IN THE FAIR WORK COMMISSION

Matter No.: AM2020/18
Re Application by: Joint Application filed by the Australian Services Union (ASU), Health Services Union (HSU), United Workers Union (UWU) and National Disability Services (NDS)

STATEMENT OF SUE CUDMORE

I, Sue Cudmore [redacted] in the state of New South Wales affirm as follows:

Background

1. I am currently the General Manager - Operations and have operational control for Alliance Health Services Group Pty Ltd (ABN: 191 007 36294).

2. I obtained my Bachelor of Nursing (Sydney University) in 1994 and I have been an APHRA qualified Registered Nurse since that time. I obtained a Masters in Public Health from University of NSW in 2000.

3. I have been working in the community and disability sector for around 17 years. For 15 of those years I have been working in executive operational and managerial roles in a nursing and disability service.

Alliance Community

4. Alliance Health Services Group Pty Ltd was established in 2002 as a nursing agency. In 2004, in response to market requests, the business expanded into the community nursing and disability services.

5. In 2015, Alliance Health Service Group Pty Ltd expanded its ownership structure which resulted in its offering being expanded into other states.

6. Since 2015, the component of the business that provided community care and disability support services was rebranded Alliance Community (**Alliance**) and expanded across existing community and disability offerings within the Health Solutions Group of branches.

7. Today Alliance delivers community care and disability support services in NSW, ACT, SA and QLD providing support and care services to over 1000 individuals.

Employees

8. Alliance engages approximately 450 employees who work in the community and disability services sector.

9. Due to the nature of Alliance's operations, the vast majority of employees are engaged on a casual basis. We have a small number of employees who are engaged on a permanent basis.

10. We operate under two industrial instruments:

    (a) Social, Community, Home Care and Disability Services Award 2010; and

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(b) the Alliance Home Care Services Enterprise Agreement.

Regulatory Framework

11. Working within the health and community space the notion of "duty of care" is paramount.

12. Community care service providers such as Alliance are generally funded by four mechanisms:

(a) Private paying clients;

(b) Federally Funded Aged Care Programs;

(c) NDIS Funded Programs; and

(d) Icare NSW

(*see table below*)

	Regulatory Authority	**Legislation/Framework/Reference to infection control management**
Private Paying Clients	Nil	'Duty of Care' Work Health and Safety Legislation
Federally Funded Aged Care Programs	Department of Health – Aged Care Quality and Safety Commission	Aged Care Act 1997 Aged Care Quality Standard Work Health and Safety Legislation
NDIS Funded Programs	NDIS Quality and Safety Commission	National Disability Insurance Scheme Act 2013 NDIS Practice Standards Work Health and Safety Legislation
Icare NSW (Compensable Injury Funded Care Programs)	iCare contracts management of the Attendant Care Industry Standards to the Australian Community Care Industry Alliance (peek body)	Motor Accidents (Lifetime Care and Support) Act 2016 Attendant Care Industry Standards Work Health and Safety Legislation

Normal PPE and Infection Control Procedures

13. Infection control and hygiene practices are one of the most essential elements of undertaking practice as a health worker and such matters are taken very seriously by Alliance.

14. In my experience, employees of Alliance have had to deal with a range of diseases while working in the community setting, including but not limited to:

(a) Hepatitis B;

(b) Influenza;

(c) HIV; and

(d) Methicillin-resistant Staphylococcus aureus (**MRSA**).

15. As such these diseases, among many others, are dealt with in Alliance's 'Infection Control Policy and Procedure Manual' (see attached at Annexure 'A').

16. There is no one source of best practice documents on these matters. Alliance is thorough in ensuring we review government published documents, primarily from the federal Department of Health, NSW Health and associated agencies such as the Clinical Excellence Commission, Aged Care Quality and Safety Commission, NDIS Quality and Safeguards Commission.

17. The principles of infection control practice, risk assessment and PPE utilisation among other matters can be found in our 'Infection Control Policy and Procedure Manual'.

18. The procedures and precautions set out in this manual are compliant with the NSW Health Infection and Prevention Control policy (PD2017_013) which has been in circulation for several years within the organisation and updated when Health Department policies change.

19. Supplementary COVID-19 protocols have been implemented based on these existing principles for the management of known existing infectious diseases in the community.

Standard Precautions

20. Standard precautions are universally accepted practices that are implemented to deal with all aspects of controlling infections and minimising the risk of transmission. Standard precautions are used in the care of all clients and residents regardless of their diagnosis or presumed infectious status.

21. A variety of infection control measures are used for reducing the risk of transmission of micro-organisms in health care settings. These measures make up the fundamentals of standard precautions and include:

(a) appropriate and correct use of personal protective equipment (**PPE**);

(b) use of aseptic technique;

(c) safe use and disposal of sharps;

(d) performing routine environmental cleaning;

(e) cleaning and reprocessing of shared patient equipment;

(f) respiratory hygiene and cough etiquette; and

(g) safe handling and disposal of waste and used linen.

Transmission Based Precautions

22. Transmission-based precautions are used in addition to standard precautions when standard precautions alone are insufficient to interrupt the transmission of a known or suspected pathogen. There are three main types of transmission-based precautions that are dealt with in our Infection Control Policy and Procedure Manual:

(a) **Airborne Precautions**: Airborne Precautions apply to clients or residents known or suspected to be infected with pathogens that can be transmitted by airborne route. Airborne precautions are designed to reduce the risk of airborne transmission of infectious agents.

(b) **Droplet Precautions**: Droplet precautions apply to any clients to be known or suspected of being infected with pathogens that can be transmitted by droplets. Droplet transmission involves contact with the conjunctiva or the mucous membranes of the nose or mouth of a susceptible person with large particles

droplets containing micro-organism generated from a person who has a clinical disease or who is a carrier of the micro-organism.

(c) **Contact precautions**: Contact Precautions are designed to reduce the risk of transmission of micro-organisms by direct or indirect contact. Direct contact transmissions involves skin to skin contact and physical transfer of micro-organisms to a susceptible host from an infected or colonised person, such as when health care worker reposition clients or residents, bath clients or residents or perform other client care activities that require physical contact.

Personal Protective Equipment

23. Alliance's Infection Control Policy and Procedure Manual goes through in detail in what circumstances personal protective equipment is required to be worn, how it is to be worn and how it is to be disposed of.

24. This includes the wearing and disposing of:

(a) Protective gowns;

(b) Gloves;

(c) Masks; and

(d) Protective Eyewear.

25. This policy is used in conjunction with risk assessments that are undertaken prior to working with each client. Such risk assessments will determine what additional precautions, if any, need to be taken when working with a particular client and any additional PPE that may be required to be worn.

COVID-19 Protocols

26. Since Alliance became aware of COVID-19, Alliance has been pro-active in putting in place a range of measures to address the risks associated with COVID-19.

27. These include the following procedures:

(a) COVID-19 Response Plan (see attached at Annexure 'B');

(b) COVID-19 Individual Support Plan (Community Clients) (see attached at Annexure 'C');

(c) Participant/Client Risk Assessment Checklist (see attached at Annexure 'D'); and

(d) COVID -19 On-Hire Workforce Screening Questionnaire (see attached at Annexure 'E').

28. Alliance took these steps and prepared these documents in accordance with the guidelines and directives issued by the Australian Government Department of Health.

29. For example, the Commonwealth Department of Health have released a number of documents containing recommendations, guidelines and resources in response to COVID-19 that apply to the disability and home care space including:

(a) 'Management and Operational Plan for People with Disability: Australian Health Sector emergency Response Plan for Novel Coronavirus' overseen by the Advisory Committee for the COVID-19 Response for People with Disability (see attached at Annexure 'F'); and

(b) 'Coronavirus (COVID-19) Guide for Home Care Providers' released by the Australian Government Department of Health (see attached at Annexure 'G').

Self - Isolation

30. Alliance' testing and self - isolation protocols are summarised below:

Circumstance	Detail	Period of isolation away
Symptoms – pre testing	All employees with flu like symptoms are advised not to attend work and to seek medical advice for consideration of COVID-19 testing.	Self-isolate immediately and await results of testing. Can return to work after supplying a medical clearance.
Symptoms – testing and beyond	All employees with symptoms who are currently being tested for COVID-19 and have been advised by a medical officer to self-isolate	If test results are negative, employee can return to work after supplying a medical clearance. If test results are positive, Isolate for 14 days from the time of testing. Employee can return to work after supplying a medical clearance. Follow advice from medical officer and Public Health Unit.
International travel	All employees who have returned from international travel.	Isolate for 14 days after returning to Australia.
Close contact*	All employees who have been in close contact with those who have proven cases of COVID-19	Isolate for 14 days from after the date of last contact with the confirmed case. Follow advice from medical officer and Public Health Unit.

31. As of the date of writing of this statement:

(a) three (3) employees returned from overseas and had to self - quarantine for 14 days in accordance with the government guidelines;

(b) three (3) employees had exposure to a person with known or suspected COVID-19 but did not present with symptoms. These employees also enacted the 14 days self-quarantine protocol in accordance with the government guidelines; and

(c) three (3) employees reported flu like symptoms. These employees were tested for

COVID-19 and self - quarantined until test results received.

32. All of the above reports occurred in March 2020.

33. As of the date of writing of this statement, none of Alliance's staff members have been confirmed to have contracted COVID-19.

COVID-19 Precautions

34. Alliance undertakes a risk assessment to ensure Alliance can provide the required care, identify any risks that may present themselves to the client or employee and ensure those risks can be eliminated or minimised. Risk Assessments occur on referral to the organisation, when the client's situation (health, social, environmental etc) changes and at prescribed intervals based on their care and support plan identified requirements.

35. Clinical staff (Registered Nurses) are also employed within the business to assess and determine risk including development of appropriate care plans and staff training. There is also oversight from the 'Clinical Governance Committee' – a peer group of nursing clinicians within the business who input and review clinical policies that are being drafted prior to implementation.

36. In response to the COVID-19, Alliance developed a COVID-19 Risk Assessment Checklist. This is similar to Alliance's normal risk assessment procedure but with additional detail specific to COVID-19.

37. Alliance staff are used to dealing with risks of infection and transmission (as set out in the 'Infection Control Policy and Procedure Manual') and, like many infectious diseases, the risk can usually be managed adequately with the appropriate training and PPE.

38. With COVID-19, like with any disease, a client may be so unwell that it is not appropriate that they remain under the care of Alliance and at that point would need to be transferred to a hospital. We are a disability service and not a medical or hospital service.

39. At this stage, Alliance has not had to deal with a client who was suspected of having COVID-19, or tested positive for COVID-19.

40. Assuming the person does not require hospitalisation because of the severity of their symptoms, I am of the view that Alliance's existing infection control management and PPE protocols would be able to suitably deal with the risk of infection, perhaps with the addition of a P2 mask which contains a filter.

41. Such a mask is slightly larger than a surgical mask but would not impact upon the ability of the employee to perform their duties.

42. The new COVID-19 procedures that we have implemented follow similar protocols and risk assessments as for any other infectious disease that our staff would encounter during the course of their work.

20 May 2020
Sue Cudmore

Alliance Community

Infection Control Policy and Procedure Manual

Supporting you

Supporting you

Contents

1. Infection Control - Introduction

The Alliance Community Infection Control Program facilitates the prevention, control and evaluation of infection incidents and issues.

The infection control program is an integrated community program that is founded on the principles of current best practice which include:

(a). Standard Precautions.

(b). Transmission based precautions.

The Infection Control Program complies with PD2017_013 NSW Health Infection Prevention & Control Policy. This program outlines the steps that must be followed, to ensure that the appropriate techniques and necessary preventative measures are followed for infection control.

1.1 Infection control in the home setting

A home setting for client supports and care provides some unique challenges in the prevention of infection. A major difference for community staff is that the home setting is controlled by the client and or family/carer. As a result of technological changes in healthcare and community expectations more treatments and procedures are being performed in the home. In the home setting Infection Control is based on the principles of hygiene, cleanliness and sterility. The Community Staff have a responsibility to ensure that both clients and/or carers understand the principles of Infection Control.

1.2 Philosophy and objective

Philosophy and Aims

Promote effective infection control practices in the home which prevents transmission infection.

Support Community staff by providing them with resources and information regarding the prevention of any transmission of infection in the home

Ensure our clients are educated and informed about principles of hygiene and cleanliness.

Objectives

The development and maintenance of a surveillance program for all infections among clients and personnel. The collection, analysis and reporting of data facilitates the provision of follow up action to limit spread from identified sources of contagion.

Regular review and updating of policies and procedures so that quality care and supports are not compromised for any client.

To provide orientation and in-service programs for all employees and Community staff relative to their role in infection control and prevention and to make all staff aware of infection control policies.

To monitor findings of any client care evaluation studies that relate to infection control activities.

Provide liaison between hospitals, General Practitioners and the Health Department for the reporting of communicable diseases

1.3 Definitions of infection

The term INFECTION denotes a state in which micro-organisms (bacteria, viruses or fungi) have established a reasonable permanent residence in host tissues. Infection is not synonymous with disease.

Bodily defences often prevent micro-organisms penetrating body surface (skin or mucous membrane) and in such circumstances the person is a CARRIER/RESERVOIR because the organisms they harbour may spread to other people.

If, however, a body is penetrated (e.g. by an operative incision, a skin abrasion or a foreign body etc.) a DISEASE may result and inflammation (pain, swelling, redness, heat fever and pus) can develop at the site of entry with possible spread, via lymphatics and the blood stream to other parts of the body.

PORTAL OF ENTRY is the mode of entry of organisms into the human body. Entry may occur via the respiratory tract as in the "flu" or via a break in the skin.

PORTAL OF EXIT is the mode of escape of organisms from the body. The more particles shed the greater the chance of reaching a new host.

NOSOCOMIAL (Hospital Acquired) INFECTION denotes an infection which was not present, or incubating, at the time of admission to hospital but which develops as a result of hospitalisation and commonly becomes apparent whilst the client is still in hospital. It is important to distinguish:

Exogenous infection when the casual organisms come from other people (doctors, nurses or other clients) either directly by breathing, touching or, indirectly, via fomites (inanimate objects in the clients environment).

Endogenous infection when the clients own organisms (on skin, nose, bowel etc.) are released into tissues not normally infected, e.g. operations involving opening of the bowel, damage to vaginal or cervical tissues during childbirth.

1.4 General Measures for Infection Control

Personal clothing and uniforms must be clean at the commencement of work.

Standard Precautions must be adhered to at all times.

Utilise hand hygiene frequently, (alcohol based hand rub ABHR or hand wash) and especially after using the toilet, after individual client care/treatment and before handling food.

Cover open cuts and grazes with a waterproof occlusive dressing. Use adequate precautions, if necessary i.e. gloves.

Use aseptic technique to prevent contamination of wounds and other susceptible sites e.g. urinary tracts.

Disinfection and sterilisation: sterilising and disinfecting can destroy microbial contaminants.

It is every individual team members responsibility to bring to the Clinical Care Coordinators attention any suspected breach in Infection Control.

2. Infection Control - Systems

Current best practice suggests that a health service infection control program must encompass both Standards Precautions and Transmission Based Precautions. (PD2017_013 NSW Health Infection Prevention & Control Policy)

2.1 Standard Precautions – Definition

Standard precautions are the minimum infection prevention measures that apply to all patient care settings, regardless of suspected or confirmed infection status of the patient.

Standards Precautions constitute current best practice in infection control.

These precautions should be used in the care of ALL clients and residents regardless of their diagnosis or presumed infectious status.

The underlying principles is that universally blood and body substances including secretions and excretions from all clients should be regarded as potential hazardous, regardless of what is known or suspected about their infection status or contamination.

These practices protect the health care worker from blood borne viruses and pathogenic micro-organisms in other body substances.

2.1.1 Standard Precautions Fundamentals

A variety of infection control measures are used for reducing the risk of transmission of micro-organisms in health care settings. These measures make up the fundamentals of standard precautions and include:

- Appropriate and correct use of personal protective equipment (PPE)
- Use of aseptic technique
- Safe use and disposal of sharps
- Performing routine environmental cleaning
- Cleaning and reprocessing of shared patient equipment
- Respiratory hygiene and cough etiquette
- Safe handling and disposal of waste and used linen

Standards Precautions apply to

- Blood;
- All body substances, secretions and excretion except sweat and hair, regardless of whether or not they contain visible blood;
- Non- intact skin; and
- Mucous membranes

2.2 Transmission Based Precautions

Transmission-based precautions must be used in addition to standard precautions when standard precautions alone are insufficient to interrupt the transmission of a known or suspected pathogen. There are three main types of transmission based precautions

There are three types of transmission based precautions

- Airborne Precautions
- Droplet precautions; and
- Contact precautions

A combination may be required for diseases that have multiple routes of transmission. The use of transmission based precautions SHOULD always be in addition to Standards Precautions.

2.2.2 Airborne precautions

Airborne Precautions apply to clients or residents known or suspected to be infected with pathogens that can be transmitted by airborne route.

Airborne precautions are designed to reduce the risk of airborne transmission of infectious agents.

2.2.3 Droplet Precautions

Droplet precautions apply to any clients to be known or suspected of being infected with pathogens that can be transmitted by droplets. Droplet transmission involves contact with the conjunctiva or the mucous membranes of the nose or mouth of a susceptible person with large particles droplets containing micro-organism generated from a person who has a clinical disease or who is a carrier of the micro-organism.

2.2.4 Contact Precautions

Contact Precautions are designed to reduce the risk of transmission of micro-organisms by direct or indirect contact.

Direct contact transmissions involves skin to skin contact and physical transfer of micro-organisms to a susceptible host from an infected or colonised person, such as when health care worker reposition clients or residents, bath clients or residents or perform other client care activities that require physical contact.

Direct Contact Transmission can also occur between two clients or residents (e.g. by hand contact) with one serving as the source of infectious micro-organism and the other as a susceptible host.

Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the client's environment.

Table 1 provides a guide for recommended infection control precautions for a variety of infected clients.

2.3 Routine use of airborne, droplet or contact precautions

In many instances the risk of nosocomial transmission of infection may be highest before a definitive diagnosis can be made and before precautions based on that diagnosis can be implemented.

The routine use of standards precautions for all clients should greatly reduce this risk for conditions other that those requiring Airborne, Droplet or Contact Precautions.

While it is not possible to identify prospectively all clients needing Airborne, Droplet of Contact Precautions certain clinical syndromes and conditions carry a sufficiently high risk to warrant the addition of enhanced precautions while a definitive diagnosis is pursued.

3. Standard Precautions

Standards Precautions designed to reduce the risk of transmission of micro-organisms from both the recognised and unrecognised sources of infection in health care settings. PD2017_013 NSW Health

3.1 Hand Washing

Hand Hygiene Technique with Alcohol-Based Formulation

Duration of the entire procedure: 20-30 seconds

Apply a palmful of the product in a cupped hand, covering all surfaces;

Rub hands palm to palm;

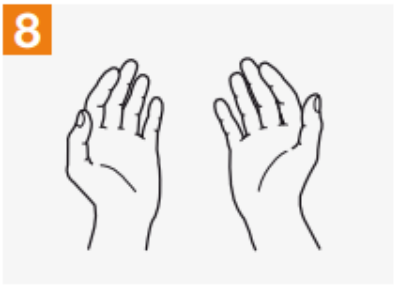
Right palm over left dorsum with interlaced fingers and vice versa;

Palm to palm with fingers interlaced;

Backs of fingers to opposing palms with fingers interlocked;

Rotational rubbing of left thumb clasped in right palm and vice versa;

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Once dry, your hands are safe.

Hand Hygiene Technique with Soap and Water

Duration of the entire procedure: 40-60 seconds

0

Wet hands with water;

1

Apply enough soap to cover all hand surfaces;

2

Rub hands palm to palm;

3

Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palm with fingers interlocked;

6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

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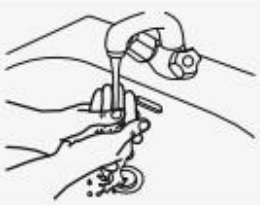


Rinse hands with water;

9

Dry hands thoroughly with a single use towel;

10

Use towel to turn off faucet;

11

Your hands are now safe.

3.1.1 Hand Hygiene guidelines

For most hand hygiene activities, alcohol based hand rub (ABHR) should be used whereas visibly soiled hands must be washed with liquid soap and running water

Cover any breaks in your skin with a waterproof dressing

The Alliance Community requirement for health care workers is not to wear acrylic nails or nail polish. Nails are to be kept short. Jewellery is to be kept at a minimum.

Hand hygiene is to be performed by everyone. Community staff should encourage clients to perform hand hygiene and provide education on the correct hand hygiene technique. Clients should be provided encouragement and education to perform hand hygiene after going to the toilet, before eating, after sneezing, blowing their nose or coughing into hands, and after touching / handling animals.

Personal protective equipment

3.2 Protective gowns

Plastic gowns are should be worn to protect skin and clothing when contamination with blood or other body substances is possible.

Gowns and protective apparel provide a barrier and reduce the opportunity for transmission of pathogens. Gowns protect the health care worker skin and clothing from exposure to blood and body substances.

Washable fabric gowns provide no protection from body substances and are not considered part of PPE for infection prevention and control.

3.3 Gloves

Gloves must be used in situations where the HW is potentially exposed to body substances. When gloves are determined to be necessary, they must be worn on both hands.

Gloves must be used in situation where the health care worker is potentially exposed to blood and/or body substance in particular:

During any procedures where direct contact is anticipated with the client blood or body substance, mucous membranes or non-intact skin:

- While suctioning a client
- While handling items or surfaces that have come into contact with blood or body substances.

3.3.2 Changing and discarding gloves

Gloves must be changed and discarded:

- As soon as they are torn or punctured or when the integrity has been altered
- Immediately after contact with a patient is complete and before care is provided to another patient
- When performing separate procedures on the same patient
- After handling blood and body fluid
- Before handling or opening sterile consumables
- Before writing in the healthcare record, answering telephone / pagers, using the computer and other social environmental actions.

Disposable gloves must not be cleaned or reused. ABHR is not to be used on gloves.

Hand hygiene must always be immediately performed before and after use of gloves

3.4 Masks and protective eye wear

A mask and protective eye wear should be worn while performing any procedure where there is a likelihood of splashing or dissemination of blood or body fluids. E.g. suctioning a tracheostomy.

All masks are single use and are to be discarded after they have been worn. Place in a double bag and dispose of in clients' waste unit.

Multi use protective eyewear must be cleaned after use as per manufacturer's directions.

3.5 Needle Stick and blood and body substance exposure

A needlestick injury is defined as a piercing injury from any sharp object that is actually or potentially contaminated with a body substance. These include lancets, butterfly cannulas, suture cutters, scalpel blades, glass blood tubes and needles (including insulin pens).

Body substances include all blood, body fluids, excretions and secretions except sweat. These include faeces, vomitus, urine and discharges.

3.5.1 Exposure

Employees are required to report all occasions of exposure to blood or body substances to their immediate supervisor. Exposure includes:

- Parental - needlestick or cut
- Mucous membrane - splash to the eye, nose or mouth
- Cutaneous exposure - skin contaminated with blood or body substance.

General Processes

- Immediate first aid.
- Medical assistance, screening and counselling
- Client screening.
- WHS and Workcover procedures.

Immediate First Aid

- Wash away the body substance with soap and water.
- If the skin is broken:
    - Encourage bleeding, then wash body substance from skin using copious amounts of soapy water.
- Eye or mouth exposure:
    - Rinse for at least 15 minutes with clean water (ensure eyes are open while rinsed).

3.5.2 Managing accidental exposure

PD2017_010 HIV, Hepatitis B and Hepatitis C – Management of Health Care Workers Potentially Exposed

1. Immediate first aid

After exposure to blood or other body substances the exposed HCW should as soon as possible do the following:

- Wash the exposure site with soap and water
- Undertake appropriate care of any wound(s)
- If eyes are contaminated then rinse them, while they are open, gently but thoroughly with water or normal saline
- If blood or other body substances get in the mouth, spit them out and rinse the mouth with water several times
- If clothing is contaminated remove clothing and shower if necessary
- Inform their Alliance Community coordinator so they can immediately be relieved from duty and attend

Their local hospital A&E or their GP for medical assessment, testing or prophylactic treatment.

Where the exposed HCW is uncertain about actions to be taken, the Blood and Body Fluid Exposure Phone line (formerly the NSW Needlestick Hotline) may assist. The Blood and Body Fluid Exposure Phone line is an information, support and referral service for NSW based

health care workers who sustain needlestick injuries and other blood/body fluid exposures during the course of their work. The line is answered by an on-call nurse 7 days a week from 7am to 11pm and can be contacted on free call 1800 804 823 within NSW.

2. Reporting Mechanism

   Contact Alliance Community Office, Supports and Care coordinator and/or the clinical care coordinator

3. Complete an Incident/Injury Form.

   You will be required to provide a Workcover Medical Certificate of capacity from the doctor.

   Alliance Community will assist you in making a Workcover claim and will provide any relevant further documentation.

4. Management of Waste

Clinical waste is material that consists of human or animal tissue, blood or body substances, excretions, drugs and other pharmaceutical products, swabs/dressings, syringes, needles or other sharp instruments.

Appropriate handling of waste assists in reducing transmission of infectious agents.

4.1 Categories of clinical and related waste

Category	Description
Infections including sharps	Waste contaminated by blood, body fluids, excreta or secretions, which may have a potential for disease. Includes sharps.
Cytotoxic	Waste material contaminated with a cytotoxic drug. This waste must be incinerated. (refer to 5.3) Low concentrations such as in urine faeces and vomit may be disposed of into the sewerage. This includes blood and body substances of person undergoing cytotoxic therapy within the previous 72 hours.
Chemical and pharmaceutical	Expired pharmaceuticals and chemicals such as paint and cleaning fluids in the home. Disposed of by an authorized carrier.
Radioactive	Materials contaminated with a radio-isotopes. Generally, the amount generated in the home setting is small enough to be disposed of into the sewerage.
Plastic	Plastics materials, Generally high volume as many health materials are disposable. Some plastics can be recycled.
General	All other waste which may be generated at home as per the normal household.

4.2 Infectious waste

Blood and body substances in the home setting are managed as household sewerage by disposing directly into a toilet whenever possible.

Waste and disposable equipment that is contaminated with blood or body substances are wrapped well in a plastic bag and placed into a second plastic leak proof bag. Fasten securely.

Deposit doubled bagged contaminated waste into the household garbage for collection by the local council.

4.3 Cytotoxic waste

The management of cytotoxic waste requires that:

- The wearing of gloves and a disposable gown whenever cytotoxic or substances or waste are handled.
- A cytoxic waste container is obtained. This container is a rigid walled purple container marked “cytotoxic waste”
- Cytotoxic waste containers are provided by the referring hospital, and are returned to the hospital department at the end of treatment for disposal.

Disposing of Cytotoxic Waste

- Wear gloves and a disposable gown whenever you handle cytotoixic (or potentially cytotoxic) substances or waste.
- At the commencement of treatment using a cytotoxic agent, make sure that a rigid walled purple cytotoxic waste container is available and marked 'cytotoxic waste'.
- Before you commence care make sure the cytoxic container is open and within reach.
- Dispose of all waste, including sharps, actually or potentially contaminated with cytotoxic material directly into the cytotoxic waste container.
- Make sure that the cytotoxic container is closed (not locked) and stored in a safe place when you complete the care.
- Seal the cytotoxic waste container when it is ¾ full. Seal it well and take it back to the centre.
- Arrange a replacement container.
- Dispose of blood and body substances as household sewerage by them directly into a toilet whenever possible.
- Flush the toilet several times to dilute any cytotoxic substances.
- Dispose of any remaining waste into a cytotoxic waste container.
- Wash receptacles, such as bedpans or urinals, several times with soap and water and rinse well.

4.4 Safe handling, use and disposal of sharps

The potential for exposure to blood borne viruses is greatest when medical devices such as needles, scalpels, or other sharp instruments are used and contaminated with body substances.[4] Therefore, the use of sharps should be minimised wherever possible and when used be disposed of immediately after use, at the point of care

A sharp is any sharp object potentially or actually contaminated with blood or body substances. They include lancets, butterfly cannulas, suture cutters, scalpels, glass ampoules and needles.

Each health care worker who use sharps is responsible for their management and disposal.

Only RN's must manage and dispose of sharps. All RN's providing direct client care must carry a sharps container in their car boot.

A needle must NOT be removed form a disposable syringe for disposal, or be purposely broken or otherwise manipulated by hand.

Needles should not be re-sheathed.

4.4.1 Sharps containers

All clients requiring the use of sharp objects for their care must have a yellow rigid walled sharps container present at all ties. These can be obtained from

- Local councils.
- Individual health care organisations which provided sharps management service.
- Local pharmacy and pathology services

4.4.2 Disposal of sharps containers

- Seal the container when it is ¾ full
- The RN is to take sharps container (in car boot) to local hospital or pathology service.

- Arrange a replacement sharps container.

4.4.3 Cytotoxic sharps

Sharps which are actually or potentially contaminated with cytotoxic materials must be out into a purple rigid walled container marked “cytotoxic waste” and disposed of. See Cytotoxic waste management

5. Processing and Cleaning Instruments and Equipment

The process indicated for an item depends of the intended use. Any micro-organisms, including bacteria spores that come in contact with normally sterile tissue can potentially cause infection. These must be eliminated from items intended for use in sterile sites by cleaning and sterilisation. For this reason Alliance Community has a policy on sterile single use instruments only.

In general, intact skin acts as an effective barrier to most micro-organisms, thus, items that touch only intact skin need only be cleaned unless contaminated by blood and other body fluids.

5.1 Sterile Instruments

Instruments that are required to be sterile for client's use are provided as single use instruments.

5.2 Single Use Policy

Definitions:

The term "single use only" means that the items will be used for one procedure only and then discarded. For example, a urinary catheter or intravenous cannula.

The term "single client use" means an item may be used for one client, more than once. For example a nebuliser mask which one client may use for 4 days, after which is discarded.

Policy:

Therapeutic items labelled "single use only" will not be reused. Instruments that are required to be sterile for client use are provided as single use instruments.

5.3 Cleaning of instruments and equipment

The following chart describes the appropriate cleaning procedures

Equipment	Home cleaning method
Bed Pan and Urinal	Clean all parts of the equipment using a detergent solution.
Thermometers and containers	Wash in a cool detergent solution after each use. Wipe dry with an alcohol swab and store in a clean dry container.
Enema equipment	Rectal catheters are single use only. Enema tubing is for "single client use"
Commode chair, shower chair, wheelchair and mobilization aids	Wash and dry with soap and hot water
Hoists and slings	Wipe over with soap and water and dry.
Syringe drivers	Damp-dust the syringe pump with a detergent and water.
Blood Pressure Cuff	Wash after soiling in a cool detergent solution.
Nebuliser Mask	Single client use only, wash and dry daily for individual client. Replace for each new client.
Stethoscope	Wipe bell and earpieces with "Isowipe" after each use.
Tourniquet	Wash after soiling with a cool detergent

5.4 Guide to cleaning products

DEFINITIONS

Washing/Cleaning:	Use of water, detergent and mechanical action to remove debris, dust, matter and stains.
Disinfection:	reduction of micro-organisms by either chemical or mechanical means.
Sterilisation:	process that destroys micro-organisms. No items are sterilised at Alliance Community as sterile items are provided as single use only.
Antisepsis:	Control of organisms contaminating skin/tissue

6. Environmental Cleaning

Good cleaning practices are important in the prevention of environmental organisms being spread.

6.1 Environmental Cleaning

At Home

Periodic cleaning such as windows and curtains is encouraged by the community staff where possible. This would be done in consultation with the client/family carer.

At Alliance Community Offices

- Periodic cleaning such as windows are completed in conjunction with the Building Maintenance Programme.
- Daily cleaning is performed under contract to a cleaning service. This is monitored by Management.

6.2 Management of spills of body substances

Spills of body substances should be managed using Standard Precautions at all times.

Materials used in cleaning spills should be handled as infectious or cytotoxic waste.

In the event of spills of blood or body substances staff involved in the management of spills should immediately:

- Don protective apparel including gloves
- Confine and contain spill
- Cover the spill with paper towels to absorb the bulk of the blood or body fluids
- Treat debris as clinical waste: and
- Clean the spill site with a neutral detergent and water.

Eyes-rinse with copious quantities of water-seek medical assistance.

Skin-rinse area thoroughly with water-wash with soap and water

It is likely that all products that can clean spills of blood or other potentially infectious materials on carpets will cause damage to the carpet. Spills on carpet should be managed as follows

Mop up as much of the spill as possible using disposable towels

Clean with a neutral detergent.

6.3 Linen

There is a potential risk of microorganism transmission via exposure to contaminated linen. HWs should handle, dispose and process used linen or linen soiled with body substances in a manner that prevents exposure to skin and mucous membranes, contamination of clothing and transfer of microorganisms to other persons and the environment.

Clean linen is handled, transported and stored separately.

6.3.1 Soiled Linen

Gloves and waterproof aprons should be worn when handling soiled linen. Linen which is heavily soiled with blood or body substances should be transferred in a leak proof container to the client's laundry.

Routine washing procedures using hot water and detergents are adequate for decontamination of most laundry items at home.

6.3.2 Special Linen

Sheepskins, hoist slings are patient specific. Sheepskins may be washed in client's washing machine.

Hoist Slings are regularly wiped and returned to supplier after use.

7. Prevention of Antimicrobial Resistance

Assessing a client's individual infection risk rating is to determine whether the client is a potential source of infection to other clients, carers and staff or whether the client is more susceptible to infection.

7.1 Antibiotic and Pathology Guidelines

Organisms with multi-antibiotic resistance are increasing with inappropriate antibiotic use and more virulent strains emerging. Examples include Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE).

Inappropriate antibiotic use results in:

- Emergence of resistant strains of bacteria
- Irritation of the gastrointestinal tract
- Infections resulting from alteration in normal flora
- Allergic reactions

The nurse's role in reducing the incidence of the above is to ensure:

- Correct storage and reconstitution
- That prescribed antibiotics are administered as ordered
- Blood concentration is maintained by administering at correct intervals
- The course is completed
- Spillage is avoided
- Disposal is appropriate

The method of transmission of both MRSA and VRE is via contact, usually on the hands of those caring for the client.

Transmission of organisms spread by contact can be blocked by adherence to Standard Precautions.

7.1.1 Specimens

Any specimen for examination should be regarded potentially infectious and Standard Precautions apply at all time.

The specimen must be collected into the container supplied by the laboratory. Specimens are not accepted by the laboratory staff unless both the specimen and the request slip are correctly labelled with the client's hospital UR number and full name and date of birth. Unlabelled specimens will be discarded.

7.1.2 Blood Collection

Blood is a sterile fluid.

Sufficient quantity of the specimen needs to be collected in the appropriate container with the appropriate medium.

All slips should be labelled prior to specimen collection to reduce risk of contamination post procedure.

It is important to direct the specimen to the appropriate laboratory.

7.1.3 Swabs

Swabs are often taken from sites where normal flora is present.

A dry swab of a dry lesion is useless. The time it takes to reach its destination is important. When swabbing an area the most inflamed, most purulent area should be selected. All specimens must reach the laboratory with minimal delay.

It is not appropriate to request medical officer authorisation for a wound swab unless there is evidence of infection, this includes:

- Pyrexia
- Pain
- Pus
- Offensive odour

- Redness and swelling

7.1.4 Transport of Pathology Specimens

Transport specimens in the sealed section of the plastic biological hazard bag.

All request slips should be placed in the separate section.

The biological hazard bag should be placed in a leak-proof insulated rigid walled container (esky) and sent to the appropriate laboratory. Absorbent cushioning such as cottonwool should be used as packaging. The container should be cleaned weekly or whenever a spill has occurred.

7.2 Multi resistant Organism (MRO)

MROs, which are predominantly bacteria, are resistant to multiple classes of antimicrobial agents. Antibiotic resistance increases the morbidity and mortality associated with infections, and contributes to increased costs.

MROs are taken to include:

- all methicillin-resistant Staphylococcus aureus—
- all vancomycin-resistant enterococci with mobile resistance determinants (e.g. VanA, VanB)—
- a range of Gram-negative bacteria with multiple classes of drug resistance or resistant mechanisms to critically important antibiotics—

Successful control of MROs is based on a combination of interventions. These involve continued rigorous adherence to hand hygiene, appropriate use of PPE and implementation of specific transmission-based precautions

In non-acute healthcare settings (e.g. in the community), general measures of infection control (particularly hand hygiene by both clients and staff) may be enough to prevent transmission. However, contact precautions, such as gowns and gloves, may be necessary

Australian Guidelines for the prevention and Control of Infection in Healthcare (2010), National Health and Medical Research Council.

7.3 Outbreak Management

When there are more cases of infection with the same organism than would normally be expected in one area or period of time, this constitutes an outbreak.

An outbreak may be defined as:

- occurrence of more cases of disease than expected in a given area among a specific group of people over a particular period of time
- two or more linked cases of the same illness.

Commonly detected outbreaks involve:

- MRSA;
- aminoglycoside or multi-resistant enterobacteriaceae or pseudomonads
- diarrhoeal pathogens (e.g. *Salmonella, Campylobacter*, norovirus)
- respiratory pathogens (e.g. influenza, RSV)
- measles (rubella), chickenpox (varicella)
- hepatitis A
- *C. difficile* enterocolitis
- Legionnaires' disease.

7.4.1 Outbreak Management Plan

Should an outbreak occur the Clinical Care Coordinator acts as an Infection Control Coordinator in consultation with the Executive and Clinical Governance Team and appropriate agencies will instigate the Outbreak Plan.

Outbreak Plan

Step 1 Recognise the outbreak and prepare to investigate	• Define the usual rate and consider if currently in excess of that • Reinforce standard precautions • Notify and communicate with staff, clients and their carers
Step 2- Verify diagnosis and confirm that an outbreak exists	Review each case and ensure there are no discrepancies between clinical diagnosis and laboratory diagnosis. Confirm cases.
Step 3- Establish case definition and find cases.	Cases can be described as • Confirmed • Probable • Suspect
Step 4-Characterise outbreak	• Person • Place • Time Plot information so as to recognise any trends in data.
Step 5- Determine who is at risk	• Identify groups at risk • Initiate precautionary measures
Step 6- Formulating hypotheses- the how and why	Formulating a hypothesis, from the factual information gathered
Step 7- Testing Hypotheses with established facts	Analyse the data
Step 8- Carry out further studies if necessary	To support the hypothesis or if analytic studies do not confirm the hypothesis
Step 9- Implement ongoing control/ prevention methods	• Review measures to date • Implement appropriate ongoing controls • Communicate and coordinate with stakeholders • Plan to evaluate effectiveness
Step 10- Communicate findings	• Prepare a report that evaluates the control of the outbreak. • Review at Clinical governance committee and executive management committee

Australian Guidelines for the prevention and Control of Infection in Healthcare (2010), National Health and Medical Research Council.

8. Staff Health

The Alliance Community staff health program encompasses immunisation recommendations, exposure protocols and illness/infections guidelines.

8.1 Health care workers Immunisation Status

Alliance Community recommends that health care workers are screened and immunised for the following:

- Tetanus
- Hepatitis B and C
- Mantoux testing for Tuberculosis

8.2 Guidelines for health care workers who are Hepatitis B, Hepatitis C or HIV Positive

Reference:

Australian national Guidelines for the Management of Health Care Workers known to be infected with Blood borne viruses Feb 2012

Health Care workers and health Care Students who have blood borne virus should wear gloves if they have exudative lesions, weeping dermatitis, cuts or other skin breaks on their hands or wrists and they are contacting clients or client- care equipment and devices used in performing clinical procedures.

Health Care worker infected with blood borne virus are not to perform or be directly involved with exposure prone procedures (i.e. exposure - prone procedures are characterised by the potential for direct contact between the skin (usually the finger of thumb) of the health care worker and sharp surgical instruments or needles in body cavities or on poorly visualised or confined body sites (including the mouth)

All health care work infected with blood borne virus must practice recommended standard precautions that comply with blood and body substance precautions and that they adhere to approved recommendation for the safety of others in the workplace.

8.3 Specific Infections and the Health Care Worker

Disease/Infection	Work status
Chicken pox	For at least 5 days after the spots appear. Do not work until the lesions are completely crusted and dried. Do not care for clients with known shingles or chicken pox if you have not had exposure to chickenpox and are pregnant or contemplating pregnancy.
Infectious Conjunctivitis	May work, but no clients contact until drainage subsides. Good hand hygiene technique is essential
Diarrhoea/Gastroenteritis	Infections of the gastrointestinal system are common in the community. A wide range of pathogens are capable of infecting the gastrointestinal tracts. Bacteria = Escherichia coli, salmonella, campylobacter, Shingella, clostridium difficile. Viruses= Rota virus, small round virus. Return to work only after faecal cultures are negative if you have diagnosed bacterial diarrhoea. Consult your medical practitioner before returning to work following viral gastroenteritis.
Draining wound	Wound should be covered at all times

Herpes simplex	May work, but no contact with high risk(immunosuppressed clients)
Hepatitis A	Do not work until 7 days after jaundice disappears & you have receives medical clearance. Hepatitis A vaccine provides active immunisation and is recommended for all Health care workers.
Hepatitis B	Wear gloves when in contact with a client's mucous membranes of non -intact skin until you have medical clearance. Hepatitis B vaccine is available and recommended. A course of 3 vaccinations is required for full protection. Approximately 10% of individuals fail to produce antibodies. Serum antibody testing is recommended on completion of the course.
Hepatitis C	Active immunisation is not available. The incubation period is 2-4 months.
Mononucleosis (Glandular Fever)	Do not work until ALL Symptoms have Subsided
Measles	Do not work until 7 days after rash appears
Mumps	Do not work until 9 days after glands began to enlarge
URTI (flu)	May work but no contact with high risk clients until symptoms subside
Vomiting	Do not work until symptoms subside
Acute Respiratory Viral Infections	During influenza epidemics in the community there is an increased risk of infection to health care workers. Always use standard precautions and wear a mask if in close contact with an infected client is anticipated.
Cytomegalovirus (CMV)	CMV is the largest human herpes virus which is likely encountered in hospitals and the general community. Identification of clients who might shed CMV is difficult because the virus is latent and is often reactivated at times of reduced immune system function. Precautions-always use standard precautions. If you are pregnant it is recommended to see your GP to arrange counselling about the risks of contacting CMV. Arrange antibody testing to determine your susceptibility to CMV infection.
Scabies	Scabies is a parasite disease of the skin caused by a mite. Penetration is visible as papules vesicles or tiny linear borrows containing mites and their eggs. Lesions are prominent around finger webs, surfaces of wrists and elbows, axillary folds, thighs, and external genitalia. Itching is intense, especially at night. Crusted scabies can occur among Immunocompromised people such the elderly or people with HIV. It presents in a more severe form and as widespread dermatitis with scales and crusts over large areas of the body.

9. Reference List

- Australian Guidelines for the prevention and Control of Infection in Healthcare (2010), National Health and Medical Research Council. https://www.nhmrc.gov.au/guidelines-publications/cd33
- PD2017_013 NSW Health Infection Prevention & Control Policy. http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_013.pdf
- PD2017_010 HIV, Hepatitis B and Hepatitis C – Management of Health Care Workers Potentially Exposed http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_010.pdf
- NSW Health PD2014_004 Incident Management Policy. http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_004.pdf
- The Australian Immunisation Handbook Australian Government, Department of Health https://immunisationhandbook.health.gov.au/
- WHO Guidelines on Hand Hygiene in health Care 2009 http://www.who.int/gpsc/5may/tools/9789241597906/en/

NSW Infection Control Resource Centre. Department of Health NSW

Albion St
Surry Hills
Ph: 93329712

The Albion Centre

150 Albion Street
Surry Hills
Ph: 9332 9600
http://thealbioncentre.org.au/about-the-centre/who-we-are/

COVID-19 Response Plan – Alliance Community

This plan sits within the wider Business Australia Business Continuity Plan, which deals with the ICT and infrastructure requirements and outputs relevant to this pandemic and the wider requirements of the business to operate remotely.

1. Workforce

Alliance Community has a support workforce of over 450 individual staff.

Issue	Considerations	Response	Principles
Workforce fitness to work (screening and monitoring)	The Government under the advice of the Chief Medical officer has released a series of workforce screening measures for the general safety of the community. These measures can change frequently in response to the COVID-19 epidemiology.	Internal policies and procedures have been developed and updated to reflect requirements. They include; • COVID-19 Position Statement – Alliance Community. • COVID-19 Branch Guideline • COVID-19 Screening Guideline and Questionnaire for On-hire Workforce • COVID-19 Mandatory Notification Protocol for On-hire Workforce. Work Health and Safety Manager provides support to workforce in relation to COVID-19 and maintains a register of notifications of symptoms, potential exposures and outcomes of medical review. *Clinical Governance Committee* provides guidance, support and clinical review.	Compliance with government advice and requirements is mandatory and will be executed.

		Updated information on screening requirements is provided to the Senior Management team and the workforce as it is received and implemented. Regular communications delivered to workforce in relation to not going to work if they are unwell and seeking medical advice. When seeking medical advice, the worker is to communicate that they are a health/community care worker.	
Workforce fitness to work (identifying vulnerable workers)	• Vulnerability. People at risk of complications from COVID-19 include: ➢ people 65 years of age and over ➢ Aboriginal and Torres Strait Islander people ➢ people with chronic or other medical conditions ➢ people with a weakened immune system (due to a disease or medication)	Some of our workforce may themselves be defined as vulnerable. Each workers situation in this regard will be assessed on an individual basis with support and assistance provided by Senior Management and the Work Health and Safety Manger.	Be available to our worker "We are all in this together" No question is a silly question. Respecting individual circumstances.
Workforce Supply Challenges	The Department of Health predicts that a 20-30% staffing deficit could present related to COVID-19 infection amongst staff and /or their family and contacts.	Care staff contingency planning by branch with focus on • Repurposing staff within programs • Upskilling staff and providing additional buddy shifts • Active new staff recruitment initiatives and drives. • Initiate strategies to build staff resilience and culture to promote them going the "extra mile" if needed. • Where critical services are required to be delivered and there is a staff deficit, engage with alternative providers.	Staff are our key deliverable. The maintenance of a core staffing cohort will better support our clients' needs and this time.

Workforce education on COVID-19	This is a pandemic. A highly unlikely event until now. All community and care workers are to be educated and receive best practice training in relation to COVID-19.	Alliance Community website provides information on COVID-19, Frequently Asked Questions and updated regularly. All care staff are required to completed and provide a certificate of evidence that they have attended the **Dept Health COVID-19 training** on-line program. Compliance is audited. https://www.health.gov.au/resources/apps-and-tools/covid-19-infection-control-training Should the business be in a specific situation whereby we are caring for a client in the community that has COVID-19, our clinical nursing team would work with the Public Health Authorities to roll out a specific program of training and competency assessment related to this client scenario. Training in relation to the wearing and removal of PPE is available from w few key resources. This would be complemented by training by the clinical nursing staff. **Coronavirus (COVID-19) wearing personal protective equipment in aged care video** https://www.health.gov.au/resources/videos/coronavirus-covid-19-wearing-personal-protective-equipment-in-aged-care-video **Clinical Excellence Commission -Contact and Droplet Precautions and PPE training when caring for COVID-19 clients.** A suite of videos outlining the steps for putting on and taking off PPE when applying combined contact and droplet precautions or combined contact droplet and airborne precautions in addition to standard precautions, when caring for patients with some infectious diseases such as COVID-19.	Training tools and information is best practice, easily available and updated and reviewed regularly.

		http://www.cec.health.nsw.gov.au/keep-patients-safe/COVID-19/Personal-Protective-Equipment-PPE/covid-19-training-videos	
Workforce Management Challenges	Workforce challenges related to • Fear and Anxiety • Misinformation • Exposure to COVID-19 • Low Morale	• Branches audit workforce capabilities and know any limitations • Focus on Facts. Source of truth are government websites and in particular www.health.gov.au and https://www.ndiscommission.gov.au/resources/coronavirus-covid-19-information#train-covid • Utilise these documents and make available to staff • Initiate strategies to build morale and teamwork during these challenging times e.g. the Alliance Community Wellness Hub, COVID-19 information for workforce, Frequently Asked Questions, social media posts. http://www.hsga.com.au/Wellbeing-Hub • Communicate with workforce what we are doing to support them. • Promote workers opportunity to access the Employee Assistance Program (EAP) • Agree/discuss at weekly management meeting worker communication requirements (responding dynamically to the environment and issues).	Don't ask staff to do things that they can't do. Be truthful and factual. Value, support and engage with frontline staff regularly and authentically. We are in this together.
Response to a **suspected** case of COVID-19 in a care worker	Workers alert to symptoms and respond quickly. Eligibility for testing – we note that health workers are considered a priority for screening. Access to testing.	Care workers and other members of staff who are unwell develop symptoms aligned with COVID-19 are immediately excluded from the work and remain away (self-isolation) whilst a diagnosis is sought. The workers details are provided to the Work Health and Safety Manager for case management review and added to the registration record. The worker must present to a medical practitioner or COVID19 clinic for assessment.	Alliance Community will adhere to best practice advice and direction.

		Support provided by management team to care worker. If COVID-19 is excluded, the staff member may be able to return to work once well and has provided a medical clearance. Approval to recommence work is validated by the Work Health and Safety Manager.	
Response to a **positive** case of COVID-19 in a care worker	Lack of face to face medical assessment – Telehealth consultations are now being conducted by GP's Ensuring information sharing is effective.	The staff member is required to advise of the outcome of their test. If a diagnosis of COVID-19 is confirmed, the staff member is suspended from work immediately. Contact tracing by the Public health Unit will likely occur. The Senior Management Team and the Work Health and Safety Manager will facilitate this process with the health department. As indicated and in consultation with the health department, all identified potentially exposed person (clients and worker peers) will be notified and supported through the process. A medical clearance is required to recommence the worker with Alliance Community. Approval to recommence work is validated by the Work Health and Safety Manager.	Alliance Community will adhere to best practice advice and direction. Alliance Community will comply with all requests from the Public Health unit in relation to contact tracing.

2. Consumer issues and challenges

Alliance Community supports over 1200 individual clients in the community.

Issue	Considerations	Response	Principles
Consumer Risks and Challenges	• Vulnerability. People at risk of complications from COVID-19 include: ➢ people 65 years of age and over ➢ Aboriginal and Torres Strait Islander people ➢ people with chronic or other medical conditions ➢ people with a weakened immune system (due to a disease or medication) • Social Isolation – stay at home to stay healthy (and avoid exposure) • Fear, born from conflicting information, being overwhelmed, information that is hard to understand • Care needs and services, many are needed. Risk of infection (related to vulnerability) and health outcomes.	1.Risk assess all clients using the **Alliance Community COVID-19 Risk Tool**. Three categories of risk can be assigned. • Category 1 - High Risk (Red) • Category 2 – Medium Risk (Amber) • Category 3 – Low Risk (Green) 2.Review all client profiles a considering COVID-19 and add to care plans (1) Risk of COVID-19 infection (2) Risk of social isolation (3) Risk of changed service delivery 3.Provide consumers with information regularly -via email and SMS alerts, website updates and social media. Include positive affirming communications in conjunction with COVID-19 information. 4. Reduce the potential for social isolation by staying connected in different ways • Regular welfare checks (quick phone calls) • Facetime catchups • Zoom meetings with clients, families, front line workers, the office team • Innovative service delivery e.g. online shopping, home delivery, meal services. • Support clients to learn new technology skills – it's the perfect time. Where possible, bring technology to the consumer.	Risk Assessment, Risk Management and Risk Mitigation. Be available to our consumers "We are all in this together" No question is a silly question. Alliance Community is your "trusted provider". Our job is to "support you" in these challenging times. Let's embrace innovation, can we do things differently?

		• Provide information on community support opportunities and how to access 5. The role of the direct care worker is most important with a greater emphasis in monitoring consumers changes in health and wellbeing and reporting back to management. 6. Innovative and flexible service delivery. Working with clients and their funding programs to meet their needs in this challenging environment.	
Feedback and Complaint Management	Within this current environment of uncertainty, it would be reasonable to consider that complaints and feedback volume may increase. This could relate to several reasons including, changes in support services, changes in staff, communication and feedback.	All feedback and complaints are acknowledged and sought to be resolved in a timely manner. Training provided to staff on complaints management and handling objections and issues relation to COVID-19. Weekly management meetings consider issues presented and actions take, which are logged in the COVID019 Issues Register. This provides group learning and consistency of approach. Complaints are entered into the eQstats incident management system.	Complaints and feedback managed in a timely manner utilising the approach - regret, reason and remedy.

3. Personal Protective Equipment, consumables and products

Issue	Features	Response	Principles
Personal protective equipment supplies and sourcing	Ensuring there is appropriate usage of PPE (as per government guidelines) and adequate supply of PPE during the pandemic. Noting that there are supply issues currently.	PPE for the community care group are: • Level 1 -gloves, gowns (as per all personal care activities) • Level 2 – for the purposes of supporting a client in the community with a respiratory infection - gloves, gown and a surgical mask (preferably for the client if the client can tolerate it, if not, in special instances for the workers). • Level 3 – for the purposes of care for a person with known COVID-19 in the community, PPE includes – appropriate face masks, eye protection, gowns, gloves and an infectious waste receptacle. Branches are seeking to obtain 8 weeks of PPE supplies to meet potential demand. A head office back up stock pile is in place to ensure we are able deliver care safely and in a way that is aligned with the Health Department advice. National PPE stockpile is accessible on application where a case of COVID-19 is suspected by a medical professional or a known case, The National Medical Stockpile can be accessed via two mechanism. • For aged care approved provider programs – agedcarecovidppe@health.gov.au. • For NDIS approved providers – NDISCOVIDPPE@health.gov.au	PPE requirements follow best practice and are relative to the care delivered and the status of the community care client in relation to • Being well • Presenting with respiratory symptoms • A known COVID-19 client.

Hand hygiene product supply and sourcing.	Effective hand hygiene is the single most effective preventative measure.	Hand hygiene products are classified as: - Alcohol based hand rub (70%), liquid soap, hand towel. Community staff are required to complete hand hygiene before and after attending any client. Community clients allow care staff to utilise their own soap and hand towels to achieve this in the home environment. Where this is not possible or available, care staff are to provide their own soap and hand towels in consultation with the office who will engage with the customer to ensure the effective handwashing can take place. Hand sanitizers are utilised within the community setting in lieu of soap and water and the required minimum hand cleaning time of 30 seconds. Where possible (supply dependent), care staff are provided with hand sanitizer or are provided with an allowance to purchase their own at this time.	Effective hand washing with soap and water is the most effective means of reducing cross contamination in the community.
Cleaning supplies and sourcing	Cleaning surfaces and workstations is an effective method of ensuring a safe work environment and supporting the client's needs.	Cleaning supplies are classified as detergent and disinfectant products. Community clients provide cleaning products relevant to the service they are receiving from our staff, Where there are concerns related to the availability of cleaning supplies, care workers liaise with the office to ensure appropriate supples are in place. This is assessed on a case by case basis.	Cleaning process follows best practice recommendations. A safe work environment is prioritised.

4. Outbreak Management

Issue	Features	Response	Principles
Preventative surveillance – Workforce and clients	The aim of surveillance is to ensure early identification of symptoms in clients and staff that may precede, or indicate early stages of, an outbreak. Identification of a client or staff member with respiratory symptoms should be followed by prompt referral to a medical practitioner.	Clients and workers that present with respiratory symptoms and/or symptoms known to be associated with COVID-19 are flagged, immediately risk assessed and referred to a medical practitioner or the **Corona Virus Help Line - 1800 020 080**. Those with severe symptoms are referred to the ambulance service via a 000 emergency call. All confirmed or suspected care worker and client cases are reported to the WHS manager. A central register is maintained.	Early assessment & identification reduces the risk of further transmission of COVID1-19. PPE requirements follow best practice and are relative to the care delivered and the status of the community care client in relation to • Being well • Presenting with respiratory symptoms • Being a suspect or known to have COVID-19.
Local Community transmission	The Health Department collates data on local community transmission rates in conjunction with transmission rates related to direct contacts. Early notification will facilitate contract tracing. This data may influence the practise for the service and the experience for the client.	Alliance Community Senior Management will monitor Commonwealth Department of Health and state/territory public health sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with undifferentiated respiratory illness. If there is confirmed local transmission of COVID-19 in the community, consult with public health authorities for guidance.	Alliance Community is a responsible and responsive community partner.
Caring for a COVID-19 client in the community.	It can be anticipated that Alliance Community client that present with COVID-19 will either be cared for within the hospitals setting or the home setting.	Alliance Community will ensure all clients with COVID-19 receive the best care and treatment with no discrimination or disadvantage.	Alliance Community will provide safe care and support to our customers delivered in a safe and

		Care interventions will be risk assessed, focused primarily on critical care activities only that cannot be performed by others. Where care requirements are considered as too high risk, a determination will be made in relation to the appropriateness of care in the community as opposed to a hospital admission. Care will be provided in consultation with the medical practitioners and public health units requirements. A specific program of care will be initiated which will include; • the development of a tailored care plan • Staff training and support activities • appropriate PPE will be insitu and maintained • Escalation pathways for deteriorating health will be articulated and agreed between the medical practitioner, the client, the clients family and Alliance Community (the service provider). Alliance community will configure a care team that meets the clients' requirements and where possible is dedicated to that client only.	appropriate way by our staff.
Notification requirements	Government funded programs have requirements for notification that Alliance Community will comply with.	All cases of workers or clients with COVID-19 will be managed by the Public Health unit. Alliance Community will follow all directions and advice from the Public Health Unit. <u>NDIS Notification Requirements</u> Notify the NDIS Quality and Safeguards Commissioner of changes or events resulting from the COVID-19 outbreak, utilising the Notification of event form - https://www.ndiscommission.gov.au/providers/notice-changes-events/notification-covid-19	Alliance Community will meet all its contractual requirements.

		Veterans Home Care (VHC)Requirements VHC Service Providers are requested to inform DVA as soon as possible of any cases of COVID-19 infections amongst their staff or clients. Aged Care Packages and Commonwealth Home Support Program Aged Care Approved Providers and CHSP funded providers are encouraged to contact their funding manager. iCare (NSW) iCare Service Providers are requested to inform iCare as soon as possible of any cases of COVID-19 infections amongst their staff or clients Brokerage Clients Notification by the branch manager to the brokerage client manager is to be made as soon as possible in relation to any cases of COVID-19 infections amongst our staff that have attended their clients or information we received in relation to their clients and COVID19.	

5. Governance and Management Leadership

Issue	Features	Response	Principles
Information Sharing and problem solving	Communication and information sharing is an essential component of crisis management execution.	Twice weekly Alliance Community – COVID-19 Action Response Meetings are convened with Managers across all branches, chaired by Sue Cudmore. Information will be shared with teams and care workers by Branch Managers as required.	Alliance Community responsible and responsive to providing up to date information to all levels of staff. Appropriate information sharing and problem solving is achieved
Internal Reporting to executive	This data may influence the practise for the service and the experience for the client.	Weekly reporting to CEO and ELT on outputs and outcomes in relation to COVID-19 Reporting to the Clinical Governance Committee Reporting to Risk Management Team Reporting to the NSWBC Board	Regular reporting supports the development of timely strategies to manage the impact of COVID-19. Data pertaining to practice and the level of risk is communicated through the appropriate channels to the Board

5.Information and Resources

For the latest advice, information and resources, go to www.health.gov.au

Call the National Coronavirus Health Information Line on 1800 020 080. It operates 24 hours a day, seven days a week. If translating or interpreting services are required, call 131 450.

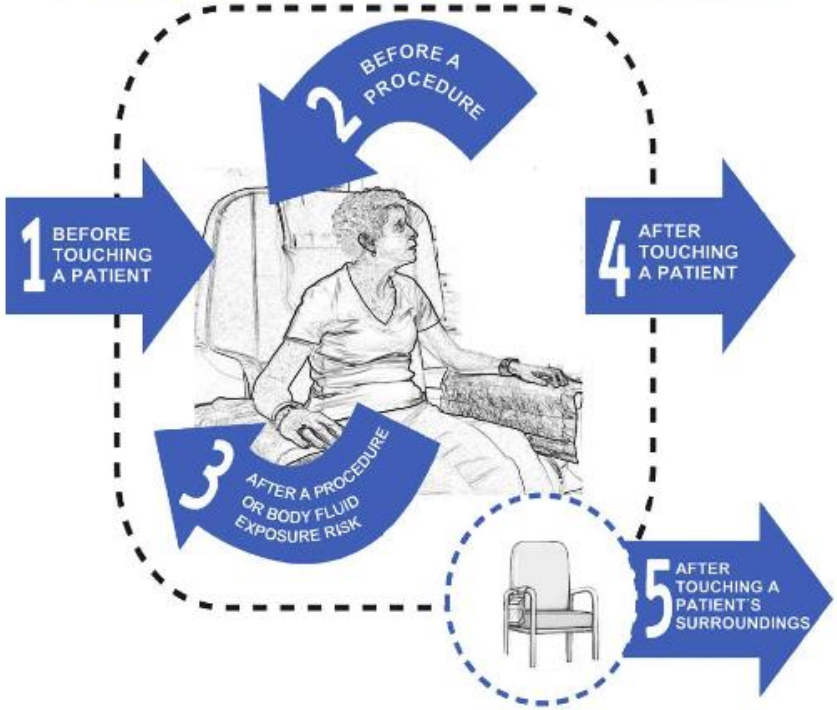
Information for NDIS participants and providers is available at www.ndis.gov.au and www.ndiscommission.gov.au

Corona Virus Health Line - 1800 020 080
https://www.health.gov.au/contacts/national-coronavirus-helpline

State/Territory Public Health Unit Contact details

State	Contact Details	Health Department Website
Queensland	13 432 584 (13 HEALTH)	https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19
New South Wales	1300 066 055	https://www.health.nsw.gov.au/Infectious/diseases/Pages/coronavirus.aspx
Australian Capital Territory	Business Hours: 02 5124 9213 After Hours: 02 9962 4155	https://www.covid19.act.gov.au/
Victoria	1800 675 398	https://www.dhhs.vic.gov.au/coronavirus
Tasmania	1800 671 738	https://www.coronavirus.tas.gov.au/
South Australia	1300 232 272	https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+topics+a+-+z/COVID+2019
Western Australia	08 9222 4222 WA Health	https://ww2.health.wa.gov.au/Articles/A_E/Coronavirus
Northern Territory	08 8922 8044	https://coronavirus.nt.gov.au/

5 Moments for HAND HYGIENE



1 BEFORE TOUCHING A PATIENT	When: Clean your hands before touching a patient and their immediate surroundings. Why: To protect the patient against acquiring harmful germs from the hands of the HCW.
2 BEFORE A PROCEDURE	When: Clean your hands immediately before a procedure. Why: To protect the patient from harmful germs (including their own) from entering their body during a procedure.
3 AFTER A PROCEDURE OR BODY FLUID EXPOSURE RISK	When: Clean your hands immediately after a procedure or body fluid exposure risk. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
4 AFTER TOUCHING A PATIENT	When: Clean your hands after touching a patient and their immediate surroundings. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
5 AFTER TOUCHING A PATIENT'S SURROUNDINGS	When: Clean your hands after touching any objects in a patient's surroundings when the patient has not been touched. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.

Hand Hygiene Australia
www.hha.org.au

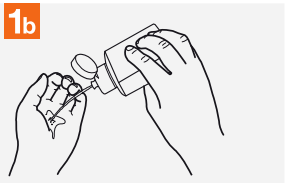
Adapted from
World Health Organization

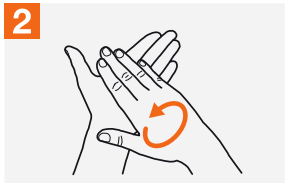
How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

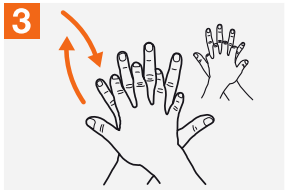
Duration of the entire procedure: 20-30 seconds

Apply a palmful of the product in a cupped hand, covering all surfaces;



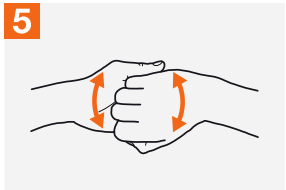


Rub hands palm to palm;



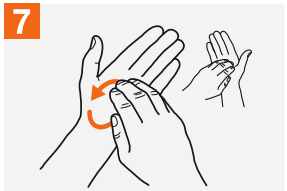
Right palm over left dorsum with interlaced fingers and vice versa;

Palm to palm with fingers interlaced;

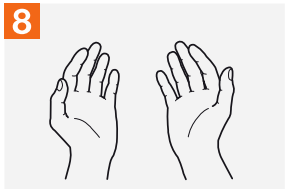


Backs of fingers to opposing palms with fingers interlocked;

Rotational rubbing of left thumb clasped in right palm and vice versa;



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

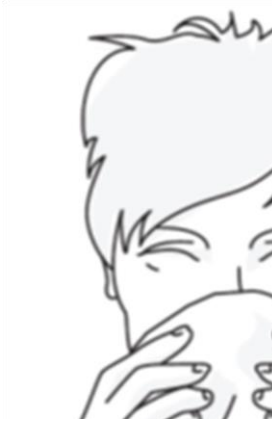


Once dry, your hands are safe.

World Health Organization | Patient Safety
A World Alliance for Safer Health Care | **SAVE LIVES** Clean **Your** Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009



- When coughing or sneezing, use a tissue to cover your nose and mouth
- Dispose of the tissue afterwards
- If you don't have a tissue, cough or sneeze into your elbow

- After coughing, sneezing or blowing your nose, wash your hands with soap and water
- Use an alcohol-based hand cleanser if you do not have access to

Remember:

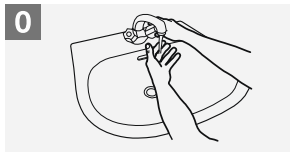
Hand hygiene is the single most effective way to reduce the spread of germs that cause respiratory disease!

Anyone with signs and symptoms of respiratory infection:

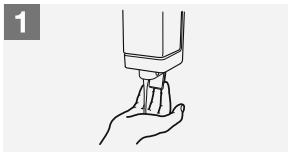
How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

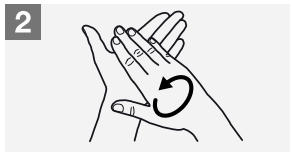
Duration of the entire procedure: 40-60 seconds



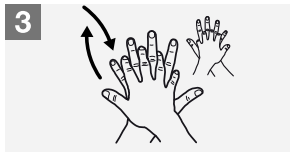
0 Wet hands with water;



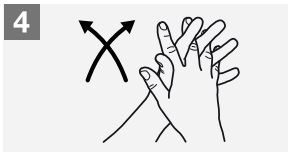
1 Apply enough soap to cover all hand surfaces;



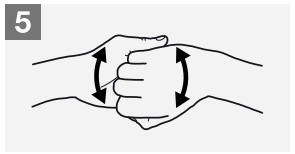
2 Rub hands palm to palm;



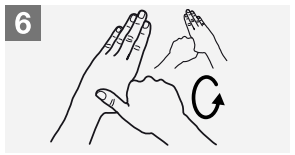
3 Right palm over left dorsum with interlaced fingers and vice versa;



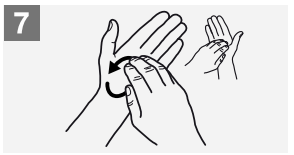
4 Palm to palm with fingers interlaced;



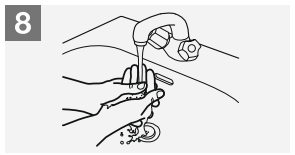
5 Backs of fingers to opposing palms with fingers interlocked;



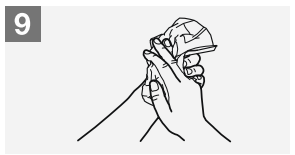
6 Rotational rubbing of left thumb clasped in right palm and vice versa;



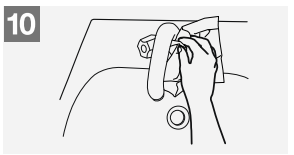
7 Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



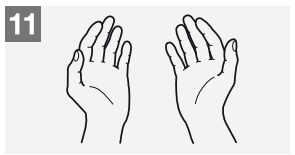
8 Rinse hands with water;



9 Dry hands thoroughly with a single use towel;



10 Use towel to turn off faucet;



11 Your hands are now safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | **SAVE LIVES** Clean **Your** Hands

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COVID-19 Individual Support Plan

The **My Support Plan – COVID-19** is to be implemented when an Alliance Community client is

1. suspected to have COVID-19 as determined by a medical practitioner resulting in a screening test
2. and/or an Alliance Community client that is known to have tested positive to COVID-19.

This Support Plan is to be approved by a Registered Nurse.

The purpose of this support plan is to provide the care team with the appropriate information and advice in relation to the care of an Alliance Community Client with suspected or confirmed COVID-19.

This support plan will be developed in consultation with the client and relevant stakeholders such as their support person/s, any other Service Providers involved in their care program, their medical practitioner and the relevant state Public Health Unit.

This Support Plan is to be used in conjunction with the **Alliance Community COVID-19 Risk Assessment.**

There are five possible COVID-19 client scenarios

1. The client has COVID-19 symptoms (flu like symptoms including fever, sore throat, cough) and has not sought medical advice. This person may or may not have COVID-19, however they are unwell.
2. The client has been exposed to a person that has known COVID-19, and does not have symptoms and has not yet sought medical advice or been tested
3. The client has been exposed to a person that has known COVID-19 and does have symptoms and has not yet sought medical advice
4. The client has been exposed to a person that has known COVID-19 and does have symptoms and has been tested, results pending
5. The client has confirmed COVID-19

There are multiple considerations within each scenario relating to the support and care provided by Alliance Community. Each client will be risk assessed, reviewed and considered individually, whilst following the advice and direction from the public health units.

Personal protective equipment (PPE) supplies

Alliance Community has implemented 3 levels of PPE requirements to ensure there is adequate and appropriate usage (as per government guidelines) and ensuring adequate supply of PPE during the pandemic:

LEVEL 1: Standard precautions required. PPE involves gloves, gowns and ensuring regular hand hygiene before, after & in-between consumer care (as per personal care activities).

LEVEL 2: Standard, contact and droplet precautions required. For the purpose of supporting a client in the community with a respiratory infection (non-COVID 19 related respiratory infection) PPE required – gloves, gown & a surgical mask (preferably for the client if the client can tolerate it, if not, in special instances for the workers) and ensuring regular hand hygiene before, after & in-between consumer care.

LEVEL 3: Standard, contact and droplet precautions required. For the purposes of caring for a person in the community with known COVID-19, suspected COVID-19 & client has been exposed to a person that has known COVID-19 and awaiting results (asymptomatic & symptomatic presentation). PPE includes – appropriate face masks, eye protection, gowns, gloves and an infectious waste receptacle.

Definitions

Standard precautions

Standard precautions include performing hand hygiene before & after every episode of contact with a client (5 moments), the use of PPE (for example gloves & gown) depending on the anticipated exposure, good respiratory hygiene/cough etiquette and regular cleaning of the environment & equipment

Contact precautions

Use Contact Precautions for clients with known or suspected infections that represent an increased risk for contact transmission. Contact precautions, when used with standard precautions, are designed to reduce the risk of transmission of microorganisms by direct and/or indirect contact.
Contact precautions should be considered for consumers colonised or infected with a multi-resistant organism (MRO) where there is significant consumer and/or environmental contact.

Contact precautions consist of:

Before entering client area

- Perform hand hygiene
- Perform a risk assessment on the need for apron/gown i.e. type of consumer contact (contact with body substance), type of MRO (new or emerging), consumer status (symptomatic or asymptomatic in clinical presentation)

After entering client area

- Perform hand hygiene
- Perform a risk assessment on the need for gloves i.e. type of consumer contact (contact with body substance), type of MRO (new or emerging), and consumer status (symptomatic or asymptomatic in clinical presentation)
- Change or remove gloves (if worn) and perform hand hygiene in between dirty and clean task

On leaving client area

- Clean shared equipment (if used)
- Remove and dispose gloves (if worn)
- Perform hand hygiene
- Dispose apron/gown (if worn)
- Perform hand hygiene

Use client-dedicated or single-use non-critical client-care equipment.

Ensure consistent cleaning and disinfection of surfaces likely to have been touched by the client and support workers.

Droplet precautions

Use Droplet Precautions for the clients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking. Droplet precautions should be employed in addition to standard and contact precautions when supporting any client known to be or suspected of being COVID-19 positive.

Specific requirements for droplet precautions are:

- Alliance Community Support Workers are to wear a disposable fluid repellent level 1 or level 2 surgical mask. Masks should be removed and disposed of when leaving the clients home or designated room and perform hand hygiene
- Protective eyewear (goggles or face shield) are to be worn
- Gloves to be always worn when assisting the client and when touching any of their belongings eg when cleaning a client's general space, assisting with personal care etc.

Personal Protective Equipment (PPE)

Personal protective equipment is special equipment that an individual's wear to create a barrier between them and infectious agents. The equipment is designed to protect the wear from the spread of infection and illness

Disposal of Personal Protective Equipment (PPE)

PPE must be disposed of in an infectious disease (biohazard) bag. Alternatively, PPE may be stored in a general waste bag (double bagged). The bags must then be put aside for 72hours before disposal and can then be disposed of in the regular manner.

Relevant PPE equipment used by Alliance Community staff includes; gloves, gowns, surgical grade masks, goggles, hand sanitiser & biohazard waste bags

Cessation of COVID-19 precautions

Cessation of COVID-19 precautions will be in accordance to the recommendations of the consumer's treating team and following the recommendations of the Department of Health

If the consumer returns a NEGATIVE COVID-19 result and are asymptomatic Level 3 PPE requirements can be reduced down to Level 1 and standard infectious control followed accordingly.

If consumer is COVID-19 negative but remains symptomatic with respiratory symptoms Level 2 PPE requirements and standard, contact and droplet precautions remain insitu until the consumer recovers from their respiratory illness and accompanying symptoms cease

COVID-19 positive consumers:
Consumers are to be reviewed by their treating team post their 14 days of isolation. Alliance Community are to follow the guidance of the consumer's treating team and the Department of Health when ceasing COVID-19 precautions. COVID-19 precautions are to only be ceased when the consumer is free of symptoms and the treating General Practitioner advises that the consumer has recovered from COVID-19 and is non-infectious. Non-essential services can be reintroduced into their care program as required

Scenario	Alliance Community Care Program position	Medical Intervention	PPE Considerations	Care documentation
1.The client has COVID-19 symptoms (flu like symptoms including fever, sore throat, cough) and has not yet sought medical advice. This person may or may not have COVID-19, however they are currently unwell.	Alliance Community staff are appropriately advised and trained in relation to the use of standard, contact & droplet precautions and the correct use of PPE in accordance with the guidance provided by the Department of Health recommendations All clients that present with COVID-19 symptoms or have been in contact with someone with a confirmed diagnosis of COVID-19 are to be referred to a medical service for assessment Alliance Community support workers should not enter the home of a person who is unwell until	Referral to GP, COVID hotline. Advice to be shared with Alliance Community	**Level 3**	Care notes are documented at each visit by the Alliance Community Worker. If the client's symptoms worsen, or if an emergency call an ambulance on 000. Otherwise, encourage client to seek medical advice ASAP and report back to office and speak with a coordinator. Alliance staff are to contact the office and report any concerns

	their status is ascertained, and PPE utilised as appropriate To ensure the appropriate PPE supplies are in place, this may require the service to be rescheduled to enable service to be attended safely Where possible, services are suspended until the client has had a medical assessment If services are **essential** and cannot be attended by a family member, standard precautions and droplet precaution measures are put in place Alliance Community will minimise the number of support workers who come into contact with the consumer, and consider which services are essential to keeping the consumer safe until diagnosis has been determined			

	Alliance Community will be transparent with the treating in-home support team in relation to the outcome of the COVID-19 testing and amend services as required If COVID-19 test diagnosis is positive Alliance Community is to access the national PPE stockpile in accordance with the program funding body			
2. The client has been exposed to a person that has known COVID-19, and does not have symptoms and has not yet sought medical advice or have been tested	Same as Scenario 1	Same as Scenario 1	**Level 3.** Same as Scenario 1 **EXCEPT -** As the client has no symptoms eyewear is optional.	Same as Scenario 1

3. The client has been exposed to a person that has known COVID-19 and does have symptoms and has not yet sought medical advice	Same as Scenario 1	Same as Scenario 1	**Level 3**	Same as Scenario 1
4. The client has been exposed to a person that has known COVID-19 and does have symptoms and has been tested, results pending	Same as Scenario 1	Same as Scenario 1	**Level 3**	Same as Scenario 1
5. The client has confirmed COVID-19	Same as Scenario 1 **PLUS** Alliance Community will work closely with the Public Health Unit and follow all their recommendations relating to the care and support of the client	GP Department of Health COVID hotline	**Level 3**	Same as Scenario 1

	Alliance Community will attend to regular welfare checks of clients who are deemed high risk and/or confirmed COVID-19 cases and escalate any concerns to relevant stakeholders as well as facilitating any required changes to service provision accordingly			

Workforce Considerations

All workers are instructed that they are NOT to attend work if they are unwell, this includes mild symptoms of cold and flu. Workers reminded regularly of this work requirement. Workers understand their role in following all requirements to keep themselves safe in the community.

We also appreciate that Alliance Community Care staff are committed to supporting their clients and if provided with appropriate information, training and support they will be able to manage their caring role with clients in the community during this pandemic.

To meet the requirements of the current environment

- All care staff have participated in COVID-19 online training module produced by the Department of Health.
- All care staff are provided with information in relation to their clients care needs and circumstances as they change and come to hand via the Procura App and special alerts via SMS.
- Appropriate support plans and instructions are in place and approved by a Registered Nurse
- Where PPE is required, all staff have been provided the appropriate training for correct utilization and disposal
- Where PPE is required it is provided by Alliance Community in line with the advice from the Department of Health
- Additional Information on COVID19 is also provided and available on https://www.alliancecommunity.com.au/en/news-and-media/march-2020/covid-19-information-for-our-workforce

Supporting documentation, fact sheets & resources

- **Clinical Excellence Commission: When to use personal protective equipment (PPE) in aged care –** http://www.cec.health.nsw.gov.au/keep-patients-safe/COVID-19
- **Department of Health: COVID-19 FACT SHEET: In-Home Care Providers –** https://www.health.gov.au/resources/publications/coronavirus-covid-19-information-for-in-home-care-workers
- **Department of Health: Guide for Home Care Providers –** https://www.health.gov.au/resources/publications/coronavirus-covid-19-guide-for-home-care-providers
- **Department of Health: Coronavirus (COVID-19) – When to use personal protective equipment in aged care -** https://www.health.gov.au/resources/publications/coronavirus-covid-19-when-to-use-personal-protective-equipment-in-aged-care
- **Department of Health: Coronavirus (COVID-19) wearing personal protective equipment in aged care video -** https://www.health.gov.au/resources/videos/coronavirus-covid-19-wearing-personal-protective-equipment-in-aged-care-video
- **Department of health: COVID-19 infection control training and portal -** https://www.health.gov.au/resources/apps-and-tools/covid-19-infection-control-training
- **Infection control & prevention signs** https://www.safetyandquality.gov.au/sites/default/files/migrated/Portrait-NSW-Standardised-Infection-Control-and-Prevention-Signs.pdf
- **Hand Hygiene – 5 moments for hand hygiene** https://www.hha.org.au/hand-hygiene/5-moments-for-hand-hygiene

COVID-19 Individual Support Plan

Name:	**DOB:**
Address:	**Home Phone:** **Mobile:**
Living arrangements: (who do you live with?)	**Living environment (e.g. supported accommodation, lock box details, entry details, group home)**
Emergency contact details: **Relationship to consumer:**	**Address:** **Home phone:** **Mobile:** **Work:** **Email:**
GP contact details: **Address:**	**Phone:** **Email:**
COVID-19 screening date:	**Date of diagnosis (confirmed COVID-19):**
Isolation commencement date (if applicable):	**Isolation conclusion date (if applicable):**

Infectious control precautions-initiated: Y/N **Commencement date:**	**Standard: Y/N** **Contact & Droplet: Y/N**
Available PPE: Y/N	**PPE requirements:** **Location of PPE:**
Relevant medical history:	**ALERTS/WH&S:**
Behaviours of concern: Y/N **Details of behaviours:**	**Active restrictive practices: Y/N** **Active Behaviour Support Plan:**

Alliance Community

Schedule of essential services

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							
Additional services							

COVID 19 – Risk Assessment Checklist

Use the COVID-19 Risk Assessment checklist below to determine the level of risk and any required controls on completion of this document. Where risk category is other than 'Category Three Green' please consult with the Manager.	
Risk Level Associated with Client:	**Category 1 – High Risk (Red)** **Category 2 – Medium Risk (Amber)** **Category 3 – Low Risk (Green)**

COVID 19 – Risk Assessment Checklist

RISK INDICATOR CHART				
• Category 1 - High Risk (red) • Category 2 – Medium Risk (amber) • Category 3 – Low Risk (green)		LIKELIHOOD		
		Very Likely Known to regularly or very likely occur, given existing circumstances or	**Likely** Known to often or fairly likely occur given existing circumstances or environment	**Unlikely** Some potential to occur based on previous experience or existing
SEVERITY	**High (red)** Life threatening or cause serious injury	**Category 1 (red)**	**Category 1 (red)**	**Category 2 (amber)**
	Medium (amber) Could result in temporary incapacity	**Category 1 (red)**	**Category 2 (amber)**	**Category 3 (green)**
	Low (green) Could result in inconvenience or first aid	**Category 2 (amber)**	**Category 3 (green)**	**Category 3 (green)**

Client Full Name: _____ **Date:** _____

Client Address: _____

COVID 19 – Risk Assessment Checklist

COVID 19 – Risk Assessment & Controls				
Client Circumstance	**Yes**	**No**	**Level of Risk**	**Controls / Strategies / Comments**
Are you currently exhibiting Flu-like symptoms? ○ Cough Fever ○ Sore throat ○ Breathing difficulties ○ Aches *If Yes – Refer to COVID19 Branch Guidelines: Workforce Management – Experiencing flu-like symptoms*				
Have you recently returned from travelling overseas? *If yes - Where:* *- Date Arrived in AUST:*				
Have you recently returned from travelling interstate? *If yes - Where:* *- Date returned*				
Have you come in contact with anyone with COVID-19 or been tested for this yourself?				
Has a member of your household been in isolation/quarantine? **if yes, provide details*				
Does a member of your family have flu-like symptoms? **if yes, provide details*				
Level of understanding / Cultural issues identified? *e.g. English as a second language*				
Any underlying health/respiratory illnesses that may increase susceptibility to COVID-19?				**Details*
How many days' worth of non-perishable essential food / groceries do you have? **If no, can this be arranged?*				
How many of the following do you currently have? 1. Gloves 2. Aprons 3. Continence Supplies 4. Cleaning Products 5. Other required Consumables. **Outline how much in stock. If not adequate – how will these be obtained?*				

How many days of medication do you have at hand?				
Do you have any scheduled mandatory medical appointments?				
Any Pets?				
Do you have any services that could be considered non-essential *(such as social groups/lawn mowing services)*				
Are there any other issues that may put client at risk? *e.g.: No informal supports etc.*				
Current Level of Independence	**Yes**	**No**	**Level of Risk**	**Controls / Strategies / Comments**
Does client have a Cognitive Impairment/Physical Disability?				
Is client Independent with Personal Care & Medication?				**Details*
Are there any considerations/risks in relation to medications and others drugs and alcohol? *E.g. confusion/cognitively impaired persons in the home (client/family/friends)?*				
Independent with Meal Preparation? **Can client access meals on wheels?*				
Accessibility to family members, friend/neighbour that can assist with Personal Care?				*Name:*
Accessibility to family member, friend/neighbour that can share accommodation?				*Relationship to Client:* *If no, what other measures are in place?*
Accessibility to family member, friend/ neighbour that can assist with Shopping?				
Are NOK details recorded in client's electronic record?				**Details*
Is client able to access telephone to seek support in an emergency?				

COVID 19 – Risk Assessment Checklist

Is there good mobile coverage?				
Does client have care link pendent/or lock box?				
Are there any other noted concerns?				

Rate any risks identified and indicate (circle) the risk level at the top of the front page and below.	
Risk Rating:	Category 1 - High Risk (Red) Category 2 – Medium Risk (Amber) Category 3 – Low Risk (Green)
Additional Information/Comments • Outline reason for the risk score and any controls required:	
Assessors Name:	
Assessors Title:	
Date:	

COVID-19 Screening Questionnaire

Suggested Introduction:

The safety of our employees, customers, clients and people we work with and care for remains Recruitment Solutions' highest priority.

To prevent the potential exposure and spread of COVID-19 we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect both yourself and our community.

Recruitment Solutions is guided by The Office of the Australian Information Commissioner guidance on how to protect privacy while ensuring safety. Details can be found here: https://www.oaic.gov.au/privacy/guidance-and-advice/coronavirus-covid-19-understanding-your-privacy-obligations-to-your-staff

Thank you for your time.

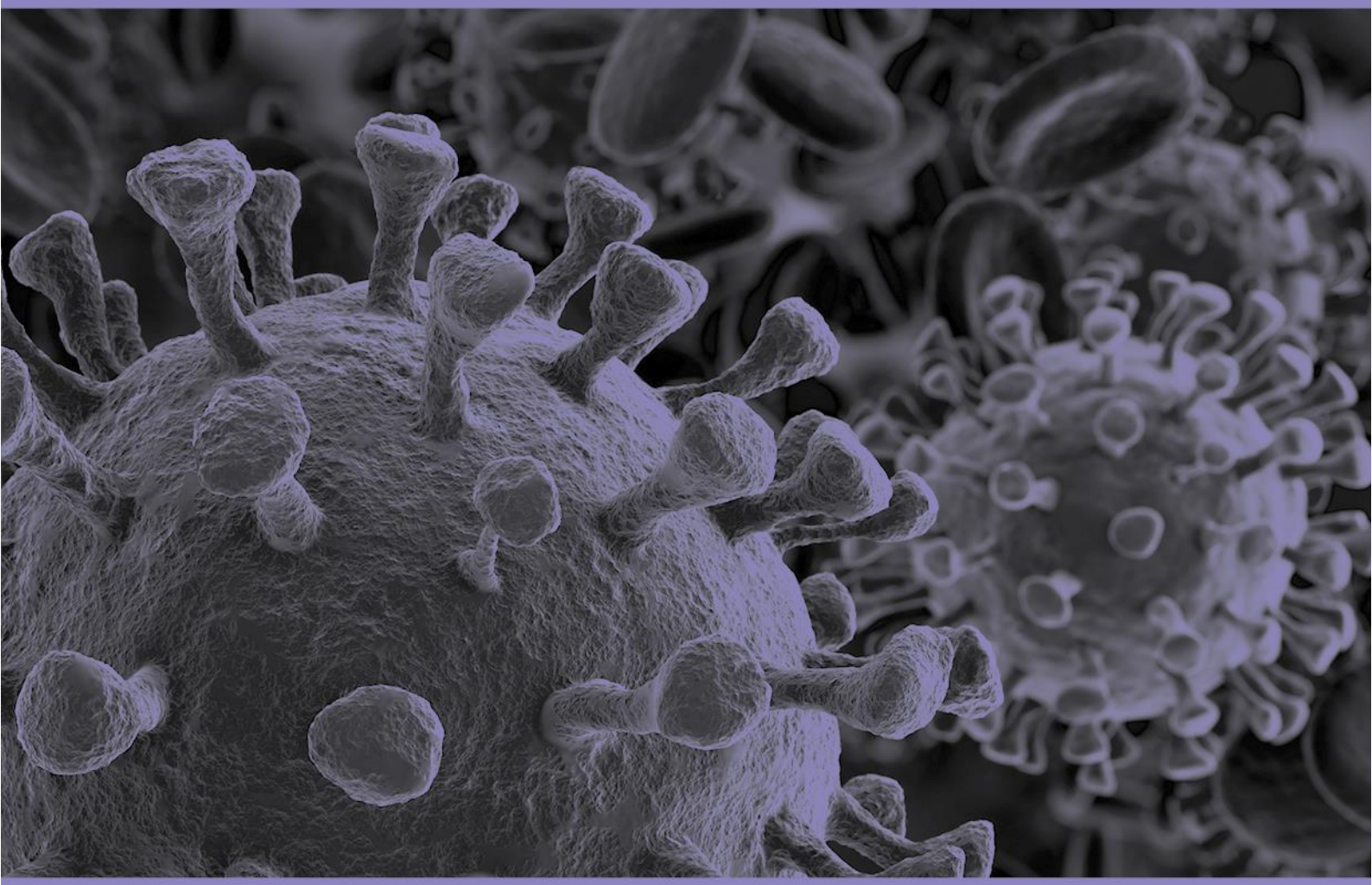
Questions:

1.	Are you currently exhibiting Flu-like symptoms? *YES – Refer to COVID19 Branch Guidelines: Workforce Management – Experiencing flu-like symptoms*	NO YES Cough Fever Sore throat Breathing difficulties Aches
2.	Have you recently returned from travelling overseas?	NO YES If yes – Where: Date Arrived in AUST:
3.	Have you recently returned from interstate? Relevent for SA, WA, NT and QLD *YES – Refer to COVID19 Branch Guidelines: Workforce Management- Recently returned from interstate*	NO YES If yes – Date returned:
4.	Have you come in contact with anyone with COVID-19 or been tested for this yourself? *YES – provide clearance for work*	NO YES
*5.	Has a member of your household been in isolation/quarantine?	NO YES (if yes, provide details)
*6.	Does a member of your family have flu-like symptoms?	NO YES (if yes, provide details)

*** Question 5 & 6:**

- Is not required for Visitors to branches.
- Should be considered for higher risk worker placements such as healthcare and community.
- May be considered prior to worker who will be placed remotely and have travel requirements, meaning isolation from the work environment would be challenging. E.g. FIFO or DIDO remote worker.

Australian Government
Department of Health



MANAGEMENT AND OPERATIONAL PLAN FOR PEOPLE WITH DISABILITY

Australian Health Sector emergency Response Plan for Novel Coronavirus (COVID-19)

April 2020

Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)

Publications Number: 12752

Contents

Introduction

On 11 March 2020, the World Health Organization (WHO) announced that novel coronavirus (COVID-19) was a worldwide pandemic. The COVID-19 outbreak represents a significant risk to Australia. It has the potential to cause high levels of morbidity and mortality including mental health impacts, and to disrupt our community socially and economically. However, Australia is well prepared and has excellent health systems to deal with the virus. All areas of the health sector are well informed and actively engaged in the national response.

The Australian Government is committed to ensuring that people with disability and their families and carers have equitable access to health care during the outbreak, including accessible health and social care advice, and access to essential supports and services. In this document people with disability refers to people who have long-term physical, mental, intellectual, cognitive or sensory impairments or conditions.

The Government has taken a precautionary approach to COVID-19, working collaboratively with state and territory governments as well as whole of government partners to implement strategies to minimise disease transmission.

In order to guide the health sector response, the Government developed the first Australian Health Sector Emergency Response Plan for Coronavirus (the COVID-19 Plan). The COVID-19 Plan outlines how key activities will operate and how the Australian public can support the national response. The following information is provided in the plan:

- what we know about the disease and the outbreak
- what sort of risk COVID-19 represents
- what the Australian Government health sector will be doing to respond
- how the Government's response will affect people
- what people can do to contribute
- how people can manage their own risk, the risk to their families and their communities.

As we learn more about COVID-19 we are:

- regularly reviewing our response
- moving resources into activities which are working well
- scaling back activities that are not working.

COVID-19 presents a significant and unprecedented challenge for many people with disability, including children and young people, the people who support them, and the disability sector as a whole. Some people with disability are more likely to be vulnerable to the effects associated with COVID-19 including impacts which continue following the pandemic period.

The Management and Operational Plan for COVID-19 for People with Disability (the Plan) has been developed to provide a targeted response for people with disability, their families, carers and support workers.

The Plan also reflects the Government's commitment to upholding the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and the National Disability Strategy 2010-2020. Both of these documents take a social model view of disability. The social model of disability recognises that disability results from the interaction between persons with impairments or conditions and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. In particular, this document seeks to ensure health services provided in response to COVID19:

- recognise that people with disability have an inherent right to life and its enjoyment on the same basis as others
- provide people with disability the same standard of health care as other persons
- provide people with disability access to health services as close to their own community as possible, including rural and remote areas
- promote dignity, autonomy, and respect for people with disability when receiving health care and that the provision of health care is free from bias or discrimination.

Additionally, under the *Disability Discrimination Act (Cth) 1992* the Australian Government is committed to eliminating discrimination against people with disability, and ensuring that the fundamental rights of people with disability are recognised on the same basis as the rest of the community.

Implementation of the Plan will also uphold the Government's commitments under the *Carers Recognition Act (Cth) 2010*.

For the purposes of this document the following definitions will be used throughout:

Carer means: a person who provides unpaid care and support to people with disability who are family members or friends.

Support worker means: a person who provides paid support to a person with disability, either directly employed by the person or employed or otherwise engaged by a provider chosen by the person with disability to deliver their supports. This includes a person who is a volunteer who might be engaged by an organisation to provide support to a person with disability.

PART 1

The Plan

The Plan has been developed for people of all ages with disability, their families, carers, support workers and the disability and health care sectors. It will provide high-level guidance on a range of factors that need to be considered in managing and preventing the transmission of COVID-19 for people with disability. The Plan will be informed by a risk-based approach, prioritising individuals whose disability, current health status and setting, places them at significant risk of adverse outcomes related to COVID-19.

The Plan will be a living document and will be reviewed periodically, in line with the Australian Health Sector Emergency Response Plan for Coronavirus. As new evidence and recommendations for how to manage the COVID-19 pandemic emerge, particularly in relation to disability, the Plan will be updated accordingly.

The Plan was developed, and its implementation will be overseen, by an Advisory Committee (see *Governance and Consultation)* and has been endorsed by the AHPPC.

The Plan has two main parts, the Management Plan and the Operational Plan.

- Part 1 – Management Plan
- Part 2 – Operational Plan
    - Initial action stage
    - Targeted action stage
    - Stand down stage.

Objectives

The Plan focuses on broad clinical, public health and communication actions which will benefit all Australians including people with disability, as well as targeted action specific to people with disability.

The objectives of the Plan are to:

- minimise COVID-19-related transmission, morbidity and mortality among people with disability
- guide action across Australia, including rural and remote areas in reducing the risk of COVID-19 for people with disability, including children, young people and adults
- inform, engage and empower all people with disability, their families, carers and support workers in relation to COVID-19
- identify and characterise the nature of the virus, and the clinical severity of the disease as it relates to people with disability

- support effective care, including rehabilitation, for people with disability who contract COVID-19, and reduce additional burden from COVID-19 for healthcare and disability support workers
- support people with disability continuing to have access to essential health care for non-COVID conditions, including mental health conditions, through the pandemic period.

Consistent with the overarching COVID-19 Plan, decisions on the implementation of public health measures may vary across state and territory governments. This includes the timing of initiation of measures and the Stand down Phase outlined in Part 2. The AHPPC will aim to support a coordinated approach across jurisdictions wherever possible.

It is important to note that a key goal of the Plan and implementation approach is to achieve a response proportionate to the level of risk. This approach acknowledges the risk is not the same across all population groups, and reducing the risk for vulnerable populations such as people with disability is vital.

Principles

The following principles underpin the Plan, from development through to implementation:

- EQUITY: The **human rights** of people with disability are upheld through an equitable, accessible and tailored health care response.
- PREVENTION: **Preventing** people with disability **becoming infected** is the primary focus.
- INFORMED: People with disability, their families, carers and support workers **understand what to do** during the pandemic and how to access support.
- TARGETED: Clear and **targeted information** and advice is communicated in a diverse **range of accessible formats**.
- SUPPORT NETWORKS: Supporters of people with disability (families, carers, support workers and others providing formal and informal supports) are **central to the safety of people with disability**, during the pandemic, and are a key target group for this plan.
- PARTNERSHIPS: There is a need for an **integrated partnership between the health sector and disability sectors** to appropriately respond to the diverse needs of people with disability, their families, carers and support workers.
- CULTURAL CONSIDERATION: **Aboriginal and Torres Strait Islander people** with disability need special focus in this plan and associated plans, with underlying **disadvantage, cultural considerations, remoteness** and other issues posing challenges for **equitable access** to health care and other supports.
- WELLBEING: protect the mental health and wellbeing of people with disability and their families by involving them in decision making and **minimising disruption to their daily lives**. Where appropriate, providing appropriate care in non-hospital settings as much as possible and facilitating the **essential support** that people with disability need.

Rationale for the Plan

The COVID-19 pandemic presents a significant risk to the health and wellbeing of all Australians, but particularly people with disability. More than 4.4 million people in Australia have disability. This equates to almost one in five Australians. Exposure, susceptibility and impact vary according to the type of disability (e.g. intellectual disability, mobility impairments or conditions) as well as individual and contextual factors such as age, gender, socio-economic status, family environment, where someone lives, whether they are Aboriginal or Torres Strait Islander, whether they are from culturally and linguistically diverse backgrounds.

People with disability live and work in a range of settings and are active members of the community. Some people live at home by themselves, others live with family members, or in congregate disability accommodation services or group homes. Some work within organisations specifically providing employment opportunities for people with disability. Some settings may increase the risk of morbidity and mortality, including when an ageing person is responsible for the informal care of a person with a disability. Such settings require increased levels of risk mitigation and support to prevent COVID-19 transmission.

In certain settings, people with disability are over-represented and this includes the use of acute care services such as public hospital emergency departments and inpatient services. For example, people with intellectual disability present to emergency departments at two to three times the rate of the general population and experience longer lengths of stay as inpatients.

People with disability experience higher rates of morbidity, which includes managing additional health concerns such as mental health conditions, chronic conditions and complex comorbidities. They consequently experience higher rates of mortality. Fifty per cent of people with disability in Australia live in households in the lowest two income quintiles, compared with 24 per cent of other Australians.

Many people with disability also come from multiple ‘priority’ population groups; this can have a compounding effect on their health needs and outcomes. For example, many people with disability from rural and remote backgrounds also have a lower socioeconomic status, may identify as Aboriginal and Torres Strait Islander, identify as LGBTI+ or are from a culturally and linguistically diverse background. There are also a number of barriers that people with disability face when accessing health care.

Table 1 outlines the Government’s advice on who is most at risk of contracting COVID-19 and people who are more likely to be at higher risk of serious illness from the virus.

Table 1 - The relationship between the risk factors for COVID-19 and people with disability

Risk Factors for COVID-19 [1]	Relation to People with Disability
People who have been in close contact with someone who has been diagnosed with COVID-19	In 2018, of the people with disability aged 0-64 years, 363,000 required assistance with self-care, 541,700 with health care and 185,000 with meal preparation. These activities are likely to require close contact. Overall,1.39 million Australians with disability required assistance with one or more activities.[2] In addition, some people with disability may not be able to follow health recommendations related to COVID-19, for example, physical and social distancing and hand hygiene guidance and isolation.
People in correctional and detention facilities	People with disability are overrepresented in custodial facilities including prisons, forensic mental health facilities, remand centres and other detention facilities. In 2018,two in five prison entrants aged 45 and over self-reported a disability.[3]
People in group residential settings	In 2018, an estimated 14,400 people with disability aged 15-64 years, lived in cared-accommodation, including hospitals, aged care, cared components of retirement villages, hostels and other homes such as group homes.[4]
Aboriginal and Torres Strait Islander people 50 years and older with one or more chronic medical conditions	In 2018-19, 46 per cent of Aboriginal and Torres Strait Islander people had one or more chronic conditions. Additionally, 27 per cent of Aboriginal and Torres Strait Islander people reported they had a disability or restrictive long-term health condition.[5] Disability among Aboriginal and Torres Strait Islander people is likely to be under-reported due to diverse attitudes to impairment among Aboriginal and Torres Strait Islander communities.
People aged 65 years and older with chronic medical conditions	In 2018, 1.13 million Australians aged over 65 had one or more long-term health conditions.[6] Some people with chronic health conditions may experience disability due to the interaction between their condition and their environment, and a lack of access to the community and employment.
People aged 70 years and older	The likelihood of living with disability increases with age, with the majority of people with disability aged 65 years and older[7].

Risk Factors for COVID-19 [1]	Relation to People with Disability
People with compromised immune systems and vulnerability to respiratory illnesses	Some disabilities are associated with a suppressed immune system and a greater incidence of complications (e.g. Down Syndrome[8]). Some types of medications prescribed for specific disabilities can also cause immune-suppression.

1 = https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19\

2 = ABS Cat. no 4430.0 - Disability, Ageing and Carers, Australia, 2018 https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4430.02018?OpenDocument

3 = AIHW, The health of Austrlaia's prisoners, 2018. https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/report-editions

4 = ABS Cat. no 4430.0 - Disability, Ageing and Carers, Australia, 2018. https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4430.02018?OpenDocument

5 = ABS Cat. No. 4715.0 - National Aboriginal and Torres Strait Islander Health Survey, 2018-19, https://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4715.0Main%20Features12018-19?opendocument&tabname=Summary&prodno=4715.0&issue=2018-19&num=&view=

6 = ABS Cat. no 4430.0 - Disability, Ageing and Carers, Australia, 2018. https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4430.02018?OpenDocument

7 = https://www.and.org.au/pages/disability-statistics.html

8=Ram, G., & Chinen, J. (2011). Infections and immunodeficiency in Down syndrome. Clinical and experimental immunology, 164(1), 9–16. https://doi.org/10.1111/j.1365-2249.2011.04335.x

In addition, the following factors play a significant role in increasing risk for people with disability:

- poor health literacy, at times due to lack of accessible communication, may affect an individual's ability to comply with the evolving COVID-19-related prevention and management measures
- the reliance on other people including family members, carers and support workers to provide essential support at close contact, often on a daily basis
- people with high and complex support needs (including behaviours of concern) may need extra health support to ensure their essential needs are met, including communication or behaviour support. People in these situations may not be able to self-isolate in the same manner as the rest of the community – relying on wide networks of informal and formal supports to meet their daily needs.

The settings in which some people with disability live and work combined with public health directions for limited community movement, and in some cases self-isolation, may create the potential for greater risk of abuse, neglect and exploitation. This includes domestic and supported living settings. The regulation of supports, such as through the National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission, the Aged Care Quality and Safety Commission and state and territory regulators and authorities for community settings, continue unchanged through the COVID-19 pandemic.

The actions outlined in the Operational Plan (Part 2) respond to the needs of people with disability in high-risk groups. These actions will be coordinated in line with actions taken under the Australian Health Sector Emergency Response Plan.

Roles and Responsibilities

Many critical partners, including the health and disability agencies of the Australian and state and territory governments, people with disability, families, carers, support workers and the healthcare and disability sectors, all have a role to play in protecting the health of people with disability from COVID-19 infection.

1. Planning

The **Australian Government** will undertake a range of specific measures relevant to the health of people with disability in the context of COVID-19, including:

- Development of the Management and Operational Plan, in partnership with the Advisory Committee, states, territories and other stakeholders.
- Coordinating the implementation of the Plan, with oversight from the Advisory Committee.
- Provision of secretariat support to the Advisory Committee.
- Coordinating and communicating with the states and territories, through the Australian Health Ministers Advisory Council, the Australian Health Protection Principal Committee and relevant disability services coordination mechanisms, to support effective communication and health service provision for people with disability in response to COVID-19.
- Preparation and dissemination of national guidelines, procedures and other resources to support this Management and Operational Plan.
- Mobilising the resources of the National Medical Stockpile, and State/Territory resources where applicable, to support the appropriate provision of Personal Protective Equipment (PPE) and other resources, according to availability and need, to people with disability, their families, carers and support workers in health and disability care settings.

Developing and supporting a national communications plan specific to people with disability, to educate people with disability, their families, carers, support workers, health care workers and others about the spread of COVID-19 and effective prevention, screening, assessment and treatment approaches.

State and territory governments will develop, where appropriate, complementary operational plans for public health, clinical and disability service responses specific to people with disability, promoting and drawing on expert and specialised sources of advice wherever possible. State and territory governments will lead the health service response within their jurisdictions. States and territories are responsible for COVID-19 surveillance, communication of new cases and outbreaks, and for providing alerts to communities.

Clinicians and public health professionals and practitioners should engage with people with disability and their carers and support workers in any planning processes.

Peak bodies, stakeholder groups and wherever possible, **carers, families, support workers and people with disability** themselves should be engaged in the planning process through the Advisory Committee.

2. Epidemiological assessment of COVID-19 specific to people with disability

The **Australian Government** Department of Health works with state and territory public health units and the Communicable Diseases Network of Australia (CDNA) to review data and evidence about the spread of COVID-19 especially for the purposes of this Plan. The Department of Health will work with the NDIS Quality and Safeguards Commission, the Australian Institute of Health and Welfare and others to help develop the information available about COVID-19 outbreaks among people with disability in residential and other settings.

State and territory government health agencies will collect notification data in their own jurisdictions, including evidence from the sector of what responses are required in communities, which also contributes to understanding the spread of the disease across the country and inform their own jurisdictional public health response activities. Once it is apparent cases are detected among people with disability, immediate responses should be enacted as outlined in this Management Plan.

3. Implementation of public health measures

Health care and disability settings providing care to people with disability should implement public health measures to minimise the spread of COVID-19, including:

- Preventive health advice directed at minimising droplet spread of the virus. This includes accessible messaging about hand washing, cough and sneeze etiquette and social distancing (also called physical distancing). Health services should work with the disability sector to develop accessible methods of disseminating this advice.
- Training the care workforce in infection control practices such as the Australian Department of Health's online COVID-19 training https://covid-19training.gov.au/

Should control measures—such as isolation and/or quarantine be required for people with disability—mitigation strategies and decisions should be implemented in collaboration with people with disability, their families, carers, support workers and stakeholder organisations.

To reduce the concurrent burden of influenza on people with disability and the confusion regarding diagnosis/causes of outbreaks, influenza and pneumococcal vaccination should be promoted by health care and disability workers supporting high-risk people with disability.

4. Safeguarding

All Australian governments play a role in minimising the risk of harm and protecting the rights of people with disability, through safeguarding systems in all jurisdictions. Disability service providers are required to ensure procedures, guidelines and standards are in place consistent with their obligations under Commonwealth as well as state and territory legislation.

5. Researching, planning and building outbreak control strategies

The Australian Government will commission research on the effectiveness and impact of public health measures in response to COVID-19, including for people with disability under this plan. The Commonwealth, state and territory governments will use this information to inform plans and provide updates continually throughout the COVID-19 outbreak.

6. Coordination

The Australian Government will coordinate national COVID-19 outbreak measures and allocate available national health resources across the country. It will support the health response in any jurisdiction, through the AHPPC, to coordinate assistance if jurisdictional capacity becomes overwhelmed.

The Australian Government and state and territory governments will work together to consider data and evidence, resource and sharing of information to determine whether and when a national response is required; advise on thresholds for escalation; share information on resource availability; and coordinate access to resources to maximise the effectiveness of the response.

State and territory governments will coordinate and provide COVID-19 healthcare services, including assessment and treatment centres as required. State and territory governments will undertake public health management of the response including contact tracing and directing isolation and quarantine.

7. Stand down and Evaluation

The Australian Government will: coordinate the stand down of enhanced measures; manage the transition of COVID-19 outbreak specific processes into normal business arrangements; and undertake public communication regarding changing risk and the stand down of measures.

The disability support sector and health care settings providing care for people with disability will advise on the timing and impact of reducing enhanced clinical COVID-19 outbreak services; and support stand down of measures. They will also manage the transition of novel coronavirus outbreak specific processes into business as usual arrangements as appropriate; and assist in communicating public messages regarding changing risk and stand down of COVID-19 outbreak measures.

Governance and Consultation

On 2 April 2020, an Advisory Committee was formed to oversee the development and implementation of the Plan. The Advisory Committee was endorsed by the AHPPC and reports to the Australian Government Chief Medical Officer. Members of the Advisory Committee are experts from a range of backgrounds including people with lived experience, Disabled Peoples Organisations, the disability service sector, the research sector, the health care sector including

medical practitioners, allied health professionals and nurses, Australian Government officials, and state and territory government officials.

The Advisory Committee presented a draft Plan to a Roundtable of health and disability sector stakeholders, including representatives of all state and territory governments on 7 April 2020. This builds on the membership of a Roundtable on the health of people with intellectual disability, originally planned for that date.

The final version of the initial Plan will be presented to the AHPPC on 9 April 2020, and updates will be presented as required.

PART 2

Operational Plan as it relates to people with disability

Phase 1: Preparedness

Maximise prevention of transmission of COVID-19 to people with disability

Aim: Reduce the risk of infection in people with disability and facilitate community preparedness through:

- Preparing and tailoring plans and guidance materials
- Preparing and supporting the health workforce
- Preparing and supporting the disability sector and workforce
- Assessing the demand for, and enable access to, personal protective equipment (PPE)
- Maintaining and preparing clinical care and public health management, including existing services
- Tailoring and targeting communications
- Supporting planning and preparedness
- Understanding the disease
- Establishing leadership and decision making.

Focus	Possible actions	Special considerations Urban/regional, rural/remote, other: group homes; residential care facilities, residential aged care facilities; in home care, hostels, places of employment, child protection facilities, prison and detention centres
Prepare and tailor plans and guidance materials	Prepare and update the Management Plan for People with Disability. Directly involve people with disability in the refinement of the Plan through the Advisory Committee, including feedback from priority populations such as Aboriginal and Torres Strait Islander populations, people with disability who identify as LGBTI+, children and young people with disability and people with disability from culturally and linguistically diverse backgrounds. Prepare and update relevant national guidelines to reflect the needs of people with disability, their families, carers and support workers, health services and others as needed to support the Management Plan, including but not restricted to: - the use of PPE - the establishment of support protocols - advice for healthcare workers in acute and primary health care settings. Tailor relevant national guidelines (such as CDNA guidelines) and protocols to disability support settings.	Respiratory disease is known to be one of the major underlying causes of death for people with disability. Areas of risk include: - people with psychotropic prescriptions and polypharmacy increasing hypersalivation, sedation and impaired swallowing exacerbating breathing difficulties - communication limitations to describe symptoms - delays in diagnosis or missed/shadow diagnosis - poor underlying health (such as chronic renal failure, chronic lung conditions, poorly controlled diabetes and poorly controlled hypertension), and compromised immune systems - people aged 65 years and over with chronic medical conditions - some types of disability which are more prone to respiratory illness and heart conditions. Areas of risk for people with disability needing formal and informal supports: - exposure to multiple people in an environment where others in the community are self-isolating – both formal and informal support arrangements - limited capacity for isolation given the need for continued access to formal and informal supports

	Use the Management Plan to inform jurisdictional plans and guidance. Health care and disability sector organisations to support dissemination of guidelines and other communications through existing and effective networks and channels, such as Healthdirect.	- potential issues with adhering to social distancing requirements - intimate supports and mealtime management requiring close contact with others.
Prepare and support health workforce	Provide information and guidance to engage health professionals and health care workers about: - the rights of people with disability to equitable access to health care in settings that are appropriate to their individual needs (including in-home health support) - engaging with and supporting people with disability and families, carers and supporters within each relevant health setting (emergency departments intensive care units, hospital wards, primary health care settings and health care in the community). Consider workforce needs including training in aspects of managing COVID-19 in relevant settings, framed in a rights based context, including: - the application of standard infection control strategies (including clear guidance on the appropriate use of PPE) and encourage infection control training of the workforce such as the Australian Government Department of Health's online COVID-19 training https://covid-19training.gov.au/	Consider less invasive COVID-19 testing approaches for some people with disability in circumstances where the approaches are safe and effective, such as using telehealth, and GP home visit services. Consider more options for the provision of any treatments within the home of a person with disability or other familiar environment, where this is preferred by the person and review these arrangements should the person's health continue to, or rapidly deteriorate. This includes timely and safe access and transportation to an alternative health care setting if required. Set out guidelines for support and management of people with complex needs (including behavioural support needs) requiring hospitalisation. This includes primary healthcare, community health, acute care and out of hospital specialist care settings. Set out guidelines for discharge procedures when a person recovers to enable return to home, or other accommodation with appropriate rehabilitation support.

	- disability awareness training (such as the NDIS Code of Conduct Workforce Orientation Module) - consider strategies to increase options when sourcing health care staff - consider the establishment of a specialised advisory phone service for health care professionals to meet the particular communication, nutritional, physical, behavioural and environmental needs of people with disability in the health setting. Prioritise influenza vaccinations for the key supporters of people with disability whose disability and current health status places them at significant risk of adverse outcomes related to COVID-19 infection.	
Prepare and support disability sector and workforce	Provide information and guidance to engage disability support professionals and carers on: - the application of standard infection control strategies (including clear guidance on the appropriate use of PPE) and encourage infection control training such as the Australian Government Department of Health's online COVID-19 training https://covid-19training.gov.au/ - guidance on behaviour support strategies and minimisation of restrictive practices - guidance for management of suspected or actual outbreaks - circumstances where PPE should be utilised.	Many people with disability whose health status places them at significant risk of adverse outcomes related to COVID-19 currently receive a relatively high degree of supports to enable them to live their daily lives. Support may include assistance with personal care, assistance with community access (e.g. health care), mealtime management, and medication management support. Continuity in health care support is required during the pandemic period. This includes access to prescriptions and equipment. These supports are delivered through regulated providers through the NDIS, or other disability support programs (both Commonwealth and state and territory).

	Provide support workers, families and carers with information and guidance on the risks of infection, avoidance of infection, infection control, and the underlying conditions which may exacerbate risks associated with infection. Equip people with disability, their families, carers and support workers to know how to access continuing health care, especially primary and mental health care for those they are supporting. Develop specific individual health care plans to reflect the COVID-19 pandemic, to ensure health and support needs are documented and immediately accessible. Develop strategies to rapidly on-board support workers to maintain critical supports where people with disability rely on these to maintain health, wellbeing and safety, and to avoid risk of harm, including where informal supports might no longer be available. Prioritise influenza vaccination for high-risk people with disability, carers, families and support workers. Formal support providers deploy business continuity planning to preserve critical supports to maintain the health, wellbeing and safety of people with disability.	
Assess demand and enable access to PPE and other resources	Mobilising the resources of the National Medical Stockpile to support the appropriate provision of PPE and other resources, according to availability and need, to people with disability and carers in health and disability care settings to:	<u>For all settings:</u> Consider options for additional supports or variation to supports where people with disability, who are confirmed

	- support carers and support workers to continue working with a person who is confirmed with or suspected to have COVID-19 - support continuity of service, where PPE is a usual and essential requirement for the delivery of particular support activities - to enable access to PPE for people who receive supports which involve significant and close physical contact. Develop guidance to: - minimise inappropriate use of PPE - utilise PPE in the correct manner. Maintain access to other essential equipment (e.g. PEG feeding, wound management, ventilation and catheters). Guidance on prescription of psychotropic medications to avoid escalation of the use of restrictive practices.	with, or suspected to have COVID-19, cannot wear PPE or comply with requirements to wear PPE.
Maintaining and preparing clinical care and public health management	People with disability continue to have access to essential health care for non-COVID-19 related conditions through the pandemic period. Direct outreach to people with disability at higher risk, including people with complex support needs and underlying health issues, or where the nature of their disability, age, cultural profile or living environment may exacerbate risks associated with infection.	N/A

	Work with people in these groups to identify the best courses of action, such as: - early presentation if they become ill - support or clinical care adjustments if a confirmed case occurs in the person's place of residence or they need to self-isolate. This includes access to temporary accommodation to enable isolation if that cannot be done safely in the person's current living arrangement. Develop pandemic-specific health care plans to manage any additional requirements associated with the pandemic response. Ensure, where possible, prescriptions are filled in advance and repeat prescriptions are accessible, where appropriate. Encourage adoption of ePrescribing and home delivery options. Develop protocols, including for emergency service staff and transport staff, which reflect the rights of people with disability to equitable access to health care. Develop strategies to enhance access and coverage of influenza and pneumococcal vaccinations for example through: - immunisation outreach teams to enable influenza and pneumococcal vaccines to be given at home without requiring people to come into clinics or pharmacies;	

	- vaccination of all people providing informal and formal support to a person with disability, not just the person themselves; and - develop mechanisms to maintain outgoing specialist support if visiting services are suspended. Implement flexible health service delivery and healthcare models, including telehealth, to accommodate a range of communication needs to assess patients and/or to access GPs and specialist services who are in isolation. As safe and effective pathology testing methods and capacity becomes available, prioritise mechanisms to test people who interact regularly with people with disability, including families, carers and support workers. Develop new testing options, while ensuring safety and efficacy, which prioritise at home and less invasive options. Support appropriate advance care plans and directives for high-risk people with disability, in case they do not respond to treatment.	
Tailor and target communications	Include in the National Communication Plan for COVID-19 communication strategies which support the implementation of this Plan and meet the needs of: - people with disability - their families - carers - frontline workers including health care workers - disability support workers	<u>For all settings:</u> Engage and collaborate with people with disability, their families, carers, health workers, disability support workers, employers of people with disability, health care and disability sector representatives about appropriate and practical ways to minimise risk, including:

	- the broader community. Improve information and communications about COVID-19 to be inclusive for all people with disability, and people providing informal and formal support. Information and communications should be in accessible formats such as easy read, Auslan, braille, be culturally appropriate for Aboriginal and Torres Islander people, and suitable for people from culturally and linguistically diverse backgrounds. Adopt alternative measures for dissemination of information to people who do not have access to internet. Coordinate resource development and dissemination between national, state and local health authorities. Provide clear guidance about what is needed/what it means to quarantine or self-isolate at home. This includes shared residential arrangements or where people have support workers coming to their home. Develop targeted information on mental health and wellbeing strategies during the pandemic. Advise people with disability, their families, carers and support workers about how to engage with health services if they develop symptoms. Advise people with disability, their families, carers and support workers about the limitations of PPE and about appropriate use in healthcare and support settings.	- determining what is needed to reduce risk in group living arrangements and in the provision of in-home personal care supports - support people with intellectual and/or cognitive disability, their families, carers and support workers to understand national restrictions, including the importance of physical distancing - advise people with disability, their families, carers and support workers about how to adapt supports to minimise infection transmission.

	Provide consistent updates to guidance for people with disability, their families, carers, support workers, employers, health services and others as needed, in accessible formats and channels.	
Support planning and preparedness	Establish guidelines to reduce the transmission of COVID-19 within shared residential and activity settings e.g. access to handwashing, hand sanitiser. Consider health promotion and education strategies to support these environmental measures. Consider maintenance of food, water and other essential supplies, including prescriptions and usual levels of PPE. Direct outreach to particularly vulnerable people who have highly complex disabilities and/or do not have networks of formal or informal supports. Consider any further options for exemptions from social isolation directions. This ensures people with disability, who require greater than 1:1 ratio of support in the community, can be safely supported by support workers and family carers where these are not already provided by jurisdictions. Provide advice on respiratory hygiene and hand washing and increase access to hygiene-related products. Ensure that widely disseminated public health advice is available and accessible to people with disability, their families, carers and support workers.	N/A

Understanding the disease	Collect and share data and evidence about the spread of COVID-19 and the health impacts to people with disability. Share the latest public health evidence and medical science, especially about risks to, and responses for, people with disability.	N/A
Establish leadership and decision making	Conduct regular meetings of the COVID-19 Disability Advisory Committee. Members of the Advisory Committee to seek input from people and groups not directly represented.	Expert advice from Advisory Committee members will be used as a vehicle for consultation between key parties engaged in the response, including the Australian Government, state and territory governments and health services.

Phase 2: Targeted action

Suspected or confirmed COVID-19 infection of people with disability

Aim: Optimise health and support responses to help recovery and minimise further transmission

- Reviewing previously implemented actions
- Triaging patients and potential patients
- Early identification of cases and treatment of confirmed cases
- Manage and support the health and disability workforce, including carers and support workers.

Focus	Possible actions	Special considerations
Review	Review “Phase 1” steps above.	N/A
Triage patients and potential patients	Individuals and health services to use videoconferencing, telehealth consultations, including Healthdirect if appropriate, to enable assessment of people with disability in a way which minimises disruption, and the need for transportation. Access to Translation Information Services (TIS) for people with disability is prioritised to support effective communication during any triage process. Enable people with disability and those supporting them to access diagnostic testing including: - providing information to patients in a format that is appropriate to their needs (easy read, braille, Auslan) - ensuring those providing disability supports know how to support a person who requires testing, and how to respond should there be a positive test result - developing advice sheets for GPs and clinics around testing considerations - providing accessible testing.	N/A

	For people presenting with respiratory symptoms, use respiratory/fever clinics with heightened infection prevention and control capacity to: a. Redirect demand for face-to-face services away from emergency departments and usual primary health care providers for respiratory presentations b. Reduce transmission risk by focussing care for respiratory presentations in a dedicated setting c. Enable specialist expertise to be sourced for risk factors affecting people with disability d. Maximise efficient use of PPE supply e. Enable people to be accompanied by families, carers or support workers (if required). Where respiratory/fever clinics are not available, prepare local clinics with access to appropriate PPE and containment measures. This may include: educating staff on the risk factors for people with disability; notices; screening; and reducing the number of visitors/other patients in the clinic. Consider the health needs of people with disability in remote retrieval and remote primary care service planning and delivery,	

	including linking with the strategies in the Management Plan for Aboriginal and Torres Strait Islander Communities.	
Early identification of cases and treatment of confirmed cases	Should COVID-19 be suspected or detected: 1) Contact relevant state/territory public health units to assess risk, and consider mobilising additional staffing to assist in testing, treating and adjustments to formal and informal supports as required to maintain continuity of disability supports during assessment and post-diagnosis 2) If appropriate, treat people with symptoms which fit the clinical case definition until laboratory confirmation of the case, and instigate infection control measures including isolation logistics in the context of the person's living arrangements. 3) Reduce the risk of severe complications by rapid testing and assessment, clinically appropriate treatment of cases with specific clinical criteria relating to the person's other health care and disability requirements. 4) If laboratory confirmation of the case is received, instigate infection control measures, including isolation of confirmed cases and contact management to maintain or enhance	<u>For all settings:</u> The person with disability, their families or guardians should be part of decision-making around quarantine and self-isolation, including: - individual home isolation - communal isolation in common property - using temporary accommodation - in-home medical support - if required, increase behaviour support strategies to minimise the use of additional restrictive practices. Alternative support settings should be considered if: 1) severe cases of people with COVID-19 require transition to a tertiary facility 2) where isolation is not an option 3) where the person infected lives with others who are more vulnerable to severe effects of exposure to COVID-19, including death 4) where a person wishes to temporarily relocate to avoid the risk of infection. <u>For hospital settings</u>: People with disability may present frequently to ED. Past inpatient experiences may affect the willingness of a person to present if COVID-19 symptoms present.

	critical supports, in accordance with guidelines. Families, carers, support workers and organisations to consider how they will support individuals or households who are in quarantine or self-isolating, including: - access to meals which meet dietary requirements; - access to activities to engage the person; - facilitating communication between the person and their families and friends; and - assisting the person to maintain personal hygiene. Rapid triage and response when people with disability present to EDs, clinics and paramedics. To support effective responses, develop and disseminate advice sheets which assist health care staff to adjust their practice to support people with disability in EDs, clinics and other settings during the COVID-19 pandemic. To ensure overall health and COVID-19 specific care needs are communicated efficiently, provide updated individual health care plans to ED and other first responders.	Some people with disability may experience diagnostic overshadowing (by support workers, and healthcare workers in EDs, ICUs and other tertiary settings) or experience more rapid clinical and behavioural deterioration. These issues could, in some instances, place the person, or health workers, and other patients at risk. Support equitable access to health care including ICU treatment, and triaging of care for people with disability. Support discharge planning for people with disability and where appropriate, include support workers and families in the process. <u>For residential support settings</u>: Sample procedures and protocols are widely available for service providers to use in the event of a suspected or confirmed case. Establishing a support worker network which enables rapid deployment of staff to replace support workers who may be required to isolate.

	Establish a national network of experts in disability-related health care to provide telephone and online support.	
Manage and support health and disability workforce, and informal supporters	Implement surge workforce options, such as sourcing nursing or other support staff to assist with the health care needs of a person with disability if their families, carers and/or support workers have confirmed COVID-19 infection. Develop guidelines for the best use of the limited supply of PPE. Develop options for technology and equipment, including telehealth, to enable remote monitoring of patients, particularly for people remaining in their home environment, and people living in rural and regional settings.	N/A

Phase 3: Stand down and Evaluation

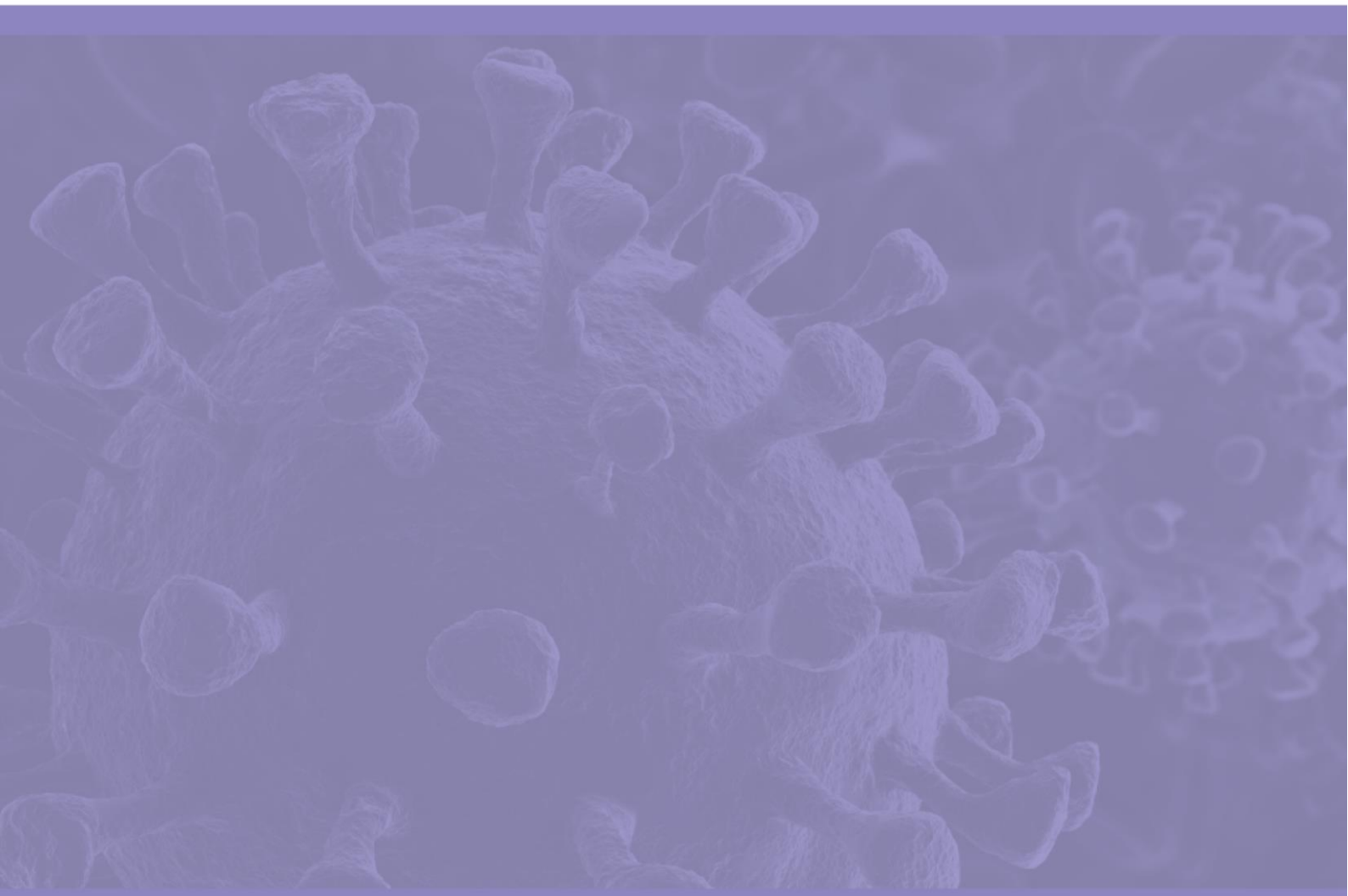
Aim: Stand down enhanced measures through:

- Sharing information between responders
- Public communication
- Assess and restock PPE and medical equipment
- Monitoring for subsequent infection risks
- Review and learn.

Focus	Possible actions	Special Considerations
Sharing information between responders	Meetings and small group discussions with people with disability, representative and industry bodies, health representative bodies, and the Advisory Committee to evaluate the response, and any response support needs which remain.	Use the review of the COVID-19 pandemic response to inform adjustments in normal health care operations to enhance the experience of people with disability. This includes the ability to access health care in a post-pandemic context to meet the needs of people with disability, and improves the equity of access and experience in order to achieve equality with the rest of the population.
Public Communication	Provide specific information to people with disability, and the disability and health care sectors about the transition of services in post-pandemic. In particular, ensure people with disability which have been isolated due to COVID-19, are not isolated for longer than required. Conduct consultations with people with disability, representative bodies and other experts to explore and understand the perspectives and experiences of people with disability during the response. Develop and implement mental health supports for people with disability, their families, their carers and support workers to address any trauma associated with the pandemic experience. In order to reduce the risk for people with disability during future pandemic outbreaks, explore the issues, barriers, infection containment strategies	N/A

	used, and areas for improvement in order to develop appropriate and effective strategies for the future. Use mechanisms to include people with disability with the full range of communication and engagement needs in this stage. Meet with the disability sector, industry and health leaders for feedback on key evaluation findings and/or the lessons learned.	
Assess and restock PPE and medical equipment	Assess the status of PPE and other equipment required by people with disability, and restock depleted. Assess workforce needs.	N/A
Monitoring for subsequent infection risks	Maintain infection control measures. Monitor for subsequent infections in previously affected settings, or changes in the virus. Analyse data and review processes and policies. Review health care capacity, processes and policies.	N/A
Review and learn	The COVID-19 Disability Advisory Committee, with input from people and groups not directly represented, will: - review COVID-19 pandemic processes and policies in collaboration with people with disability	As part of the review, consider as indicators: - infection rates and settings - death rates and settings - the extent to which formal support services had to be withdrawn in infection cases - health care responses and methods

	- update protocols and plans in line with the lessons learned.	- rates of abuse, neglect and exploitation.



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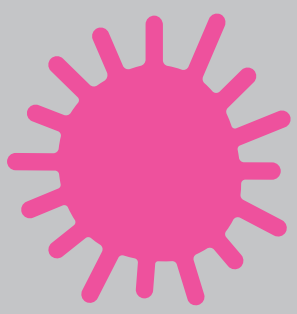
Coronavirus (COVID-19)

Australian Government
Department of Health

GUIDE FOR HOME CARE PROVIDERS



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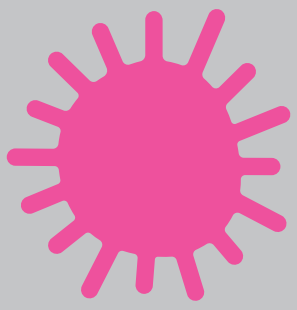


Overview and purpose

This document is intended as a guide for providers of assistance to persons living at home.

Preparation guide for home care providers

ORGANISATION

- Review clinical governance processes and apply to the current situation, which may change rapidly. Develop plans with local GPs and other primary care colleagues, to agree on escalation processes, and communication plans about consumers' changing care needs.
- Review business continuity plans and consider how the service will respond if staff unwell or unable to work, this may include deploying an alternative workforce.
- If parts of organisation have closed (e.g. day centres or day respite) consider how staff can be redeployed according to their skills and personal circumstances.
- Consider whether your organisation can implement flexible work hours in order to maintain services.
- Consider which teams need to extend operational hours, or link to other services (such as out of hours general practice) to provide the best possible care for consumers in the community.
- Consider how to contact consumers who are temporarily not receiving services to monitor their safety and wellbeing. Organisation might explore alternative models of care, including tele-care, to provide advice and guidance to consumers and their loved ones.

EQUIPMENT AND RESOURCES

- Aged care providers that require Personal Protective Equipment (PPE) must now email agedcarecovidppe@health.gov.au for all requests.
- The following information must be provided in your email request:
  - the facility, program or service requiring PPE
  - if you have had a confirmed case of COVID-19 at your facility, program or service
  - types and quantities of PPE required – please note, only masks are available at this stage and other PPE will be provided when available
  - details of other suppliers you have attempted to source PPE stock from.
- In addition, confirm that hand sanitiser and/or liquid soap is available for carers delivering face to face care.
- Monitor stock levels of PPE, and implement measures to reduce opportunities for theft.
- Review cleaning practices, and implement regular, scheduled cleaning of frequently touched objects and services (several times a day, or when visibly soiled).

STAFF

- Review and update all staff contact details, and emergency contact details.
- Provide regular updates to staff as new information is released, and when there is any change to processes and priorities. Identify how you will communicate regularly with staff and who is responsible for contacting staff.
- Identify any staff members in at risk groups, staff who are unwilling to deliver face to face care, and in what circumstances.
- Identify whether these staff can be redeployed to alternative roles, such as making phone calls to consumers who are unwell at home, monitoring daily staffing and updating supervisors, contacting families of any concerns or emergencies, completing paperwork etc.
- Identify who staff should contact if they are unwell or are unable to come to work, and provide that person's contact details to all staff.
- Keep records of training, particularly training relating to infection prevention and control.
- Identify the moments of hand hygiene, when delivering care to consumers in the community e.g. immediately before entering the home, before touching the consumer, after touching the consumer or surfaces within their home, immediately after exiting the home.
- Confirm availability of hand sanitiser and liquid soap for all staff.
- Confirm whether the organisation has developed procedures to address unforeseen circumstances, and who will be responsible for managing and coordinating the response to unforeseen circumstances.
- Identify who is responsible for providing information to consumers and families as situations change.
- Keep a record of staff members who have recovered from COVID-19 and and therefore may be immune.
- Encourage and promote flu vaccination. Keep records of staff immunisation.

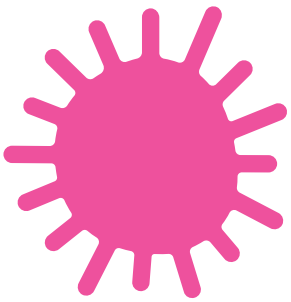
CONSUMERS

- Update consumers' records, including their contact details, emergency contact details, and current GP.
- Make a record of any consumers who may only be contacted by a face to face visit (for example, if they do not have a phone, or cannot use the phone independently).
- Consider the implications for each consumer, if the delivery of services is interrupted.
    - For example, the risk to the consumer might be low, if the provider is unable to mow the consumer's lawn. However, for other services (such as cooking) the provider may need to consider alternative delivery models (such as delivering premade meals) to mitigate the high risk to the consumer.
- Make contact with the consumer's family members and friends, to discuss alternative delivery models if required. Identify whether the consumer has family or friends who can provide assistance in the short-term if the delivery of services is interrupted (e.g. cooking meals for the consumer).

- Identify whether the consumer has the support of family or friends to do online shopping for groceries, and/or delivery of medications.
- Identify any consumers in high risk categories (such as frail consumers, or those on immunosuppression medications or those with underlying chronic medical conditions).
- Provide consumers and their family with a phone number to call if there is any change to their health condition or circumstances e.g., if they are in self-isolation, have been in contact with a confirmed COVID-19 case, or develop respiratory symptoms. The number must be monitored by a staff member with the capacity to provide advice, assess risk, and notify relevant parties.
- Identify any consumers at risk of harm due to non-compliance with public health requirements e.g., hand hygiene, or self-isolation.
- Identify consumers who have advance care plans, and keep a copy if possible.
- Encourage advance care planning, and discussion between consumers, their doctors and families to clarify wishes and intentions.
- Encourage and promote flu vaccination.

CONSUMERS' EMERGENCY PLANS AND READINESS

- Develop an emergency plan for use by consumers and carers.
- The emergency plan should contain:
  - details of the name, address and other contact details of the consumer;
  - emergency contacts, such as their friends, family, legal representative, or others;
  - details of any medications they take, including dose and frequency;
  - details of current GP and any other relevant professionals;
  - details of any ongoing treatment; and
  - details of the advanced care plan (if the consumer has one).
- Encourage the consumer to ask their GP for a shared health summary on their MyHealthRecord (if the consumer has not opted out), and update the shared health summary as applicable.
- Consumers who are at risk should have a hospital bag prepared, which includes the details listed above, as well as any planned care appointments and things they might need for an overnight stay (snacks, pyjamas, toothbrush, medication etc.). Remember to pack phone and charger if going to hospital.



MEDICAL CONSIDERATIONS

- Make a list of any services which the consumer's GP can deliver to keep them safe, such as telehealth consultations, testing for COVID 19 (where required), and advice on local testing arrangements etc
- Identify the contact details for the relevant Population/Public Health Unit, State Department of Health, and Commonwealth Department of Health.
- Keep up to date with the current protocols and logistics for admission to local hospital services as they become more stretched and practices change.

OTHER PARTIES

- If other organisations or volunteers are involved in care of consumers, maintain contact and assist each other in times of need.
- Consider how volunteer groups can stay in touch with consumers to provide psychosocial support, especially consumers who have become socially isolated.

Potential scenarios

THE CARE WORKER

A CARE WORKER IS CONCERNED THEY HAVE COVID-19

If a member of staff or care worker is concerned they have COVID-19 they should seek medical advice from their GP or call the National Coronavirus Hotline on 1800 020 080. The member of staff should tell their doctor or the hotline they are a care worker.

If the care worker is advised to self-isolate they should follow the self-isolation guidance on the Department's website.

If advised to self-isolate at home, they should not visit or care for people (consumers) until told it safe to do so. Care workers should notify their employer immediately.

THE CARE WORKER HAS PROVIDED CLOSE PERSONAL CARE TO A PERSON WHO IS DIAGNOSED WITH COVID-19

If staff have been in close contact with a confirmed COVID-19 case, and did not don PPE, they must notify their employer. Organisations must then notify the local public health unit in the relevant territory/state. The carer will be required to self-quarantine for 14 days and be alert for symptoms of the COVID-19.

If staff have been in close contact with a confirmed COVID-19 case, while donning PPE, the staff member can continue to deliver care to consumer. The staff member does not need to self-isolate. However if PPE was not used correctly, staff should be alert for symptoms for 14 days and deployed to other roles if possible (including care for people have COVID-19). The Public Health Unit can provide advice regarding whether PPE was used correctly.

THE CONSUMER

THE PERSON BEING CARED FOR HAS CONFIRMED COVID 19 OR IS A SUSPECTED CASE WAITING FOR A TEST RESULT

Carers should not enter the home of a person who is unwell until their status is ascertained, and PPE utilised as appropriate. Carers should notify their employer of any confirmed or suspected COVID-19 cases.

Organisations should minimise the number of carers who come into contact with the consumer, and consider which services are critical to keep the consumer safe.

Carers should also notify the consumer's family and friends (with their consent), and request their assistance to monitor the consumer's health condition. If the consumer's condition deteriorates, carers should escalate to the consumer's GP or call an ambulance.

PERSONAL PROTECTIVE EQUIPMENT

Carers should complete **online training** to understand how COVID-19 is transmitted.

When caring for consumers with undiagnosed respiratory infections, carers should use standard, contact and droplet based precautions.

Standard precautions are a group of infection prevention practices always used in healthcare settings.

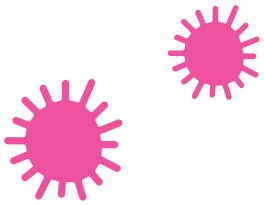
Standard precautions include performing hand hygiene before and after every episode of contact with a consumer (5 moments), the use of PPE (including gloves, gown, and appropriate mask) depending on the anticipated exposure, good respiratory hygiene/cough etiquette and regular cleaning of the environment and equipment.

Contact and droplet precautions are the additional infection control precautions required when caring for consumers with suspected or confirmed COVID-19. Contact and droplet precautions include gloves, surgical masks, and gown.

The care worker should don (put on) the PPE before they enter the home. Hand hygiene should always be performed before donning PPE and immediately after removal. PPE should be removed in a manner that prevents contamination of the carer's clothing, hands and the environment.

Gloves, gowns and masks must be disposed of in an infectious (biohazard) waste bag. Alternatively, PPE may be stored in disposable rubbish bags. These bags must be placed in another bag, tied securely and kept separate from other waste. Rubbish should be put aside for at least 72 hours before being put in the household waste bin for disposal. After 72 hours the material should no longer be infectious.

Care workers must change their PPE and perform hand hygiene after every contact with an ill person, when leaving the home, or coming into contact with a new person.



CLEANING

If care workers undertake cleaning duties, they should use usual household products. Frequently touched surfaces should be cleaned several times a day, and also if visibly dirty or soiled.

Cleaning is an essential part of disinfection. Cleaning reduces the soil load, allowing the disinfectant to work. Removal of germs such as the virus that causes COVID-19 requires thorough cleaning followed by disinfection. This can be done by a 2-in-1 clean - a physical clean using a combined detergent and TGA-listed hospital-grade disinfectant with activity against viruses (according to label/product information) i.e. a combined detergent/disinfectant wipe or solution.

A 2-step clean requires physical cleaning with detergent, followed by disinfection with a chlorine based product such as bleach. The bleach will not kill the virus if the surface as not been cleaned with a detergent first.

Further information is able in the fact sheet '**Coronavirus (COVID-19) Environmental cleaning and disinfection principles for health and residential care facilities**'.

Personal waste (for example, used tissues, continence pads, other items soiled with bodily fluids and used PPE) and disposable cleaning cloths should be disposed of in an infectious (biohazard) waste bag.

Alternatively, they may be stored in disposable rubbish bags. These bags should be placed into another bag, tied securely and kept separate from other waste. Rubbish should be put aside for at least 72 hours before being put in the household waste bin for disposal. After 72 hours the material should no longer be infectious.

LAUNDRY

If care workers support a person with laundry, they should not shake dirty laundry before washing. This minimises the possibility of dispersing the virus through the air.

Wash items using hot water in accordance with the manufacturer's instructions.

Dirty laundry that has been in contact with an ill person can be washed with other laundry. If the ill person does not have a washing machine, wait a 72 hours after the isolation period has ended, then the laundry may be taken to a public laundromat.

If laundry is heavily soiled (for example, with vomit or diarrhoea), or cannot be washed, dispose of the items after getting permission from the consumer.

Clean and disinfect clothes hampers or baskets which held dirty clothes.

THE PERSON BEING CARED FOR (CONSUMER) DOES NOT HAVE SYMPTOMS BUT IS PART OF A HOUSEHOLD THAT IS ISOLATING

If the consumer and their care worker can remain at a safe distance from the symptomatic member of the household, then care can be provided without additional precautions. For example, the symptomatic family member should remain in their own room, use separate bathroom facilities, and stay at least 2 metres away from other family members.

If the symptomatic persons cannot remain a safe distance away from other members of the household or the care worker, then other members of the household and the care worker should implement standard, contact and droplet based precautions.

Care workers should stay more than 1.5 metres away from any household member that has symptoms and avoid touching surfaces.

General interventions may include increased cleaning and keeping property properly well ventilated by opening windows.

The carer has also been working in a residential care facility when there is a confirmed COVID-19 case in that facility but they have not had any contact with this case

Care workers do not need to self-isolate or wear PPE if they had no close contact with a confirmed COVID-19 case.

THE PERSON (CONSUMER) IS FOUND TO BE UNWELL OR HAVE NEW SYMPTOMS

At times carers may arrive at the home of a consumer and find they are unwell and have not sought medical advice. Carers should not enter a consumer's home if they are unwell, until the person has been assessed by a medical practitioner and/or the carer has access to PPE (if required). If the person is very unwell then the carer should call an ambulance.

Further guidance is available through the **online training module**.

THE PERSON BEING CARED FOR (CONSUMER) HAS SOME SYMPTOMS OF COVID-19 BUT THEY ARE NOT A CONFIRMED CASE AND NOT CONSIDERED A SUSPECTED CASE BY HEALTH PRACTITIONERS

This scenario may occur if the consumer has a chronic cough.

Carers should implement standard precautions, and general interventions such as increased cleaning and keeping the property well ventilated by opening windows.

Further guidance is available through the **online training module**.

THE PERSON (CONSUMER) DOES NOT HAVE SYMPTOMS OF COVID-19

If neither the care worker nor the person receiving care are symptomatic, then personal protective equipment is not required. However, carers should still implement standard precautions to minimise the risk of infection.

Care workers should strictly follow advice on hand hygiene at all times.

Appendix

DEFINITIONS

SYMPTOMS OF COVID-19

- The most common symptoms of COVID-19 are: fever, cough, sore throat, and shortness of breath.
- Other symptoms of COVID-19 include: headache, fatigue, myalgia/arthralgia (muscle and joint aches), chills, confusion, nausea or vomiting, haemoptysis, loss of appetite, diarrhoea, and chest pain.

WHAT IS CLOSE CONTACT?

A 'close contact' is defined as requiring:

- Greater than 15 minutes face-to-face contact in any setting with a confirmed (or probable) case in the period extending from 24 hours before onset of symptoms in the confirmed (or probable) case, or
- Sharing a closed space with a confirmed (or probable) case for a prolonged period (e.g. more than 2 hours) in the period extending from 24 hours before onset of symptoms in the confirmed (or probable) case.

PPE

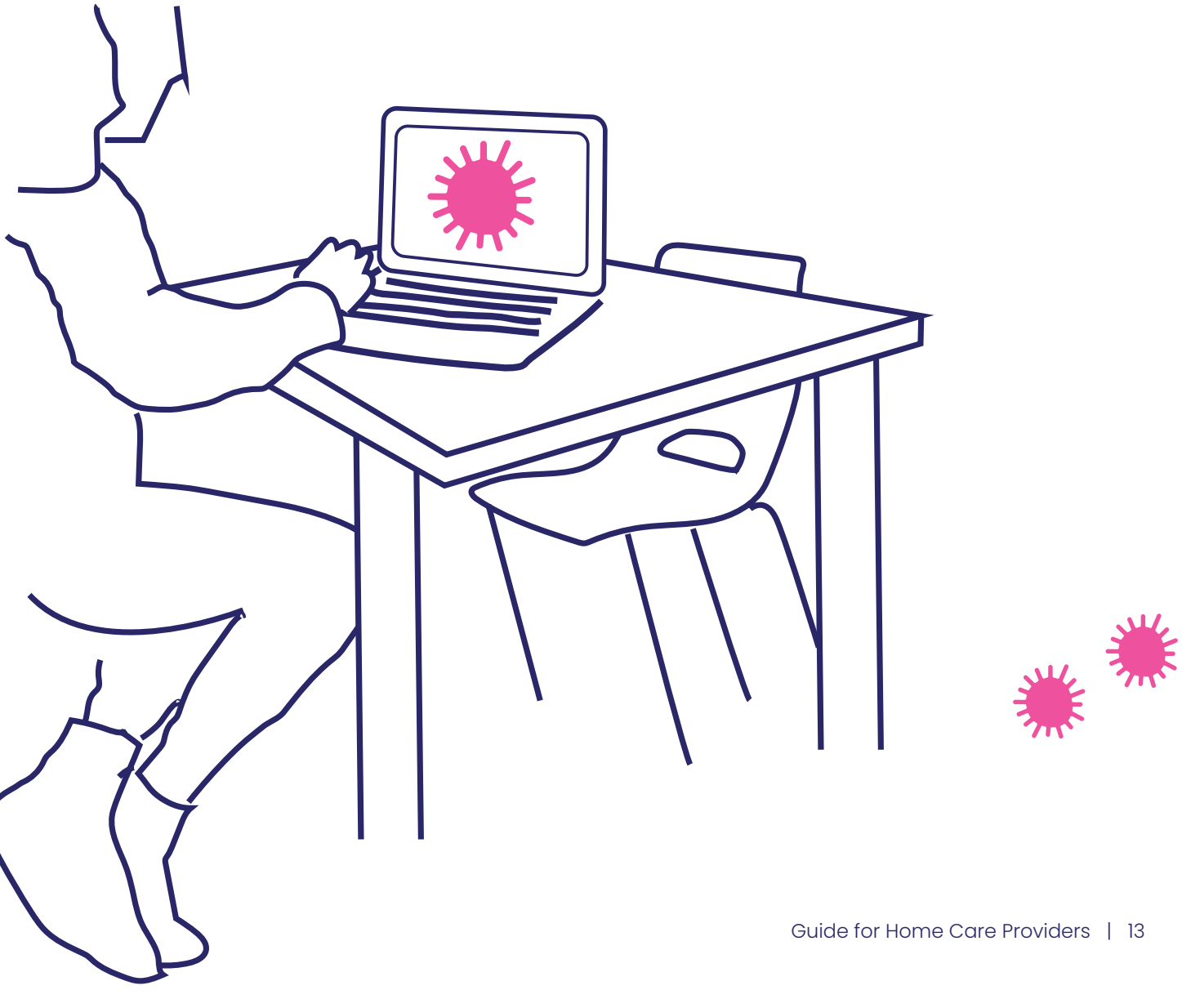
- Aged care providers that require PPE must email **agedcarecovidppe@health.gov.au** for all requests.
- All requests will be triaged by the Department of Health with **priority given to facilities, programs and care workers where there has been a confirmed case of COVID-19.**
- Requests can be made by aged care services and any care workers providing support to people receiving aged care support living in the community.
- The following information must be provided in your email request:
  - the facility, program or service requiring PPE
  - if you have had a confirmed case of COVID-19 at your facility, program or service
  - types and quantities of PPE required – please note, only masks are available at this stage and other PPE will be provided when available
  - details of other suppliers you have attempted to source PPE stock from.
- If your facility, program or service is experiencing an outbreak of influenza the above process applies.
- The Department of Health will triage your request to determine priority and may be in contact with you for further information.

Training on the use of PPE is **available online**.

Resources

The Australian Government has launched a new **COVID-19 training program** for care workers. The program includes modules on:

- Module One: Personal Safety
- Module Two: Families and Visitors
- Module Three: COVID-19 and aged care
- Module Four: Outbreak management procedures
- Module Five: Personal Protective Equipment
- Module Six: Laundry
- Module Seven: Catering
- Module Eight: If you suspect a case
- Module Nine: COVID-19 in-home care settings



Information sheets for consumers

NOTICE TO FAMILY AND VISITORS – GENERAL WARNING AND INFORMATION

COVID-19 is a respiratory illness caused by a new virus that is currently rapidly spreading throughout the world. It is important to limit the risks to vulnerable people

The virus spreads from person to person through:

- close contact with an infectious person (including in the 24 hours before they started showing symptoms);
- contact with droplets from an infected person's cough or sneeze; and
- touching objects or surfaces (such as doorknobs or tables) that have cough or sneeze droplets from an infected person, and then touching your eyes, nose or mouth. People are considered to be infectious from 24 hours before they develop symptoms, though they are most infectious while symptomatic. Even people with very mild symptoms can be infectious

COVID-19 is a particular risk of serious illness and death to:

- people with compromised immune systems (e.g. cancer, transplant);
- elderly people (older than 60 in the general population and older than 50 in the Aboriginal and Torres Strait Islander population);
- Aboriginal and Torres Strait Islander people (as they have higher rates of chronic illness);
- people with chronic medical conditions (e.g. heart, liver, lung, kidney disease, diabetes);
- people in group residential settings (such as residential aged care facilities); and
- People in detention facilities.

Symptoms of COVID-19 include fever, cough, sore throat and shortness of breath. If you experience symptoms of COVID-19 you should stay at home until you can see a doctor for a medical assessment. Wherever possible, you should not visit higher risk people including older Australians, to protect them and prevent them from becoming unwell.

If older people become unwell, in addition to the above symptoms, they may also experience increased confusion, worsening of chronic lung conditions, and loss of appetite. Be on the lookout for symptoms when visiting older Australians to help identify illness.

There is no vaccine for COVID-19. Scientists from around the world are working on developing a vaccine. The World Health Organisation believes this may be available within 18 months.

To prevent the spread of COVID-19, it is important to practice good hygiene and social distancing.

GOOD HYGIENE INCLUDES:

- covering your cough or sneeze with your elbow or a tissue (and then disposing of tissues properly);
- washing your hands frequently with soap and water or an alcohol-based hand rub, including before and after eating, and after going to the toilet;
- cleaning and disinfecting frequently-touched surfaces and objects such as phones, keys, rails, and door handles (several times a day, and when visibly soiled); and
- staying home if you are sick.

PRACTISING SOCIAL DISTANCING SLOWS THE SPREAD OF VIRUSES. SOCIAL DISTANCING MEANS:

- stay at home and only go out if it is absolutely essential;
- stay at least 1.5 metres away from other people, even to talk;
- no more than one person per 4 square metres of space;
- avoid physical greetings such handshaking, hugs and kisses;
- travel at quiet times and avoid crowds; and
- avoid public gatherings and at-risk groups like older people (where possible).

For more information about your particular circumstances please visit the Department of Health website or call the national coronavirus helpline on **1800 020 080**.

PLAN AHEAD

- All carers and people they care for should develop an emergency plan – this is important for you and all those you look after.
- Having a plan in place can help ease your worries if you are not able to care for those you look after at any point in the future.
- The emergency plan should contain:
  - details of the name, address and other contact details of the consumer;
  - emergency contacts, such as their friends, family, legal representative, or others;
  - details of any medications they take, including dose and frequency;
  - details of any ongoing treatment; and
  - details of the advance care plan (if the person has one).
- Encourage the person to ask their GP for a shared health summary on their MyHealthRecord (if they have not opted out), and update the shared health summary as applicable.
- Elderly people who are at risk could have a hospital bag prepared, which includes the details listed above, as well as any planned care appointments and things they might need for an overnight stay (snacks, pyjamas, toothbrush, medication etc.). Remember to pack phone and charger if going to hospital.

ATTENTION: ALL STAFF LETTER

There is currently a global pandemic of COVID-19. COVID-19 primarily causes respiratory illness in humans, and while all types of respiratory viruses can cause sickness in the elderly, COVID-19 is a particularly contagious infection that can cause severe illness and death for vulnerable people.

IF YOU HAVE SYMPTOMS OF ANY RESPIRATORY ILLNESS (FEVER, SORE THROAT, COUGH, SHORTNESS OF BREATH):

- you should isolate yourself in your home until you can be medically assessed;
- notify your supervisor immediately; and
- call the National Coronavirus Helpline on 1800 020 080 to seek advice about medical care and testing;

YOU MUST NOT RETURN TO WORK UNTIL YOU ARE FREE OF SYMPTOMS, OR YOUR DOCTOR ADVISES YOU ARE FIT AND SAFE TO RETURN TO WORK.

There is a risk that any of us will acquire COVID-19. To prevent the spread of viruses, it is important to practice good hygiene and social distancing:

- notify your supervisor if you believe you are in a special risk group;
- cover your cough and sneeze with your elbow or a tissue (and dispose of tissues properly).
- Wash your hands frequently with soap and water or alcohol-based hand rub;
- Clean and disinfect commonly touched items and surfaces frequently;
- stay at least 1.5 metres away from other people;
- avoid physical greetings, such as handshakes, hugs and kisses;
- get your annual influenza vaccination.

WHEN CARING FOR CONSUMERS THAT ARE UNWELL WITH RESPIRATORY INFECTIONS, YOU SHOULD USE STANDARD, CONTACT AND DROPLET BASED PRECAUTIONS, INCLUDING:

- performing hand hygiene before and after every episode of contact with a consumer (5 moments),
- using PPE as required (including gloves, gown, and appropriate mask); and
- practice cough and sneeze etiquette.

You should don (put on) the PPE before entering the consumer's home. Hand hygiene should always be performed before donning PPE and immediately after removal. You must change PPE and perform hand hygiene after every contact with an ill person, when leaving the home, or coming into contact with a new person.

Thank you for your co-operation.

Sincerely, Manager/DoN