Health
Murrumbidgee
Local Health District

MLHD COVID-19 Outbreak Management Plan

July 2021

Revision

Version	Date	Reason/Change	Endorsed By
5.0	06/08/2021	Annual Review	MLHD HEOC
4.0	13/08/2020	Amendments (RAC)	MLHD HEOC
3.0	23/07/2020	Feedback	MLHD HEOC

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Introduction

The purpose of this plan is to outline the COVID-19 response required to an outbreak in a Murrumbidgee Local Health District (MLHD) Facility or other area. The plan aligns with the:

- PD2017_013 Infection Prevention and Control Policy
- CEC Infection Prevention and Control Practice Handbook
- CEC COVID-19 Infection Prevention and Control Manual- For Acute and non-acute healthcare settings
- ACSQHC National Safety and Quality Health Service Standards-2021
- CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia
- Aged Care Quality and Safety Commission Outbreak management planning in aged care
- Protocol to support joint management of a COVID-19 outbreak in a residential aged care facility in NSW
- Incident Action Plan for a public health response to a confirmed case of COVID-19 in an Aged Care Facility
- MLHD COVID-19 Outbreak Management Plan for Residential Aged Care Facilities

Unlike other major incident responses, which tend to be short-lived, response to an outbreak requires a sustained response that will inevitably impact other clinical services. A governance process including executive sponsors and senior clinical leaders is essential.

For the latest information updates on COVID-19 in general, Healthcare workers (HWs) should regularly check the Our COVID-19 Response page on My Hub, NSW Health COVID-19 webpage and the CEC COVID-19 web page.

Acronyms and Abbreviations

CE	Chief Executive
CEC	Clinical Excellence Commission
CG	Clinical Governance
CDNA	Communicable Diseases Network of Australia
GP	General Practitioner
HEOC	Health Emergency Operations Centre
HWs	Healthcare Workers
IPAC	Infection Prevention and Control
LHAC	Local Health Advisory Council
MLHD	Murrumbidgee Local Health District
MPHN	Murrumbidgee Primary Health Network
MoH	Ministry of Health
PHU	Public Health Unit
PHRB	Public Health Response Branch
PPE	Personal Protective Equipment
RACF	Residential Aged Care Facility
REOC	Region Emergency Operations Centre
STEP	Short Team Escalation Plan

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What is an outbreak?

It can be difficult to tell the difference between a respiratory illness such as COVID-19 and a respiratory illness caused by other viruses based on symptoms alone. Suspected COVID-19 cases are referred to as a *'suspect case'* until a causative pathogen is identified through diagnostic testing (for example, nose and throat swab collection). If the COVID-19 virus (SARS-CoV-2) is detected during an outbreak this is referred to as a COVID-19 outbreak.

While all respiratory viruses can cause outbreaks and significant morbidity and mortality, COVID-19 is acknowledged as a significant health risk particularly for the elderly and individuals with co-morbidities or low immunity. These guidelines will assist MLHD facilities to manage all types of respiratory outbreaks, however the focus is predominantly on COVID-19.

An outbreak is considered to have started if **2 people in 3 days become sick with the symptoms AND at least one of these has a positive test for COVID-19. In addition a single positive COVID case in a Residential Aged Care Setting (including resident, staff, or frequent attendee) will also trigger a response**. While this is a guideline, **the public health unit will assist in deciding whether to declare an outbreak**.

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What does the District Outbreak Support Response Team provide?

MLHD will provide an initial Outbreak Support Response Team to arrive at a health facility within 2-3 hours of notification of a possible outbreak. This would be a 2-3 person team on site to support local management at the facility. This team will coordinate additional supports as required once the situation has been assessed.

Early support will assist the local management to take control of the outbreak and provide an Infection Prevention and Control resource to assist with advice and support. The Outbreak Support Response Team deployment may also be offered to external industries, schools, businesses and private aged care facilities.

The Outbreak Support Response Team will undertake a Preliminary Risk Assessment with the facility manager and other key operational managers within 24 hours of notification of a confirmed outbreak as determined by the Public Health Unit and co-ordinated by Clinical Governance. The Outbreak Support Response Team will consist of the public health unit, infectious diseases specialist, infection prevention and control, clinical governance, HEOC, Medical controller and members of the patient/resident cohort speciality group e.g. specialist or other clinician. Noting not all the support response team members will be on-site.

Roles and responsibilities

The primary responsibility of managing COVID-19 outbreaks at the facility lies with the Facility Manager. All facilities should have in-house(or access to) infection control expertise, and a Short Term Escalation Plan (STEP) in place. Residential Aged Care Facilities (Corowa, Holbrook, Leeton and Murrumburrah-Harden) are required to have a separate Outbreak Management Plan.

The Outbreak Support Response Team will consist of the following:

Public Health Unit (PHU)

- Case interview & contact identification and follow up
- Situation risk analysis
- Referral to accommodation & LHD wellbeing support as per Protocol to support joint management of a COVID-19 outbreak in a residential aged care facility (RACF) in NSW
- Link into daily virtual care for cases. Link into MoH follow up of contacts (daily) for wellness checks
- Participation in Outbreak Management Team as per Incident Action Plan for a public health response to a confirmed case of COVID-19 in an Aged Care Facility

HEOC (Command, Control and Communication)

- Fact finding discussion with the site
- Notification via chain of command to the Chief Executive (CE)
- HEOC briefing with the MLHD Executive Team as required
- Support to the facility manager through the HEOC representative on the MLHD Outbreak Support Team
- Participate in Workforce huddle with facility manager within 24 hours for assessment and predictions of workforce needs to maintain service delivery
- Provide accommodation support to staff and community members referred by the Public Health Unit
- Resourcing and logistics support including
    - Personal Protective Equipment (PPE)
    - Pharmacy Supplies
    - Pathology e.g. swabs, courier services
    - Linen supplies
    - Other warehouse items e.g. cleaning products

  - Waste Management/Collection
- Mobile testing resources as per PHU request to manage the outbreak
- Ongoing assessment as outbreak evolves

Clinical Governance (CG)

- Infection Prevention and Control (IPAC) advice and education provided through representation on the MLHD Outbreak Support Team
- Co-ordinate a preliminary risk assessment in consultation with HEOC representative, Chief Executive, Medical Controller, Integrated Operations team representation, People and Culture Industrial Specialist/Work Health Safety and other invitees as required e.g. HealthShare & Pathology
- Participation in Outbreak Management Team as per Incident Action Plan for a public health response to a confirmed case of COVID-19 in an Aged Care Facility

Clinical Support/ Medical Controller

- Critical Care Advisory Service 1800 904 355 Option 1
- Patient Flow Unit 1800 904 355 Option 3
- COVID-19 Physician on call
- Infectious Disease Physician advice
- COVID-19 Testing as guided by the PHU
- Virtual Care Team to support COVID-19 cases in home isolation
- Liaise with Patient Flow Unit to confirm processes in place for transferring of patients/residents if required with minimal flow between units/services

People & Culture

- Preliminary Risk Assessment will include an assessment of workforce needs and predictions to maintain service delivery e.g. Medical, Nursing, Allied Health, Administration, HealthShare, Asset management
- Review Health Roster for workforce gaps which may impact service delivery
- Consider current workforce availability to maximise short term cover

- Consider adjusting shift times (split shifts or maximum 12 hours) in short term to accommodate rostering gaps
- Determine Inter-cluster or geographical neighbour staffing availability to be escalated through cluster manager
- Ensure appropriate skill mix on roster
- Review staff establishment vacancy skills needed
- Escalate Site or service anticipating service failure
- Co-ordinate wellbeing support for staff redeployed or working longer hours
- Consider nearby accommodation for deployed staff or staff working longer hours
- Orientation of deployed staff to the site including liaising with the local Clinical Nurse Educator or Infection Prevention and Control practitioner for critical clinical skill assessment e.g. PPE Donning and Doffing assessment, Basic Life Support, Medication Administration Competencies, Local Fire and Evacuation processes
- In the event of staff COVID-19 infection acquired through the course of their work, WHS & Wellbeing to support Facility Manager in making a mandatory notification to SafeWork NSW

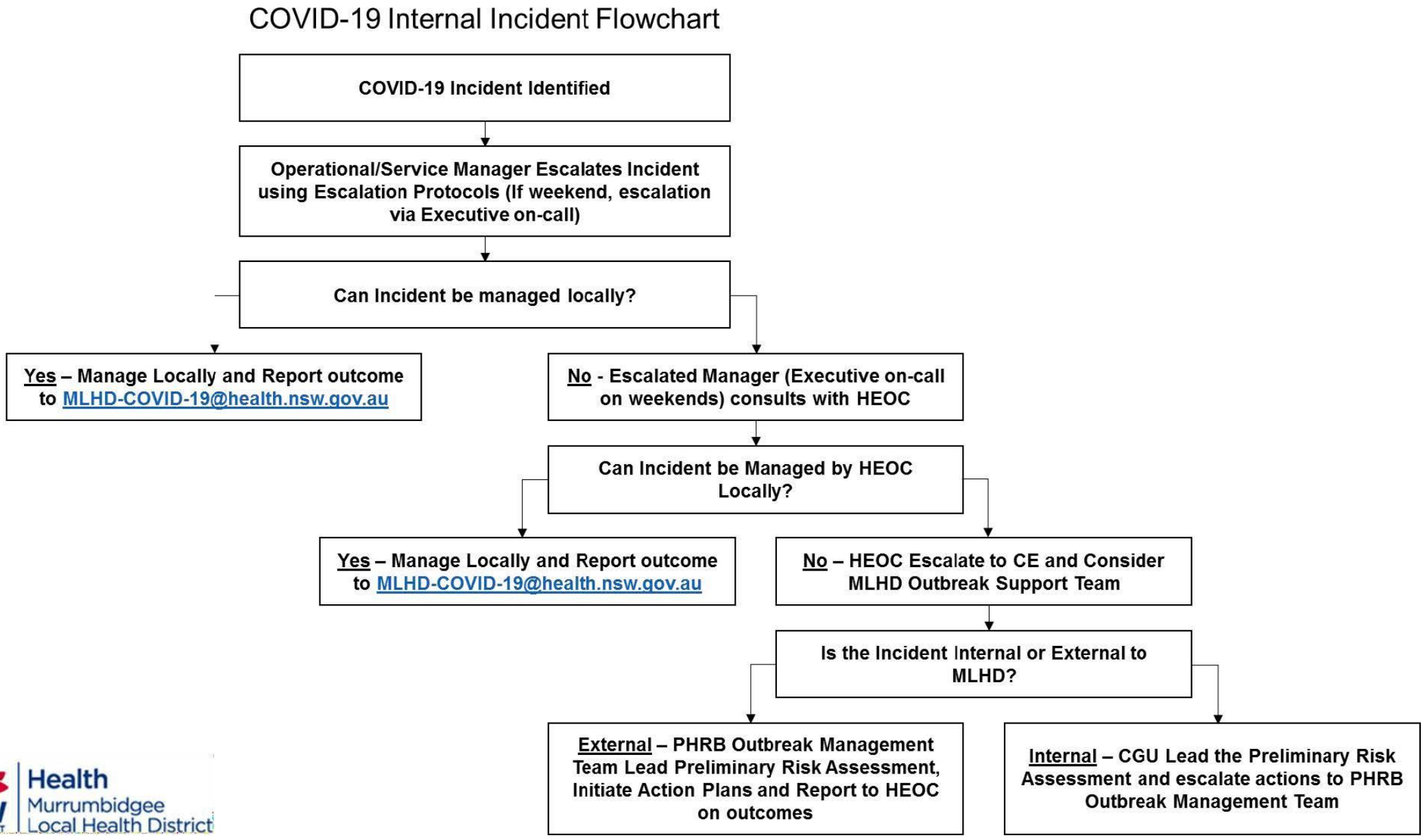
Reporting

The following incident reporting actions are to be commenced by the Facility Manager:

- Commence MLHD Facility Outbreak Management Checklist
- Incident notification on ims+ if patient/resident unwell with possible exposure of others
- Incident notification on ims+ for each positive case acquired in the health care facility
- SafeWork NSW notification (workplace acquired case of COVID-19 in staff)
- Commonwealth Department of Aged Care reporting as required

APPENDICES

Appendix A: Outbreak Management Flowchart



Appendix B: Outbreak Support Team

The Outbreak Support Team will consist of a Health Emergency Operations Centre (HEOC) representative,a member from the Public Health Unit (remote support) and an Infection Prevention and Control staff member from Clinical Governance. Identified staff are required to be ready for deployment within 1 hour of notification that outbreak support is required. On arrival at the facility the team will receive a briefing from the facility manager and the Public Health Unit.

Command, Control and Communication – Outbreak Support Team Leader (HEOC representative)

- Support the local manager in collaboration with the Public Health Unit to mitigate the risk of virus transmission for those at the site and the wider community. Stakeholders will include but are not limited to:
    - Chain of Command to Incident Controller or Executive on call
    - MLHD Communication Team
    - Ambulance NSW
    - HealthShare NSW (identified HealthShare Liaison Officer at the facility)
    - General Practitioners (GPs)
    - Pathology
    - Region Emergency Operation Centre (REOC)
    - Patients/Residents and families
    - Community
    - Murrumbidgee Primary Health Network (MPHN)
    - Local Health Advisory Council (LHAC)
    - Local Council

- Support the facility manager in the completion of a preliminary risk assessment co-ordinated by ClinicalGovernance. This may include the Public Health Response Branch (PHRB) Outbreak Management Team if established.
- Workforce support through assistance with roster development and liaison with the Cluster/ General Manager and Workforce Team.
- Liaise with local management and the MLHD communications team to provide information to all stakeholders. Consider different strategies for each audience to meet their needs and the way they like to receive information. It will be important to consider culturally appropriate messages.
- Understand the local STEP plan and capacity and capability to assist in managing the

response.Make adjustments as appropriate or escalate for further MLHD support.

- Use a whiteboard / smartboard/ or document to capture the details of the situation at a point in time. This may be as simple as noting the date and time and writing dot points of what you know to be verified information at that point. Over time this will develop into a situational report noting date, time, who is in charge, background information of the event, what has change since the last situation report, impact assessment including capacity to continue providing services, resources required to maintain service delivery, communications strategies, WHS risks assessment, prognosisand expected date for the event to be resolved.

Infection Prevention and Control (Clinical Governance representative)

- Screening Procedures
    - Review and monitoring of people entering the facility – staff and visitors
    - A risk mitigation strategy may include temporary closure of the facility to visitors and non-essential staff
    - Review access to buildings – one entry only
    - Patient/resident access and flow through the unit/facility
    - Vaccination Status-patients/residents and staff

- Testing Processes
    - Encourage testing for any symptoms including repeat testing as per Medical Controller advice
    - Review supplies of swabs and other
    - Assess capability of staff to perform swabbing
    - Liaise with HEOC representative for courier services and advice to Pathology Service

- Staff (Medical, Nursing, Allied Health, Administration, Asset Management and HealthShare) movement
    - Promotion of social distancing
    - Reduce movement of staff between facilities and wards
    - Isolate/segregate staff from high risk clinical areas e.g. Emergency Department, Intensive Care/Critical Care units , Maternity Wards, Paediatric Wards, Oncology Units, Renal Units and/or Residential Aged Care homes
    - Staff amenity access to bathrooms, staff rooms identified to maintain segregation
    - Ensure staff have identified equipment that will be available in areas e.g. portable computerand observation monitoring equipment

- Appropriate use of Personal Protective Equipment (PPE)
    - Identification of required usage of PPE for the next 3 days (ensure to include

HealthShare) –notification to HEOC logistics team for further resources if required
    - Identify an Infection Prevention & Control lead on site for each shift.
    - Refresh PPE education including donning and doffing, correct P2/N95 mask checking and/or fitting and Hand Hygiene
    - Ensure buddy system for PPE donning and doffing is normal practice
    - Continued monitoring and auditing of PPE supplies

- Cleaning
    - Liaise with HealthShare regarding environmental cleaning schedule and ongoingrequirements
- Isolation/Cohorting of confirmed cases
    - Isolation procedures and cohorting to occur with advice of Medical Controller and theInfectious Disease Specialist

Public Health (Public Health Unit)

- Case interview & contact identification and follow up
- Situation risk analysis
- Referral to accommodation & LHD wellbeing support as per Protocol to support joint management of a COVID-19 outbreak in a residential aged care facility (RACF) in NSW
- Link into daily virtual care for cases. Link into MoH follow up of contacts (daily) for wellness checks
- Participation in Outbreak Management Team as per Incident Action Plan for a public health response to a confirmed case of COVID-19 in an Aged Care Setting

Outbreak Support Team Deployment

- Identified Outbreak Support Team staff to have a 'go bag' pre packed with
  - 3 days' supply of clothing and toiletries
  - Personal items such as medications
  - MLHD identification
  - Bottle of water
  - Snacks
- Outbreak Support Team resource package
  - Visible colour signage for the facility; contact and droplet precautions, Hand Hygiene, visitors posters, Donning and Doffing posters, Respiratory Hygiene and Cough etiquette signage
  - Butchers paper and white board markers
  - MLHD Facility Outbreak Management Checklist COVID-19 Response (Appendix F)
  - On arrival at site maps of facilities to be available to enable review for co-horting and entry points
- Employees identified and available for Outbreak Support Team Deployment

Core Team

- Emma Field
- Nicole Moloney
- PHU Delegate

Relief Staff

- Keryl Dallinger
- Mary-Clare Smith

Note: An outbreak in Wagga or Griffith would also utilise the infection prevention & control practitioner on site.

Key Outbreak Contacts

Requirement	Name	Number	Email
Exec On Call		0428 113 675	For HSFAC contact Exec On Call
PHU		02 6053 4800	
		1300 066 055	
	Tracey Oakman	0429 378 845	Tracey.Oakman@health.nsw.gov.au
	Tony Burns	0428 693 374	Tony.Burns1@health.nsw.gov.au
HEOC		0439 573 345	MLHD-COVID-19@health.nsw.gov.au
Incident Controller	Carla Bailey	0419 286 218	Carla.Bailey@health.nsw.gov.au
Deputy Incident Controller	Emma Field	0477 308 403	Emma.Field@health.nsw.gov.au
	Keryl Dallinger	0420 897 400	Keryl.Dallinger@health.nsw.gov.au
	Denise Garner	0419 270 203	Denise.Garner@health.nsw.gov.au
	Ray Godbier	0436 642 044	Ray.Godbier@health.nsw.gov.au
CG	Jill Reyment	0428 960 175	Jill.Reyment@health.nsw.gov.au
IPAC	Nicole Moloney	0436 911 752	Nicole.Moloney@health.nsw.gov.au
	Mary-ClareSmith	0447 240 566	Mary-Clare.Smith@health.nsw.gov.au
Clinical Support	COVID-19 Hotline	1800 831 099	For staff and community screening
	Critical CareAdvisory Service	1800 904 355 Option 1	For all deteriorating patients includingCOVID-19
	Patient FlowUnit	1800 904 355 Option 3	For all patient flow enquiries includingCOVID-19
	Geriatrician viaMLHD Aged Care Services	1800 512 415	
Aged Care	Rosy Garthwaite	0429 308 764	Rosemary.Garthwaite@health.nsw.gov.au
Residential Aged Care	Department ofHealth	1800 836 799	agedcarecovidcases@health.gov.au
Information Services	Jacinta Ducat	0409 888 148	Jacinta.ducat@health.nsw.gov.au

Appendix C: Outbreak Management Checklist COVID-19 Response

This checklist is designed to guide and assist MLHD facilities in identifying and managing an outbreak of COVID-19. A number of key actions should be taken to reduce the risk of transmission and to manage the outbreak effectively and efficiently. This step-by-step approach does not require each action to be undertaken sequentially; in practice many of the steps may be carried out simultaneously.

The outbreak will be managed in accordance with the MLHD local COVID-19 Outbreak Management Plan and overseen by the Outbreak Support Team.

TASKS	ACTIONS/COMMENTS	Date & Time Complete
Recognise potential or suspected outbreak		
Patients/residents		
Identify confirmed, probable or suspected case/s		
Testing of confirmed, probable or suspected case/s completed		
Determine how test results will be received and the timeframe		
Seek urgent medical review of probable and suspected cases		
Notification of a staff member with suspected, probable or confirmed symptoms		
Confirmation of test positive. If at work, remove staff member immediately from work area and send home for self-isolation		
Determine shifts worked during period of infectivity (48 hours prior to onset of symptoms)		
Notify local Cluster/General Manager or Exec On-call of: - Number of residents; and/or - Number of staff - Complete incident notification on ims+		
Escalation to HEOC and/or Public Health Unit by Cluster/General Manager or Exec On Call		
HEOC facilitate Fact Finding discussion		
Outbreak declared Based on definition from Public Health Unit		
Outbreak Support team deployed		

TASKS	ACTIONS/COMMENTS	Date & Time Complete
Facility Manager- make available site Map, patient/resident list and staff list (includes date of birth and vaccination status) for Outbreak Support team's arrival at site		
HEOC Representative - Set up daily briefing sessions for Local management team/CE and MLHD Executive / Incident Controller and other relevant stakeholders		
HEOC Representative - Determine what will be included in the daily team briefing and risk assessments		
MLHD Communication Team-Communication strategy activated		
Determine if visitors will be restricted or no visitors permitted		
Determine staff members who are suitable trained in administrative processes including rostering and cohorting of staff		
Begin collection of preliminary information (Contact Tracing & Outbreak Investigation)		
This information will be required with the ongoing notification to the local NSW Public Health Unit – preference is the information is recorded electronically on an excel spreadsheet. Paper based records are also acceptable **Patients/Residents** • Resident name, DOB • Room and building number • Signs and symptoms and date ofonset • Possible source of transmission		
Staff • Signs and symptoms and date ofonset • COVID safe App installed • Possible source of transmission • Number of patients/residents cared for during the period - names • Review of staff roster for period of infectivity • Review of staff allocation forperiod of infectivity		

TASKS	ACTIONS/COMMENTS	Date & Time Complete
Staff who work across multiple facilities • Ask staff to self-declare secondary employment • Determine if there is a transmission risk if staff work across multiple facilities or has a secondary employment		
Visitors • Visitor log – legible names, contact details, date/time andwho they visited • QR Code – obtain data as advised by Information Services Unit and Public Health		
TASKS	**ACTIONS/RESPONSIBILITY**	**Date**
Notifications		
Notify GPs of suspected patients/residents included in the outbreak (contact and/or symptomatic) – document in health record		
Notify patients/residents and families of suspected outbreak – document in health record		
Notify staff of suspected outbreak		
• Executive/management		
• Nursing and care staff		
• Allied health staff		
• HealthShare		
• Asset management		
• Patient Flow Unit		
• Chief Pharmacist		
• Information Services		
• Volunteers		
• Others (e.g. chaplains, pet therapy, gardeners)		
Reinforce/implement infection control measures		

TASKS	ACTIONS/COMMENTS	Date & Time Complete
Reinforce/re-educate standard precautions throughout facility immediately. Keep education records of staff trained		
Ensure access to adequate supply of hand soap, paper towels and TGA registered/approved alcohol-based handrub. Review placement of alcohol-based hand rub products		
Ensure adequate availability of tissues and lined waste bins throughout facility and in patient/resident's rooms		
Display Respiratory Hygiene and Cough etiquette signage		
Educate affected patient/residents + provide tissues, bin and hand hygiene product (depending on capability of resident/patient)		
Offer COVID-19 vaccination to residents/patients and staff who have not been immunised		
Implement transmission-based precautions immediately. Keep education records of staff trained		
Determine all staff have a PPE Buddy – review of PPE breaches		
Identify and isolate / cohort all symptomatic patients/residents, and suspect and probable cases until negative test result received in consultation with the medical controller		
Dedicate staff to affected resident/s or identified outbreak zones		
Provide PPE stations outside affected patient/resident room/s (gloves, surgical masks,long-sleeved impermeable gowns, Individual eye/face protection, waste bins) – for contact and droplet based precautions		
Display contact and droplet signage outside affected rooms		
Display PPE donning and doffing signage		
Dedicate equipment to affected patients/residents if possible. Shared equipmentmust be cleaned and disinfected between each patient/resident use		

TASKS	ACTIONS/COMMENTS	Date & Time Complete
Provide cleaning products/equipment (detergent/disinfectantwipes) for cleaning of shared equipment		
Display outbreak signage at entrances to facility and visitor posters		
TASKS	**ACTIONS/RESPONSIBILITY**	**Date**
Increase environmental cleaning frequency in collaboration with Health Share (see below) • Provide enhanced cleaning for specified shared areas that mayhave been used by suspected COVID-19 patients/ residents and staff • Review furniture and fixture in outbreak zones to ensure theyare in good repair and fit for purpose – able to be cleaned		
Declutter furniture and store those not required to reduce cleaning		
Avoid the use of nebulisers and use spacers where possible.		
Screening and testing		
Organise the collection of specimens by a trained healthcare professional or pathology collector		
Advise staff to monitor themselves for symptoms of respiratory illness and to stay home and seek testing if unwell. Determine how information can be gathered for staff taking sick leave – for symptoms of COVID-19		
Closely monitor the health of staff, including fever screening, where appropriate		
Exclude symptomatic staff until test results available		
Restrict		
Restrict movement of staff between areas of facility and between other facilities		
Avoid patient/resident transfers within the facility, if possible		

TASKS	ACTIONS/COMMENTS	Date & Time Complete
Ensure staff and GPs are aware of infection prevention and control guidelines for transferring patients/residents to and from hospital, including isolation requirements for new and returning patients/residents		
If visitors are restricted: Screen visitors for risk factors and exclude as necessary + • Flu vaccination (Residential Aged Care requirement for all Visitors) • COVID-19 Vaccination • Temperature check • Scheduled visits • Ensure physical distancing • Limit number of visitors • Decide if children will be restricted • Other – to be decided by facility		
Restrict movement of visitors. Visiting in patient/resident rooms only – not communal areas		
Close communal areas in affected areas		
Suspend non-essential group activities e.g. excursions, concerts, art and craft activities		
Postpone visits from non-essential external providers (e.g. hairdressers and Allied health professionals).		
Organise/facilitate Telehealth options for residents with GPs and other health providers		
Ensure other means of electronic communication between patients/ residents and family/friends		
Monitor		
Continue to monitor clinical symptoms of patient/rresidents, not just for COVID-19		
Monitor outbreak progress through increased observation of residents for symptoms of respiratory illness		
Maintain line listing of suspect, probableand confirmed cases (staff and residents)		
Screen new and returning patients/ residents before entry		

TASKS	ACTIONS/COMMENTS	Date & Time Complete
Update Public Health Unit daily – same person to provide reports to enable consistent information is provided. Information discussed at Outbreak Response Meeting		
Review care plans every shift particularly for at-risk and vulnerable patients/residents		
Staff break room away from resident outbreak zones Separate staff break room away for staff caring for isolated patients/ residents		
Environmental cleaning and disinfection in collaboration with Health Share		
Allocate trained staff for cleaning of affected areas – ensure they are skilled to perform routine, additional and terminal cleaning		
Provide HealthShare staff with disposable gloves, surgical masks, gowns/aprons and eye/face protection for cleaning tasks		
Schedule daily cleaning of all none isolated patient/resident's rooms and communal areas using neutral detergent		
Schedule **at least daily** cleaning and disinfecting of symptomatic patient/resident's rooms (2-step or 2-in-1 clean)		
Schedule **at least twice daily** (or more frequent) cleaning and disinfecting of frequently touched surfaces (2-step or 2-in-1 clean) e.g. taps, handrails, bedside tables, tables, doors, counters, taps, toilets, light switches and shared equipment		
Schedule terminal cleaning of resident's rooms when moved, transferred or discharged		
Supply suitable detergent/disinfectant solution/wipe for cleaning and disinfecting shared equipment betweeneach resident use.		
Catering in collaboration with Health Share		
Ensure only catering staff perform food and drink preparation activities		

TASKS	ACTIONS/COMMENTS	Date & Time Complete
Wash crockery and cutlery as usual. Disposable crockery and cutlery are not required		
Laundry in collaboration with HealthShare (if relevant)		
Adhere to AS/NZS 4146:2000 Laundry practice		
Provide laundry staff with long-sleeved fluid-resistant gowns and disposable gloves for transporting or handling soiled/contaminated linen/laundry		
Provide plastic bags for soiled/contaminated linen and educate staff on double bagging if required for transfer to laundry		
Ensure linen is washed using hot water(>65 degrees for 10 minutes) with standard laundry detergent		
Ensure shared linen is dried in a dryer on a hot setting		
Ensure personal laundry is laundered onsite and not taken home by family members		
Waste management		
Manage waste in accordance with routine procedures		
Dispose clinical waste in clinical waste streams		
Provide staff with gloves and aprons for transporting or handling contaminated waste		
Other priorities as decided by management team		
Staff stations		
• Free of clutter • No shared food or drinks • Free of personal mobile devices • Personal drink bottles/cups must be cleaned and labelled • Regular shift cleaning of shared electronic equipment e.g. phones, computers • Maintain physical distance when able to		

TASKS	ACTIONS/COMMENTS	Date & Time Complete
Other priorities to be decided by aged care facility		
Public Health- Exit strategy for the outbreak – declare the outbreak over		
Communication and debriefing at thecompletion of the outbreak		

Appendix D: MLHD COVID-19 Incident Governance Process (Version 3)

Aim: To provide direction for a consistent approach to managing and investigating COVID-19 related incidents, ensuring compliance with the requirements of the Health Administration Act 1982 and PD2020_047 Incident Management Policy

All incidents involving serious/possible harm, including exposure or potential exposure of COVID-19 to consumer, injury to staff or service delivery failure must be reported immediately to the Hospital Emergency Operations Centre (HEOC), who will conduct an initial fact finding process and if deemed appropriate notify the Director of Clinical Governance or delegate to arrange a Preliminary Risk Assessment (PRA) meeting. This must occur as soon as practicable.

Step 1 Initial Fact Finding Discussion

HEOC team member receiving notification of a serious/possible incident are to gather all relevant information from the notifier (directing the notifier to log an incident notification onto the ims+ system). The HEOC team member is to contact the Medical Controller to discuss the incident and actions to be taken. Following the initial fact finding discussion if it is determined the incident is serious (Harm Score 1 or 2) the Director of Clinical Governance or delegate is to be notified to arrange a Preliminary Risk Assessment as soon as practical.

During this initial fact finding discussion it is to be determined if there is a need to deploy the Outbreak Support Team. The team are deployed by the HEOC representative.

This discussion is to be recorded on the Fact Finding Discussion Record & Action Log template (see appendix C). This document is then attached to the incident notification in ims+.

Step 2 Preliminary Risk Assessment

Huddle arranged within 24 hours of incident notification by Clinical Governance. Huddle invites to include:

- Hospital Emergency Operations Centre Representative
- Chief Executive
- Executive Director Medical Services and/or representative
- Director Clinical Governance and/or representative
- Integrated Operations representative(s) as appropriate
- People & Culture Industrial Specialist / Work Health Safety Representative
- Other invites as required

A risk assessment and identified actions (including person responsible and timeframe) to be documented on tCOVID-19 Preliminary Risk Assessment template.

Step 3 Initial Response and investigation based on risk assessment.

Consideration may include:

- Need to undertake a Serious Adverse Event Review and if inclusion of external MLHD team members are required
- M3 Team attendance at incident location within 48 hours of notification. If Outbreak Support team have not been deployed.
- Undertake COVID-19 Work Plan evaluation and develop in collaboration with key stakeholders animprovement plan (QARS)
- All actions will have timeframes and be risk rated

Step 3 Follow Up action

- Outbreak report will be provided to MLHD Chief Executive, Executive Director Medical Services and Director Clinical Governance within 30 days. Recommendations and actions to be time framed and riskassessed.
- Other incident responses will require a work plan and associated improvement plan to be provided to Director Clinical Governance, Director Operations/General Manager/Cluster Manager (as relevant) preferably within 14 days of incident notification

Step 4 Lesson Learned

Advice to be shared with MLHD staff outlining best practices and any lessons learned.

Step 5 Reporting

Reporting is required to relevant Safety & Improvement meetings and the MLHD District Clinical Governance Council on outcome of incident and improvement plan progress is to occur within 4 weeks of incident date.

Appendix E: COVID-19 Fact Finding Discussion Record & Action Log – Immediacy, Empathy and Accountability

This template is to be utilised by the COVID-19 Pandemic Emergency Operations team to record initial fact finding discussions and resulting action when notified of serious incidents (Harm Score 1/2) or nearmiss (Harm Score 3/4)

ims+ number		**Notification Date**	
Incident Date		**Facility/Service**	
Date of meeting		**Time of meeting**	
Attendees			
Fact finding record completed by			

Issue	**Action**	**Response**
1. Description ofincident	Assess the worker and/or patient/s anddescribe immediate care provided.	(insert text)
	Record the known facts of the incident.	(insert text)
	Confirm the harm score.	1 – Unexpected death or Australiansentinel event 2 – Major harm 3 – Minor harm 4 – No harm or near miss
2. Immediate Clinical Risks identified andmanaged	Record any risks or hazards that requireimmediate action, Consider: • exposure other patients/workers/community members • number and characteristics of case/sand the population at risk • Infectious agent; mode of transmission, infectiousness, andclinical significance • Likely source of the outbreak • Potential impact on service delivery • Potential public health risk • PPE stock • Removal of equipment	(insert text)
	Actions taken to mitigate risks / hazards.Consider: Cleaning	(insert text)

Appendix F: COVID-19 Preliminary Risk Report

ims+ number		**Notification Date**	
Incident Date		**Facility/Service**	
Date of meeting		**Time of meeting**	
Attendees			
Incident notification attached	☐ Yes		

The *Health Legislation Amendment Act 2018* requires **immediate escalation in writing to the Chief Executive(CE)** if:

- Other patients are at risk of serious or imminent harm; and / or
- Professional misconduct, unsatisfactory professional conduct or impairment of a health practitioner issuspected.

The CE must also be notified of a potential state-wide risk or media interest.

Issue	Action	Response
1. Description of incident	Assess the worker and/or patient/s and describe immediate care provided.	(insert text)
	Record the known facts of the incident.	(insert text)
	Confirm the harm score.	1 - Unexpected death or Australian sentinel event 2 - Major harm 3 - Minor harm 4 - No harm or near miss

Issue	Action	Response
2. Immediate Clinical Risks identified and managed	Record any risks or hazards that require immediate action, consider: • exposure other patients/workers/community members • number and characteristics of case/s and the population at risk • Infectious agent; mode of transmission, infectiousness, and clinical significance • Likely source of the outbreak • Potential impact on service delivery • Potential public health risk • PPE stock • Removal of equipment	(insert text)
	Actions taken to mitigate risks / hazards. Consider: • Cleaning • Isolation of area/ward/facility • Contract tracing • Expediting pathology results	(insert text)
	Is a person at risk of serious or imminent harm?	Yes / No Yes – written advice to: • CE • General Manager • Other – specify
3. Patient's healthcare team	Which members of the patient's health care team have been notified of the incident?	Clinical team e.g. Consultant and Nurse Unit Manager Team caring for patient when incident happened General Practitioner Others – specify
4. Patient, worker Carer and Family	Have the immediate needs of the patient/worker, carer and family been addressed?	Yes/No (insert text)
	Has a dedicated contact person been appointed for patient/worker/community?	Yes/No (insert text)
	Will additional support be provided? Consider: • Accommodation • Welfare Notify TMF if out of pocket expenses paid	Yes/No (Specify)

Issue	Action	Response
5. Open Disclosure	Has **clinician disclosure** been initiated within 24 hours?	Yes/No If no, what is the plan or reason?
	Has the organisation offered an apology?	Yes/No If yes, name the lead and date of apology Who was the apology to: If no, why not
	Have **ongoing open disclosure** touchpoints been identified? (e.g. after findings report; after recommendations report)	Yes/No If yes, date of next touch point:
	Is a Formal Open Disclosure Team required?	Yes/No
6. Staff	Has the staff wellbeing been considered, including need for swabbing, isolation etc.?	Yes/No If yes, specify actions
	Is stress debriefing/peer support to take place?	Yes/No If yes, specify when:
	What support has been provided to staff directly or indirectly involved?	(insert text)
	Have staff been informed of the next steps in the incident investigation process? (e.g. RCA, site visit from M team)	Yes/No If no, what is the plan?
	Who will lead final staff feedback after the investigation is complete?	(insert name and contact details)

Issue	Action		Response
	Has the organisation acknowledged distress and been visible to staff?		Yes/No If no, what is the plan
	Are there concerns about the conduct of any clinicians directly or indirectly involved in the incident?		Yes/No If yes, specify intended action
7. Complete Reportable Incident Brief (RIB)	Have the facts been clarified to complete the RIB?		Yes/No
	Who is writing the RIB?		(insert name and contact details)
8. SafeWork NSW Notification	Does this incident require notification to SafeWork NSW (refer to WHSW-FAC-17-COVID-19)		Yes/No
	Who is making the notification?		(insert name and contact details)
9. Type of Investigation	Specify investigation type		(insert type)
	Have M3 team members been identified to undertake site visit?		Yes/No
	Investigation team membership Consider leader, clinical experts, independent expert.		(insert title and/or name and contact details)
10. The Organisation	**Is there an immediate state-wide risk that requires notification e.g. Safety Alert, Public Health Unit?**		Yes/No If yes, specify
	MEDIA	Is there potential for media interest?	Yes / No
		Who is the LHD/SHN contact for communications?	(insert name and contact details)
		Has the worker / patient / carer / family agreed on information to be released?	Yes/No
		Are clinical experts available to assist with communications?	Yes/No/NA
		Has a holding statement been prepared?	Yes/No/NA
	MoH	Should MoH advice / assistance be obtained (e.g. Legal Branch)?	Yes/No

Issue	Action		Response
	External Notifications	Has the Coronial Checklist been completed?	Yes/No/NA
		Has the **Coroner** been notified?	Yes/No/NA
		Which organisations have been notified? (Tick all that apply)	☐ Family and Community Services ☐ Treasury Manager Fund (TMF) ☐ Therapeutic Goods Administration ☐ SafeWork NSW ☐ NSW Ombudsman ☐ NSW Police ☐ Other – specify
11. Other	Other comments		(insert comments)

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Issue	Actions Arising – preliminary risk meeting	Person Responsible	Due
1. Incident			
2. Immediate clinical risks			
3. Patient/resident's healthcare team			

Issue	Actions Arising – preliminary risk meeting	Person Responsible	Due
4. Patient/resident, carer, family			
5. Open Disclosure			
6. Staff			
7. Complete RIB	• RIB Part A to MoH within 24 hours • RIB Part B to MoH within 48 to 72 hours or as directed by MoH		
RIB Parts A and B can be submitted together. For extreme incidents, a prompt call to MoH and RIB submission within 24 hours is expected.			
8. Safe Work (NSW)			
9. Investigation	Send copy of Preliminary Risk report to investigation team		
10. Organisation			

Issue	Actions Arising – preliminary risk meeting	Person Responsible	Due
11. Other			

Health
Murrumbidgee
Local Health District

References

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