Australian Government
Department of Health

BE COVIDSAFE

# FIRST 24 HOURS – MANAGING COVID-19 IN A RESIDENTIAL AGED CARE FACILITY

December 2021

## The first 24 hours

The first 24 hours in the management of a confirmed COVID-19 case in a residential aged care facility (RACF) is critical to minimise the spread of the virus.

Following the identification of a COVID-19 positive case in either a resident or a staff member RACFs should follow these steps. These steps may occur simultaneously.

RACFs should use this guide, in conjunction with your COVID Outbreak Management Plan to minimise the spread of the virus.

The Communicable Diseases Network Australia (CDNA) has developed national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities. You can find the CDNA guidelines **here**.

In planning for an outbreak, you should regularly review and stay up to date with Commonwealth guidance and your state and territory advice and directions. You should also review Aged Care Quality and Safety Commission resources including the COVID-19 management flow chart and Outbreak management planning in aged care. This checklist complements these resources.

In this document, the Commonwealth Department of Health is referred to as the Commonwealth.

## 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:

- apply a surgical mask, leave the premises and isolate at home as directed by the public health unit (PHU). They must stay in isolation until the PHU clears them.

The positive staff member is unable to work in an aged care facility until cleared to do so by the PHU.

If the COVID-19 positive case is a resident, RACFs must:

- sensitively inform residents of their diagnosis
- immediately isolate the resident in a single room with an ensuite, if possible
- discuss other accommodation options with the resident and/or nominated representative, such as hospital transfer if it:
    - is required for clinical care; or
    - aligns with local public health requirements.

Following identification of a suspected or positive case, use personal protective equipment (PPE) when interacting with any residents until confirmation of initial test results.

Place all of the following outside all affected residents' rooms –

1) contact and droplet precaution signs
2) signs to avoid aerosol generating procedures, i.e. nebulisers
3) alcohol-based hand sanitiser
4) appropriate PPE and hands-free bins for used PPE.

Sensitively inform the resident and their family or primary contact of their diagnosis. Refer to the templates created as part of your outbreak management plan. Ensure residents have appropriate identification i.e. wristbands, keep current photographs on their file and ensure they are easily accessible. This will assist with testing, resident movements and will assist temporary staff providing care.

## 2. Contact your local Public Health Unit (PHU)

Immediately notify your state or territory PHU. It will coordinate the public health response to the outbreak.

- NSW - 1300 066 055
- WA - 08 9222 8588 or 08 6373 2222 (if confirmed COVID-19)
- SA – 1300 232 272
- NT - 08 8922 8044
- ACT - (02) 5124 9213 After Hours: 02 9962 4155
- QLD - 13 432 584 (13 HEALTH)
- TAS - 1800 671 738
- VIC - 1300 651 160

You can find contact details and websites of local state and territory health departments here.

Your Commonwealth case manager will inform the emergency response centre (if activated in your state or territory) of the positive case.

You must also report the positive case to the Work Safe organisation in your jurisdiction in accordance with the requirements in your state.

## 3. Contact the Commonwealth Department of Health

Notify the Commonwealth Department of Health of any resident or staff COVID-19 cases by emailing: agedcareCOVIDcases@health.gov.au. Under the *Privacy Act* 1988, this information should be de-identified and should not include personal or private information that can identify an individual, such as their name, address, date of birth or contact details. It should also not include information about a resident's movements or passing.

An example of the information required by the Commonwealth is:

- Resident #1 – positive result confirmed 12/08 at 8.15am
    - Asymptomatic
    - Close contact of positive staff member
    - In a wing with 25 other residents
    - Isolated since 11/08
- Staff member #1 – positive result received 11/08 at 9am
    - AIN/RN/kitchen staff
    - Last worked 9/08
    - Felt unwell 10/08

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

The case manager will connect you with resources to manage the outbreak. Resources include 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. Providers must sensitively inform residents of the reason for the lockdown and that the facility may be testing for COVID-19 as a precaution.

Avoid resident movements including transfers or leaving the facility where possible. You must consult the PHU prior to a transfer.

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

# Minutes 30-60

## 5. Activate your outbreak management plan

Activate your outbreak management plan. Your plan should already include a range of actions ready to respond to an outbreak. Guidance on appropriate actions based on your COVID-19 situation is outlined in the CDNA National Guidelines for the Prevention, Control and Public Health Management of Covid-19 Outbreaks in Residential Care Facilities.Notify all relevant stakeholders that the plan has been activated. Establish an outbreak management team to meet within hours.

The provider is responsible for the quality care and safety of residents and is responsible for everything that occurs within their facility. Providers need to take a strong leadership role and have clear and visible governance arrangements.

The PHU is responsible for the management of infectious outbreaks and will:

- undertake case investigations
- make decisions on testing
- conduct contract tracing
- advise on infection control and isolation.

The PHU will require information from the facility to investigate the outbreak.

Convene your outbreak management team to direct, monitor and oversee the outbreak in accordance with your outbreak management plan. The outbreak management team will provide key decision making and crisis management during the outbreak. The team should include:

- a Chairperson (facility Director, Manager or nursing manager)
- senior and middle level management
- a secretary
- on-the-ground facility management
- an outbreak coordinator (nurse infection control practitioner or delegate)
- clinical personnel / registered nurse
- a person who can report on the current status and implement actions agreed by the outbreak management team. This includes communicating to both internal (staff and residents) and external (PHU, Commonwealth Departments, OPAN, families) stakeholders
- media spokesperson / Primary family communication contact
- visiting GPs
- public health officers

Nominate an outbreak coordinator, and designate and agree key roles and responsibilities.

A small number of staff may need to perform multiple roles in the team, as specified in your outbreak management plan.

### 6. Review screening protocols

Review your screening protocols for all people entering the RACF. Routine entry screening should already be in place. Ensure you are familiar with any screening requirements under your state or territory public health directions.

Screen new and returning residents entering the facility for respiratory symptoms and fever. Ensure these residents remain isolated for at least an initial 14-day period, in case of underlying infection. These residents need to be treated as suspected COVID cases during this period.

PHU clearance is required to accept new or returning residents during an outbreak.

You can find advice on entry screening for residential aged care facilities **here**.

### 7. Release an initial communication

In the event of a COVID-19 diagnosis, RACF's need to inform:

- residents
- staff and contractors
- primary family contacts
- resident advocates (if a resident with cognitive impairment)
- key stakeholders of a COVID-19 diagnosis within the residential aged care facility.

An effective outbreak management plan should have some pre-prepared email templates already drafted for this initial communication. The National COVID-19 Residential Aged Care Emergency Communication Guide can provide more resources to support communication activities.

Services like **OPAN** can assist.

Providers with multiple services should consider whteher communications are required for the other sites.

## Hours 2-3

### 8. Contact tracing and monitoring of residents

The local PHU will lead contact tracing and identify or assist you to identify close contacts. The PHU may require some staff to go home immediately to quarantine. You may need to bring other staff on site.

Maintain clear records of contacts between staff and residents to strengthen the timeliness and veracity of the contact tracing.

Increase monitoring of all residents for any symptoms (however mild), of COVID-19. Take clinical observations two to three times a day.

## 9. Identify key documents

Both the PHU and the state branch of the Commonwealth will need:

a) A detailed floor plan. It should include residents' rooms, communal areas, food preparation areas, wings, and how staff are apportioned to each area.
b) An up-to-date list of residents, that identifies residents with COVID-like symptoms, including:
    i. onset date
    ii. testing status
    iii. location within the facility
    iv. whether the residents have had contact with confirmed case and/or staff contacts
    v. residents with higher risk profiles (wandering, behaviours of concerns, aerosol generating behaviours, requiring clinical interventions e.g. nebuliser) highlighted.
c) A list of all staff employed by the facility, including any agency staff
    i. include their full names, contact details, dates of birth and Medicare numbers
    ii. include people providing primary care or allied health services
    iii. note if staff work across multiple aged care services (including other residential facilities, home care, etc).
d) A list of the respiratory specimens collected and the results of any recent tests or investigations. Staff rosters and visitor logs.

## 10. PPE stocktake

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

Providers are responsible for sourcing PPE and should have sufficient levels on hand for any infectious outbreak.

If you require additional PPE and cannot source it through your usual means, you can contact the Department of Health at agedcareCOVIDPPE@health.gov.au

The PHU may be able to help you access state and territory stocks until the supplies arrive from the Commonwealth.

### 11. 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 exceed 1,000.

Appoint staff to manage communications and take the calls.

Establish a single point of contact for media queries.

Develop a script or talking points to assist those taking the calls.

Prepare a holding statement and update as appropriate.

Services like **OPAN** and **Dementia Australia** can assist.

## Hours 4-6

### 12. First meeting of the PHU Outbreak Management Team

The PHU outbreak management team should meet within 4-6 hours of identifying a case. These meetings will continue to occur at least daily (or more often if required) to direct and oversee the management of the outbreak.

The PHU outbreak management team will be supported by:

- state/Territory Health representatives responsible for in-reach services
- commonwealth case manager to assist with providing PPE, access to supplementary pathology testing (if required), and surge workforce
- the Aged Care Quality and Safety Commission who will ensure the safety and welfare of residents is maintained.

### 13. Bolster your staff and plan your roster

In line with your outbreak management plan:

- review current rosters
- confirm the location of positive cases
- determine the estimated number of staff that may be unable to work
- confirm staff that have nominated they will continue to work in an outbreak setting.

Implement workforce mitigation arrangements, i.e. contacting workforce suppliers, and/or moving to an adjusted roster (12 hour shifts).

The RACF will need more staff and a higher proportion of clinically experienced staff including Registered Nurses during a COVID-19 outbreak. Keep in mind in some cases up to 80-100 per cent of the workforce may need to isolate in a major outbreak.

The provider should fill the roster through usual workforce arrangements and agency contacts as far as possible.

If you are unable to fill your surge/outbreak roster through your usual sources, discuss your needs with your dedicated Commonwealth case manager. They can facilitate access to a temporary surge workforce.

Ensure there is 24 hour coverage of staff with required skill sets. You should allocate separate staff for COVID-19 positive, COVID-19 suspected and non-COVID-19 residents.

Ensure there is an adequate orientation process for any surge workforce and ensure there is a clinical handover of all residents' assessed care plan.

You should also consider how information will be provided to temporary staff and how these staff will record resident updates. If resident records are stored electronically, ensure you can provide temporary staff with access or have a printed version available.

Providers should also consider how temporary staff will access other essential items including medication cabinets, PPE storage and policies and procedures.

Plan what you would do if key staff or the CEO became unwell.

Please refer to the Frequently Asked Questions for more details.

## 14. Conduct testing

In collaboration with the PHU, urgently arrange COVID-19 testing for all residents and staff to understand the status of the outbreak.

Testing may be undertaken by:

- the PHU
- a Commonwealth contracted testing organisation
- a general testing clinic in the community.

The PHU will advise on available mechanisms and testing regimes for staff and residents.

The Commonwealth can support testing through Sonic Healthcare if required and following consultation with the PHU. The Commonwealth's case manager can assist with this.

## 15. Clinical management of COVID-positive resident cases

Clinically manage resident COVID-19 positive cases to address all their needs. Assess each resident to determine whether the resident's condition warrants a transfer to hospital. Do this in consultation with the resident, their carer and their treating clinician.

Decisions to transfer residents to hospital should be made on the basis of the clinical care needs of the individual. They need to align with the resident's and family's wishes and be made in consultation with the PHU. Decisions to transfer residents to hospital may also be based on your jurisdictional public health requirements.

Providers should be prepared to transfer residents quickly (if required), including having a bag packed, medications available and medical documents accessible.

Facilitate GP and relevant clinical visits for unwell residents (including COVID-19 positive, suspected and negative residents and close contacts) regardless of whether an outbreak is present or not.

If a COVID-19 outbreak is present, inform all visiting GPs and allied health workers prior to them attending the facility. To ensure all residents care needs are addressed the facility should also be engaging with the Primary Health Network (PHN) and other relevant clinicians during an outbreak.

# Hours 6-12

## 16. Cohorting / zoning and relocation

Determine what cohorting/zoning arrangements to implement at the facility to manage infection control. Base this on infection prevention and control advice.

Facilities where residents share rooms or bathrooms or if rooms are not well ventilated may require off site cohorting. Discuss cohorting options with the PHU.

1. Separate positive, suspected positive, close contacts and negative residents into separate zones within the facility
2. Where possible ensure residents have their own room and bathroom
3. Consider the needs of residents with cognitive impairments and ensure they remain in their allocated zones. Consult the PHU for assistance with wandering residents and how best to keep them safe
4. Increase staff numbers for the positive, suspected positive zones and close contacts zone to account for time required to don and doff PPE
5. Ensure staff work in a single zone and do not cross into other zones
6. Establish separate PPE storage and waste removal areas in each zone to reduce PPE contamination
7. Review flow of food, servery items, supplies, equipment, waste, laundry and ensure there is no or limited cross over. Shared items must undergo a sufficient decontamination processes between residents
8. Establish separate staff break areas in each zones to ensure staff do not cross into another zone to take breaks.

Discuss any cohorting/zoning challenges with the PHU.

## 17. Move to a command-based governance structure

Clearly communicate the command and governance structure, including who is in charge 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
- what to do if there is a problem
- what the escalation processes are.

Ensure thorough briefing and orientation of new staff each shift, including infection prevention and control education, and PPE usage.

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

## 18. Rapid PPE supply

The Commonwealth will help facilitate rapid delivery of PPE if required.

RACFs should be mindful of where large volumes of PPE can be safely and securely stored. Waste disposal systems must be in place to support increased volumes and usage of PPE. This includes contacting existing waste removal suppliers and informing them of the potential increase in clinical waste removal needs. Staff also need to know how to identify clinical waste and how and where to dispose of it safely.

## 19. Infection control

The nominated infection control lead for the service must ensure infection control processes and practices are in place. This includes checks of correct donning and doffing of PPE and disposal of used stock.

All staff should refresh their infection control training.

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
- no entertainment materials, i.e. books, puzzles, toys, computers, phones, etc, moving between zones in the facility. If sharing between zones necessary appropriate decontamination and cleaning practices need to be implemented

- reviewing laundry arrangements.

Commence enhanced environmental cleaning twice daily at a minimum.

Thoroughly clean resident rooms daily. Clean COVID-19 positive, suspected and close contact resident's rooms more often. Clean frequently touched surfaces (including bedrails, bedside tables, light switches, handrails, and door knobs/entrance ways) more often.

Clean and disinfect COVID positive, suspected or close contact residents rooms often, as per ICEG guidelines on environmental cleaning and the CDNA guidelines.

# Hours 12-24

## 20. Clinical First Responder assessment

The Commonwealth will arrange a Clinical First Responder (where required) to assist:

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

State or territory governments may provide this support.

## 21. Review advance care directives

Clinical staff should familiarise themselves with any positive residents' advance care directives. Ensure clinical decisions about residents who develop COVID-19 consider these plans.

## 22. 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:

- screening processes are reviewed and any required changes implemented
- robust induction process for all new agency and surge workforce staff coming onsite
- that all staff working are competent using PPE
- infection prevention and control practices are maintained i.e. hand hygiene, correct donning and doffing and physical distancing (where possible).

Consider having workforce competency reviews for all staff.

## 23. Maintaining social contact

Implement social contact procedures as outlined in your outbreak management plan. Ensure you have sufficient staff to assist with Facetime/Whatsapp etc. where these are available to residents.

Where possible, IT equipment should be assigned to a single resident's room. Clean and decontaminate shared IT equipment after each use.

Ensure your IT support contact information is readily available to staff. Alert your IT support team prior to an outbreak to prioritise issues using phone support.

You will need extra staff to assist residents with communications/use of technology.

## 24. Follow up communications

Establish and maintain 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.

**OPAN** can assist with residents and families' communications if needed.

## 25. Continue primary health care

Ensure there is strong ongoing governance of "routine" care. Understand residents will be anxious and need reassurance.

Consider governance structure to maintain and monitor normal activities and limit deconditioning as far as possible. This includes nutrition, physical activity, and preventing boredom, loneliness and unhappiness. Provide additional psychological care as required.

Notify residents' GPs who may contribute to monitoring, care planning and discussions. Where possible, continue GP and allied health consultations. Noting different modalities such as telehealth may be used. Ensure residents have adequate supply of medication and an up-to-date clinical summary and plan.

RACFs should also notify their PHN. The PHN may be able to source primary and allied health care practitioners to attend your facility. This will ensure continuity of care for residents during an outbreak if your usual practitioners are unable to.

## 26. Support your staff

Start establishing fatigue management plans. Ensure Employee Assistance Program (EAP) information is readily available.

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

Consider implementing a "buddy" system for peer support during the outbreak period.

27. Continue to monitor state / territory guidelines

- New South Wales
- Victoria
- Queensland
- South Australia
- Western Australia
- Tasmania
- Australian Capital Territory
- Northern Territory