LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

HEALTH UPDATE

COVID-19 Lessons Learned for Age Services Providers.

The COVID-19 pandemic is an evolving 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, social 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

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" (ie 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.

Planning and preparation

COVID response plans should include a trigger for escalation to the next level from the basic readiness activities, on which information on lessons learnt 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.

- **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.
- **Infection Hot Spots:** 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

Included below are trigger factors which providers may need to reflect in their plans and the lessons from providers who have experienced an escalation of activities or an outbreak.

1. Pandemic Alert: Basic readiness 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 (eg 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; should a back up plan need to be implemented identify the key handover information that would be required
- 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
- The plan needs to be understood and agreed with all other stakeholders (inc. PHUs, hospitals, State/Territory health departments, emergency services, staff unions, NDIS providers, retirement living operators etc);
- The plan needs to be stress tested to deal with initial infection and widespread outbreak scenarios (testing to take account of PPE access, staff furloughs (care staff, cleaners, cooks, etc), surge workforce, communication team on-site, hospital transfers, 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
- 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, OH&S authorities will play to ensure a coordinated response to a COVID outbreak
- If practical, ensure your crisis management plan includes identifying vulnerable clients and those with no informal supports, who have essential service requirements and details of their care and service schedules are readily accessible for handover
- 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 spotters
- 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.
- 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? – eg. over a chair, bed, table, etc – Ensure staff are aware
- Establish clear processes for hazardous waste collection and coordination, including discussion with local suppliers
- Staff should practice using, donning and doffing PPE prior to any outbreak
- 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
- Set the basic standard of care – what is acceptable in survival mode when resources are limited?
  - 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
- Symptom screening of staff, residents and visitors established and documentation to support
- 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)
- 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

- In the workforce plan included 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 etc should a surge workforce be required to assume services
- Multiple site working arrangements understood and minimised where possible
- Cohorting within service where possible which 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
- 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
- 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
- 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
- Arrangements for the transfer to hospital for early cases are documented
- 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
- 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
- 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
- Discuss and agree what off site working could be undertaken by staff who are required to isolate and are well. Eg 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)
- 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:
  - So there are shared expectations and understanding – START prior to an event
  - How will information be shared and at what frequency
  - Who will do what – which staff could be the link to families? ie know the residents
  - 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
  - Consider equipping the team with smart phones or iPads to use for communication with families, and provide them with training on usage
  - Set up virtual conference facilities such as MS teams, Skype or Zoom, to communicate with families
  - Share plans with residents
  - 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)
  - Share plans with staff - Staff details up to date – addresses, phone, emails
  - Create posters for donning and docking 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 directions and arrangements for certification
  - 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 - eg if hospital in the home is introduced

2. Infection Hot Spots: 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 reading 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 & 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? What contact?
  - 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
  - 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 being brought into a facility.
- If staff are in isolation, have them on hand to advise new workers by phone, join resident and family discussions via iPad video link, etc
- Stand up cleaning activities
- Refresher training on infection control and PPE
- Response plan drill
- 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
- Every non staff member to sign in and out – phone number, time in, time out – important to know how long someone was on site

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

- Heightened readiness plus
- Single site implemented
- Notify the Department of Health and State officials immediately - In addition to notifying 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 agedcareCOVIDcases@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 for any other contractors/suppliers 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 – eg. 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

- Transfer out of residents where possible, including healthy residents, potentially, in collaboration with PHU and State Health
- Transfer COVID 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

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. deaf or blind)
- 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 – eg. 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

- Ensure brokerage agencies and contractors you have hired, including allied health, gardeners, tradespersons, who attend clients' homes have done COVID safe training and are using PPE as appropriate. Provider needs to understand what each of their contractors is doing – evidence this is appropriately managed
- Ensure home care workers are not only trained but have practiced donning and doffing full PPE, there is a disposal procedure and cars are stocked with adequate PPE and hand cleaning supplies
- 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, at least weekly, including hotspot locations
- Include 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
- Identify how deep clean at infected locations would be provided
- Update screening questions for workers (for visiting hotspot locations) on a daily basis and develop mechanisms to enable this to occur
- Call before visits to check on wellness, and if unwell, identify whether planned services are essential, if there is any additional support needed (eg. 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 receiving these services

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

- Deal with every individual on a case by case basis
- Meet as a team to decide what the essential services are and who will deliver the
- 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
- 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, level 3 workers
- Consider sponge baths over showers, as the latter can reduce PPE effectiveness
- Try to 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. 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	Gov service does 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

Don't forget that as part of your LASA membership you can contact us for all your specific needs. Please reach out to us during normal business hours by calling **1300 111 636**.

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