Transcript

Aged Care Quality and Safety Commission

Webinar for NSW/QLD Providers

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**Presented by:**

**moderator:**

Nicola Dunbar

National Manager, Organisational Development, Aged Care Quality and Safety Commission

**Speakers:**

Christina Bolger  
Executive Director, Regulatory Policy and Performance, Aged Care Quality and Safety Commission

Tracey Hugel   
Aspen

Dr Melanie Wroth  
Chief Clinical Advisor, Aged Care Quality and Safety Commission

Ann Wunsch   
Director, Approvals, Compliance and Investigations, Aged Care Quality and Safety Commission

[The visuals during this webinar are of each speaker presenting in turn via video]

**Nicola Dunbar:**

Hi. Welcome to this webinar run by the Aged Care Quality and Safety Commission about being ready at times of heightened alert. My name is Nicola Dunbar. I am the National Manager for Organisational Development at the Commission and I’m going to be facilitating the webinar today.

First of all I’d like to begin by acknowledging the traditional owners of the lands on which we meet and pay my respects to Elders past and present.

What we’re going to be doing today is to hear from people who have been involved in outbreak situations in New South Wales and Victoria with the purpose of providing you with some information that will help you be ready in case this happens to you. We want to provide some insights about the Commission’s work both in monitoring and supporting residential aged care facilities and responding to an outbreak. So really about helping you be ready if something like this happens, helping you to kind of test, fine tune your preparation, identify and manage your risks and get the best possible outcomes for your residents.

We’ll have three speakers today and then we’ll have plenty of time for questions at the end. We’ll be hearing first of all from Christina Bolger who is Executive Director of Regulatory Policy and Performance at the Commission who will provide an overview about the Commission’s role both in supporting residential aged care but also in monitoring performance. Then we’ll hear from two people who have really been involved on the ground. Tracey Hugel from Aspen who’s been a clinical first responder who’s been involved in a number of outbreak situations, and also Melanie Wroth who is our Chief Clinical Advisor at the Commission talking about her experience and what we’ve learnt over the last few months around experiences of working with services.

We will have plenty of time for questions at the end. You can ask questions all the way through. So there’s a blue hand icon above the video player so please start to put your questions in any time that something triggers and we’ll be pulling all of those together for the question period at the end.

So I’m going to hand over now to Christina who will first of all take us through the Commission’s role in this situation. Thanks Christina.

**Christina Bolger:**

Thank you Nicola. I’d just like to open by really acknowledging the very profound impact that COVID-19 has had in the residential aged care sector. And I think we’re all watching the state of disaster unfolding in Victoria and the worrying levels of community transmission that are being detected there. I think this is a real alert for the residential aged care sector and it has been significantly impacted, there’s no doubt about it, with this resurgence of community transmission.

So this is a call to arms really and we hope that the information and the additional resources that the Commission is providing and the insights that this presentation will provide from people who have been at the coalface with outbreaks will assist you in your preparation and allow you to take every possible action to be ready should you have a positive case at one of your services.

So I just want to take a step back. The Commission’s focus and mandate during this time has been very much central to our functions which are to protect and enhance the quality and safety, health and wellbeing and quality of life of aged care consumers. And we really have endeavoured to both support and monitor providers at this time to try and do the best work they can to keep consumers safe and to be ready for a possible outbreak at their service. And we’ve been using all of our regulatory tools to do this. So our education and engagement such as this webinar, all of the resources that are available on our website of which there are many and they are very practical and fit for purpose resources that have been built out of the experience of the COVID outbreak to date. So I’d encourage you to access them and to really be referencing them in your preparation. And I know that Dr Wroth and Tracey will reinforce those messages with you.

Monitoring of services. We have really deployed a large range of monitoring activities that are both risk-based and proportionate. So different ways of reaching out to providers during this time. Many of you will have had phone calls from the Commission. We’ve undertaken self-assessment surveys online and we continue short notice and unannounced visits to homes. We have had to defer our accreditation program which is picking up again now in states where there are low levels of community transmission. But you’d appreciate those activities are much more intensive in terms of a face to face consumer engagement, staff engagement and so on. So most of our activity has been around monitoring of compliance and those visits to services.

We’ve also kept our complaints functions going and that has been a very important source of information, outreach to consumers through our interactions with OPAN, and also our consumer engagement interviews that we have undertaken including of home services consumers. And we’re using all of this intelligence from these activities to support our regulatory approach and to understand the risk and to respond to that risk. And that’s really probably underpinned by three things. The spread of the virus which is part of our understanding about where the hotspots are and areas that need to be on a very heightened level of alert, our understanding of the preparedness of the service and the actions that you’ve taken to get ready and to have your COVID response plans ready to enact within short notice, and also all of our understanding of the previous history of your compliance, so your [0:06:43] that is well known to the Commission.

So we have learned a lot. I’m sure these lessons will be useful to share. We know that effective systems and outbreak management is underpinned by a few key things. And Dr Wroth and Tracey will take you through some of those learnings. I think they can be actually characterised by solid planning, really being ready – that’s critical within the first 24 hours – strong leadership and governance with the leadership team really leaning in, and being ready with capable clearly defined roles, and really that effective [0:07:33] coordination which we’ll hear more about this evening. So we want you to really use this opportunity and give you every possible opportunity to engage with us this evening. We hope this information will support your preparedness and we’d like to hear from you as well during the questions and answers about your issues and concerns. So thank you Nicola.

**Nicola Dunbar:**

Fantastic. Thank you so much for that really useful overview Christina. Now I’m going to pass to Tracey. We had a little bit of a problem with Tracey coming in and out so Tracey I’m hoping that you’re back in again and can give us your perspective as a clinical first responder with Aspen. Tracey.

**Tracey Hugel:**

Thanks Nicola. Yeah. Sorry about that technical issue. So I have just spent the last month down in Victoria, part of the clinical first responder team. So basically there’s a group of us that go on site within the first ideally 24 hours of any residential aged care facility becoming affected through either their workforce or a resident or a visitor that’s had a positive COVID test. We basically come on site and work through any of the concerns or issues or gaps or give guidance and provide that guidance to the facility in regards to what they kind of need to put into place immediately to ensure that the transmission is reduced as much as humanly possible.

So a couple of things that I’d like to just point out that I have found vitally important during this process. Obviously always the resident comes first in residential aged care. That’s absolutely what we have to uphold. But I think in this kind of a situation we really do need to appreciate that our workforce must be protected at all costs. So when I’m talking about protecting our staff that then does ensure continuity of care. So we need to ensure that things like our social distancing etiquette is upheld as much as humanly possible and as much as reasonably practicable. What we’ve been finding is recent times we’ve had complete workforces furloughed because they have been either testing positive themselves or they have been close contacts of people that have been tested positive. So it’s really vitally important that you get that definition from your local public health unit to state what is the definition of a close contact and do everything in your power to make sure you work outside that scope. That’s vitally important.

So even things like making sure that when you’re looking at how you get into work, are you carpooling, making sure that you’re not carpooling. And if you are and if that’s the only way that you’re going to get to work make sure that you’ve got a mask on and the person that is in the back seat away from you also has a mask on so then you’re really ensuring that divide is there. No sharing of food or fluid. So if you’ve made this beautiful lunch for everybody it needs to be single item use at the moment for this point in time. Things like ensuring that if the facility provides food like big serves of pizzas that we reduce that. It needs to be single serve as much as practicable. It’s very important that we do that.

Even looking at things such as we all need to wear masks in the residential aged care facility but where do we not wear our masks. So we certainly don’t say your break room or your staff room is a non-mask environment. What we would say is have a look at the capacity. How many people can this room ideally hold? And we need to really make sure it’s one person per four square metres. Have that on your door for your break rooms or any confined space that you do have. If you then are able to doff your mask after doing your hand hygiene, if you can then go into that environment, clean the table with alcohol wipes, sit down, enjoy your meal because you absolutely deserve it, and then ensure that you’ve done your hand hygiene, you’ve wiped the table again, you’ve then popped yourself off outside that break room then absolutely you can not wear a mask. That’s fine.

But what we can’t say is you don’t need a mask and you don’t really need to be careful because that’s okay. Hopefully you’ve got one person per table or one person per 1.5 metres away from each other, because this is one of the highest risk environments that we’re in where we don’t have a mask on and we’re potentially sitting close to each other, we’re eating, we’re talking and we have no protection there. So to ensure that we are safe in ourselves and within our practices we need to make sure other controls are then put in place. So your staff room definitely make sure that you do adhere to that social distancing etiquette. It’s vitally important. And it might be that you need to identify a secondary break room that your other staff can go to if they need to.

That brings me onto my next point which is screening. Screening of your staff is so vitally important. Residents don’t generally walk this in. It is your staff and your contractors, your service providers, your allied healthcare people that will walk this in unknowingly. They don’t want to do it. That’s why screening is so vitally important, that we actually make sure that we have our checks and balances before we even let anyone in the door. And that goes from your managers to everyone else under those personnel. So making sure that you have someone at the door that is checking temperatures. And it might be that you designate someone specifically for that reason. Making sure that they’ve had their annual influenza vaccination. Also very important.

I’d also ask in those questions ‘Have you been in a hotspot in the past 14 days? Have you been overseas? Have you been on a cruise ship?’ They’re a little bit more unlikely but in this climate you can never be too sure where people have been. Asking things like ‘Do you currently have any signs or symptoms of acute respiratory illness or influenza-like illnesses or have you had anything like that in the last seven days?’ So then you’re really putting the onus back onto the people that are potentially going to walk this into the environment. They should know exactly where they’ve been and who they have been with and the outcomes of that. Because if this walks into your facility it’s a world of hurt for everybody and it’s very hard to control once it’s in there.

That brings me onto my next point which is cohorting. So as we know when we look at the hierarchy of controls your elimination is the most important part, then you’ve got substitution. So as much as we’d love to eliminate we can’t really and that’s what we’re striving for. After those two points we’re then looking at engineering controls. So cohorting really does come into play and it’s extremely important when we’re looking at this. So what I would recommend today, get on the phone, put out some communications, ask everyone that you need to if and when we do get this in our home we need to then start looking at room spaces and putting like for like people. The highest risk is when you’ve got someone that’s non-COVID between two COVID areas, two COVID rooms. And ideally what we need to do is put like for like. So designate a red zone for your people that have been tested as positive and then hopefully you’ve got some sort of barrier or control or empty room and then hopefully you’ve got your red space separate from your orange or your green space.

I do understand about security of tenure and I do understand about people’s choice and dignity however I think we really do need to get a communal approach in regards to making sure that we are meeting the needs of every resident as much as we can. And if that means designating specific wings that will look after this cohort of people then we need to at least try to do that. As well as cohorting you need to be very mindful about your segregation of your staff. So when I talk about you go into a room, a break room and you take your mask off and you wash your hands and you eat, you need to ensure where you can you’ve got two separate break rooms, you’ve got two separate toilet facilities, where as much as possible you’ve got two entry/exit points for these cohorts of people. Hopefully they will never meet each other in the street sort of thing because you really do need to separate them out as much as possible. Again it’s not going to be your residents that will walk this around. It will most likely be your workforce which is one of the things that we really do need to get into control with.

Another really good point in regards to your cohorting, do you have enough equipment? Do you have enough blood pressure cuffs? Do you have enough hoists? Do you have enough slings? Can you hire some equipment? What can you have readily available now so you’re not going between your COVID and your non-COVID with equipment and blood pressure cuffs and slings and hoists. We could be doing all of these amazing things and putting so much in place but if we’re not cleaning blood pressure cuffs – and it’s really hard to clean Velcro – between your COVID residents and your non-COVID residents then it’s all for nothing. So we really do need to look at the traffic flow and the equipment and the items between the two cohorts and groups there.

The last thing I’ll just quickly touch on is in regards to your residents that choose to stay out of their rooms due to they might be living with dementia or have some sort of cognitive impairment. And you’ll know who I’m talking about straight off the bat when I do discuss this. Don’t be one of the care staff that say ‘I knew that they were going to be a problem’. Please if you know, if you can see the future, please help us and to mitigate that immediately. So who do you normally talk to when you have residents that have some sort of behavioural concerns that you can try and reduce those concerns with? If you talk to Dementia Australia can you get those people back to just have a look at your environment and have a look at what sort of systems that you have in place currently and how can you use those tools when you do need to try and cohort and segregate this cohort of residents against everyone else. Because it’s happened time and time again. You’ll have those residents that choose to stay out of their room and they do test positive and then you see where they’ve tracked and everyone else is positive. And it’s deeply saddening and if you know you’ve got this on your hands right now what are you doing to ensure that everybody is protected as much as reasonably practicable?

The other things that you can do if you have the resources and the staff, special them. So maybe you’ve got a separate lounge that you could just entertain them in in your full PPE, making sure that you’re safe as well. Do they tolerate wearing a mask? Most likely the answer is no but have you tried? Have you had play with the masks? Have you let them explore what that looks like? And then cleaning is vitally important, making sure that if you do have those residents that choose to walk around the facility you’ve got someone cleaning up behind them where you can. And it might be to the point where your PPE, your donning stations are then put into a container so they’re confined and contained so you know that they’re not going to go through and breach that PPE you’re about to pop on your face. So be very proactive and make sure that you do speak up and you say ‘Hey I do have a concern with this resident. If they become COVID what are we going to do about it?’ And it’s not just up to you to have the answers. It’s up to the whole facility and then any external providers that are able to provide that support and assistance with.

**Nicola Dunbar:**

Fantastic. Thank you so much Tracey. That was really useful, practical, on the ground information that I’m sure everybody will appreciate. I’m going to hand over to Melanie who will give her perspective as somebody who’s been involved in a number of outbreaks as well from a different perspective to Tracey. Melanie.

**Dr Melanie Wroth:**

Thanks very much Nicola. Look what I thought I’d start with is trying to help you see how prevention of getting the virus in or if it gets in prevention of it spreading and becoming a large outbreak before you even know you’ve got one. And ultimately that really comes down to attention to the minutia. Now the challenges with this virus is that overwhelmingly the number of people who come into an aged care facility are not coming in wantonly knowing they’re positive or symptomatic. So it would almost always be somebody who is asymptomatic and either becomes symptomatic shortly afterwards or never becomes symptomatic. And we now know that people who are asymptomatic spread the illness which as you can see makes it very, very difficult.

And compounding this problem is the fact that elderly people have often got an atypical presentation as is the case with a lot of illnesses in the elderly where a person may not give you the exact symptoms that you might get yourself but they may just be not themselves or may be off their food or they may have a flu.

So it’s really important to be continually aware of how these risks can be dealt with. It’s obviously related to the community prevalence. So a person is much more likely to have the virus from another person and bring it into the facility if there is lots of it in the community. So your vigilance needs to escalate. But a time of limited prevalence would be the time when you’re best able to test and see what’s happening and really try and embed practices which you have to concentrate on initially and then eventually they become habit and practice.

So the more contact that staff have with each other and the more contact residents have with each other and the more contact staff have with residents the greater the ability for the virus to spread. So looking at those things now and limiting that is really important. Part of it’s going to be by [0:22:42] them in the way that Tracey described but also focusing on rostering. So if people are rostered in one cohort today and a different cohort tomorrow and the next day one of them tests positive there will be two staff cohorts who will be close contacts rather than just one. If somebody works through every area of the service then all the residents may be a contact to that person. So you can just have a look at how you can limit the ability of the virus to spread.

So the messaging that I like to use is that every time you touch something you pick something up, and every time you touch something you leave something behind. And that something might well be a COVID virus. The other message I like to give is that if I test positive for COVID tomorrow are you going to be happy that you’re this close to me today. And you can translate that message when you look around your own service and see how close people are and how they’re interacting. So really look at the five moments of hand hygiene, mask use and distancing and just see if it’s actually happening on the ground. It’s all very fine to have the five moments of hand hygiene if people are forgetting it or if in fact the sanitiser is not close enough for it to be practicable for them to do it.

And those who are unaware of these things, those who are constantly breaching distancing and hand hygiene, of course they’re the people who are at greatest risk of contracting the virus so they’re also the people at greatest risk of spreading it. So you do need to target these people in your kindest possible way and develop a culture where everyone notices what everyone else is doing and isn’t afraid to say ‘Just a little bit too close. Just step back sorry. Sorry. I feel I’m too close to you’. And attention again to the screening. And we do hear of screening that’s being done by somebody leaning very close to someone not wearing gloves, touching the temperature device on the forehead of the person they’re screening and not sanitising between. So just check what’s actually happening.

And this vigilance and monitoring, if you can develop a mechanism to do this across really every shift group and every area of the service. So that includes the kitchen. Do you actually know what’s happening with the hands of the people who are in the kitchen and do you know what the night staff are doing? And I could give you a very clear example of a service that thought everyone was doing their hand hygiene and their mask wearing extremely well and the initial outbreak was three staff members who were all nightshift workers. And if all your nightshift are positive then that’s really impacting on all your residents. So just look at everywhere.

Now in terms of preparedness the Commission’s produced a document which really covers the dominant areas in which you can be prepared and the areas that you might want to consider when you’re reviewing your outbreak plan. Outbreak plans that are prepared for such things as norovirus or flu are proving to be fairly – they’re not as extensive as they need to be and they haven’t considered everything they need to consider. So I would suggest you get out your outbreak readiness plan now and review it. Review it against the Commission document which is called Are You Alert and Ready. It was initially prepared for Victorian services but it’s now got links and resources that are suitable for the whole of Australia. So have a look at that. Check your own outbreak readiness plan.

There will be people with roles in your outbreak readiness plan that may now be out of date and you really need to look and see that you’ve thought of everything that can possibly be done. And I really think that that means sitting down and road testing how this might impact. So as Tracey said you could get one positive staff member who appeared to have got it from a family member and they self-isolate, and you have everyone in your facility tested and everything’s negative. And it’s technically an outbreak but it has not a very high impact on you. Or your first case will be a resident who’s wandering and symptomatic and you know that it’s going to be more widespread than the first scenario. So really look at all areas. See if you can develop a worst case scenario and see what you’re going to do. So if your first positive is in the kitchen and all your kitchen staff are stood down because they’re close contacts where are you going to access your new kitchen staff? And we absolutely have seen this. It’s past dinner time and there is no kitchen staff and no food. So how are you going to problem solve that? Who’s going to be responsible for doing those practical things?

So check that all the details of the key personnel are up to date and if those key personnel are your index cases or are affected who’s going to take their place and what can they do from home? So it’s increasingly clear that many things that are necessary to be done in an outbreak setting can actually be done remotely and if you have many staff in isolation most of them will not be unwell and a lot of those things can be done remotely particularly if you’ve got electronic records where your registered nurses can really track what’s happening to residents with issues that might place them at clinical risk.

There are other people who’ve developed a buddy system so that if you’ve got mainly agency staff there’s a regular staff member who can dial in to handovers and who can be on call to problem solve such things as – and again these are real examples – how do we get into the drug cupboard? Where is the linen? And if you’ve got multiple patients in a dementia support wing who are unable to identify themselves how are they going to be identified by agency staff who don’t know them? So it’s probably worthwhile getting some armbands in that setting, the hospital style arm identification bands so that people who have cognitive or language problems can have identification details put on them instantly.

You should know your own layout and I might actually come to a floor plan. So we always ask for a floor plan in an outbreak where residents are affected so that we can get an idea of how that’s going to impact on residents around them and as further cases develop where they are and how people who are as yet hopefully unaffected can best be protected. And sometimes it takes people days to find a floor plan that includes a list of who’s in what room, their COVID status, if a room’s vacant, if a person’s wandering or if they’re in hospital. Obviously the more vacant rooms you’ve got the greater your flexibility. If your service can easily be divided into zones or wings it makes it much easier to cohort. And given that in an outbreak setting a lot of common areas are no longer going to be used then how can you put those common areas to good use.

And there was a service recently where their common area was used to store their PPE and that happened to be an area that one of their women with dementia loved to go to, and they spent three days trying to get that person out of that room when actually what they needed to do was get the PPE out of that room. So it’s really having a problem solving flexible approach. And there are certainly services who’ve identified areas that they can use as isolation areas to move people into temporarily especially in high risk settings where residents are sharing rooms or sharing bathrooms.

It’s also really good to have an idea of what you can and can’t do with positive people. So it’s quite counterintuitive to realise actually that two positives can be together but two negatives can’t. The reason for that is that two people who test negative, one of those might actually be incubating and test positive soon and the other one might still be genuinely negative. And so you’re actually wanting to protect whichever one’s negative from the other person whereas two positives can’t give it to each other. And the same applies to sharing bathrooms. So don’t have a fatalistic approach. If residents are sharing bathrooms and you can move positives in with each other that’s all right. If you can’t then you can allocate the bathroom to one person and the other person can potentially be sponge bathed and use a commode. Now all of these things are obviously going to be in the short term but protection is crucial.

**Nicola Dunbar:**

How are you going for timing? I’m just thinking about timing?

**Dr Melanie Wroth:**

That’s fine. I just wanted to talk about communications because communication can be overwhelming where the phones run so hot and the staff are so occupied doing other things that nobody can answer. And it easily translates to anxiety and discontent and if you’ve got communications prepared in advance so that you’re proactive in letting everybody know that you’ve got an outbreak, updating them, letting them know how they’re going to be communicated with rather than have them not know and be trying to contact you.

So just really road test what’s happening in your own particular circumstances and try and identify where the problems are going to be and try and identify in advance how you’re going to solve them.

**Nicola Dunbar:**

Fantastic. Thank you Melanie. Okay. What we’re going to do now is we’ve got questions. And as well as the three speakers – and thank you very much for the really useful information that everybody has provided – we also have on the webinar Ann Wunsch who is another one of the Executive Directors at the Commission who for the last week and a half has been with the Victorian Aged Care Response Centre that has just been set up. And so she has been involved with the outbreaks along the way and is now ensconced in Melbourne so will also be able to bring her experience to the conversation that we have now over the next 20 minutes or so with questions.

We’ve got quite a few already and so please send them through. We probably won’t be able to get through them all but I will try and pull apart the kind of key issues and themes that are coming across in a number of questions. We’ve got some questions about cohorting. And so both Melanie and Tracey you talked about cohorting and how that is really important. A question around:

*Q: What happens if you have a lot of shared rooms and you have high occupancy rates? What kind of strategies can you use in that situation where you don’t necessarily have free space?*

So Mel or Tracey I don’t know whether you have some suggestions around that?

**Dr Melanie Wroth:**

Really in this situation where risks are clear particularly in a setting where there are multiple consumers involved then the various Government agencies come together, including the clinical first responders and the public health unit, to try to problem solve and decide what the best solution to the particular issue is in your circumstances and in the current circumstances. So if for example transfer to hospital of a wandering patient is an option then that would be considered. If the hospitals are full then that’s not going to be the solution. So sometimes offsite cohorting can be considered and sometimes it has to be internal cohorting. And it’s dynamic. So the next round of testing may reveal a new cohort of positives and things have to change again. And that’s absolutely not to underestimate the challenges involved in moving people around internally. It is a major challenge but it really does lead to protection of people from being exposed unnecessarily.

**Nicola Dunbar:**

Okay. Thanks.

**Ann Wunsch:**

Nicola can I hop in there? It’s Ann. Hi. Look one thing that’s really important to have in place before your outbreak is a letter that goes out to families and representatives saying ‘In the event of an outbreak we may need to move your person. We will do that with the minimum inconvenience to you and to them. It will be a temporary measure. We will look after their possessions and look after them and return them to their room as soon as we can. And thank you for your cooperation’. So you are seeking an agreement and thanking them for agreeing to assist you with the necessary process. That then frees you up to think creatively about how you use your spaces. You don’t want to find yourself having to consult and deal with consultation in the event that you’re in an outbreak and you’re already in difficulty.

Now you might need to use your spaces creatively and that includes rooms that are common areas that could be used differently. And we know of an outbreak in New South Wales where a common area was cordoned off in a way that allowed it to be used as a caring space and that might need to be the kind of compromise that you make in the event that you’ve got high occupancy and shared rooms. But once you free up yourself from the stress of knowing that you’ve got to do this and you’ve allocated the task to your team, so you’ve got several people that understand their responsibility will be to assist people to move, pack up their possessions safely, settle them in new rooms etcetera, that is a psychological hurdle that once services get over they seem to come to a better place to problem solve. So please put yourself in the best position to do this, because it is another protective factor that along with effective use of PPE can prevent transmission of the virus.

**Nicola Dunbar:**

Fantastic. Thank you Ann. And that’s actually a good segue. We’ve had a number of questions about PPE and two angles on that. One question about:

*Q: How much PPE is necessary?*

And I guess that probably varies a bit depending on the situation. But as a broad thing how much PPE does a service need? But also around donning and doffing of PPE.

*Q: Do you need set places for donning and doffing? Do you have to think about donning and doffing separately in different units, different sections of a service? If you’ve got a green zone, an amber zone and a red zone are you donning and doffing separately in each of those?*

Maybe if we could go through that in a bit more detail? I don’t know who would like to – Ann or Tracey or Melanie – talk about that?

**Dr Melanie Wroth:**

I’ll talk about the amount of PPE and then I’ll let Tracey answer the donning and doffing question. But when you’ve got all your residents in isolation then you need to don and doff prior to entering each room for each episode of care. So you need to try and calculate how many times a shift and therefore a day that it will be needed for each resident. And it is absolutely phenomenal. We just all the time see that providers underestimate the amount of PPE they will need. Now the Commonwealth stockpile, that process works really well in an outbreak setting and it’s available to you fairly quickly but you do need to estimate how much you want or need and you do need to have enough on the ground to cover you for that crucial first 24 hours where everyone needs to use PPE but the stockpile stock hasn’t arrived. And in relation to the vast quantity of it is also the disposal of it and also when it arrives it’s the storage of it. Because this stuff doesn’t come in packets. It comes on pallets. And again I think people are taken aback completely by the volumes.

**Nicola Dunbar:**

Thanks Melanie. And Tracey do you want to talk about donning and doffing?

**Tracey Hugel:**

Yeah. And completely agree. The burn rate of PPE itself is quite phenomenal to the point where it’s an idea just to ask your service provider of your waste disposal, of your clinical waste, to provide more waste bins and ensure collection is a lot more frequent than just once a week.

In regards to your donning and doffing stations you’ll generally get some advice from the public health unit in regards to what areas you need to ensure are incorporating donning and doffing and the practice of. The donning stations doesn’t really matter so much as long as – if you’ve got four rooms on a corridor that are quite close in proximity you can have one donning station however your doffing station ideally would be inside each resident’s room to confine and contain that potential clinical waste. If for whatever reason, if it’s quite a narrow entry/exit door to the resident’s room or if there’s a risk of falls or whatever it might be, you can doff on the outside. What we usually do if we advocate for that is we zone the doorway to just have tape on the ground to say this is your dirty doffing zone. You are to go no further past that marking on the ground. And you doff there. You hopefully have a doffing bag or a doffing waste receptacle straight away where you doff, hand hygiene and away you go.

I think the most important thing when you identify where you are doffing is ensuring that your egress is still clear. So if you have got doffing stations throughout your corridors and if you’ve got tables and if you’ve got a lot of PPE gear, in the event of an alarm being activated how are you going to get everybody out safely? So you do really need to make sure that when you do make a decision on doffing inside the room or doffing outside of the room those sorts of fundamentals that you would always have in the back of your mind, they come to the forefront and you actually really think about how you’re going to activate that.

Another thing is if you choose to – for your communal rooms, for your memory support units, if there is a lot of people that choose to stay out of their rooms you might want to do that reverse donning. So you don, you go into the communal area, but you must make sure that before you’re providing care into a room you doff that gear from the communal area, you don clean gear, you provide your care, you then doff and you re-don. So the burn rate for memory support units is usually a little bit greater than what you would normally expect as well. But don’t wait for this to happen in your facility. Work through this now. And everyone has experienced influenza. Everyone has experienced norovirus. What did you do? What worked better for your facility and your floor plan? Just think about that.

**Dr Melanie Wroth:**

Can I just also say that donning and doffing is a practical step and looking at something online a month ago is not going to ensure safe practice and it’s something that probably needs to have capability checks. And remember staff that are going to use it will not have had to use it in the past such as cleaning staff etcetera, so just bear that in mind.

**Nicola Dunbar:**

Okay.

**Ann Wunsch:**

I just wanted to jump in. Just in relation to mask use I’m working out of the Victorian Aged Care Response Centre and in this Response Centre there’s about 60 of us and we all wear masks in the office. So we’re wearing masks 13 hours a day. We change our masks every four hours to make sure that we have a clean mask on us. The first couple of days I didn’t know how this was going to play but now wearing a mask is just like putting undies on. You notice actually when you don’t have your undies on and the same with the mask. So you will all get used to having a mask on and you should practice and get your staff to practice. And the same with PPE. As Mel said it’s a practical exercise that involves an action and then hand hygiene, an action, then hand hygiene. And the only way people can become competent at it is through practice. So get your staff practicing using PPE and hand hygiene so that they are competent and they can do it fluently both donning and doffing.

**Nicola Dunbar:**

Fantastic. Thank you Ann. We won’t be able to get rid of that image for some time I think. Anyway I’m going to move on from PPE. A question about isolating staff.

*Q: So if you have staff that need to be furloughed dealing with that from a practical sense around thinking about shifts, thinking about care provided, ensuring that the care needs for your residents are maintained, what are some of the things that you need to think about to make sure that people continue to get the care they need even though you may have a large proportion of your staff that need to be furloughed?*

I’m not sure whether Mel or Tracey or Ann, who would like to provide some thoughts on that question?

**Dr Melanie Wroth:**

Well that really goes to my point about road testing your outbreak and if you do have large amounts of staff where are you going to get your next lot of staff from? Have you got good relationships with the agencies? Are there numbers completely to hand? Do you understand what sort of staff they can provide? And then failing that do you know how to progress your needs for staff through the Commonwealth agencies etcetera? And just remembering also that your staff needs are likely to be higher because of the burden of donning and doffing and the increased burden of monitoring residents to ensure early detection and monitoring the positive residents.

And also in relation to staff clearly monitoring staff wellbeing. Some people who are in isolation because they’ve been close contacts may become positive and they will likely need support. But it’s really important that somebody is keeping track of staff, who’s actually positive, who’s been tested and when and who’s just in isolation because they’re a close contact, in which case what day are they due for their day 11 testing and when can you clear them to come back to work. Because if they’re back to work on the day they’re cleared that is much better than worrying about it and thinking gosh they could have been back last Thursday. So keeping track of those things is really important.

**Nicola Dunbar:**

Okay. Thank you Mel. Is there anybody else would like to comment on that issue? From your kind of on the ground experience Tracey what’s your thoughts about that?

**Tracey Hugel:**

Yeah Nicola. So to be clinically unwell with COVID is one thing but to be just furloughed and still be able to provide that assistance remotely is a completely different ball game. So making sure that you have that communication structure and that overarching governance. You can still do that from being furloughed in your home. So making sure that the communication is still there but also being prepared for this. So what are the codes to the doors? Where did someone leave off that you need to pick up on? Where do you get the codes to the computers and to the care planning? Is it computerised or is it paper based?

You’ll still have those sort of structures in place in regards to your systems and your processes. How do you communicate that to the next team that’s potentially coming on? And how do you then also ensure that people that are coming on, they’ve been inducted and orientated appropriately? Because they really do need to have some sort of baseline to then be able to build on top of. Can you outsource anything? Anything that can be outsourced should be outsourced. So when we talk about cohorting of residents and clearing some spaces does that really have to be your staff that are in making sure that everything’s boxed up or can you actually get Hire a Hubby or whoever it might be to get in and actually assist with that process? And how are you going to escalate things? So how do you want the people that are on the ground to escalate things to you and what do you need to know when you’re working remotely to support them?

**Nicola Dunbar:**

Okay. Thanks Tracey. We’ve just got time for one last topic that I want to raise and that’s about transferring residents. So a couple of questions that have come up about issues around whether or not residents can be taken home and what might be some of the things you need to think about for that, but also transferring residents to hospital as a strategy. So I don’t know Melanie whether you would like to start with this?

**Dr Melanie Wroth:**

Yep. So again this is going to be on a case by case basis. In relation to residents going home, in the absence of a public health order covering that particular person saying they can’t then they can. But like any decision that’s made it needs to be made in possession of all of the facts. So a robust conversation needs to be had with family about what the requirements are, that someone coming from an outbreak setting will be in isolation, they may become positive, they may need testing. Can the person really care for them safely? What equipment will they need? Who’s going to transfer their medications? How are they going to be transported? What medical attention are they going to get should they become unwell? All of those things need to be considered, including the fact that people caring for people in isolation are at risk and if there are other vulnerable elderly people can they be moved out for the isolation period etcetera? So that’s not an exhaustive list of issues but it’s a list of issues that need to be discussed so that the person proposing to take the person home is in full possession of the facts and understands the risks.

In relation to going to hospital the decision will primarily be made on the clinical need of that resident. So if there are clinical needs or distressing symptoms, particularly if the person’s wanting to be transferred to hospital then that will be the first consideration. And as we’ve previously discussed the ability of the service to provide care in the circumstances that they find themselves and in the circumstances that the community’s in at the time. So if there is a real problem with staff and that’s because there are 15 outbreaks in your locality then those things would obviously start to come into play. And the other thing that’s taken into account is the ability to protect other residents within the service for various reasons.

**Ann Wunsch:**

This is Ann. I’ll just add one more comment to the issue about families taking residents home. In the event that families are able to satisfy all those issues that Mel raised and they are informed about the risks and benefits and they choose to do so it’s in your interests as a provider to support that. Because it will create vacant rooms in your service and that will support cohorting and reduce some of the burden of care on you. And if you can provide support to those families over the phone when they do take people home and that may assist them in delivering care you should see that as an investment.

**Nicola Dunbar:**

Thank you Ann. One last little point that’s just been raised about whether there are specific things that need to be thought about in rural areas where actually the facility may be a long way away from anywhere else. Some of these solutions that we’re talking about may be more suited in metro areas. Are there strategies that can be suggested in rural areas where you’re further away, you may not have the same resources?

**Dr Melanie Wroth:**

I would say look at what resources you may need and see how you can access them pre‑emptively. Is there a geriatric service remotely or a geriatrician or a behaviour support specialist or an infection control specialist who would be prepared to give remote support at short notice or come and have a look at your service in advance to just see how well prepared you are in terms of infection prevention and control? Liaise with your local GPs and your local hospital and just see what support they can give and in what circumstances. And of course you’ll always have the public health units and the Commonwealth support by phone in an outbreak setting as well.

So every effort is made to give every service the best outcome in the particular circumstances of community prevalence and stretched resources and the needs of the service and the consumers within it.

**Ann Wunsch:**

And I’d just like to add you need to develop your relationships now before you are in an outbreak. You need to know the people that you need to talk to. You need to be on first name terms with all the various parties that Mel just mentioned. Because once you’re in a crisis you don’t want to be searching through health services to identify the relevant people that you need to talk to. The other is if you’re in a regional area you should have networks with other aged care services and talk together about how you are going to respond and just road test some of your strategies with them and use your colleagues and other services to try and develop an approach that makes sense for the geographical location you’re in. So once again relationships are key to managing in a crisis.

**Nicola Dunbar:**

Fantastic. Thank you Ann. We’re going to actually bring the questions to a close now. And I’m sorry that we didn’t get to all of the questions. And I’m sorry about that. We will try and address these and come out to you. But thank you very much for the involvement that you’ve had in terms of the points that you raised.

So a few things as we close. This session is being recorded and will be available on our website so you’ll be able to go in and hear the great advice that’s been provided. We’ve talked about a number of resources particularly the Are You Alert and Ready resource that’s on our website. What we’re going to do now is actually play a short video. We’ve done a whole lot of resources for consumers in terms of things that they may need to be aware of in the kind of COVID environment that we’re in. We’ve got some fact sheets, some posters and also some animations. And what we would like to play now is an animation that gives information to consumers about the things that can happen in an outbreak. So this is something that is on our website. You can use it with your residents to let them know here’s what might happen. If we have an outbreak these are the things. And so it provides information that can reduce the anxiety of outbreaks occurring. So we’ll play that now.

But I want to say thank you to our speakers. Thanks to all the people that have been involved. It’s been a great session. And please go to our website for information that can help you. So Grant if we could cut to the video now.

[START VIDEO PLAYBACK]

[*Visual of slide with text saying ‘What to expect during a COVID-19 outbreak’, ‘Residents in aged care homes’, ‘Australian Government with Crest (logo)’, ‘Aged Care Quality and Safety Commission’*]

§(Music Playing)§

**Speaker:**

COVID-19 is a new infection that can be more serious in some older people. If someone has COVID-19 in your residential aged care service, a number of changes will take place quickly to help stop the spread of the virus and to keep you, the staff and other residents safe.

One of the first changes you will see is the lockdown of the service. This means that any visitors will be asked to leave and you will have to stay in your room. Staff will explain what is happening and why these changes are necessary to reduce the risk of the virus spreading.

If you have tested positive for COVID-19, you will continue to be isolated until you are no longer infectious. This may involving moving you to a different room. People will wear personal protective equipment such as gowns, gloves and masks. Don’t be alarmed. This protective equipment is designed to help all staff and residents stay safe and stop the spread of the virus.

All residents and the staff may be tested for COVID-19. This may need to take place more than once as the outbreak is managed. The staff will carefully monitor your condition with temperature and breathing checks and will look out for other changes. This will allow any symptoms to be identified as early as possible.

While managing the outbreak your service will communicate regularly with you, your family, other residents and staff. They will provide information about the steps being taken to manage the outbreak. Staff changes may occur as the outbreak is managed. This means that different or new staff may assist with your care as the usual staff may need to isolate in their homes. This could involve more individual care to ensure your needs are met.

During the outbreak, your service will also put in place different arrangements to help with infection control. Your food may appear different and will be served to you in your own room. The trays, cutlery and crockery may be replaced with disposable items. Signs will be placed across the service confirming that the home is in lockdown and responding to a COVID-19 outbreak. Other signs will be used to divide your home into different zones to help stop the spread of the virus.

All the changes might be unsettling and make you worried. That’s understandable. But it’s good to know that there are a lot of people doing their best to keep you safe. Importantly you can assist by understanding that the changes are designed to protect you, other residents and the staff.

You should also remember to wash your hands often with soap or sanitiser, keep at least 1.5 metres away from other people and report any symptoms of illness immediately.

If you have any concerns the staff are there to assist. You can ask them to answer any questions you may have or to help you contact your family.

By working together we can all help to stop the spread of COVID-19.

§(Music Playing)§

[END VIDEO PLAYBACK]

[*Closing visual of slide with text saying ‘Australian Government with Crest (logo)’, ‘Aged Care Quality and Safety Commission’, ‘agedcarequality.gov.au’*]

[End of Transcript]