
- Establish and advertise EAP to all staff
- For residents who may return following an absence of 28 days a review and reassessment with a new ACFI pack submitted will be required

8. Service level triggers COVID-19

Trigger	Description
Indirect contact with service	A person linked to the service has been confirmed as a close contact of a confirmed case
Symptoms at service	Staff, residents or visitors at service exhibit symptoms of COVID-19
Infected staff or resident / no confirmed transmission	A staff member has been confirmed as a COVID-19 case but there is no confirmed transmission within the service
Confirmed transmission within service	There has been confirmed transmission within the service
Ongoing transmission identified within service	New cases continue to be identified within the service even after initial protective measures have been put in place
Capacity constraints in outbreak context	In the context of ongoing outbreak service forms the view that capacity constraints are limiting the delivery of care

Triggers general

Trigger	Description
Service unable to access gov services outside of outbreak	Government service does not provide promised support in relation to PPE testing contact tracing
Service unable to access contracted support outside of outbreak	Contracted services cannot provide promised support including staffing, waste disposal, food
	Community transmission in locality of service/locality of workforce
	Commonwealth defined hotspot declared

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