COVID-19 Outbreak Management

Preparing and responding — Guidance for Residential Aged Care Facilities in Queensland

Queensland Government

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Introduction

Effective management of a COVID-19 confirmed case or outbreak in a facility is dependent upon preparedness. Since the start of the COVID-19 pandemic, a number of resources have been developed to support facilities in preparing for and responding to outbreaks.

This document has been prepared to support Residential Aged Care Facilities in Queensland to prepare for, prevent against and respond to COVID-19 outbreaks. It aims to distil key points from this emerging body of knowledge, place those points in a Queensland context, and refer providers and facility staff to further, more detailed resources that can be used to help develop outbreak preparedness and guide responses.

A list of existing resources that support outbreak preparedness can be found below:

- Checklist for Residential Aged Care Facility (RACF) preparation for COVID-19 prevention and outbreak management
  This checklist is intended to guide requirements for RACF pandemic preparation.
- Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities
  The Communicable Diseases Network Australia (CDNA) developed these national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia.
- Acute respiratory illness (suspected COVID-19) in RACF resident pathway
  This pathway details isolation and treatment steps to be taken in managing suspected COVID-19 cases in residential aged care facilities.
- Coronavirus (COVID-19) – Case studies of successful outbreak management in aged care services
  These case studies outline how aged care services have successfully managed COVID-19 outbreaks.
- Management of suspected RACF COVID-19 outbreak
  This checklist will assist residential aged care facilities in managing a potential or confirmed COVID-19 outbreak.
- First 24 hours in a COVID-19 outbreak
  This fact sheet describes the steps you should take in the first 24 hours following the identification of a COVID-19 positive case.
- RACF rapid response flow chart
  This flowchart outlines the steps to mobilise and engage relevant partners to respond to COVID-19 in an aged care facility in Queensland.
- Management of suspected or confirmed COVID-19 in residential aged care facilities
  A suite of collaborative pathways for General Practitioners and Registered Nurses.

While existing documents will provide useful guidance on how to prepare for and respond to an outbreak, each facility will need to determine how that guidance can be operationalised in their own circumstances. This will require significant consideration, planning and preparation and will likely be aided by consultation with response partners including Public Health Units, Hospital and Health Services, the Commonwealth Department of Health, and, where relevant, the facility's head office. Consultation with peak bodies, the Older Persons Advocacy Network and residents and families may also be beneficial.

It is important to remember that in an evolving situation, printed resources will become out of date from time to time. Facilities should refer to electronic resources which are updated to reflect changing policies and practices, as well as new clinical information.

Queensland Health has a collection of online COVID-19 resources for the Aged Care sector which facilities are recommended to review regularly for the latest resources. These resources can be accessed here.

Outbreak Management

As part of its preparedness activities, every facility should develop an outbreak management plan and determine an outbreak management team.

The roles and the responsibilities of the outbreak management team should be clearly documented and communicated. Members of the outbreak management team should be of appropriate seniority. A senior member of the facility leadership team and alternate should be identified as outbreak lead, and have responsibility for making key decisions, directing staff and liaising with other agencies and stakeholders.

The CDNA Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities provides detailed guidance on development of outbreak management plans and the formation of an outbreak management team.

Facilities should refer to the CDNA guidelines in the preparation or review of outbreak management plans and the formation of outbreak management teams.

Responding to an outbreak will require effective collaboration between a number of response partners. The CDNA guidelines identify members and functions that should be should be included in an outbreak management team, with the membership including representatives from the facility, the Public Health Unit, the Local Health District (Hospital and Health Service, in the Queensland context), a Commonwealth Case Manager and an Aged Care Quality and Safety Commission case officer.

Facilities should liaise with response partners, including their local Hospital and Health Service, Public Health Unit, the Commonwealth Department of Health, the Aged Care Quality and Safety Commission and, where applicable, their head office in relation to outbreak management teams and plans.

Consideration should be given to undertaking scenario testing exercises involving relevant response partners.

A list of the contact details for relevant parties needs to be available to staff at all times, including after hours and weekends.

Facility access, messaging and hygiene arrangements

The first and best opportunity to prevent a COVID-19 outbreak in a Residential Aged Care Facility is to prevent the physical introduction of the virus into facility premises. Access restrictions; screening requirements and processes; and messaging, hygiene and distancing protocols can support this strategy.

In Queensland, Aged Care Directions determine the access restrictions and screening requirements that facilities must implement. Aged Care Directions are updated in response to the changing environment and should be checked regularly. Facilities can subscribe to receive updates on changes to Aged Care and other Public Health Directions through the Queensland Health newsletter here. To ensure effective implementation, facilities should ensure that robust processes are in place to operationalise access restrictions and screening regimes.

Additionally, screening should be supported by clear, consistent and regular messaging to staff, residents, families, contractors, volunteers and service providers about the nature of COVID-19 and their role in preventing introduction of COVID-19 to facilities. Signage, fact sheets and regular multimodal communication should be used to convey these messages in appropriate language and plain English.

Queensland Health has developed a resource Transitions between hospital and residential aged care facilities during the COVID-19 pandemic to provide guidance in relation to the transition of residents between Residential Aged Care Facilities and hospital treatment.

Facilities must ensure that adequate hand washing supplies, hand sanitiser, paper towels and large lined disposal bins are available for persons entering the facility to use. In circumstances where Directions require persons entering facilities to use masks, facilities must ensure that there are arrangements in place to facilitate this.

In the event of a COVID-19 confirmed case or outbreak, Public Health Units will undertake contract tracing. To be able to support these efforts, facilities should maintain an electronic list of everyone who has entered the facility – staff, contractors, visitors, service providers – along with the date, time of entry and exit, purpose of visit and comprehensive accompanying contact details (phone number, email and address). Aged Care Directions require that this information be securely stored for 56 days, and deleted thereafter.

Staffing

Experience indicates that staff, contractors and service providers represent one of the major pathways by which COVID-19 is introduced to Residential Aged Care Facility environments. When levels of COVID-19 in the community increase, authorities are likely to further restrict visitor access and resident movements. In these circumstances, the aged care workforce will be the key population circulating between the community and facilities. Accordingly, vigilance in relation to staff health is imperative for preventing outbreaks and limiting outbreaks when they occur.

In addition to screening requirements, facilities should ensure that they are providing clear, consistent and frequent messages to their workforce (including contractors, service providers and volunteers) about the importance of ensuring that they arrange testing and do not work while unwell; that they follow screening, infection control, hygiene, PPE and social distancing protocols; and that they comply with any restrictions in place. Facilities should work with staff to ensure that they are aware of supports that are in place in the event that they are unable to work due to being unwell, or have undergone testing. Particular attention needs to be paid to service providers and staff that move between facilities.

Pre-cohorting

One of the major challenges experienced by facilities in event of a confirmed case/outbreak is the stand down for isolation/quarantine of staff who are close contacts of a confirmed case. Facilities may be able to limit the impact of isolation/quarantining requirements by implementing measures to cohort their facilities' operations prior to and in the event of an outbreak.

Cohorting facility operations may include rostering and workflow practices that segregate staff into defined groups with limited contact between staff-groups – for example, in a facility with 3 wings, staff may be rostered to work in a specific wing, with no cross-over of staff between wings.

Hand-over practices can be modified through use of technologies to minimise cross-infection potential between shifts.

Consideration should be given to ensure that cohorting measures are sufficiently comprehensive and account for potential contacts both on and off shift.

Training

Each facility is responsible for ensuring the staff are trained and competent in all aspects of outbreak management prior to an outbreak. Staff should know the signs and symptoms of COVID-19 so they can identify and respond quickly to a potential outbreak.

Further, all staff need to understand facility infection control guidelines and be competent in implementing these measures during an outbreak.

From 1 October 2020, Aged Care Directions require facility operations to take reasonable steps to ensure employees, contractors who have contact with residents, volunteers and students undertake face to face infection control and personal protective equipment training.

Additionally, all staff should be trained and competent in relation to:

- recognising symptoms and signs of COVID-19
- exposure risk levels for COVID-19, including being aware of hotspots, restricted areas, and the importance of travel history
- what to do if experiencing symptoms of COVID-19
- hand hygiene and infection control
- application and removal of PPE
- appropriate handling and disposal of sharps and clinical waste, environmental cleaning, laundry and food handling processes.

Online information and training resources are available to support Residential Aged Care staff, including:

- a Queensland Health virtual leadership and skills development series designed to support residential care facilities respond to COVID-19
- training and competency in hand hygiene
- Resources on the safe removal and fitting of PPE
- Guideline on managing clinical and related waste.

Residential Aged Care Support Service (RaSS) teams may also be able to support facilities if further help is needed.

Surge workforce

In the event of a confirmed COVID-19 case in a Residential Aged Care Facility, a significant number of staff are likely to be stood down for testing, isolation and quarantine. At the same time, staffing requirements within facilities will increase to meet the care, treatment and cleaning requirements of an outbreak response.

Notwithstanding that positive cases are generally to be transferred to hospital, a higher proportion of nursing and ancillary staff will be required to deliver the clinical response (testing and observations), additional cleaning and care staff will be needed to support an outbreak response, and attrition of surge workforce due to illness and quarantine/isolation requirements should be expected.

Facilities will need to develop strategies to respond to such scenarios. From 1 October 2020, Queensland facilities will be required under Aged Care Directions to identify how surge workforce requirements will be met as part of their workforce management plan.

Such strategies may include exploring whether current part-time staff are able to work extra shifts, whether staffing agencies can provide extra staff at short notice and, in the case of facilities belonging to large organisations, whether organisation-level surge workforce arrangements can be developed.

Facilities should ensure they are aware of processes and requirements to access emergency staff via the Commonwealth. The Commonwealth document FAQS – Aged Care Workforce Measures provides guidance on this and should be consulted.

Electronic lists of staff contact details and electronic rosters should be kept up to date and accessible to facilitate development of emergency rosters in response to a confirmed case and processes for developing and confirming such rosters should be agreed in advance.

In a situation where a surge workforce is required to respond to an outbreak and regular staff are stood down, processes and guidance should be in place to ensure the surge workforce is able to perform its role. Requirements will include:

- PPE and infection control training and supplies
- Accessible guidance on the needs of individual residents and processes specific to the facility
- Access to IT systems, swipe cards and keys as necessary
- Plans to feed surge workforce staff.

It is possible that an affected facility's leadership team will be required to isolate/quarantine and will be unable to work. Consideration should be given to how leadership would be provided in these circumstances.

Responding to workforce stand downs will be a challenging aspect of outbreak management and should be explored with response partners when plan review and scenario testing is undertaken.

Experience of outbreaks has demonstrated staff who have been quarantined/isolated can support the surge workforce via virtual participation in handover activities.

Consideration should be given to planning to support such practices.

Workforce Management Plan

Aged Care Directions require all aged care facilities in Queensland to develop a workforce management plan that:

- requires employees, contractors, volunteers and students to notify a residential aged care facility of their additional place of employment, and
- requires employees, contractors, volunteers and students if they become aware of a COVID-19 case identified at an additional place of employment, to notify the operator of a residential aged care facility
- provides that the operator must notify the local Health Emergency Operations Centre of a critical workforce shortage for notification purposes.

Additionally, from 1 October 2020, workforce management plans must identify how workforce surge requirements will be met if there is a COVID-19 event at the facility.

The requirement to develop a workforce management plan has been implemented to reduce the risk of transmission of COVID-19 into aged care facilities, support contact tracing and ensure facilities are prepared to respond to workforce issues in the event of a confirmed case.

Staff members working across multiple facilities and workplaces must advise each employer of their other workplaces. The residential aged care facility must keep a record of this advice.
Guidance on what constitutes a critical workforce shortage is contained in the Aged Care Directions.

Contact details for local Health Emergency Operations Centres will be provided directly to facilities by Queensland Health. This information should be incorporated into facility workforce management plans.

Staff who work across multiple facilities

Aged Care Directions recommend that facility operators ensure, to the extent possible, that employees, contractors, volunteers and students do not work across multiple care facilities.

The Directions further provide that facility operators must ensure that where employees, contractors, volunteers and students do work across multiple care facilities, they must not enter, or remain on, the premises of the residential aged care facility without wearing appropriate personal protective equipment, in accordance with Queensland Health's Pandemic Response Guidance Personal protective equipment in Residential Aged Care and Disability accommodation services.

As part of outbreak preparedness activities, facilities should develop processes and strategies to ensure they are able to comply with these requirements.

General Practitioners, in-reach services, contractors and telehealth

Facilities should consider their involvement with General Practitioners, in-reach services and contractors in terms of both infection prevention and outbreak response. In relation to infection prevention, facilities should review how in-reach services and contractors are involved in the facilities operations and ensure that steps are taken to minimise the risk of such services transmitting COVID-19 into the facility.

In relation to outbreak response, facilities need to review how the essential functions performed by these services would be maintained in the event of an outbreak. Telehealth and other virtual platforms may be able to be employed to deliver a number of services in COVID-19 context and should be considered. Facilities should ensure ICT to support the use of telehealth are in place as part of preparedness.

Full contact details of visiting services should be stored electronically in an accessible format so services can be informed in the event of anoutbreak.

Medicines

In preparing for an outbreak, facilities should consult with their local pharmacies and develop a plan on continued access to medicines if either the facility or the pharmacy are required to go into lockdown. The plan should address access both for imprest medications (if facilities have an imprest) as well as residents' usual medicines.

PPE

Queensland Health has developed a resource – Pandemic Response Guidance Personal protective equipment in Residential Aged Care and Disability accommodation services – that provides guidance on the use of PPE in residential aged care in the COVID-19 context. Facilities should consult this document to understand requirements for PPE use in facilities. In particular, this document addresses preventative use of PPE in response to the level of COVID-19 in a community.

From 1 October 2020, Aged Care Directions require facility operations to take reasonable steps to ensure the following, in accordance with relevant guidance provided by Queensland Health:

- employees, contractors who have contact with residents, volunteers and students undertake face to face infection control and personal protective equipment training; and
- an adequate supply of personal protective equipment is available to respond to a confirmed case of COVID-19 within the residential aged care facility.

Facilities need to ensure that they have adequate stocks available for use during the initial phase of an outbreak and that staff are trained in the use of and donning and doffing procedures for PPE. This includes non-clinical staff.

While regular staff will be required to undergo training as part of facility preparedness activities, consideration should also be given to the training and orientation requirements of any surge workforce called up during an outbreak.

Facilities should work to ensure that they have adequate PPE supplies, and that a process for storage and stocktake of supplies is in place.

In considering their PPE needs, facilities should have regard to their individual circumstances, and whether remoteness, climate or case-mix (e.g. residents requiring baseline frequent interventions) may impact their requirements.

As a starting point, facilities should consider holding three days supply of PPE to respond to an outbreak, or six days supply if they are in a rural or remote area with longer lead time on supply and distribution. PPE for outbreaks should be kept separately from PPE that is used routinely, though attention should be paid to expiration dates.

The volumes of PPE required for an outbreak are likely to be significantly larger than facilities hold routinely hold. Facilities will need to plan for the movement and storage of PPE stock that they hold for outbreaks, as routine processes may not be sufficient.

While the Commonwealth can provide emergency stock in the event of an outbreak, facilities need to be aware of the processes and requirements in relation to accessing such stock. The email to organise additional (free) PPE in an outbreak is: agedcarecovidppe@health.gov.au

Facilities may benefit from liaising with their local Hospital and Health Service, visiting GP and RaSS teams, and, where relevant, their facilities' head office in relation to PPE preparedness.

Further resources developed in relation to PPE in the COVID-19 context are set out below:

- Queensland Health resources on PPE
- Coronavirus (COVID-19) wearing PPE in aged care video

Cleaning

While cleaning is a constant and crucial element of outbreak prevention and preparedness, cleaning requirements increase in the event of an outbreak. As part of outbreak preparedness activities, facilities should ensure that materials and processes are in place to support enhanced cleaning in the event of an outbreak.

The Commonwealth Department of Health factsheet Coronavirus (COVID-19) Environmental cleaning and disinfection principles for health and residential care facilities provides detailed guidance on processes that should be followed and should be consulted.

In preparing facilities should consider:

- what enhanced cleaning practices will be required in the facility in the event of an outbreak, and how they will be implemented (including how clean and dirty areas will be identified)
- whether they have sufficient stock of detergents, disinfectants and other cleaning supplies to implement enhanced cleaning
- whether additional cleaning staff will be needed in the event of an outbreak, and how such staff can be accessed
- PPE requirements for cleaning staff in the event of an outbreak.

Early consideration of existing Resident Aged Care Facility frequently touched surfaces and their amenability to appropriate standards of cleaning should be assessed. Facilities should consider urgent reduction of clutter and, where appropriate, replacement of furnishings that do not lend themselves to appropriate standards of cleaning.

PPE use in the event of an outbreak will increase the waste generated by the facility. As part of preparedness activities, providers should ensure that waste management service providers are able to increase the frequency of collection to manage this issue.

Communication

Communication is crucial to the effective management of an outbreak and depends on planning and preparation. In the event of an outbreak, facilities are likely to be inundated with a demand for information from a broad range of stakeholders.

Communication plans, including roles, responsibilities and templates to be used in the event of an outbreak should be developed and put in place prior to an outbreak.

Facilities should maintain comprehensive, up to date, electronic contact lists for a range of stakeholders, including:

- residents, their families, next of kin and health care decision makers
- staff, contractors, volunteers and service providers
- Public Health Units, Primary Health Networks, Residential Aged Care Facility Support Service (RaSS) teams, pathology providers and Hospital and Health Services
- GPs
- other Residential Aged Care Facilities in the area, especially those with shared staff
- peak bodies
- key contacts (head office, communications, pandemic response officers) in the organisation to which the facility belongs.

A number of communications will need to be handled with particular sensitivity, including:

- initial communications with residents' next of kin/health care decision maker to advise of the outbreak
- communication with residents' families/health care decision maker in the event of deterioration in their condition or death.

Decisions are required to determine who will be responsible for sensitive communications and how these communications will be conducted. These responsibilities and relevant accountable officers should be documented in the communication plan. Residents' GPs should be involved in planning for sensitive communications.

Other essential considerations include:

- communicating with First Nations people and stakeholders from culturally and linguistically diverse backgrounds, especially families and next of kin of residents, and the need for interpreters
- modes of communication, including telephone, email, teleconference and videoconference
- how technology can be used to facilitate communication between residents, their loved ones and services while the facility is locked down and/or residents are isolating (devices, wifi and telehealth).

Health Consumers Queensland has produced and hosts a number of resources on communicating with residents and their families on its website here. A checklist developed by Health Consumers Queensland, Council on the Ageing Queensland, Queenslanders with Disability Network, ADA Australia, Palliative Care Queensland and Carers Queensland is also included at the end of this document.

Testing

Queensland Government COVID-19 testing strategies are outlined in the document COVID-19 Testing framework implementation plan: Testing Strategies for Residential Aged Care which should be consulted by facilities as part of planning and preparedness activities.

A range of Pathology Services provide laboratory testing services in Queensland. The Commonwealth Government has engaged Sonic Healthcare (Sonic), within Queensland, Sullivan Nicolaides Pathology, to provide a dedicated pathology service for rapid sample collection and testing for suspected cases of COVID-19 in residential aged care facilities.

This service has been made available in addition to existing public health pathology services to ensure the testing of residents and staff of residential aged care facilities is supported during the pandemic. It recognises the unique challenges in providing COVID-19 testing for these individuals and their heightened vulnerability.

Under the service, Sonic will:

- establish and maintain a dedicated national toll-free number (1800 570 573) operating from 8am to 6pm local time in each state and territory to receive and prioritise requests for COVID-19 testing of residents and/or staff of a residential aged care facility from a referring doctor
- arrange for a specialised COVID-19 pathology collector to attend a facility as soon as possible (between 8am and 8pm in each state and territory) and return the sample to the laboratory for immediate testing
- provide results by phone to the referring doctor and registered nurse attached to the facility within a 24 hour turnaround time for metropolitan areas or 48 hour turnaround time for regional areas, measured from receipt of the request
- at the referring clinician's request, if a result is positive, send a specialised COVID-19 collection team to collect samples from all staff and residents.

If, due to remoteness, Sonic is unable to provide collection services, pre-prepared COVID-19 collection kits will be sent to a residential aged care facility. A training video and support will be provided to staff to support the collection of samples.

In all cases the service must be requested by a referring doctor. All testing provided under this service will be bulk billed under Medicare.

Sullivan Nicolaides Pathology (SNP) has a turn-around time key performance indicator (KPI) of 24 hours for Residential Aged Care Facilities in metropolitan areas, and 48 hours for rural and remote locations from time of request of receipt. If a remote location is not within a reasonable reach of an SNP service, arrangements to test via Pathology Queensland will be made.

Further detail in relation to testing can be found in the document COVID-19 Testing framework implementation plan – Testing Strategies for Residential Aged Care.

Hospital transfer for COVID-19 positive residents

Facilities operating in Queensland should be aware that transfer of residents who are confirmed COVID-19 cases to hospital for treatment is the overarching principle in Queensland. The Queensland Health document COVID-19 Outbreak Management – Guidance for Transfer of residents of aged care facilities in the event of a COVID-19 outbreak provides guidance on how this will be implemented. This should be considered when preparing for and responding to outbreaks.

This approach will not necessarily be reflected in guidance documents from other jurisdictions.

Decisions about hospital transfer will still need to be considered on a case by case basis by clinicians in consultation with affected residents. There may be some situations, such as circumstances where a resident is receiving end-of-life care, where hospital transfer will not be the most appropriate approach.

While facilities should incorporate the Queensland position on hospital transfer into planning, outbreak management plans should also include contingency planning for the treatment of COVID-19 cases in place, to cover circumstances where hospital transfer is not possible or appropriate.

Isolation/cohorting of residents

In the event of an outbreak, infection control will require the isolation and cohorting of residents and staff. The document Infection Control Expert Group – COVID-19 Infection Prevention and Control for Residential Care Facilities provides guidance on infection and prevention control in this context and should be consulted in the development of the outbreak management plan.

Residents with suspected or confirmed COVID-19 should be isolated and cared for in single rooms with a private bathroom/ensuite immediately.

As discussed above, transfer of confirmed COVID-19 cases to hospital for treatment is a first preference in Queensland, and should be considered as part of the response, with decisions made on a case by case basis.

Any resident who remains well but has been in contact with a confirmed or probable case, in the period extending 48 hours before symptoms began in the confirmed or probable case, should be quarantined in a single room.

If a probable case returns a negative test result, contacts can be released from quarantine.

If the probable case is confirmed, contacts should be quarantined for 14 days.

The ease with which facilities can achieve this will vary greatly depending on the layout of the facility, as well as the particular circumstances of the outbreak (e.g. number of confirmed cases/close contacts).

Accordingly, it is imperative that facilities develop plans for achieving isolation and cohorting under a number of scenarios, and consult with key partners, including the local Public Health Unit, in relation to plans.

Signage, hygiene stations and PPE donning and doffing stations will need to be planned for and implemented to support cohorting.

Resident isolation or cohorting measures will need to be accompanied by staff cohorting to further reduce the risk of transmission.

In relation to staff arrangements, facilities will need to ensure that:

- there are sufficient registered nurses at the facility to facilitate staff cohorting – also consider cohorting of support and services staff to minimise risk of business continuity failure
- a register of staff members caring for patients with COVID-19 is maintained
- staff do not move between their allocated room/ section and other areas of the facility, or care for other residents
- staff continue to monitor themselves for signs and symptoms of COVID-19 and do not attend work if unwell (even if symptoms are very mild)
- staff do not work in other facilities or workplaces, until the outbreak is declared over.

Supporting residents with dementia and high care needs

Consideration will need to be given to how the needs of residents with dementia who wander, and residents with challenging behaviours will be met, including in circumstances where such residents are confirmed cases. Pre-emptive implementation of change prior to an outbreak may improve ability to reduce behavioural escalation at a time of crisis.

Dementia Support Australia's help sheet Understanding and managing behaviours in a time of pandemic is a resource that may assist facilities supporting patients with dementia.

Identification of residents

One of the lessons learned from COVID-19 outbreaks experienced in Australia is that the implementation of processes to support identification of residents becomes critical during outbreak response in circumstances of regular staff stand downs and resident movements. This is particularly crucial for the management of residents with dementia. Accordingly, Aged Care Directions require facility operators to take reasonable steps to develop and document appropriate processes to ensure residents and their unique needs can be immediately identified in a COVID-19 event.

As part of outbreak preparedness activities, Residential Aged Care Facilities should ensure they have supplies of resident identification armbands that can be applied at the start of the response process. Identification bands should be linked to accessible resident information packs that allow staff unfamiliar with a resident to quickly understand crucial information needed to care for the resident, as well as other items that may need to travel with the resident if they are moved (Advance Care Directives, medication chart, known allergies, a 24 hour supply of continence products (if required) and any special care advice). Considerations to ensure accurate resident identification further include:

1. Arm-bands utilised are consistent with relevant patient identification standards and identify risk e.g. allergies
2. Photos that accompany resident records are recent and updated on a regular basis
3. Establishment and regular drilling of staff in a process to facilitate rapid printing and matching of arm-bands and identification photos to residents
4. Establishment of processes to allow resident identification in the setting of Information Technology system down-times.

Aerosol Generating Procedures

In the event of an outbreak it may be necessary to prevent or limit the use of aerosol generating procedures due to their capacity to facilitate airborne transmission of COVID-19.

As part of outbreak preparedness activities, facilities should arrange for GP review of all residents who are currently prescribed nebulisers (regular or as required) to evaluate change of these to metered aerosols with spacers where clinically appropriate.

Where aerosol generating procedures cannot be avoided, such as undertaking regular suctioning of a resident's pre-existing tracheostomy, infection prevention and control and PPE requirements should be planned for, implemented and strictly followed.

Advance Care Planning

As part of preparedness activities, facilities should communicate with each resident and their care partner/ families to determine if they have an up-to-date advance care plan or would like to complete one.

Queensland Health provides a number of resources in relation to Advance Care Planning here.

Residents and facilities can provide Statements of Choice, Advance Health Directives, Enduring Powers of Attorney, QCAT orders and revocation documents to the Office of Advance Care Planning (acp@health.qld.gov.au Fax: 1300 008 227) to make these accessible to Queensland Health Clinicians, Queensland Ambulance Service, authorised Registered Nursing staff and authorised GPs.

AHPRA registered nursing staff working in non-Queensland Health Residential Aged Care Facilities can register for secure online access to their residents' Queensland Health records, including Advance Care Planning records, through an online Health Provider Portal. Staff who register to access the Health Provider Portal are able to view residents' uploaded Advance Care Planning documents and related comments.

Links for Residential Aged Care Facility nursing staff wanting to register for and access the Health Provider Portal are set out below:

- Preparing to register
- Creating an HPP account
- Signing into HPP
- Searching for your patient
- Viewing patient healthcare information
- Support using the HPP
- Enquiries to connectingqld@health.qld.gov.au

Palliative Care Management

It is possible that in the course of the outbreak, some residents may require end-of-life care.

Planning should be undertaken to ensure the outbreak response accounts for and is able to provide appropriate care and support to any residents requiring end-of-life care and associated support of their families and loved ones.

There may be circumstances when the Aged Care Directions allow end-of-life visits to take place when all other visiting is restricted. Facilities should ensure they keep up to date with the position on end-of-life visits in the Aged Care Directions, and should establish processes to facilitate such visits in circumstances where they are allowed.

Facilities will need to ensure that they have adequately stocked imprests or arrangements to facilitate timely provision of medication to ensure emergent end-of-life symptom management.

The RACGP palliative and end-of-life care clinical guide as well as HealthPathways provide guidance to GPs on providing palliative care to older people in community and Residential Aged Care Facility contexts. Residential Aged Care Facilities will need to register to access HealthPathways and should do so in advance. PallConsult is a 24/7 statewide QH specialist palliative care clinical advice line available to prescribers, registered nurses and allied health staff in any setting including Residential Aged Care Facilities needing ready access to specialist palliative care clinical advice.

Residential Aged Care Facilities are also encouraged to connect with their local or closest specialist palliative care HUB Services to ensure ready access to support.

A range of resources in relation to palliative care, bereavement and self-care for staff are available online including:

- Queensland Health bereavement resources
- Australian Centre for Grief and Bereavement COVID-19 resources
- End of Life Directions for Aged Care COVID-19 tools
- National COVID-19 Clinical Evidence Taskforce flowchart on management of people with COVID-19 who are receiving palliative care
- Palliative Care Australia's self care matters kit for staff

Responding – confirmed case/outbreak – first 24 hours

The Commonwealth has developed a resource – First 24 Hours – Managing COVID-19 in a Residential Aged Care Facility – that provides detailed guidance on steps that Residential Aged Care Facilities should undertake following confirmation of a positive case.

It is recommended that facilities review the Commonwealth resource in full when preparing their outbreak response. To provide an indicative overview of the actions that need to be undertaken in an outbreak, a condensed summary of the key elements of the Commonwealth document is provided below.

First 30 minutes

1. Isolate and inform the COVID-19 positive case(s)

If the COVID-19 positive person is a staff member they must immediately:

- notify their employer/s, leave the premises and isolate as directed by the Public Health Unit either at home or in a clinically appropriate environment.

If the COVID-19 positive case is a resident they:

- should be immediately isolated in a single room with a private ensuite, if possible
- may be transferred to hospital or other accommodation.

Use droplet and contact precautions for any interactions with positive cases.

Place all of the following outside the affected resident's room:

1. Contact and droplet precaution signs
2. Alcohol-based hand rub
3. Appropriate PPE and hands-free bins for used PPE.

Sensitively inform the resident and their family of their diagnosis. A senior clinician should perform this task.

2. Contact your local Public Health Unit

Immediately notify the local Public Health Unit.
It will coordinate the public health response to the outbreak.

3. Contact the Commonwealth Department of Health

Immediately notify the Commonwealth Department of Health at agedcareCOVIDcases@health.gov.au of any cases of COVID-19 among residents and staff.

The Commonwealth will appoint a case manager who is the Commonwealth's single point of contact for the residential aged care facility.

The case manager will connect you with resources to manage the outbreak (PPE, surge workforce, supplementary testing, and access to primary and allied health care).

4. Lockdown the residential aged care facility

Review the visitor log to determine who is on site. Evacuate non-essential people from the residential aged care facility. Ask all residents to remain in their rooms and sensitively inform residents of the reason for the lockdown.

Reinforce standard precautions including hand hygiene, cough etiquette and staying 1.5m away from other people throughout the facility.

Minutes 30-60

5. Convene your outbreak management team (OMT)

Bring together the outbreak management team to direct, monitor and oversee the outbreak. They will provide key decision making and crisis management during the outbreak. Nominate an outbreak co-ordinator and designate and agree key roles and responsibilities. Key participants who must, at a minimum, participate in meetings in the first 24 hours include:

- CEO, facility manager or other facility/provider representative who can report on operational issues and has authority to implement directions of the OMT (Chair)
- Queensland Health Public Health Unit Lead (co-Chair where possible)
- Commonwealth Case Manager
- Infection Prevention and Control Practitioner
- Communications Officer from facility

Additional representatives should be invited as required e.g.

- Public Health Unit Contact Tracer
- Public Health Unit epidemiologist
- Aged Care Quality and Safety Commission Case Officer
- Clinical Oversight Manager
- Infectious Disease physician

The Commonwealth Case Manager is to be notified of OMT meeting occurrences and invited to participate in daily meetings, or as needed to respond to the outbreak.

6. Activate your outbreak management plan

Activate your outbreak management plan. Review to determine if there are any gaps in the plan that need to be addressed. Distribute the plan to all involved stakeholders so they are across the plan.

7. Establish screening protocols

Review screening protocols for people entering the residential aged care facility and determine whether changes are required as part of outbreak management.

8. Release an initial communication

Inform residents, staff, families and key stakeholders of a COVID-19 diagnosis within the residential aged care facility. Providers with multiple services should consider communications for other sites.

Hours 2-3

9. Contact tracing

The local Public Health Unit will lead contact tracing. They will identify anyone who has spent 15 minutes or more, within 1.5 metres of the COVID-19 positive person. The Public Health Unit will likely send some staff home to quarantine and you will need to make arrangements to bring additional staff on site who are not subject to quarantine or isolation requirements.

10. Identify key documents

Both the Public Health Unit and the state branch of the Commonwealth will need:

1. A detailed floor plan.
2. An up-to-date list of residents, including residents who are currently off-site. It should identify residents with COVID-like symptoms, onset date, testing status, their location in the facility, and staff contacts.
3. A list of all staff employed by the facility.
    - Include their names, contact details, dates of birth and Medicare numbers.
    - Include people providing primary care or allied health services.
    - Include contracted providers (clinical and non-clinical (e.g. cleaners, food service providers (etc)
    - Note if staff work across multiple aged care services (including other residential facilities, home care, etc).
4. A list of the respiratory specimens collected and the results of tests.

11. PPE stocktake

Carry out an analysis of current PPE and hand sanitiser stock levels. Estimate what you will require over the coming fortnight.

You may be able to access state stocks until the supplies arrive from the Commonwealth.

12. Communication

Expect and prepare to manage a very high volume of calls from families and the media. Incoming calls within the first 24 hours alone could be 1,000-2,000.

Appoint appropriately trained staff to manage communications and take the calls.

Establish a single point of contact for media queries.

Hours 4-6

13. First meeting of the Outbreak Management Team

The outbreak management team should meet within 4-6 hours of identifying a case. It should continue to meet daily to direct and oversee the management of the outbreak.

14. Bolster your staff and plan your roster

The residential aged care facility will need more staff and a higher proportion of RN staff than usual, as well as additional cleaning and personal care workers, and primary health providers. Keep in mind up to 80-100% of the workforce may need to isolate in a major outbreak. Where the provider is unable to sufficiently staff the facility, the Commonwealth case manager can assist.

15. Conduct testing

Urgently test all residents and staff for COVID-19 to understand the status of the outbreak. In conjunction with the Public Health Unit, establish a staff and resident testing regime.

16. Clinical management of COVID-positive cases and consider hospital transfer

Clinically manage COVID-19 positive cases to address all their needs. Queensland Health supports the transfer of positive cases to hospital for treatment as a first preference. Explore transfer to hospital in consultation with the resident.

Hours 6-12

17. Cohorting and relocation

Determine in collaboration with public health what cohorting arrangements to implement at the facility to manage infection control.

Move to a model where staff work with fewer designated residents.

18. Move to a command-based governance structure

Establish and document a governance structure collaboratively agreed upon by response parties. Clearly communicate the command and governance structure for every shift. All staff must be aware of who will be in charge, at all points in time, at the facility.

Clearly spell out for every shift:

- everyone's roles and responsibilities, and
- what the clinical and business continuity escalation processes are.

Ensure thorough briefing and orientation of new staff each shift, including education on PPE usage and use of PPE spotters.

Ensure handovers for all staff at the start of a new shift including clinical and care needs.

Consider how technology can be used to facilitate handover, to reduce cross-exposure of staff and to allow participation of quarantining staff where appropriate.

19. Rapid PPE supply

The Commonwealth will help facilitate rapid delivery of PPE if required. Note that PPE will require a designated storage area and identified staff to facilitate unloading/unpacking.

20. Infection control

Review the systems and processes of the residential aged care facility to minimise risk of material, surfaces or equipment moving between areas.

This would include, where possible:

- replacing all servery items such as trays, cutlery and crockery with disposable items
- ensuring there is sufficient medical equipment like thermometers for each separate zone of the residential aged care facility, and
- reviewing laundry arrangements.

Staff should refresh their infection control training. Commence enhanced environmental cleaning twice daily at a minimum.

Clean well residents' rooms daily. Clean frequently touched surfaces (including bedrails, bedside tables, light switches, handrails) more often.

The rooms of ill residents should be cleaned and disinfected.

Hours 12-24

21. Clinical First Responder from Aspen to commence

The Commonwealth will arrange an Aspen Clinical First Responder on day 1 or 2 to assist:

- reviewing preparedness for managing the outbreak,
- analysing workforce capacity,
- reviewing infection control processes,
- assessing PPE stocks and competencies,
- recommending enhanced cleaning protocols, and
- assisting with any significant capability gaps.

22. Review advance care plans and directives

Note any advance care directives for residents on the list of residents. Update where necessary and use the list to inform any clinical decisions about residents who develop COVID-19 in partnership with the responsible medical lead and the resident and, where indicated, their appointed substitute health decision maker.

23. Establish strong induction and control processes

Determine who will be the on-the-ground infection control lead. Identify this role on the roster for each shift.

The responsible person must ensure:

- robust induction for all new agency and surge workforce staff coming onsite, and
- that all staff working are competent using PPE.

Consider having workforce competency reviews for all staff.

24. Maintaining social contact

Consider how you will enable staff to assist with Facetime/Whatsapp etc. where these are available to residents. Ideally ensure that there is a dedicated communication device for each resident. Where this is not feasible, ensure that there are robust infection control processes implemented to minimise risk of shared devices.

25. Follow up communications

Establish a clear and consistent pattern of daily follow-up outbound communications. This will ensure residents, families and stakeholders are informed of developments as they unfold.

26. Continue primary health care

In collaboration with facility's primary care providers, ensure there is strong ongoing governance of "routine" primary care, nursing and personal care. Understand residents will be anxious and need reassurance.
Consider governance structure to maintain and monitor normal activities as far as possible – this includes nutrition, physical activity and preventing boredom, loneliness and unhappiness. Additional psychological care may be required.

27. Support your staff

Implement fatigue management plans for staff. Ensure Employee Assistance Program (EAP) information is readily available.

Establish pathways to maintain contact with staff who are isolating or quarantining.

28. Continue to monitor state and federal guidelines and directions

Ongoing outbreak management

Monitor Progress of the Outbreak

Increased and active observation of all residents for the signs and symptoms of COVID-19 is essential in outbreak management. This will enable:

- daily identification of any ongoing transmission and potential gaps in infection control measures
- implementation of additional or stronger infection control measures to reduce transmission and the duration of the outbreak.

Testing (including repeat testing) and ongoing actions for individuals in the defined setting should be undertaken in line with the CDNA COVID-19 National Guidelines for Public Health Units and in collaboration with local public health units.

This includes:

- isolating individuals who test positive in an environment best suited to meet the resident's care need and in keeping with their goals of care, with appropriate clinical monitoring and appropriate escalation of clinical concerns
- quarantining individuals who test negative
- repeat testing for those in quarantine.

Information should be updated daily in the Outbreak Management Team meeting.

End of an outbreak

In most circumstances, a COVID-19 outbreak can be declared over if no new cases occur within 14 days following the date of isolation of the last case.

The Public Health Unit will formally declare the outbreak over and inform the Residential Aged Care Facility of this decision.

Appendix 1 – Communication and Engagement Checklist

Communication and Engagement Checklist: Residential Care Facilities (Aged care, disability and community support)

Developed by COTA QLD, Health Consumers Queensland, QDN, ADA Australia, Palliative Care Queensland and Carers Queensland

This is a living document and may be refined over time as the situation changes. The scale and pace of a global pandemic is new to us all and we make continuous improvements to our work.

This document outlines steps to be taken by facilities including residential aged care facilities and those that have shared or communal living arrangements in the event of COVID-19 outbreaks in the facility or local area.

This could include:

- Short term stay
- Long term stay
- Residential Aged Care Facilities
- Residential facilities for people living with a disability
- Retirement villages
- Independent living
- Rehabilitation, including for mental health, alcohol and other drugs

Context

This document is to provide extra depth on communication for residents and their family/care partners/guardians/advocates and is to be read in conjunction with Queensland Health's Pandemic checklist for aged care facilities.

Although most facilities have plans for and faced outbreaks of infections such as influenza in the past, none have faced the prospect of a global pandemic. The scale and pace are different to anything people have experienced before, and requires a flexible and open approach so we all learn together.

The checklists are divided into three key sections:

- Communication actions to take for pandemic preparations
- Communication actions to take when there is a suspected outbreak
- Communication actions to take when there is a confirmed outbreak.

Communication actions to take for pandemic preparations

Response	Action	
Communicate	Review the facility's communication plan with Queensland Health (where relevant) and other stakeholders. The following factors should be considered: a. Specific staff are dedicated to managing communications. b. Where direct communication is required, e.g. door knocking to inform residents directly of the outbreak and maintain ongoing communication, ensure adequate human resources are available to do this and appropriate PPE is worn. c. Use your Rapid Response Team as a guide on which residents may be more open to communication from a specific support person (e.g. case manager, social worker, preferred member of staff, guardians). d. Identify communication channels (email, calls, webinars, website, and social media) in addition to those identified in the outbreak management plan. e. Develop email templates and talking points on the initial announcement of the outbreak and what can be expected during the outbreak. f. Ensure you have a clear strategy for providing regular information to staff, volunteers, residents and their family or caregivers, including: • Advice for staff on how infection risks are managed and the support available for staff • How families will be updated on the status and welfare of residents • What options are available for families to connect with residents • What options are available for residents to connect with fellow residents g. Assign a family liaison officer who will be available to support family members of residents and provide them with regular updates. h. Ensure that your organisation's protocols are in place for managing media enquiries.	☐
Identify stakeholders	1. Brief and involve in key decision-making the following key organisations: COTA QLD, Aged and Disability Advocates Australia (ADA), Carers Queensland, Palliative Care Queensland and Health Consumers Queensland. These organisations are here to support you, and can provide advice.	☐
	2. Create a stakeholder list of the broader residential care facilities in your local area/ key organisations across the state.	☐
	3. Create a stakeholder list for key updates including: • COTA • ADA Australia (OPAN) • Carers Queensland • QDN (Queenslanders with a Disability Network) • Dementia Australia • Ethnic Communities Council Queensland (FECA) • National Seniors • Aged & Community Services Australia • Aged Care Guild • Anglicare Australia	☐

	• Baptist Care Australia • Catholic Health Australia • Leading Age Services Australia • Uniting Care Australia • Dementia Australia • Palliative Care Queensland	
	4. Notify all staff (including those on leave, casual, contractors etc.) around the communication process that you'll be undertaking including who will be responsible for communication.	☐
Communication plan	5. Determine who is responsible for the implementation of your communication plan. 6. Develop and regularly review key messages (about 5) for all stakeholders. 7. Revise the principles that will underpin your communication: e.g. open, timely, honest, caring.	☐
Communicate with residents	8. Transparent and honest, timely and consistent communication.	☐
	9. Be aware of communication needs e.g. if they will need a translator, disability communication requirements.	☐
	10. Conduct a communication devices audit to identify residents with no means of communication.	☐
Communicate with families/care partner/guardian/advocate	11. Identify the person/people you need to communicate with about each resident.	☐
	12. Understand their communication needs e.g. translator required, culturally appropriate communication.	☐

Suspected outbreak:

Identification of triggers for this should be aligned with your overall COVID-19 management plans

Communicate with residents	13. Transparent and honest, timely and consistent communication.	☐
	14. Develop FAQs to be used with phone scripts, email templates, daily newsletters etc. This will be frequently updated: - likelihood of infection - steps taken now to reduce spread of infection - what is happening now to keep residents safe - how residents will be kept informed and frequency of communications - if you have a question(s) who/when to ask - how their families/carers will be kept informed and frequency of communications - Queensland Health CHO visitation directions and visitor advice - the use of PPE e.g. masks only at this point and why, - how to communicate in lockdown, how to stay involved with their family - residents may also be concerned for the safety of staff and other residents. Consider responding to these concerns as well including how you communicate about resident's changes (transfers, death) and operational changes for staff.	☐

	15. Use teach-back method to check what the resident has understood.	☐
	16. Communication is two-way – answer the questions the resident has and let them know if they think of any further questions, how to ask them. If you don't know the answer, it's better to say and check the information, then to give wrong or inconsistent information. Ask residents if they are getting too much/too little information.	☐

Confirmed outbreak:

Identification of triggers for this should be aligned with your overall COVID-19 management plans.

Provide high quality care *The Rapid Response Team and the provider should discuss early in the outbreak the ongoing management options of COVID-19 positive residents*	1. Work with the health providers to clarify the general clinical care arrangements, including arrangements with existing in-reach health care providers and alternative models of care, if required.	☐
	2. Whether the resident has a pre-existing advance care plan, COVID-19 isolation plan or has complex chronic health care needs.	☐
	3. Consideration of individual client needs and access to services including: • Mental health • Disability requirements and current providers • Providing information about COVID-19 to the person in a way that is accessible, and the person can understand • Pre-existing health conditions	☐
	4. Whether the resident or residential facility has access to additional (non-QLD Health) financial, clinical or other support in the event of an outbreak. For example: • Material support that can be provided by other branches of an organisation • Psychological or medical support from existing service providers or • Support that can be offered by other similar services e.g. aged care, disability care, etc.	☐
	5. Ensure continuing access to all medications that the resident may require.	☐
	6. Where NDIS recipients reside in the facility; the person's Supports Coordinator or NDIS Local Area Coordinator to plan and coordinate with service providers.	☐
	7. Ensure the facility stays updated if and when NDIS service providers can provide their usual service within a facility, and if not what is in place to support the resident.	☐
Communicate with residents and/or families (where appropriate)	8. Follow all of the advice for residents for communicating with their families/care partner/guardian/advocate especially the need for a translator, using teach-back method to check the person has understood and had an opportunity to ask questions.	☐
	9. If a resident's Advanced Care Plan is to request hospital care, and if this is still possible, discuss this option and ensure that the wishes of the resident/family are central to decision-making.	☐
	10. Discuss care options if the resident tests positive to COVID 19 with the resident/family.	☐

	11. Discuss with residents/ families who may usually provide daily care or have an NDIS plan, what the plans are moving forward.	☐
	12. Discuss with residents/ families how arrangements can be made for those who want to bring their loved ones home during this period. Full transparency of what implications this may have on family (i.e. continuing to pay the RACF fees + new home care fees + sometimes they will need GP changes if they are in a different area, & that's not an easy task as the best of times.) a. The family will need to carefully consider how they will provide care for their family member (e.g. do this themselves, get some extra support in from family or other community providers, continue to pay for their relative's care home).	☐
	13. Ensure that residents with dementia or cognitive impairment understand as much as they can. If appropriate for the resident's cognitive and emotional state, include them in communications and planning.	☐
Resident to resident	14. Residents will want to remain connected with their friends and fellow residents. Consider how you will support communication between residents. Often it's the catering staff or cleaners or diversional therapists who share hellos between the rooms	☐
Other stakeholders	15. Continue to communicate and respond to other stakeholders' questions and concerns.	☐
Your organisation's crisis management plan	16. Ensure your communications are aligned with your organisation's crisis management plan. If your facility is not supported with communication expertise consider as a priority, engaging a communication specialist who can be on-call to provide advice, especially crisis communication	☐

After the outbreak

Outbreak declared over	17. Queensland Health declares the outbreak over.	☐
	18. Review and evaluate the outbreak communication management.	☐
	19. Continue your communication with residents beyond the outbreak being declared over until their questions and need for information stops.	☐

Key contacts for each organisation:

Organisation	Key contact	Contact
Health Consumers Queensland	Melissa Fox, CEO	0404 882 716
COTA Queensland	Mark Tucker-Evans	07 3316 2999
QDN	Paige Armstrong, CEO	07 3252 8566
Palliative Care Queensland	Shyla Mills	07 38423242
Carers Queensland	Debra Cottrell, CEO	07 3900 8100
ADA Australia	Geoff Rowe, CEO	1800 700 600

Appendix 2 – Rapid Response Overview

Rapid Response – COVID-19 in a Residential Aged Care Facility (RACF)

Background

The Rapid Response – COVID-19 in a Residential Aged Care Facility (RACF Rapid Response) was developed by a joint state/ Commonwealth working group with expertise in disaster planning and management, public health and aged care.

The RACF Rapid Response forms an appendix to the Queensland Whole of Government Operational Rapid Response Plan.

Aims

To ensure Queensland Government mobilises quickly and effectively and engages all relevant partners in its response to COVID-19 in an aged care facility.

The RACF Rapid Response will be enacted in the early stages of a COVID-19 incident to support local level outbreak management responses and other existing plans.

This document provides an overview of the RACF Rapid Response. It is primarily aimed at external (non-Queensland Government) Stakeholders.

Queensland Government stakeholders should contact strategicpolicy@health.qld.gov.au for further information.

Phase 0 Monitor/Activate

Monitoring and Preparation

- PHUs monitor, plan and prepare
- RACF and treating clinicians will monitor residents and test as required.
- Vigilance - staff and visitors exhibiting symptoms tested and excluded
- Ensure adequate supply of PPE
- Refer to and implement advice from QH, C-DoH and ACQSC e.g.

1. QH: https://clinicalexcellence.qld.gov.au/sites/default/files/docs/improvement/racf-covid-19-preparation-checklist.pdf
2. C-DoH: https://www.health.gov.au/resources/collections/coronavirus-covid-19-resources-for-health-professionals-including-aged-care-providers-pathology-providers-and-health-care-managers#aged-care-services
3. ACQSC: https://www.agedcarequality.gov.au/covid-19-coronavirus-information

Phase 1 Response

Suspected Case(s)

Notifications
- Testing GP/Clinician/RACF notifies PHU of suspected case(s)

Infection Control
- Resident: the individual is isolated. Infection control measures implemented
- Staff member: Excluded from the facility until test results known
- PHU: undertakes initial assessment. Advice and support to RACF as needed.

Communication
- Communications as required

Confirmed Case

Notifications
- Local pathology service notifies the COVID Incident Management Team (COVID IMT)/PHIC, PHU and testing GP of the positive test.
- PHU Advises Relevant Parties:
  CHO C-DoH Director-General, QH RACF Chief Executive HHS PHIC DDMG QAS

Infection control
- RACF implements infection control measures, establishes OMT
- Queensland Health Rapid Response Team deployed. Site visit by Rapid Response team, HHS and PHU.
- Commonwealth Case Manager helps RACF access workforce, PPE, business continuity (financial), and other support.
- PHU undertakes assessment and implements/supports RACF to implement, infection control measures

Continuity of care
- Local Incident Management Team / Incident Lead appointed. Clinical management (and governance) locally determined between HHS and treating GPs
- Where relevant, HHS' Aboriginal/Torres Strait Islander Health Director consulted

Communication
- RACF to notify staff, families and GPs.
- HHS/Queensland Health initiate external communications processes

Phase 2 Road to Recovery

Transitioning

- Consultation with local PHU. Decision that outbreak can be declared over
- Ongoing vigilance for further cases required from last identified case
- The RACF and C-DoH will plan for this phase, but implementation will be undertaken as per existing recovery arrangements

Whole of Government Response Stakeholders (Glossary)

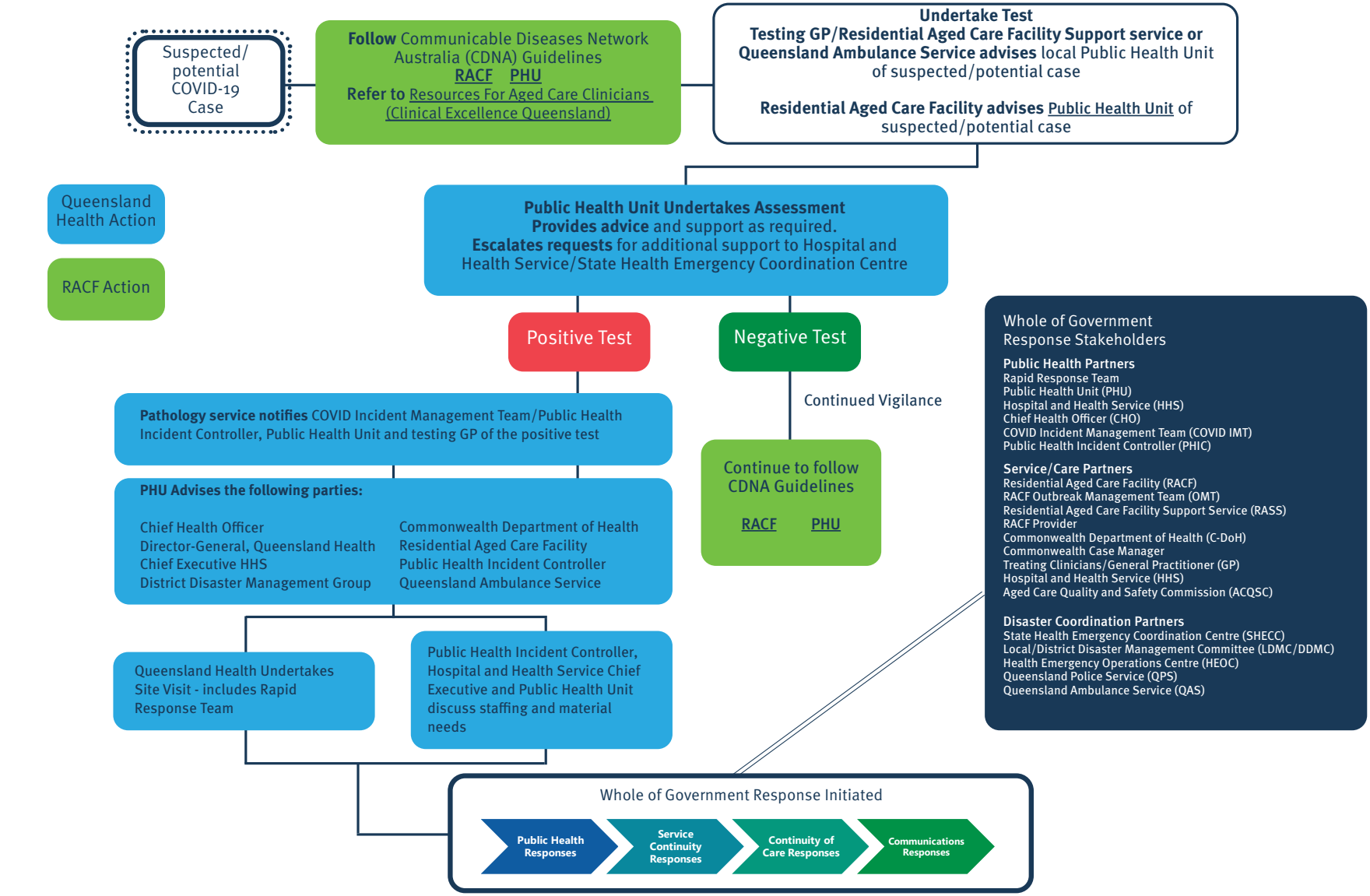
Public Health Partners
Rapid Response Team
Public Health Unit (PHU)
Hospital and Health Service (HHS)
Chief Health Officer (CHO)
COVID Incident Management Team (COVID IMT)
Public Health Incident Controller (PHIC)

Service/Care Partners
Residential Aged Care Facility (RACF)
RACF Outbreak Management Team (OMT)
Residential Aged Care Facility Support Service (RASS)
RACF Provider
Commonwealth Department of Health (C-DoH)
Commonwealth Case Manager
Treating Clinicians/General Practitioner (GP)
Hospital and Health Service (HHS)
Aged Care Quality and Safety Commission (ACQSC)

Disaster Coordination Partners
State Health Emergency Coordination Centre (SHECC)
Local/District Disaster Management Committee (LDMC/DDMC)
Health Emergency Operations Centre (HEOC)
Queensland Police Service (QPS)
Queensland Ambulance Service (QAS)

Supports implementation of and augments other stakeholders' specialist/local plans and actions e.g. RACF Outbreak Management Plan, Workforce Plan, Business Continuity Plan etc.

Rapid Response – COVID-19 in a Residential Aged Care Facility (RACF) – Trigger Process



Rapid Response – COVID-19 in a Residential Aged Care Facility (RACF) – Trigger Process

Roles and Responsibilities in the Event of a Confirmed Case

Queensland Health

Support clinical governance in RACF.

Determine clinical lead and outreach model (e.g. HITH) with specialist clinician support (e.g. geriatrics, infectious diseases,RaSS palliative care).

Support staff/GPs to deliver patient-centred care and review/develop advance care plans.

Liaise regularly and provide information and support to GPs.

Determine appropriate care, including care in RACF and/or transfer to hospital or other facility based on public health requirements, clinical advice and the resident's wishes.

Assess and consider provision of support for the RACF including: infection prevention and control, PPE, workforce, communications.

Liaise with other government agencies and disaster management bodies to ensure infection control, continuity of care, service continuity and communications.

Queensland Health - Public Health Unit

Lead public Health response and support the RACF.

Notify and liaise with relevant parties.

Active surveillance, investigation and management of cases in staff and residents.

Contact tracing and management.

Ensure public health and infection control measures are implemented to contain the outbreak.

Commonwealth Department of Health

Provide subsidy funding for aged care services and support the RACF's capacity to manage the outbreak.

Support viability and capacity of service.

Allocate state-based 24/7 case manager.

Facilitate access to primary care for residents.

Facilitate access to resources, including surge workforce and PPE.

Support relocation/ decanting of cohorts based on clinical advice and in partnership with Queensland Health.

Provide rapid response COVID-19 in-reach pathology testing services, if required.

Aged Care Facility/Provider

Lead and manage the response to the outbreak in the RACF as required by legislation, including the Aged Care Act 1997, the CDNA Guidelines and relevant legislation.

Regularly communicate with residents and representatives.

Implement public health and clinical directions and advice.

Activate outbreak management plan.

Notify and liaise with PHU and the Commonwealth DoH.

Establish an Outbreak Management Team. Contingency planning in the event of significant staff loss and surge staff planning.

Work with Queensland Health and the Commonwealth to ensure the highest standards of infection control, clinical care and wellbeing.

Aged Care Quality and Safety Commission

Lead public Health response and support the RACF.

Notify and liaise with relevant parties Active surveillance, investigation and management of cases in staff and residents.

Contact tracing and management.

Ensure public health and infection control measures are implemented to contain the outbreak.