MJA
The Medical Journal of Australia

Supporting Information

Supplementary table

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to: Aitken GE, Holmes AL, Ibrahim JE. COVID-19 and residential aged care: priorities for optimising preparation and management of outbreaks. *Med J Aust* 2021; doi: 10.5694/mja2.50892.

Appendix 1. Summary of immediate and medium-term priorities for preparation and emergency response to outbreaks within RACS from short and rapid consultation with senior aged care medical and nursing professionals.

Recommendation	Immediate Priority	Medium-term Priority
Outbreak management plans	**Aged Care Sector** An aged care sector-wide management plan should be developed to ensure a consistent message and action plan. **Local** Each RACS should develop a local management plan for the occurrence of an outbreak (COVID-19 or non-COVID-19 related) in the facility. This should be developed in conjunction with their local hospital, GPs, palliative care, Residential In-Reach services and pharmacy. Situations each management plan should address include the following: • The ability to isolate residents within RACS – this may be through allocation of staff to different areas, segregating of residents and physical isolation of areas of the building. This will be individual to each RACS depending on their capability. • Guidelines for rapid testing of suspected COVID-19 cases • Protocol for admitting non-COVID-19 residents during the pandemic – one suggested solution is for all residents admitted undergoing a 14-day quarantine in the facility on admission. This would require a single room with bathroom and adequate staffing and PPE allocation. • Guidelines for triaging unwell residents who are suitable for hospital care if available and appropriate that can be followed by RACS staff, paramedics and GPs. Guidelines should consider and be in-line with the resident's advance care plan and preferences where applicable.	Local and nation-wide management plans need to be implemented and followed. Staff must be aware of the management plans and should be provided with guidance. Protocols need to be developed for isolation and care of residents returning from hospital who have COVID-19. Plans for if there are mass casualties need to be developed and published, and should include considerations for body disposal, funerals, mourning etc.
Training and support for staff	**New staff training** All new staff will need training prior to commencement to upskill and provide them with basic skills and knowledge. **RACS staff training** Training should be provided to all RACS regarding education about COVID-19 and their roles and responsibilities. This should include training on correct use of PPE, hand hygiene, social distancing within RACS and infection prevention. Regarding COVID-19 positive residents, staff should be educated about identification of COVID-19 positive residents, assessment, management, transfer options and infection control safety. Staff will require clear communication regarding possible new roles including upskilling to manage COVID-19 positive residents.	**Staff training** New and existing staff need to be trained, in advance, in the appropriate use of PPE and COVID-19 care practices, including minimising risk of infection. **Mental health support** Counselling should be provided to support the mental health of staff and supports put in place to keep staff working.

	Consideration should also be made to training locum GPs, who are being increasingly used by RACS, to create a standardised approach for PPE and hand hygiene practices, and screening and management of COVID-19 residents to minimise transmission between RACS. This training could be delivered in an online format, including utilising existing Government resources that have been made.	
Staffing	**Hiring** There is a need for hiring and rapid training of new staff to work in RACS. This could be done with RACS working together to create a staff bank. Sources of such staff may be: • Existing staff who work less than fulltime; students – including health care students; • Recently unemployed persons from other sectors (e.g. hospitality workers, air stewards, personal trainers). RACS need to have contingency for increased staff should a facility become COVID-19 positive, to account for increased staffing needs and staff becoming sick. It is likely these residents will need dedicated staff to reduce transmission to other residents therefore RACS need to identify staff willing/able to care for residents with COVID-19. There needs to be clear communication with new and existing staff regarding possible new roles should this occur. **Rostering** RACS should aim to have continuity of shifts to minimise the number of people coming in and out over a 24-hour period (e.g. create 12-hour shifts).	**Hiring** Local management plans need to be developed for finding extra staff (particularly when people call in sick or isolation areas are set up) and upskilling of new staff. A shared register of aged care staff should be made available to RACS, including a register of potential new staff who can be called upon as needed. It is necessary to consider the availability of a re-deployable workforce for RACS care if there are high attrition rates in the existing workforce. RACS should consider providing staff dedicated to COVID-19 outbreak management (e.g. extra RN to co-ordinate responses with external providers).
Availability of Personal Protective Equipment	There should be an adequate supply of PPE provided to each RACS, with clear plans for use. Contingency planning for situations where there is a shortage should be in place. Such plans may include, pooling of PPE with RACS in the area or having access to emergency PPE stock owned by the local health service.	
Advance Care Plans	RACS nursing staff and GPs need to have discussions to update goals of care and advanced care plans with all residents and their families. These should create clear plans of action for healthcare staff, residents and their families prior to COVID-19 happening and ensure that goals are reflective of the resident's values and wishes. These plans should be guided by the specific circumstances and can be revisited and changed at a later date if circumstances change.	
Communication with residents and families	**Facility-Family Communication** A communication plan should be put in place to ensure accurate and consistent information is given to residents and families. This should include realistic expectations of what will occur in the event of worsening of the pandemic and consequent outcomes.	**Resident-family communication** Families need to be kept informed. A guide for contingency planning should be provided to residents and families. Changes in arrangements should be communicated to families. RACS need to provide families with realistic expectations, including the likelihood of high mortality rates.

	Resident-family communication Each facility should develop or engage someone to be responsible for facilitating facetime/videoconferencing between residents and their loved ones. Loneliness and dislocation are already causing harm to residents, and with isolation potentially continuing for months this needs to be addressed.	RACS should ensure that iPads/tablets are available for palliative care residents in isolation, to enable communication with families and religious support.
Medical and primary healthcare support	**Primary Care** Each health district needs a central service that can offer 24/7 support to RACS. This may be through GPs or Residential In Reach services already servicing RACS. Increased resources to Residential In-Reach programs, or their equivalent, would allow them to be a central contact point for RACS and have capacity to make decisions and communicate with the health service. The use of telehealth to review residents remotely would also increase capacity to review residents. A central service will also lessen the number of people entering the RACS each day – e.g. not having multiple GPs seeing a couple of residents each. **Infrastructure** RACS need to ensure they have the infrastructure and technology to support telehealth so that infrastructure inadequacies do not prevent residents from receiving care. This may be simply investing in iPads with 4G+ dongles.	**Primary Care** RACS should identify, in advance, which health professionals/services can provide advice on issues such as resident management plans, hospital transfers, medication suggestions etc. After-hours medical support (e.g. through Residential In-Reach) will also need to increase. **Infrastructure** Telehealth infrastructure should be put in place, with staff trained in advance.
Influenza vaccination for all staff and residents	Some have suggested bringing forward, and making mandatory, the annual flu vaccination for all RACS residents and staff. While it would not help COVID-19 infection, it would help reduce the severity and spread of seasonal influenza, which can lower a person's immunity and make them susceptible to other illnesses.	
Screening of healthcare workers and residents	Clear plans need to be put in place for screening of RACS staff and residents. Screening will help maintain viability of the aged care system, as well as keep older people safe from COVID-19. Ways in which some facilities have implemented screening of staff is mandatory temperature checks of staff before and after work.	
Physical capacity/segregation		Plans need to be put in place for segregating areas of RACS into COVID-19 positive and COVID-19 negative areas. Cohorting facilities or large scale COVID management areas should be established to manage residents who cannot be managed or cared for in existing RACS.
Adequate resources		It is necessary to ensure the availability of palliative care resources, in case there are is a rapid increase in the number of casualties. Adequate PPE is required.
Accreditation		ACQSC needs to have a strategy for: accreditation, compliance and security of tenure issues, amidst COVID-19

Abbreviations: RACS = residential aged care services; COVID-19 = Coronarvirus Disease 2019; GP = general practitioner; PPE = personal protective equipment; RN = registered nurse; ACQSC = Aged Care Quality and Safety Commission