UnitingCare

Blue Care Aged Care & Community Services ACCS

COVID-19 Response Plan

Proudly representing
Blue Care | Lifeline | ARRCS | The Wesley Hospital | Buderim Private Hospital
St Stephen's Hospital | St Andrew's War Memorial Hospital

ACCS.V1.0. March 2020

Contents

WARNING: This plan may be varied, withdrawn or replaced at any time. Printed copies of this plan or part thereof are regarded as uncontrolled and should not be relied upon as a current reference document. It is the responsibility of the staff member printing the plan to always refer to UCQ Intranet Page for the latest version. Compliance to this plan is mandatory.

1. Introduction

1.1 Background

The novel coronavirus outbreak represents a significant risk to UnitingCare. It has the potential to cause high levels of morbidity and mortality and to disrupt our community socially and economically.

Viral respiratory diseases have the greatest potential to cause pandemics and the key threat of new pandemic virus strains lies at the human–animal interface. (Australian Government Department of Health 2020). Coronavirus (COVID-19) is a respiratory illness caused by a new virus that has not previously been identified in humans.

COVID–19 is spread from person to person most likely through:

- Close contact with an infectious person
- Contact with droplets from an infected person's cough or sneeze; or
- Touching objects or surfaces (such as door knobs or tables) contaminated by cough or sneeze droplets from a person with confirmation COVID-19 Infection, and then touching your mouth or face

Possible risk factors for progressing to severe illness include, but are not limited to:

- older age
- underlying chronic medical conditions such as:
    - lung disease
    - cancer
    - heart failure
    - cerebrovascular disease
    - renal disease
    - liver disease
    - diabetes and immunocompromising conditions

The Communicable Disease Network Australia Guidelines National Guidelines for Public Health Units summarises interim recommendations for surveillance, case definitions, infection control, and laboratory testing and contact management for coronavirus disease (COVID-19).

The *Queensland Whole-of-Government Pandemic Plan*, the *Australian Health Sector Emergency Response Plan for Novel Coronavirus* and the Australian Government Department of Health Operational Plan for People with Disability are designed to guide the Australian health and community service sector response. The UnitingCare Pandemic Plan has been developed in the context of the Australian Health Sector Emergency Response Plan for Novel Coronavirus and has been informed by detailed scenario planning (**Appendix 1**) within UnitingCare. This document supplements the UnitingCare Pandemic Plan by outlining the practical implementation of the response at the operational level specifically for Blue Care Aged Care and Community Services.

1.2 Purpose

This document outlines the pandemic operational response for Blue Care Aged Care and Community Services to:

- Minimise transmissibility, morbidity and mortality;
- Minimise the burden on/ support care / service delivery systems; and
- Inform, engage and empower our staff and clients.

1.3 Scope

This plan does not include:

- Strategic crisis management arrangements as outlined in the UnitingCare Crisis Management Plan
- Whole of UnitingCare pandemic response arrangements as outlined in the UnitingCare Pandemic Plan.
- Restoration activities for a loss of services that are covered in Group and Service Business Continuity Plans
- Emergency response procedures covered in Fire and Evacuation Plans (FEP).

The actions contained in this document have been tailored to reflect the most current intelligence provided by the Australian Government and World Health Organisation (WHO). During a pandemic, this plan will remain flexible to respond to changes in planning assumptions and severity.

1.4 Related documents

- UnitingCare Crisis and Incident Management Policy
- UnitingCare Crisis Management Plan
- UnitingCare Business Continuity Management Policy
- UnitingCare Business Continuity Management Manual
- UnitingCare Pandemic Plan

1.5 Exercise, maintenance and review

This document will be exercised, maintained and reviewed on an annual basis in accordance with the UnitingCare Business Continuity Management Policy and Manual.

Debriefing should be conducted within 14 days of the declaration to stand down and/or returning to normal business. Refer to the Business Continuity Management Manual regarding debriefing and for Post Event Report Templates.

1.6 Document information

Version	**Date**	**Amendment**	**Author**
0.1	March 2020	Initial draft	Rebecca Bell/ Megan Lunney
Document location:		*UCQ Intranet*	
Document Owner:		*GM Care & Clinical Governance*	*Rebecca Bell*

Authorised by:	*GE Aged Care & Community Services*	Cthomas
Distribution:	*ACCS teams*	

2. Authority to activate

The Group Executive Aged Care and Community Services or the Group General Management South East Queensland are authorised to activate this plan. The triggers to activate this plan will be:

- activation of the UnitingCare Pandemic Plan;
- declaration of a pandemic by the World Health Organisation (WHO);
- advice from a credible source that sustained community transmission of a novel virus with pandemic potential has occurred; or
- notification from the Australian, State or Territory Government Department of Health of the emergence of a novel virus with pandemic potential in Australia or overseas.

3. Roles and responsibilities

Where possible, during a pandemic the business as usual management process and hierarchy structures and reporting should be maintained unless the matter is pandemic response related.

Entity	**Roles and responsibilities**
The Department of Health	The Australian Government develops and maintains a national health sector plan to prepare for and respond to pandemics. The Australian Government will coordinate the allocation of available resources required for clinical care. The Department of Health via their website (www.health.gov.au) will make available a collection of resources (fact sheets, posters etc.) for the general public, health professionals and industry about the pandemic influenza. These resources should be used to ensure consistency and accuracy of information. The National Medical Stockpile (NMS) provides a national reserve capacity of medicines, vaccines and equipment that can be rapidly deployed in the event of a pandemic. The Australian Government Department of Health is responsible for maintenance and deployment plans relevant to the NMS.
The Queensland Department of Health	The Queensland Department of Health is the functional lead agency for a pandemic in Queensland and is responsible for implementing national and state plans to ensure a coordinated, whole-of-health response in Queensland.
UnitingCare Crisis Management Team (CMT)	• Strategic management and decision-making authority • Direct and track recovery progress and associated costs • Analyse risks and consequences • Represent service stream operational groups and recovery teams and report progress, as agreed • Internal and external communication lead
UnitingCare	• Provide Subject Matter Expert advice and support in accordance with

Operational Management Team	the business capability they deliver • Execute and coordinate the response on behalf of the CMT • Perform additional tasks as directed by the nominated Operations Team Lead or CMT Controller

ACCS Response Team	
Position	**Roles and responsibilities**
Executive Lead	Responsi*ble for command and control of the crisis including:* • Report to UnitingCare Crisis Management Team • Chair ACCS Response Team • Appoint the ACCS Operations Team Advisor • Convene the Blue Care General Manager and Cluster Operational Working Group (BC- GMCOWG) • Assessing wider strategic issues and consequences • Requesting additional subject matter experts to support the operational response • Review and advise on media statements and other communication • Establish and make known emergency delegations
ACCS Operations Team Advisor	• Represent ACCS on the UnitingCare Operations Team • Facilitate scenario planning to inform development of action plans • Relay information to and from the UnitingCare Operations Team and the BC-GMCOWG and ACCS Response Team SMEs including logistical, intelligence and operational related information • Manage and direct members of the BC-GMCOWG and ACCS Response Team SMEs as required • Set up and manage the issues log – collated from the communications and expenditures logs • Communicate incident issues • Gather intelligence reports from Logistics and Operations
ACCS Liaison	• Support ACCS operational communication and reporting • Provide advice to the Executive Lead, ACCS Operations Team Advisor, BC- GMCOWG and ACCS Response Team SMEs • Undertake planning and response activities (as required)
Aged Care & Community Government and Peak Body Liaison	• Engage with aged care peak bodies, Queensland Health, ACSA and UCA raising emerging concerns and contributing to resources • Provide appropriate communication to the ACCS Liaison *Note: Operational relationships continue to be maintained by GGMs/ Operational Leads including weekly updates to Department of Health and ACQSC representatives*
ACCS Operational	• Coordinate activities on behalf of the ACCS Operations Team

ACCS Response Team	
Position	**Roles and responsibilities**
Response Team SME's	Advisor, BC-GMCOWG and the ACCS COVID-19 Pandemic Response Plan.
ACCS GM and Cluster Operational Working Group (BC-GMCOWG)	• Communicate the key messages and issues for the day • Understand key challenges and concerns from a service perspective • Monitor and assess resource requirements and allocations • Manage the response for areas of responsibility for the duration of the pandemic period • Provide information and report issues in a timely manner • Manage the incident log of client and staff cases • Identifying, acquiring and distributing the required support services and equipment
Service Managers and care/nursing staff	• Follow the actions outlined in this plan accordingly. • For Residential Aged Care facilities, Service Managers should assess special circumstances for visitors on a case by case basis. In particular for those visiting residents on end of life cares. • Have a heightened level of suspicion of cases with symptoms and history compatible with the case definition for COVID-19. • Consistent urgent notification following the appropriate process of suspected or confirmed cases of COVID-19 in accordance with this plan.

4. Communications

The below table outlines the communication and reporting processes during a pandemic:

Queensland Health	State legislation sets out the responsibilities for reporting and managing outbreaks of communicable diseases. Their aim is to improve infectious disease control through improved disease notification procedures. Services are responsible for becoming familiar with and adhering to the relevant State legislation. Specific reporting requirements for confirmed cases involves contacting Queensland Health through the state Public Health Unit (PHU). Alternatively, if ACCS is contacted by Queensland Health, any requests for information or assistances should be communicated through the ACCS Operations Team Advisor to the UnitingCare Operations Team. Refer to Blue Care Reporting Requirements for additional information.
Funding bodies and regulators	Government funding bodies and regulators have contractual and legislative reporting requirements for critical incidents, including outbreaks during a pandemic. Where the funding body or regulatory request is part of the services business as usual process, the service is to respond accordingly. Where a service receives a request from a funding body or regulator around the pandemic and/or reporting mechanisms, they should escalate the request through their cluster General Manager of whom will escalate the matter through to the BC- GMCOWG.

	Specific reporting requirements of confirmed cases involves contacting the Commonwealth Department of Health via agedcareCOVIDcases@health.gov.au. A Commonwealth departmental officer will be in contact to offer case-by-case assistance and support to help you manage the case or outbreak. Refer to Blue Care Reporting Requirements for additional information.
Media Spokesperson	Identified by the UnitingCare Crisis Management Team as the appointed media point of contact in addition to the Head of Corporate Affairs.
The UnitingCare Operations Team	Coordinates and approves all pandemic communications across external (customer and other stakeholders) and internal (staff and volunteer) for all business channels.
ACCS Operations Team Advisor and ACCS Liaison	Responsible for identifying communication requirements, drafting content, including information and resources for external and internal aged and community care audiences and providing to Operations Team Communications Advisor for review and distribution. **Refer to Communication Plan Appendix 2.**
UnitingCare Intranet Site unitingcareqld.com.au/covid19	A UnitingCare Micro Site provides the central point of truth for all information and resources as it relates to the pandemic.
Riskman	Staff Incidents are to be recorded in the Riskman system and managed in accordance with UCQ policy.

5. Infection Control

Minimising disease transmission is the ultimate aim of pandemic planning. In the absence of an effective vaccine, good infection control practices are the most effective way of reducing the spread of disease and offer a level of protection to staff and the community during a pandemic.

Good infection control practices should be reinforced in accordance with the Blue Care Infection Control Manual. All staff should be made aware of and adhere to recommended personal and organisational practices, specifically:

- hand washing / hygiene and personal hygiene;
- respiratory hygiene / cough etiquette;
- standard and applicable additional precautions;
- any special service requirements (e.g. cleaning and disinfecting surfaces/workstation areas and equipment such as keyboards, mousse, door handles); and
- social distancing: staff and clients are reminded that they must maintain the following physical (social) distancing: 2.00m indoors and 1.5m outdoors.

5.1 Personal Protective Equipment (PPE)

Use the **COVID- 19 Personal Protective Equipment Matrix** to determine what PPE should be utilised in what scenario. Disposable face masks can only be used once. If you are not ill or looking after someone who is ill then you do not need to wear a mask. There is a world-wide shortage of masks, so the World Health Organisation (WHO) urges people to use masks wisely.

5.1.1 PPE when treating a suspected or confirmed case

Staffs should use personal protective equipment (PPE) when looking after residents or clients who are confirmed to have, or suspected of having, COVID-19.

- **Contact and droplet precautions** are recommended for routine care of patients in quarantine or with suspected or confirmed COVID-19.
- **Contact and airborne precautions** are recommended when performing aerosol-generating procedures, including tracheostomy care and administration of nebulized medication.

5.1.2 Donning PPE

The correct process for fitting PPE is as follows (as found on the L & C Portal):

- Perform hand hygiene.
- Put on long sleeve fluid resistant gown. Fasten the back of the gown at the neck and waist.
- Put on surgical mask. Secure the ties of the mask at the middle of the head and neck. Fit the flexible band to nose bridge and ensure mask is fitted snug to face and below the chin.
- Put on protective eyewear/face shield.
- Put on gloves. Extend to cover wrist of long-sleeved gown.

5.1.3 Doffing PPE

The correct process for removing PPE is as follows (as found on the L & C Portal):

- Staff should not remove PPE until they have exited the area.
- Remove gloves being careful not to contaminate bare hands during removal. The outside of the gloves are contaminated.
- Perform hand hygiene.
- Remove protective eyewear/face shield. The outside of protective eyewear/face shield is contaminated. Remove eyewear/face shield by tilting the head forward and lifting the head back or ear pieces. Avoid touching the front surface of the eyewear/face shield.
- Perform hand hygiene.
- Remove surgical mask. Do not touch the front of the surgical mask. Remove the surgical mask by holding the elastic straps of ties and remove without touching the front.
- Perform hand hygiene.
- PPE should be disposed into clinical waste.

5.2 Isolation of a confirmed, suspected or probable case

People who are confirmed, suspected or probable cases of COVID-19 need to be isolated from other members of the community or residential aged care facility until they no longer pose a risk of transmission. Where a person with suspected or confirmed COVID-19 does not require hospitalisation, they can be isolated in their usual place of residence if it is safe to do so.

While recommendations on isolation and PPE for managing confirmed, probable, and suspect cases initially took a deliberately cautious approach, emerging evidence and expert advice now supports requirements commensurate with the risk in particular clinical circumstances.

For requirements of release from isolation in various scenarios, follow the directions from the *Coronavirus Diseases 2019 (COVID-19) CDNA National Guidelines for Public Health Units*.

5.3 Infectious Outbreak Cleaning in a Residential Aged Care Facility

All current procedures must be followed. At this time there is no difference in cleaning as an infectious outbreak control using a detergent and disinfectant daily and managing frequent touch point clean methods as per the Blue Care Cleaning Manual.

For the room of a resident who is has a suspected or confirmed case of COVID-19, the preferred cleaning process involves:

- Using a yellow colour coded microfiber or disposable microfiber cloth and keeping equipment disinfected between cleaning rooms. Refer to the Blue Care Infection Control Manual.
- Cleaning and disinfecting frequently touched surfaces, such as doorknobs, bedrails, tabletops, light switches, resident handsets, in the residents' room daily. Using the types of chemical products outlined below.
- Performing terminal cleaning of all surfaces in the room (as above) plus floor, ceilings, walls and blinds after the resident is discharged/deceased. Using the types of chemical product outlined below.

Infectious cleaning chemicals required:

- A physical clean and disinfect using a combined detergent and 1,000 ppm available chlorine solution for wet mop and disposable systems (2 – in – 1 clean) (Actichlor from Bunzl).

OR

- A physical clean and disinfect using one step (2-in -1 clean) combined detergent Accelerated Hydrogen Peroxide (AHP) disinfectant solution for microfiber (Oxivir From Bunzl).
- Food dining areas using a Quat sanitiser will assist in complying with HACCP regulations (as chlorine and AHP are non-food based solutions) (clean shot Quat sanitiser from Bunzl).

Cleaners should observe **contact and droplet precautions** by following the Blue Care Infection Control Manual. Please refer to the Blue Care Cleaning Manual for further instructions.

5.4 Cleaning in the community

Where staff undertake cleaning duties, they should use usual household products. Frequently touched surfaces should be cleaned several times a day, and also if visibly soiled. Cleaning is an essential part of disinfection. Cleaning reduces the soil load, allowing the disinfectant to work. Removal of germs such as the virus that causes COVID-19 requires thorough cleaning followed by disinfection. This can be done by a 2 in 1 clean- a physical clean using a combined detergent and TGA listed hospital grade disinfectant including a combined detergent/ disinfectant wipe or solution.

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

Further information is available in:

- The fact sheet Coronavirus COVID-19 Environmental cleaning and disinfection for health and residential facilities.
- The toolbox talk for cleaning of cars and devices providing information for infection control cleaning of cars and devices.

5.4.1 Case and Outbreak notification and Commonwealth Support

If a provider has a confirmed or suspected case or outbreak of COVID-19, it is critical that they report to their Public Health Unit and also inform the Commonwealth Department of Health of confirmed cases and potential and/or confirmed outbreaks at agedcareCOVIDcases@health.gov.au . A Commonwealth departmental officer will be in contact to offer case-by-case assistance and support to help you manage the case or outbreak. This is the fastest pathway to access Commonwealth support.

Assistance available ranges from accessing more staff if you have staff off work being tested for COVID-19 or in isolation due to infection, to accessing PPE if you have an outbreak or an incident.

Refer to Blue Care Reporting Requirements for community or residential services for additional information.

Other enquiries that do not relate to a positive COVID-19 case should be directed to the following:

Personal protective equipment queries	agedcareCOVIDPPE@health.gov.au
Access to additional staffing resources	My Aged Care at: 1800 836 799
Offers and suggestions to support the Department's response to COVID-19	Covid19.triage@health.gov.au
Other general enquiries regarding COVID-19 in aged care	AgedCareCOVIDLiaison@health.gov.au

5.5 Influenza Vaccination

From 1 May 2020, those accessing or working in a Residential Aged Care Facility must have an up to date influenza vaccination. This includes staffs, volunteers, visitors, contractors, allied health professionals and General Practitioners. Those with a genuine medical reason for declining will need to provide a medical certificate. This requirement does not apply to residents.

While influenza vaccination is not mandatory for community staffs, they are strongly encouraged to get vaccinated to protect themselves and vulnerable clients.

All staffs and volunteers will be offered an influenza vaccination through several channels. These include, on site clinics, visiting General Practitioner's and accessing a pharmacy. Those that nominate to visit a General Practitioner will be reimbursed the vaccine fee only, not the General Practitioner fee.

6. Finance and supply

The UnitingCare Operations Team will conduct financial and revenue modelling which includes establishing a process to understand the financial implications related to the pandemic. The processes for reporting revenue losses or purchasing additional items to support our clients and staff through this time have been updated. These updates will also create opportunities for service streams to better respond to the events and identify funding opportunities or changes that are required.

A pandemic expense is a typical purchase or increase in expenditure that your service would not have otherwise incurred prior to the pandemic commencing.

Similarly, pandemic revenue loss refers to the financial impact of any fee-for-service that has been reduced or terminated outside of normal cancellation trends. This may include reduced site hours or service provisioning, and the cancellation of activities or events.

For expenses that will be invoiced and paid for through the normal accounts payable process, please note that specific cost centres, sub-codes and service classifications will be created to capture pandemic expenses.

6.1 Procurement

During a pandemic, the supply stream will be severely impacted. Procurement of items such as Personal Protective Equipment (PPE) will be coordinated through the Operations Team.

6.2 Other pandemic related expenditure

The UnitingCare Operations Team will develop an online tool to clearly capture pandemic related expenditure that does not follow the processes mentioned above. This includes purchases made with petty cash and/or procurement cards. This process will be in addition to complying with normal process such as Promaster and petty cash reconciliation where it is mandated that transaction descriptions include the identified title, for example: “pandemic expense”. UnitingCare Business Units should update the online tool on a daily basis. An example of the online tool can be found at: https://form.jotform.com/200768340889870

6.3 Supply Chain Management

Existing channels for ordering products are to be leveraged in the first instance using the current procurement process.

Clusters need to monitor and redistribute resources (including PPE and clinical resources). If unable to redistribute stock or there is risk of unacceptably low stock levels, Clusters are to escalate orders through the ACCS Operational Response Team SMEs for review and further escalation to procurement.

Refer to the ACCS COVID-19 Cluster Centralised PPE and Clinical Resources Process for ordering and escalation processes during this time.

For cleaning chemicals and paper goods consumables (e.g. toilet paper), Services are to place orders through Bunzl using the normal procurement process. An up to date stocktake should be completed weekly and monitored by the ACCS Hospitality Corporate Manager. This will be used to identify services with critical stock levels. These sites will be prioritised and provided with stock. All other sites will then be supplied with stock.

7. Workforce management

Existing employment and management legislation, industrial relations agreements, policies and practices in relation to salaries, wages and conditions continue to apply and are enforceable, unless varied through appropriate processes. Particular care should be taken to ensure meal breaks, shift changes and rest periods continue to be observed, to offset the risk of fatigue compromising the quality of services.

People and Culture have conducted staff profiling utilising the Better Impact application to inform workforce planning decision during a pandemic.

7.1 Flexible work arrangements and worksites

An appropriate risk assessment must be undertaken for temporary work sites. Arrangements may not be ideal but should not present an unacceptable level of risk to consumers, staff, volunteers or visitors.

During a pandemic, the Australian Government will recommend all Australians who can work from home, should do so, where practical. Based on this, staff who can work from home without negatively impacting their ability to conduct their daily duties, will do so.

Working from home arrangements for staffs must be prior-approved by the staff's Senior Leadership Team (SLT) member.

Home sites should be secure, appropriate and kept separate from daily living. Managers and staff should have established timings for regular contact both individually and collectively by email, phone or conference call and maintain appropriate work process.

In order to support everyone working from home, staff are required to use Citrix to deliver critical functions will be identified and able to continue to do so.

Staff that do not need to use Citrix, please use other forms of access (e.g. Webmail).

Staff that require documents remotely, will be advised to download these BEFORE going home. Only copy the files you need.

In addition to this, each business unit and corporate support function will nominate a 'digital concierge' person who can access the majority of files stored on UnitingCare servers for their team, in the event they need to be accessed remotely.

Resources to support staff working from home will be available from the microsite however staff are reminded to print these resources prior to working from home as the microsite can only be accessed through Citrix.

During a global pandemic it is likely that the UnitingCare My Service Desk will be impacted. For this reason, staff will be reminded that the My Service Desk team should only be contacted for widespread, high impact, critical urgency. All other requests are to be logged via My Service Desk Portal.

All managers and leaders are to keep track of any hardware assets that staffs take home for remote working during the pandemic period.

7.2 Staff obligations

Symptomatic staff will be excluded from work and referred directly to a fever clinic or medical practitioner for assessment, diagnosis and advice about safe return to the workplace.

All staff will be reminded of their obligations in regards to not working if unwell.

Residential services will implement a system to screen staff for possible symptoms prior to entering the workplace/commencement of shift.

7.3 Leave management

Leave resources will be available through the established UnitingCare Pandemic Intranet Site:

- Leave Management Guide
- Leave Decision Tree
- Community and Residential Staff Factsheets.

7.4 Support mechanisms

The following mechanisms are in place to support UnitingCare during and outside of a pandemic:

- Our Chaplains: missionteam@ucareqld.com.au
- Staff Assistance Programs: Benestar 1300 360 364
- Lifeline: 13 11 14.

7.5 Education and Training

In addition to the stand infection control training conducted, during a pandemic staff will be required to complete the online SABA training packages developed (L & C Portal) as they relate to infection control practices, hygiene, and Personal Protective Equipment (PPE).

8. Response stages

The Queensland Health response activities reflect the Australian Health Management Plan for Pandemic Influenza (AHMPPI) response stages which are:

- Prevention
- Preparedness
- Response and
- Recovery.

Additional stages are added for a Pandemic within the Response stage.

Once response activities are completed arrangements will return to the Preparedness stage, to monitor for any future novel coronavirus outbreaks; maintain plans and response agreements; and ensure resources are available and ready for a rapid response.

STAGE	SUB STAGE	ACTIVITIES
Prevention	Prevention	No novel strain detected or emerging strain under initial investigation. • promote good personal hygiene measures to health care workers and the general public e.g. hand hygiene, respiratory etiquette (cover coughs/sneezes, use of disposable tissues) staying away from others whilst sick • to establish communication systems to keep updated on developments overseas and within Australia • to refine policies and processes for identification and management of suspected cases of pandemic influenza • to advise staff and consumers of symptoms to be aware of • to maintain high levels of infection control • to monitor the epidemiology and aetiology of the disease overseas and update infection control advice accordingly • to enhance practices and behavior to minimise the risk of transmission
Preparedness	Preparedness	No novel strain detected or emerging strain under initial investigation. • to develop, review, maintain and test the ACCS Pandemic Response Plan • to raise awareness of this plan and the key strategies to respond to a pandemic • to strengthen awareness and understanding of staff and volunteers, consumers and families about ACCS preparedness for a pandemic, and what actions they should take • to further build awareness within external audiences of ACCS plans for an influenza pandemic, and assure ACCS has taken all possible known precautions to protect and care for consumers and staff
Response	Standby	Sustained community person-to-person transmission overseas.

STAGE	SUB STAGE	ACTIVITIES
	Initial Action Targeted Action	Activate the Uniting Care Crisis Management and Pandemic Response arrangements. Action is divided into two groups of activities: *Initial (when information about the disease is scarce)* • Minimise transmission • Prepare and support system needs • Manage initial cases and contacts • Identify and characterise the nature of the disease within the Australian and Queensland / Northern Territory context • Provide information to support best practice care and to manage the risk of exposure and • Confirm and support effective governance arrangements. *Targeted (when enough is known about the disease to tailor measures to specific needs)* • Ensure a proportionate response • Support and maintain quality care • Communicate to engage, empower and build confidence in the organisation and our community and • Provide a coordinated and consistent approach.
	Stand Down	• Support and maintain quality care • Cease activities that are no longer needed, and transition activities to normal business or interim arrangements • Monitor for a second wave of the outbreak • Monitor for the development of resistance to any pharmaceutical measures (if being used) • Communicate to support the return from emergency response to normal business services.
Recovery	Recovery	Virus no longer presents a major public health threat • Contribute to community recovery and restoring business as usual operations • Conducting post event debriefing and evaluating systems, revising plans and procedures • Advise external stakeholders about changes to services as they return to business as usual operations • Re-supply stores including PPE.

9. ACCS Response Team Actions

	Activities	Responsibility	Resource
Pandemic planning and coordination	Identify ACCS Response Coordinator	Executive Lead	
	Activate ACCS Response Team and Operations and Working Groups	Executive Lead and Response Coordinator	ACCS COVID-19 Response Plan
	Cancel all non-essential travel	UnitingCare Crisis Management Team	
	Reduce or close functional areas/ non-essential services as required to temporarily redeploy staff to priority areas	Executive Lead	
	Ensure currency of contingency arrangements to provide continuity of essential services during a pandemic	Response Coordinator and ACCS GM and Cluster Operational Working Group	ACCS COVID-19 Response Plan
	Implement and monitor management of suspected and confirmed staff cases	UnitingCare Crisis Management Team	
	Implement and monitor suspected and confirmed resident cases	Response Coordinator	Riskman Reports
	Add suspected and confirmed case definitions to Riskman	UnitingCare Crisis Management Team and Response Coordinator	Riskman Reports
	Develop and deploy process guide for Riskman	Response Coordinator and ACCS GM and Cluster Operational Working Group	
	Maintain records and report on numbers of infected staff and consumers	Response Coordinator and Government and Peak Body Liaison	
	Monitor staff wellbeing and business activity	Response Coordinator and Communication Liaison	
	Liaise with State and Federal departments and report information through ACCS GM and Cluster Operational Working Group	ACCS GM and Cluster Operational Working Group	

	Daily review of federal and state requirements and impacts based on public health advice	Response Coordinator, Government and Peak Body Liaison, and Communication Liaison	Daily Round Up email to ACCS Response Team and GM and Cluster Operational Working Group
	Managing changes between delivered and contracted outputs	Response Coordinator	
	Regular check for information on government response and recovery efforts, including any assistance packages that may be available	ACCS GM and Cluster Operational Working Group	
	Communicate regularly with other UnitingCare services and Crisis Team	Executive Lead	ACCS COVID-19 Response Plan
	Liaise with Queensland Health on surge capacity issues	Executive Lead and Response Coordinator	
Care	Continue monitoring admissions and admission processes with Customer Service Centre	ACCS Operational Response Team SMEs	CSC Script for new admissions Client Letter Resident Letter Residential Preparation Checklist Part 2 Community Preparation Checklist Communication Plan Letter to GPs COVID-19 Community Preparation Checklist Residential preparation Checklist Part 1
Infection control	Continue education for consumers on the correct use of surgical mask, cough etiquette and hand washing	ACCS Operational Response Team SMEs	
	Review and update policies and processes as required to ensure the prompt identification, isolation and medical assessment of consumers with influenza-like illness	ACCS Operational Response Team SMEs	Guidelines for proof of immunisation record for all visitors, contractors & students
	Review Advanced Care Planning and Palliative Care Processes	ACCS Operational Response Team SMEs	Influenza Vaccination Register

	Review vulnerability profile of community clients and prioritize support for most at risk cohort.	ACCS Operational Response Team SMEs	ACCS Immunisation Proof Card
	Communicate with community services re Procura essential services/priority codes	ACCS Operational Response Team SMEs	ACCS Immunisation Proof Card
	All community services to complete Preparation checklist	ACCS Operational Response Team SMEs	
	Explore options for telehealth and use of technology to keep families connected	ACCS Operational Response Team SMEs	ACCS COVID-19 Outbreak Management Plan
WH&S	Identify staff who have recovered from illness to support recovery process as these staff may have immunity in the event of a second or third wave	ACCS Operational Response Team SMEs	Temperature Log for Staff in RACF Fact Sheet Temperature Checks for Residential Aged Care
	Development of resources to assist managers and staff	ACCS Operational Response Team SMEs and UnitingCare Operational Management Group	Leader Guide UnitingCare Latest Staff Update COVID-19 Leave and Quarantine Decision Tree COVID-19 Leave Guide
	Initiate workforce policies and processes for school and child care closures	ACCS Operational Response Team SMEs and UnitingCare Operational Management Group	Leader Guide
	Reinforce availability of pastoral, counselling and staff assistance programs	ACCS Operational Response Team SMEs and UnitingCare Operational Management Group	ACCS COVID-19 Response Plan UnitingCare Pastoral Toolkit
	Manage central call point for staff queries	ACCS Operational Response Team SMEs	Temperature Log for Staff in RACF Fact Sheet Temperature Checks for Residential Aged Care
Training	Develop working from home processes and risk assessment	ACCS Operational Response Team SMEs and People and Culture	Work from home checklist

	Reinforce education package for consumers on the correct use of surgical mask, cough etiquette and hand washing	ACCS Operational Response Team SMEs and People and Culture	Resident and client letters New resident/client information sheets Client Emergency Preparedness Plan
	Deploy additional resources as developed to support staff	ACCS Operational Response Team SMEs and People and Culture	SABA Training Packages
	Ensure completion of training		SABA Reports
Communication and reporting	Obtain latest information from Commonwealth and State health departments and communicate it to response team, including updates on legislation impacting aged care.	ACCS Operational Response Team SMEs and Communication Liaison	Daily Round Up email to ACCS Response Team and GM and Cluster Operational Working Group
	Establish regular Cluster briefings on developments: - Daily teleconferences with GMS and Cluster leads - Implementation and monitoring of Question Log - Development and communication of Question Log processes	ACCS Operational Response Team SMEs	ACCS COVID-19 Working Group Question Board Process Question Log
	Develop and implement communication plan	UnitingCare Operational Management Group and Response Coordinator	Communication Plan
	Provide access to information released by health departments: - Staff Information Booklets community & residential - Restrictions to RACS - Resident, GP and families Letters	ACCS Operational Response Team SMEs and UnitingCare Operational Management Group	Letter to ACCS family members COVID-19 Letter to Residents COVID-19 Letter to GPs COVID-19 COVID-19 Factsheet for ACCS Community Staff COVID-19 Fact Sheet for ACCS Residential Staff
	Provide regular updates to key contacts at the Department of Health and Aged Care Quality and Safety Commission	Response Coordinator and Communication Liaison	Updates to departments
	Establish Aged Care and Community Services COVID-19	ACCS Operational Response Team	ACCS COVID 19 In Box and email group

	inbox for centralised communication and information management	SMEs	
Procurement	Coordinate distribution and resupply of PPE: - Inventory of PPE Stock across Clusters - Inventory of Clinical Resources stock review across Clusters - Deployment of Outbreak Kits	ACCS Operational Response Team SMEs and UnitingCare Operational Management Group	PPE Spreadsheet Clinical Resources Spreadsheet
	Monitor and evaluate levels of PPE: - Development & Implementation of PPE& Clinical Resources escalation process	ACCS Operational Response Team SMEs	ACCS COVID-19 PPE and clinical resources process COVID -19 PPE Matrix
	Initiate stockpiling plans for medications, clinical resources, other essentials expected to be in short supply	ACCS Operational Response Team SMEs and UnitingCare Operational Management Group	Procurement Processes
Facility, maintenan	Liaise with contractors to provide continuity of service	ACCS Operational Response Team SMEs and Facilities Maintenance	Letter to Contractors COVID-19 Smart Tec system requirements for COVID 19
Product and services	Adapt community business processes and Procura Management to changed service delivery models	ACCS Operational Response Team SMEs	Factsheet - Understanding funding and charges
	Review services that can be offered in replacement of suspended services and restrictions: - Fact sheet social support - Fact sheet client shopping - Information sheet clinical services - How to guide continuing care in the new environment	ACCS Operational Response Team SMEs	Factsheet - Community client shopping Factsheet - Social Support How to guide Continuing care in the new environment Factsheet - Clinical services
Policy	Identify policy deficiencies and address	Aged Care and Community Services Care Governance and Quality Team	COVID -19 Response Team actions and Communication Plan
	Identify policy deficiencies and address – Review Infection	Aged Care and Community Services	

	Control Manual	Care Governance and Quality Team	

10. Residential Aged Care Actions

The following information is specific to Residential Aged Care Facilities and must be followed:

Category	Activities
Greeter checklist	Services should also support and enforce infection control practices by staff, consumers and visitors. This is to be achieved by using the Greeters Checklists prior to entry to the facility.
Food supply	The supply of food to services will continue to be monitored and reported upon through the ACCS Operational Response Team SMEs. Services should continue to order as per the normal process through Bidvest, Mercy or Wesley Mission kitchen.
COVID-19 Outbreak Management Plan	While the definitions above provide guidance, the Queensland Health Public Health Unit will assist Residential facilities in confirming the presence of an outbreak, identifying control measures, and testing initial respiratory specimens. In the case of an outbreak follow the COVID-19 Outbreak Management Plan. Services can also refer to the COVID-19-Outbreak-Management-in-Residential-Facilities Information Sheet
Definition of potential COVID-19 outbreak	Two or more cases of Acute Respiratory Infection (ARI) in residents or staff of a Residential Care Facility within 3 days (72) hours.
Definition of a confirmed COVID-19 outbreak	Two or more cases of Acute Respiratory Infection in residents or staff of a Residential care Facility within 3 days (72 hrs) and at least one case of COVID-19 confirmed by laboratory testing.
Confirmed or probable COVID-19 case	Follow the directions of the residents GP after referral of a suspected case of COVID-19 in relation to collecting of specimens. Sonic Healthcare (Sonic) provide a dedicated pathology service for rapid sample collection and testing for suspected cases of COVID-19. National toll-free number (1800 570 573) from 8am to 6pm for COVID-19 testing of residents and/or staff. If, due to remoteness, Sonic is unable to provide collection services, pre-prepared COVID-19 collection kits will be sent to a residential aged care facility. A training video and support will be provided to staff to support the collection of samples. Specimen collection centres also include: QML COVID-19 specialist collection centres – see qml.com.au SNP dedicated collection centres – see smp.com.au
	If a provider has a case or outbreak of COVID-19, it is critical that they report to their Public Health Unit and also inform the Commonwealth Department of Health at

	agedcareCOVIDcases@health.gov.au. A Commonwealth departmental officer will be in contact to offer case-by-case assistance and support to help you manage the case or outbreak. This is the fastest pathway to access Commonwealth support. Refer to Blue Care Reporting Requirements for additional information regarding reporting requirements for suspected or confirmed cases/outbreaks.
	If a resident with a confirmed or suspected case of COVID-19 needs to be transferred out of their isolation room, the resident should wear a "surgical" face mask and follow respiratory hygiene and cough etiquette.
	For requirements of release from isolation in various scenarios, follow the directions from the *Coronavirus Diseases 2019 (COVID-19) CDNA National Guidelines for Public Health Units*.
Queensland Public Health Direction – Aged Care. 21 March 2020 **Additional requirements**	Decline access to the facility for staff and visitors who have returned or arrived from overseas in the last 14 days. Also, interstate for visitors.
	Decline access to the facility for staff and visitors who have had contact with a confirmed case of COVID-19 in the last 14 days;
	Decline access to the facility for staff and visitors who have not been vaccinated against influenza (after 1 May 2020).
	Decline access to the facility for staff and visitors with fever (greater than or equal to 38) or symptoms of acute respiratory infection (e.g. cough, sore throat, runny nose and shortness of breath).
	Limiting visits to a short duration (less than 2 hours).
	Limit visits to a maximum of two immediate social supports (family members, close friends) or professional service or advocacy at one time, once per day.
	Visits should be conducted in a resident's room, outdoors, or in a specific area designated by the aged care facility, rather than communal areas where the risk of transmission to residents is greater.
	No large group visits or gatherings, including social activities or entertainment, should be permitted at this time.
	No school groups of any size should be allowed to visit aged care facilities.
	Children aged 16 years or less must be permitted only by exception, as they are generally unable to comply with hygiene measures. Exemptions can be assessed on a case-by-case basis, for example, where the resident is in a palliative care scenario.
	Measures such as phone or video calls must be accessible to all residents to enable more regular communication with family members. Family and friends should be encouraged to maintain contact with residents by phone and other social communication

	apps, as appropriate.
Cleaning during pandemic	All cleaners observe contact and droplet precautions and follow the Blue Care Infection Control Manual and Blue Care Cleaning Manual.
	Using a yellow colour coded microfiber or disposable microfiber cloth and keeping equipment disinfected between cleaning rooms.
	Cleaning and disinfecting frequently touched surfaces, such as doorknobs, bedrails, tabletops, light switches, resident handsets, in the residents' room daily. Using the types of chemical products outlined below.
	Performing terminal cleaning of all surfaces in the room (as above) plus floor, ceilings, walls and blinds after the resident is discharged/deceased. Using the types of chemical product outlined below.
Cleaning for suspected / confirmed cases	A physical clean and disinfect using a combined detergent and 1,000 ppm available chlorine solution for wet mop and disposable systems (2 – in – 1 clean) (Actichlor from Bunzl) **OR**
	A physical clean and disinfect using one step (2-in -1 clean) combined detergent Accelerated Hydrogen Peroxide (AHP) disinfectant solution for microfiber (Oxivir From Bunzl).
	Food dining areas using a Quat sanitiser will assist in complying with HACCP regulations (as chlorine and AHP are non-food-based solutions) (clean shot Quat sanitiser from Bunzl).
Care of deceased	Those handling bodies should be aware there is likely to be a continuing risk of infection from body fluids and tissues of cases where COVID-19 infection is identified through a clinical diagnosis or laboratory confirmation.
	Contact and droplet precautions apply for bodies that are suspected or confirmed to be infected with COVID-19. No additional precautions are needed unless Aerosol Generating Procedures (AGPs) are being undertaken. In this case contact and airborne precautions are recommended.

Appendix 1: Scenario Planning

Each outbreak is unique and clinical severity and transmissibility is likely to vary each time. To assist in understanding the impacts of the COVID-19 pandemic on ACCS, scenario planning for COVID-19 was completed in March 2020. The findings of each scenario are summarised below:

Residential care scenario one:

One to five residents or staff members are found to test positive for COVID-19

Aged Care is well prepared if a small number of residents present with COVID-19 symptoms

	Impacts	Mitigation
Clinical operations	• Access is limited for visitors and non-essential staff • Majority of residents and staff are relatively unaffected across other facilities	• Resident is transferred to a Queensland Health hospital in line with established outbreak management plans • Infected residents or staff will be tracked for self-isolation where necessary • Frequency of cleaning is increased across all facilities
Workforce	• Staff or residents who had/have contact with infected individual will be at greater risk • Rostering may be greatly impacted as staff members who are moved to isolation are unable to cover shifts	• For suspected cases, staff are not self-isolated, but residents are isolated in situ • For confirmed cases, positive residents and staff are isolated • Locational rostering to prevent spread across facilities • All staff expected to maintain compliance with normal rules and regulations
Supply chain	• Supply shortages impact available PPE across Aged Care • Cleaning services are under greater burden from increased demand across Aged Care • Food and hospitality may be affected depending on staff member affected	• PPE is deployed from warehouses to affected facilities • Education pushed out to staff around conserving PPE for future use • PPE is housed off site to prevent loss • Cleaning services increase, incurring additional cost • Food service model changed (trays left at door) to prevent infection
Residents	• Low impact to majority of residents and staff • Families and communities experience greater anxiety	• Staff, family, all local residents, and regulators are contacted • Pastoral care on-hand to assist clinicians, patients and their families • Staff members and pastoral care support end-of-life practices and communications (using multiple communication modes)

Residential care scenario two:

10% to 20% of residents are infected, and hospital burden forces Aged Care to treat residents in situ

Aged Care can continue providing most normal services even if some COVID-19 patients were managed within facilities

	Impacts	Mitigation
Clinical operations	• Facilities are caring for moderate and severe respiratory illness • Staff risk is significantly elevated and facilities begin to operate at reduced staffing levels • Agency capacity is unavailable and cannot relieve staff • Shortage of external medical support (i.e. GPs)	• Current palliative care model holds (i.e. Advanced Directives) • Aged Care nurses resourced to care for moderate to severe patients • Infected patients are cohorted to isolate whole sections of facilities in line with building layout and segmentation plan • Facilities use Nurse Practitioner and Telehealth models to substitute medical support shortage (i.e., isolated carers supporting Telehealth)
Workforce	• 15%+ of staff absent due to isolation, sick leave, or family care • Rostering is greatly impacted as affected staff members who are unable to cover shifts • Acute care nurses may be required on site • Some services staff (i.e. food) are likely in isolation	• Residents and staff are isolated when suspected or confirmed • Locational rostering to prevent spread across facilities • Staff profiling of top of license skills will allow for need-based rostering • External casual resourcing considered where staff gaps can be filled through a demand management plan (i.e. food services)
Supply chain	• Supply shortages impact available PPE across Aged Care • Clinical supplies for treating moderate to severe cases are in shortage, requiring alternative vendor use • Food supplies may be affected by external supply chain impacts	• PPE is deployed from warehouses to affected facilities • Alternative supply provision may apply, allowing use of regulated and unregulated PPE • Clinical supplies ordered to serve moderate to severe patient needs • Alternative food models considered where supply chain is interrupted
Residents	• Resident anxiety is high, with all facilities impacted by multiple resident infections • Mortality rate of infected patients may reach >5%	• Staff, family, all local residents, and regulators are contacted • Pastoral care on-hand to assist clinicians, patients and their families • Staff members and pastoral care support end-of-life practices and communications (using multiple communication modes) • Palliative visitors are educated in use of PPE

Residential care scenario three:

50% to 80% of residents are infected, and hospital burden forces Aged Care to treat residents in situ

Aged Care will be required to make care rationalisation and significant workforce decisions in a severe COVID-19 scenario

	Impacts	Mitigation
Clinical operations	• Facilities are caring for moderate and severe respiratory illness • Staff risk is significantly elevated, and facilities begin to operate at reduced staffing levels • Agency capacity is unavailable and cannot relieve staff • Shortage of external medical support (i.e. GPs)	• Current palliative care model holds (i.e. Advanced Directives) • Aged Care nurses resourced to care for moderate to severe patients • Infected patients are cohorted to isolate whole sections of facilities in line with building layout and segmentation plan • Facilities utilise Nurse Practitioner and Telehealth models to substitute medical support shortage (i.e. isolated carers supporting Telehealth)
Workforce	• 20%+ of staff absent due to isolation, sick leave, or family care • Rostering is greatly impacted as affected staff members who are unable to cover shifts • Acute care nurses may be required on site • Some services staff (i.e. food) are likely in isolation	• Residents are isolated, all staff well enough to work are available • Locational rostering to prevent spread across facilities • Staff profiling of top of license skills will allow for need-based rostering • External casual resourcing considered where staff gaps can be filled through a demand management plan (i.e. food services)
Supply chain	• Supply shortages impact available PPE across Aged Care • Clinical supplies for treating moderate to severe cases are in shortage, requiring alternative vendor use • Food supplies may be affected by external supply chain impacts	• PPE is deployed from warehouses to affected facilities • Alternative supply provision may apply, allowing use of regulated and unregulated PPE • Clinical supplies ordered to serve moderate to severe patient needs • Alternative food models considered where supply chain is interrupted
Residents	• Resident anxiety is high, with all facilities impacted by multiple resident infections • Mortality rate of infected patients may reach >5%	• Staff, family, all local residents, and regulators are contacted • Pastoral care on-hand to assist clinicians, patients and their families • Staff members and pastoral care support end-of-life practices and communications (using multiple communication modes) • Palliative visitors are educated in use of PPE

Community care scenario one:

One to Five staff members or clients are confirmed to have COVID-19

Community clients and services will be relatively unaffected in the event of single or small quantity staff or client infection

	Impacts	Mitigation
Clinical operations	• Majority of clients and staff are unaffected by low infection count • Visit model is unaffected, though extra precautions are taken • Significant cancellations occur, driving down revenue across Community Services	• IT capabilities required to manage response to positive case • Identify all staff and clients who may have come into contact with infected staff member • Risk assessments are performed prior to all client contact • Staff take alternative approach to maintain client service volume
Workforce	• Majority of staff are unaffected, with small effects to current staff assignments and rostering	• Suspected and confirmed staff self-isolate in line with current guidance • Alternative staff assigned to clients attended to by infected staff member
Supply chain	• PPE use may be requested for all visits or beyond standard practice • Queensland PPE supply will be on shortage	• PPE use does not stray from standard practice, and exceptions only considered in cases of suspected client infection
Clients	• Vulnerable clients (i.e. diabetes, etc.) are at greater risk with likely greater anxiety related to possible infection	• Vulnerability profile is built for client base to ensure public health can prioritise tracking of most vulnerable individuals • Next of kin and other service providers receive coordinated communications

Community care scenario two:

15% of workforce is infected and 10% of clients are infected or suspected to be infected

Community will look to local partnerships and alternative services if some COVID-19 clients were managed at home

	Impacts	Mitigation
Clinical operations	• Significant cancellations occur, driving down revenue figures • Demand grows for higher license services, especially for infected clients	• All affected staff and clients are identified • Risk assessments are performed prior to all client contact • Moderate to severe patients are transferred to hospitals • Case by case decisions are made in rationalising non-essential care • Cancellations are proactively communicated to all impacted staff • UnitingCare partners with other community services providers
Workforce	• Staff rostering is significantly affected • High license carers may be on shortage, requiring alternative staffing models	• Suspected and confirmed staff self-isolate in line with current guidance • Alternative staff assigned to clients attended to by infected staff member • HITH carers are deployed as necessary to fill gaps in high license care delivery
Supply chain	• PPE requirements ramp up significantly for staff • Queensland PPE supply will be on shortage	• PPE is routed from Lifeline warehouses to meet increased demand • Carers are given PPE education to ensure responsible, sustainable, and safe use of supply
Clients	• Vulnerable clients (i.e. diabetes, etc.) are at greater risk with likely greater anxiety related to possible infection • Mortality rate for vulnerable infected clients will grow significantly	• Vulnerability profile is built for client base to ensure public health can prioritise tracking of most vulnerable individuals • Next of kin and other service providers receive coordinated communications • Communications are centralised to relieve burden on staff

Community care scenario three:

50% to 80% of staff and clients are infected

Community will have to make hard decisions around rationalisation of care, as well as adopting new care palliative care models in an extreme scenario

	Impacts	Mitigation
Clinical operations	• Significant cancellations occur, driving down revenue figures • Demand grows for higher license services, especially for infected clients	• All affected staff and clients are identified • Risk assessments are performed prior to all client contact • Palliative care and pastoral support delivered in home, and non-essential services are cancelled • Cancellations are proactively communicated to all impacted staff • UnitingCare partners with other community services providers
Workforce	• Staff rostering is significantly affected • High license carers may be on shortage, requiring alternative staffing models	• Suspected and confirmed staff self-isolate in line with current guidance • Alternative staff assigned to clients attended to by infected staff member • HITH carers are deployed as necessary to fill gaps in high license care delivery
Supply chain	• PPE requirements ramp up significantly for staff • QLD PPE supply will be on shortage	• PPE is routed from Lifeline warehouses to meet increased demand • Carers are given PPE education to ensure responsible, sustainable, and safe use of supply
Clients	• Vulnerable clients (i.e. diabetes, etc.) are at greater risk with likely greater anxiety related to possible infection • Mortality rate for vulnerable infected clients will grow significantly	• Vulnerability profile is built for client base to ensure public health can prioritise tracking of most vulnerable individuals • Next of kin and other service providers receive coordinated communications • Communications are centralised to relieve burden on staff

Appendix 2: Communication Plan

Rationale	Focus area	Key content / Key message	Audience	Target Audience	Format	Channel	Status
Specific changes to the way we deliver existing services	Social Support Groups Community	Stopping Social Support Group and Centre Based respite services	Internal	Service Managers - Centre Based Respite, Social Support Groups	Factsheet	Email Intranet	Complete
	Social Support Groups Community	Stopping Social Support Group and Centre Based respite services	External	Clients Families / Loved ones	Web content	Phone Call Website Social Media	Not Commenced
	Clinical services Community	Stopping Group Nursing and Allied Health	Internal	Service Managers - Centre Based Respite, Social Support Groups	Factsheet	Email Intranet	Complete
	Clinical services Community	Stopping Group Nursing and Allied Health	External	Clients Families / Loved ones	Web content	Phone Call Website Social Media	Not Commenced
	Shopping Community	Ways we can continue to help you with your shopping	Internal	Service Managers - Centre Based Respite, Social Support Groups	Factsheet	Email Intranet	Complete
	Shopping Community	Ways we can continue to help you with your shopping	External	Clients Families / Loved ones	Web content	Phone Call Website Social Media	Not Commenced
	Role specific changes Community	Role specific changes that have happened (will be multiple, specific per role type)	Internal	All frontline staff in Residential sites and delivering community services	Factsheet	Email Intranet	Complete
	If you're unwell Community	Providing advice to customers about what to do if they become unwell before their visit	Internal	CSC Local service admin All frontline staff delivering community services All SMs and TLs	Customer FAQs	Email Intranet	Complete

	Screening questions Community	We're starting to ask COVID-19 screening questions	Internal	CSC MAC team CSC Phone Team Local Teams pre-service calls Service Delivery staff	Scripting	Email	Complete
	Screening questions Community	We want to make sure you're safe to receive services so we're going to ask you some questions about your health	External	New Clients New Residents	In person (using Procura screening function)	Blue Tech devices	Complete

Rationale	Focus area	Key content / Key message	Audience	Target Audience	Format	Channel	Status
Changes we've made to make access easier for staff	Video conferencing with clients Community	How we can deliver services via telephone or video conferencing	Internal	SSG coordinators PCs delivering social support Allied Health staff Nursing staff	Factsheet	Email Intranet	Complete
	Gov't COVID19 app	We've helping you stay informed and educated about what you need to know about COVID-19	Internal	Blue Tech users	Factsheet	Email Intranet	In progress
	New Workplace users	You now have access to join up with Workplace	Internal	Blue Tech users	Factsheet	Email Intranet	In progress
New services we are starting to offer	Check-in texts Community	We want to keep in contact with you so will start providing wellness check-ins	External	Clients / Families	Letter Website Content	Email Website Social Media	In progress
	Check-in texts Community	We want to keep in contact with you so will start providing wellness check-ins	Internal	Community staff for action) All Staff (for info)	Factsheets	Email	Complete
	Care App Residential	We're helping you keep in touch with your loved ones	External	Residents Families / Representatives	Letter Website Content	Email Website Social Media	In progress

	Care App Residential	We're helping you keep in touch with your loved ones	Internal	Residential staff for action) All Staff (for info)	Factsheets	Email In person	In progress
	Tele Health Residential	We are seeking options to access Telehealth services to broaden access to GP's and other Health Professionals should the need arise.	External	Residents Families / Representatives	Letter (could include content in other letters)	Email / In person / Post	In Progress
	Tele Health Residential	Tele Health - We're introducing new things to better support our clients, residents and their loved ones	Internal	Residential staff for action) All Staff (for info)	Factsheets	Email In person	Not Commenced
Supporting changes our customers want to make or addressing specific concerns they may have	Cancellations	Supporting customers who want to cancel services	Internal	CSC Local service admin	Scripting	Phone calls	Complete
	Seeking to leave Residential - for entry / exit and visitors	Providing support and reassurance to residents and families	Internal	RAC Staff	Scripting	Phone calls / visits	Complete
	PPE questions	Do staff need to wear masks?	External	Clients Families / Loved ones	Factsheet Flyer Website content	Deliver in person On website	Complete
	Emergency plans & readiness	Supporting community clients to get plans in place in case of an emergency	External	Clients	Form to complete	In person	In Progress

Rationale	Focus area	Key content / Key message	Audience	Target Audience	Format	Channel	Status
Overall ongoing management of COVID-19	Staff FAQs	We're supporting BC staff and we need you to start doing some things differently	Internal	Residential staff	FAQs	COVID-19 website	Complete
	Staff FAQs	We're supporting BC staff and we need you to start doing some things differently	Internal	Community staff	FAQs	COVID-19 website	Complete
	Initial client letter	We are managing this and we're here for you	External	Clients	Letter / Content	Post Website Social Media	Complete

	Initial resident letter	We're making changes to keep you safe including changes to visitation and your access to the community.	External	Residents	Letter & FAQ's	In Person	Complete
	Initial resident family letter	We're making changes to keep you / your loved ones safe	External	Resident families	Letter	Post	Complete
	Initial visitor letter	We're making changes to keep you / your loved ones safe	External	Visitors	Poster / Letter	In person	Complete
	Initial GP letter	Ways we need you to change what you do during COVID-19	External	GPs - Residential sites	Letters	In person / Email	Complete
	Initial contractor letter	Ways we need you to change what you do during COVID-19	External	Contractors / Subcontractors - Community services	Letters	In person / Post	Complete
	Initial contractor letter	Ways we need you to change what you do during COVID-19	External	Contractors - Residential sites	Letters	In person / Post	Complete
	Outbreak letter	We have had an outbreak at a Residential site	External	Residents	Letter	Post / Email	Complete
	Outbreak letter	We have had an outbreak at a Residential site	External	Resident families	Letter	Post / Email	Complete
	Outbreak letter	We have had an outbreak at a Residential site	External	GPs - Residential sites	Letter	Post / Email	Complete
	BC COVID-19 Response plan	Overall COVID-19 Response plan for ACCS	Internal	COVID-19 Crisis Management Team ACCS Managers	Document	Email	Complete