Australian Government
Aged Care Quality and Safety Commission

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“We saw the best in people”

Lessons learned by aged care providers experiencing outbreaks of COVID-19 in Victoria, Australia

Foreword

The second wave of elevated community transmission of COVID-19 in Victoria which started in late June 2020 presented a significant and growing risk to residents and staff at local residential aged care services.

The Aged Care Quality and Safety Commission worked closely with the Commonwealth Department of Health, the Victorian health authorities, and the Victorian Aged Care Response Centre in responding to this situation. All agencies reinforced the importance of aged care services focusing on minimising the risk of, preparing for, and responding promptly and decisively to a potential outbreak at their service.

Where an outbreak occurred in a residential aged care service, the experience for that service was both challenging and demanding. Some providers coped better than others, but lessons were learned by all.

From July to September 2020, the Commission imposed an enforceable regulatory action – in the form of a Notice of Requirement to Agree to Certain Matters ("Notice to Agree") – on over twenty residential aged care providers in Victoria that struggled to respond effectively to a COVID-19 outbreak at one or more of their facilities. In some circumstances, local Victorian health services were given authority to deploy staff to provide clinical support for the operation of services under the Notice to Agree which contributed to protecting the safety of residents.

Tragically, many residents lost their lives to the virus, and their families' grief was felt across the country. This is the sombre context for this document.

The Commission has undertaken this project to gather together, synthesise and reflect back to the sector the lessons learned by thirty-four providers that experienced an outbreak at their Victorian residential service(s). The Commission greatly appreciates the willingness of those providers to share their experiences openly and honestly for the benefit of others.

The photographs that appear throughout this report were provided by many of the providers interviewed and are published with their consent.

All providers of residential aged care services across Australia are encouraged to reach out, form networks and build partnerships with those who have experienced outbreaks. It is vital that the sector continues to learn from this experience to improve emergency readiness and maintain vigilance in a COVID normal environment.

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Executive summary

The COVID-19 pandemic has presented an unprecedented challenge to the Australian aged care sector. For providers of residential aged care services in Victoria, the period of June-September 2020 was beyond any crisis they had previously experienced. Providers with COVID-19 outbreaks were required to take action at another level, scale and pace, and while there were devastating outcomes for many, there were also countless stories of innovation, resourcefulness and resilience. Much can be learned by all of us from the experiences of these providers.

While many providers undertook detailed outbreak management planning prior to any outbreak occurring, none felt they were fully prepared for the magnitude of what they encountered.

> "We prepared for a big storm, but we were hit by a tsunami."

Providers saw great value in stress testing and practising their outbreak management planning to strengthen their readiness and enable staff to act quickly when an outbreak did occur.

Strong and decisive leadership was imperative. Many providers utilised a command and control structure that provided clear reporting lines and defined roles. Providers that acted quickly and strongly generally contained the outbreak faster to reduce any further spread. The Aged Care Quality and Safety Commission (the Commission) observed the importance of visible on-site leadership, clear roles and responsibilities, clinical expertise and having contingencies or back-up staff available for critical roles.

Workforce planning and being able to source surge staff was an enormous challenge for providers. When an outbreak occurred at a service, all staff who tested positive were required to isolate and large numbers of close contacts had to be immediately stood down. In this way, a new meaning for the word 'furlough' was created over the course of the outbreak, referring to the standing down of staff who were potentially exposed to a COVID-19 positive person.

Many providers were unprepared for the number of additional staff required to provide care and services and continue to manage operations during an outbreak. Surge staff had to be quickly trained in delivering aged care services and infection control procedures. The Commission saw that it was necessary for providers to think through the minutiae of each task from beginning to end to identify potential breaches in infection control requirements.

Delivering care and services while maintaining infection control proved difficult, particularly in relation to food services. Providers found innovative ways to encourage residents to eat, lift morale and bring joy to each day. Supporting access and keeping residents connected with their families and loved ones was found to be crucial to maintain the emotional and mental wellbeing of residents, who were often under prolonged periods of stress and grief.

The extent of the infection prevention and control procedures and the level of constant vigilance required presented a challenge for providers, their staff and contracted service providers. A number of providers experienced delays in testing and stood up their own testing regime to enable faster action.

Cohorting of residents presented both a logistical and physical challenge. A range of different assumptions were made – by both providers and health services – about the need for and timing of transferring COVID-19 positive residents to hospital. These assumptions were tested and renegotiated in real time as outbreaks commenced and progressed. The providers who had notified residents and their families in advance of the possible need to move rooms during an outbreak were able to act quickly to cohort residents and staff, and these providers seemed to have more success in suppressing outbreaks.

The amount of personal protective equipment (PPE) required, and the amount of clinical waste generated throughout an outbreak, were unforeseen for a number of providers, who had to quickly find or create additional storage space for these items.

Regular, consistent and comprehensive communications (particularly with residents and their families) were found to be critical throughout an outbreak. Providers reported experiencing challenges communicating with numerous government agencies, noting some instances of conflicting instructions and delays in advice.

Despite these difficulties, many providers rose to the challenge and found innovative ways to adapt as quickly as needed to ensure the health, safety and wellbeing of residents. Staff demonstrated tremendous resilience, pulling together and going above and beyond what is normally expected to support the needs of residents and their families.

> "Staff were willing to do anything to support residents. We saw the best in people."

Many found that enduring an outbreak has strengthened bonds within services and the relationships of staff with residents. Providers expressed gratitude to the staff and other services who stepped up to support their response, and to the government agencies that provided advice and access to resources.

Providers who experienced outbreaks are now reviewing their systems, governance and processes to ensure they are well prepared for any future crisis. Many are willingly and openly sharing their ideas and suggestions and working with others to improve practices and enhance the sector as a whole.

Providers expressed an understanding of the need to maintain a proactive and vigilant approach in a COVID-normal environment. Their focus has always been, and continues to be, protecting the safety and wellbeing of their residents and staff.

Context

Throughout the 2020 COVID-19 pandemic, 219 residential aged care services across Australia experienced at least one COVID-19 outbreak with 191 of these services located in Victoria. The COVID-19 outbreaks in Victoria impacted over 2,000 aged care residents and more than 2,200 staff. Tragically, 660 aged care residents died from COVID-19 in Victoria and 693 residents died from COVID-19 nationally.[1]

While the overall community prevalence of COVID-19 infections has diminished, reducing risk for residents and staff in aged care, the sector must remain vigilant. The Commission, as the regulator of Commonwealth-funded aged care services across Australia, has engaged with providers experiencing an outbreak in Victoria to consider lessons learned for the sector to help plan what may be done differently in future to better prevent and manage outbreaks, and protect the safety of aged care residents.

Senior representatives from 36 residential aged care providers with services in Victoria experiencing outbreaks of COVID-19 were invited to participate in interviews. Thirty-four of these providers accepted this invitation and a range of CEOs, board chairs and senior managers participated in interviews with the Commission and representatives of the Victorian Aged Care Response Centre during October-November 2020. Between them, these 34 providers operate 104 residential aged care services in Victoria which experienced a COVID-19 outbreak.

As part of these interviews, the Commission sought to understand:

- what was learned prior to, during, and following, COVID-19 outbreaks
- what providers are doing differently as a result of their experience
- the roles played by other parties, including the Commission, in responding to the residential aged care outbreaks in Victoria.

In this document, the Commission has synthesised the responses by aged care providers to identify common themes, challenges and learnings. The document also includes a summary of changes that providers made that worked well in the context of an outbreak, as well as those that did not, and provides examples of the innovative ways that different providers dealt with common challenges. These insights are relevant for all providers in their ongoing consideration of how to keep residents safe from infection while also promoting their physical, social and emotional wellbeing in a 'COVID normal' environment.

We acknowledge the significant challenges that providers (including their residents, families and staff) faced when confronting COVID-19 outbreaks and we thank them for their efforts in managing these. We also thank providers for sharing their experiences openly and honestly for the benefit of others.

1 Department of Health, as of 8 December 2020.

Outbreak management planning

"We already had a COVID-plan, but we didn't really prepare for the avalanche of it all."

Most of the providers interviewed had developed an outbreak management plan, with varying levels of detail and specificity. Providers overwhelmingly identified that the more detailed and specific the plans were, the more useful they were when dealing with an outbreak.

Providers who had plans that were unique to the service recognised that this approach worked better than a general or "one-size-fits-all" approach. Effective plans took into account:

- the building design and the layout of the service
- the individual residents and their care needs
- the impact of the layout on capacity to deliver certain services (for example, one provider noted that at one service, it was safer to send laundry offsite due to the service's layout, whereas laundry could be managed onsite for other services)
- local service providers and contractors and their capacity and availability to help.

Overwhelmingly, providers identified the importance of practising and stress-testing plans prior to an outbreak. Many providers had undertaken detailed outbreak management planning in March 2020 when the COVID-19 pandemic first arrived in Australia, however found that they were still significantly underprepared when an outbreak actually impacted their service.

The Commission found that in general, providers that had thoroughly practised, stress-tested and reviewed their plans in detail were better prepared than those that had not tested plans to manage outbreaks. Different providers had undertaken trial runs, simulations or mock scenarios, and all commented that this had contributed significantly to their preparedness. Providers that hadn't done this agreed that this was something they would "definitely" do in the future.

"Stress testing and being ready, having the right people in the right roles is critical."

Many providers emphasised the need to collaborate with others (including residents, staff, external contractors/service providers and government agencies) in the development of an outbreak management plan.

A number of providers also highlighted the importance of drawing on past experience and the experience of others.

CASE STUDY

Mock COVID outbreak scenario

One provider undertook a mock outbreak scenario in March to determine if there were any gaps in their preparedness should an outbreak of COVID-19 occur in one of their services. The provider employed a company experienced in crisis management to run a trial situation. The management team were not given prior notice of the trial. Management were called to a 'finance' meeting and, once all staff were present, were told they needed to manage an outbreak in a service.

As part of the trial, people phoned the service from around the country posing as family members of residents, journalists and others to test the provider's communication strategy. A major learning from the trial was that communications needed to be strengthened. Stemming from this, the provider introduced structured meeting agendas, email template and a process for triaging phone calls, and also established a network to undertake staff welfare checks and developed a process for the approval of communications.

Some providers described lessons learned from previous experiences such as severe influenza outbreaks, evacuations during bushfire season, disaster recovery events and early false-positive COVID cases in helping them to prepare and initiate a rapid response when an outbreak did occur. Some of these providers had already invested in additional PPE stockpiles, storage space, infection control experts and had robust business contingency plans in place.

Some providers acknowledged the value of speaking with others who had experienced outbreaks to revise and improve outbreak management planning. In particular, providers described applying published learnings from the Newmarch House outbreak in NSW earlier in 2020 as part of their preparedness efforts.

One provider suggested using well prepared 'provider champions' and others sought lessons learned from overseas colleagues who had gone through outbreak experiences.

"We had very open and collaborative conversations with CEOs of other providers, even to the degree of discussing whether we could share staff. What came out of COVID was that everyone wants to share knowledge to help each other look after our residents."

In particular, the Commission observed the value that smaller providers (with limited resources/capacity) could gain from working with a more established provider champion to leverage their systems, processes and learnings.

Providers also noted the value of reviewing their outbreak management planning and response since experiencing an outbreak.

"With the benefit of the knowledge we have now, we are completely revising our outbreak management plan and introducing a raft of new systems to put us in better stead should anything like this ever happen again."

Governance

Leadership and management

Effective leadership and management were seen as critical for providers to be able to "get on top of an outbreak". The providers interviewed adopted a range of governance models that differed based on their organisation's structure and the risks they were managing.

Providers who implemented a command and control structure across their service(s) found this structure was effective in enabling a decisive and rapid response. Providers found that having a single lead or commander who gave clear directives that were followed by everyone provided clarity and allowed staff to focus on their particular role.

"We lent towards a centralised, command and control approach as we wanted a tight set of instructions and protocols to be followed."

Providers emphasised the importance of:

- **strong visible on-site leadership** – many increased the number of management staff on site during outbreaks
- **clinical expertise** – providers found that leadership needed to include (or be informed by) clinical/infection control expertise
- **role clarity** – a number of providers appointed dedicated leads and resources across different critical aspects of care delivery (e.g. one person responsible for managing food, one responsible for ensuring the mental wellbeing of residents, etc.) with a clear reporting structure
- **contingencies** – some providers described being unprepared for the length of the outbreak and the associated burnout experienced by managers. They emphasised the need to have back-up contingencies in place to enable key management roles to take a break.

The Commission observed that providers with an effective command and control leadership model in place managed outbreaks in a more disciplined and organised way. The need for quick and decisive action was observed in relation to all aspects of dealing with an outbreak. Providers that acted on instructions without hesitation and found a way to make things happen without delay generally had better outcomes.

The board

Providers highlighted the importance of having diverse skills and expertise on their board, and in particular, the need for clinical expertise and an understanding of contemporary infection control practice.

> "It should be mandated that someone who is clinical be on the board. This helped the board understand and manage the pandemic."

A number of providers reported that since experiencing an outbreak, they are looking to recruit board members with clinical expertise.

Some providers highlighted the critical role the board played in helping to manage the outbreak, while others noted that it was "helpful that the board left them to get things done and kept involvement in management level decision making to a minimum". Overall, providers noted increased communication between the board and management during the outbreak and emphasised the importance of good relationships, communication and confidence between the board and management during an outbreak.

> "When you've got strong leadership in your organisation, you have confidence you're going to be able to handle these things as well as possible."

Some providers noted the board provided unlimited budget approval to senior managers to manage the response and "do what they needed to do to have residents and staff survive".

Clinical governance

A number of providers noted that recent investments and changes made in response to the introduction of the Aged Care Quality Standards in relation to clinical governance and infection control "paid off" during the pandemic. Other providers highlighted this as an area for ongoing improvement into the future, noting they quickly became aware of any gaps in their clinical governance systems during an outbreak.

Many providers described taking actions to appoint clinical leads/coordinators, increase registered nurse numbers, establish clinical governance committees and recruit clinical skillsets within the executive and on boards. One provider found that the outbreak highlighted a lack of succession planning for critical management roles and business continuity.

> "Our whole clinical governance side has been revisited – there's obviously a heightened awareness now."

A number of providers noted that while there were initial challenges working closely on-site with clinical staff from acute care settings, this helped to improve their clinical governance and has encouraged them to embed stronger relationships with local health services and hospitals.

> "Since the outbreaks, the thinking is very different now. We're looking at how we can build relationships. We can't get caught again."

Human resources

Workforce planning

Providers were generally not prepared for the large number of staff who were unavailable to work during an outbreak. A number of providers experienced an initial sudden reduction in workforce as many staff were awaiting test results. Staff who were infected with COVID-19 and those who had close contacts had to be furloughed. Some staff did not work due to fear of contracting COVID-19 or infecting a family member and many staff were anxious working under conditions of heightened stress.

Many providers were also unprepared for the number of additional staff required to deliver care and services and manage operations during an outbreak. Providers commented that infection control procedures (particularly the donning and doffing of PPE) meant that staff took longer to complete tasks, cohorting required the creation of at least two separate workforces, looking after COVID-19 positive residents was time consuming, and the increased frequency of cleaning and laundry services required additional staff. Extra staff were also required to manage the increased care needs of some residents suffering from isolation, to maintain connections between residents and their loved ones and to manage communications.

> "When in the full thrust of COVID, we had more than triple the amount of staffing that we normally had."

Providers highlighted the importance of having many staff 'on the ground' who knew what they were doing and who knew the residents at their service. Some providers noted that during an outbreak, rosters were set at 1.5, double or triple the usual staffing (depending on the service and the extent/impact of the outbreak) and they moved to two, 12 hour shifts each day to support cohorting of residents.

The Commission observed the value of having contingency staff on standby for all key roles throughout an outbreak. Providers explained that it was important to have 'back up' staff for critical roles within the service or to create 'shadow teams' to account for staff being furloughed or taking leave. One provider noted that the period of an outbreak can be very long for critical roles to be maintained by a single staff member without a break.

"We undertook workforce management planning on how to support our services if 30%, 50% or 80% of staff are furloughed. In this, we considered what roles are essential and what sorts of things can you stop doing while your staff numbers are greatly reduced, i.e., what types of things can you 'park' without causing risk to the residents?"

Agency, contractors and surge workforce

Many providers acknowledged the difficulty in sourcing additional staff to support their workforce during outbreaks. Some providers noted that requirements for staff to work at only one site, which made sense from an infection prevention perspective, nonetheless contributed to staff shortages and some providers had trouble accessing agency staff due to overwhelming demand.

Providers experienced challenges with some agency/contracted staff, including where they weren't able/willing to do certain tasks, weren't familiar with infection control requirements, were inexperienced in working in an aged care environment, and/or had limited English language skills. A number of providers noted they had incorrectly assumed all agency staff would understand infection control procedures in a COVID-19 outbreak and did not check this.

"Surge workforce arrived but some had never worked in an aged care home and needed training in everything, for example, how to put a continence aid on a resident."

Providers expressed their gratitude to the health professionals who provided surge support to impacted services, while also noting key differences in service delivery between clinical/hospital settings and aged care settings. Some providers were more easily able to convert their facility into a defacto acute care setting, which tended to result in good clinical outcomes for residents. This was attributed to strong existing relationships with local health services and good clinical governance. Providers also described a palpable sense of relief among residents, family members and staff when a service returned to being a residential aged care facility at the end of an outbreak.

Some providers came up with innovative ways to find staff to do basic tasks so they could free up care staff to look after the residents. One provider employed students to unpack and restock PPE and other items, provide companionship to residents and support them with technology. One provider had staff reach out to their networks to find people to help out with "unskilled" tasks. Another provider reported that they are currently trialling a project to enable them to keep a surge workforce "warm" and ready to support their services in an emergency situation.

Providers with services in other states had staff volunteer to support services experiencing an outbreak. These providers found this helped to lift staff morale, build relationships, facilitate information sharing across services, and has improved organisational culture.

Induction, training and guidance for staff

Many providers were not well prepared to induct, orient and train so many new staff during a period when the staff responsible for induction were already so busy. As a result, many providers identified that they are looking to improve and simplify onboarding procedures in the future and will take additional steps to ensure new staff meet key competencies, including COVID-19 specific requirements, infection control and PPE usage.

Some providers described developing simplified rostering, induction and handover processes and tools to enable new staff to quickly onboard and facilitate handover. This included things such as:

- an employee self-service system that notifies of roster changes on phones
- having hard copies of (or ready to print) care planning documentation
- having key resources translated
- using checklists and posters as reminders
- video education tools and holding training sessions by videoconference
- developing detailed operating procedures and work instructions with sequenced steps.

Providers reported that such measures were well received by staff and provided a level of reassurance needed in a time of uncertainty and high workload. The Commission observed that it was necessary for providers to think through the minutiae of each task from beginning to end to identify potential breaches in infection control requirements. Providers that took the time to analyse and consider tasks found this limited the opportunity for human error.

Impact on staff

Most providers described not being prepared for the human toll of managing an outbreak. Staff were required to work under extreme conditions, working long shifts in full PPE, feeling stressed and fearful for the people they were caring for, their colleagues, families and themselves. Providers noted that over the course of an outbreak, staff became exhausted and burned out, staff who had COVID-19 felt guilty, and services that experienced COVID-19 related deaths had residents and staff who were grieving.

Many providers felt they did not have a good understanding of their staff's individual circumstances or their capacity to work during an outbreak and described having a better understanding of their workforce since experiencing an outbreak.

"We know our staff better now – who is available to travel, who has vulnerabilities in their families, who is prepared to drive 50km or 100km. This is something that is now embedded in the organisation. We have developed a questionnaire of 5-10 questions to get to better understand our staff and their situation."

Providers acknowledged the challenges for staff who were furloughed, including the financial impact of being unable to work (where wage support was not available), the fear of transmitting COVID-19 to family members, and the inability to undertake caring responsibilities. Providers variously described:

- working with staff to identify what could be done to enable them to continue to work during an outbreak
- having staff who were unable to work on-site work remotely, including to support communications, manage administrative tasks, etc.
- accommodating COVID-19 positive staff in hotels to mitigate concern of transmitting COVID 19 to their family members
- providing accommodation for staff looking after COVID-19 positive residents who wanted to take precautions against potentially infecting family members
- providing taxis, food, care packages and other personal and family support during the outbreak
- ensuring regular communications and phone calls with furloughed and COVID-19 positive staff to check in, monitor wellbeing and keep them connected to the service.

"We had one young staff member who only lived with her 13 year old daughter who became very anxious. The staff member tested positive and couldn't go out to get groceries. We organised to have groceries delivered to their home and called her and spoke to her and to her daughter."

Many providers recognised that, in hindsight, counselling and mental health support for staff should have been provided sooner. Providers reported they are now providing counselling services and debriefing sessions in response to the trauma experienced.

"We notice increased tiredness and trauma – some staff infected family and children and felt the loss of residents. Support will be ongoing to the tail end of the trauma."

While many providers were aware that their staff worked across multiple sites, some were surprised by the extent of this practice and recognised the impact this would have on trying to control an outbreak. Some providers found that where they weren't aware of (and therefore uninformed about the potential risk of) the living arrangements of staff, this impacted their ability to limit potential transmission. For example, some staff shared living arrangements with staff working in different zones/areas of the service or with staff from other outbreak sites and some staff members socialised outside work or shared transport to and from work.

A number of providers have reviewed their HR policies over the course of the pandemic as they identified these were not conducive to limiting possible transmission. The providers encouraged staff to stay home from work when sick or to disclose when they were working across multiple sites. Some providers experienced a positive shift in culture resulting from an outbreak, including a more open, 'no blame' culture, where staff feel confident to provide feedback and highlight gaps.

Providers across the board expressed their appreciation for their staff and any others who supported them during an outbreak.

"We saw the best in people."

Supporting access

Providers found visitor access and restrictions to be a constant challenge during outbreaks. Some providers noted conflicting information from different government agencies and the difficulties in maintaining the "balance of keeping residents safe and maintaining social visits with family". Many providers found innovative ways to continue to support visitor access and enable residents to maintain connections with their loved ones. For example:

- some providers sought dispensation from their public health unit to enable face-to-face visitation from close family members or to allow carers to take them for a drive. This was particularly important for any residents who were struggling and for residents with physical or mental health issues, cognitive impairment or receiving palliative care. Providers found that "as long as we managed the visitations properly, we were able to do those things"
- providers used videoconferencing technology to connect residents with their loved ones. Some had staff available specifically to help residents use the technology and ensure they were feeling connected
- where residents did not have a landline in their room, providers purchased additional mobile phones to support access
- some providers facilitated window visits or visits through a transparent screen or barrier. A team member was present where necessary to assist with communication and help ameliorate issues related to hearing, vision or cognitive impairment
- some providers established a process to facilitate deliveries from families. One provider erected a marquee specifically for drop offs, which often included medication, hearing aid parts, personal care items and special treats
- one service established a "Letters to Loved Ones" service allowing anybody to send a message to a resident via the service's website.

Some providers used a risk-based approach (balancing the active case numbers in their Local Government Area against the emotional needs of residents) to guide their escalation and de-escalation of visitor restrictions. Some providers consulted with residents throughout the outbreak to check whether they were comfortable having visitors return.

Providers generally recognised the critical importance of enabling residents to maintain important relationships outside the service, and noted that if an outbreak occurred again, they would put a stronger emphasis on this. One provider noted that staff had been "severely traumatised by the experience and don't want another outbreak, resulting in harsh interpretation of social distancing requirements". The provider has strengthened ongoing communication and education for staff in response to address concerns and reinforce visitor access requirements.

Care and service delivery

Transferring residents to hospital

In the context of rapidly increasing hospital admissions for COVID-19 and depleted health care staff numbers, the transfer to hospital of individuals from residential aged care facilities experiencing an outbreak was determined based on a fairly narrow range of criteria, with medical need as a key (but not the only) consideration.

Providers found the hospital pathways challenging to navigate and noted difficulties in transferring residents to hospital. Many felt that if they had been able to transfer residents to hospital sooner, this would have significantly reduced the extent of their outbreak. (It is noted that there are different views on this matter.)

The Commission found that some providers assumed they would be able to transfer residents to hospital at any time, and rather than quickly cohorting residents, waited to hear from local acute health services to see if they would accept transfers.

Providers noted that relationships with local health services were paramount and indicated that in hindsight, engagement with local hospitals to understand parameters for transferring residents would have improved their outbreak management planning significantly.

Delivery of care during an outbreak

Providers described the challenges in delivering resident-centred care in line with the Aged Care Quality Standards while providing the acute clinical care required during an outbreak. Challenges in care delivery were compounded where regular staff were furloughed and where additional staff were brought in from acute settings.

> "We felt that the clinical surge workforce didn't go beyond providing acute clinical care, while the aged care workforce found the hospital-like care difficult."

Providers emphasised the importance of being able to quickly identify residents (including by using wristbands or photos), the need for effective and detailed care planning that included residents' preferences, and to have this readily accessible for any new staff or surge workforce. A number of providers described having key documents (including resident profiles, care plans, exercise plans, wound/behaviour management plans, medication charts, etc.) printed, laminated and left inside residents' rooms or stuck to their walls/doors for ease of access.

Providers highlighted that "handover notes to the surge workforce needed to transcend basic clinical requirements and include each resident's idiosyncratic preferences. This inspired confidence in residents and reassurance they were in safe hands". Where possible, providers buddied new staff with staff who were familiar with the residents to go through their profile/care needs or had furloughed staff remotely guiding and advising on resident care needs.

Having simplified documents, checklists and charts available at the point of care made staff and residents alike feel more confident in the delivery of care and services.

Some providers found that in the initial stages of an outbreak, many residents were not eating well and lost weight. Food and fluid charts were considered critical to monitor the food intake of residents and ensure they were well hydrated. Regular weighing of residents to enable real time identification of any significant weight loss was also vital.

Some providers identified difficulties in delivering the care that residents needed with limited staffing. One provider employed "spotters" to guide and monitor care delivery. Other providers described that the key to maintaining continuity of care was being able to re-assign duties such as rostering, waste management, restocking, and managing calls away from on-site care staff to 'free up' these staff to focus on resident care.

Many providers noted the challenges in ensuring residents remained active and maintained their mobility and function when movement within the service was restricted.

> "We had staff doing in-room exercises and activities with residents to try to keep them active."

Providers generally found the support of telehealth and in-reach health services to be of significant value to ensure ongoing access to specialists and allied health providers. Some partnered with local health services and sourced alternative health service providers.

A common challenge was providing adequate, individualised support for residents with high needs, particularly those with cognitive impairments and wandering behaviours. Some providers sought the support of specialist services or engaged with the resident's family to help calm residents who were disoriented by significant changes to service layout, staffing and care delivery.

Supporting resident wellbeing during an outbreak

Providers recognised the significant impact of a COVID-19 outbreak and associated restrictions on resident wellbeing (including for residents who did not have the virus).

Many providers implemented new and different measures to help maintain the physical, mental and emotional wellbeing of residents during an outbreak. Examples included:

- engaging allied health professionals to help residents to exercise to maintain their mobility and function. Many service providers also used telehealth services to facilitate exercise classes
- celebrating milestone events, such as Mother's and Father's Day, birthdays and cultural celebrations to the extent possible
- placing a 'Wishing Well' form on each resident's door so residents could communicate any special requests/wishes
- engaging additional services (including from social workers and mental health professionals) to provide counselling and emotional support to residents
- for residents with chronic pain that was usually alleviated by heat packs, placing microwaves in residents' rooms so they could continue to safely use heat packs
- small gestures such as "a humble cup of tea" played a pivotal role in calming and reassuring residents
- ensuring residents had access to advocates and welfare services, including Elder Rights Advocacy and Older Persons Advisory Network (OPAN).

"Maintaining routine to provide a sense of normalcy is important. This includes shower times, mealtimes, medication preferences and newspaper deliveries."

Providers noted that the relationships between care staff and the residents are vitally important. This was challenged when regular staff were not available, staff were in PPE and where new staff were not aware of residents' preferences. Having effective care planning documentation and handover processes were highlighted as critical.

Moving to an acute (hospital style) setting rather than a "homely" aged care environment was difficult for residents and staff alike. Providers also noted that surge staff from acute settings found it challenging to understand the Aged Care Quality Standards and to balance concepts such as consumer dignity and choice with the need to deliver clinical care in line with requirements.

Food and laundry services

Providers highlighted the planning and resources required to manage food and laundry services during an outbreak, including needing to account for infection control requirements. Some providers noted they hadn't fully thought through how these essential services would be managed in an outbreak environment and some underestimated the additional time these tasks would take, and the associated resources required.

> "We didn't realise the investment of resources needed in these areas and the fine details of each task, such as the fact the person touching clean laundry couldn't be in contact with dirty laundry."

Providers described needing more than one 'back up' contractor to ensure essential services were maintained during an outbreak. Providers also highlighted the importance of ensuring contractors had systems in place to maintain a high standard of infection control, and that contractors should be included in all infection control communications and training to ensure a consistent approach across the service(s). In efforts to reduce transmission risks, many providers switched to single use cutlery and crockery but found this had an adverse impact on some residents' nutritional intake and body weight.

Some lessons learned regarding kitchen and food services included:

- the need to provide clear, step-by-step instructions to any staff/service providers involved in preparing and delivering food to ensure appropriate infection control measures are in place from the moment food is prepared until it is delivered to the resident. Providers found they had to plan every detail of how food would be moved throughout the service to prevent potential contamination across different residents and areas of the service
- specific education and training was required for kitchen staff. One provider made their infection control nurse available to contractors to advise on safe food handling procedures and answer any questions
- many providers switched to disposable cutlery and crockery during an outbreak to reduce risk of transmission but found this was "flimsy and difficult for older people to use". They also found this increased the amount of contaminated waste requiring safe disposal
- in switching to disposable plates, meals were often cold by the time they were delivered to residents. Providers managed this in different ways, including switching to foil containers and delivering meals to different areas of the service in an esky to retain heat or providing microwaves in residents' rooms to enable reheating.
- using bottled water/drinks was generally found to be simpler and safer than managing plastic cups and jugs.
- food trolleys can act as a source of transmission – many providers commented on the need to establish procedures for cohorting and/or disinfecting trolleys and tightly managing how food (and food waste) is moved around the service.

"We created some very good documents on catering to break down every part of the service that included the fine details, e.g. procedure for morning tea service."

Infection control processes meant that food was often less appetising for residents. Providers noted significant challenges in maintaining food quality and the pleasurable experience of having a meal under outbreak conditions, noting this was "even more vital during an outbreak and has a measurable impact on the overall experience for residents and helps prevent deconditioning". Providers found innovative ways to enhance food enjoyment and ensure residents were well nourished and hydrated, including:

- providing milkshakes, portioned snacks or snack packs with "goodies" to entice residents to eat (for example, including cookies, chocolates, etc.)
- varying the menu and food experience to "add a sense of anticipation to the day"
- organising a coffee van to provide coffee and pastries in the morning
- having a hot toast trolley to deliver warm and freshly buttered toast in the evening
- arranging a happy hour trolley to "positively close out the day"
- regularly surprising residents with a treat of choice, such as a favourite chocolate bar, beverage or takeaway meal
- providing an array of beverages, including bottled water, juice, cordials and hot drinks throughout the day
- allocating staff with responsibility for monitoring food intake and encouraging people to eat.

Infection prevention and control

Infection control procedures

All providers interviewed identified the critical importance of effective infection prevention and control planning and procedures. Despite being familiar with infection prevention and control, many providers felt unprepared for the intensity and complexity of infection control requirements across all areas of the service.

Providers were often not prepared for the time, number of staff and expertise required to properly use and monitor PPE, the number of staff required to care for a COVID positive resident, for food and laundry services, and the additional support needed for residents who wander.

> "We had calculated the longer time it took in clinical care, but we underestimated it in the hospitality and cleaning aspects."

Many providers described that, in hindsight, they would have provided more infection control training earlier for staff across the service (including cleaning, kitchen and laundry staff). Providers noted the need for frequent and ongoing infection control training to reinforce messages and minimise complacency.

Some measures providers implemented included having staff demonstrate certain infection control competencies (such as hand hygiene or use of PPE) before working 'on the floor', using a train the trainer model to distribute knowledge, having task checklists, providing instruction videos to support staff with limited English, using a buddy system to check each other's practices on site, sending text messages to remind staff of certain requirements, encouraging open feedback loops and having infection control 'spotters' on site for every shift.

"We did a huge amount of hand wash training after our first false-positive, we had monitors who helped monitor washing and providing feedback on whether people were doing it properly. We put out masses of hand-sanitiser, one for every bedroom coming out and one for every bedroom coming in. This is now something that will be there forever and part of our healthcare infection plan going forward."

Since experiencing outbreaks, providers continue to focus on infection control by promoting infection prevention champions, employing infection control leads, providing ongoing training and communications to all staff on site, undertaking hygiene spot checks and increasing the amount of hand hygiene stations, PPE stations and clinical waste bins.

One provider noted they continue to undertake ongoing weekly updates with service management, clinicians and on-site infection control teams to reinforce infection control procedures, including requirements for social distancing, hand hygiene, etc.

Screening, monitoring and testing

A number of providers with services across Australia highlighted a degree of confusion around requirements and responsibilities for screening, contact tracing and testing, noting that these differed across states and territories.

Many providers found they could not easily provide detailed information to support contact tracing (including the areas within the services where different staff had worked and times they had entered and exited the service). As a result, a number of providers have established more structured processes for signing in on entry to the service.

"We have established an electronic sign-in system using QR codes and mobile phones – this reduces risk of contamination by handling of pens to sign-in."

Many providers that experienced an outbreak also now have more robust processes for screening all people on entry to the service and recording the results of screening.

"We've now implemented health screening for staff on individual phones reporting to the manager."

CASE STUDY

Screening residents

"We were screening residents about twice a day. If you are with the resident during the day, it makes sense to undertake a thorough screen of the resident. The Alfred hospital bought in an approach to screening that was useful, and we are instituting this across all residents"

One provider implemented a screening tool across all of their residential services in Victoria and the rest of Australia (and are still using it).

When a service was experiencing an outbreak, this tool would be used twice a day with residents (i.e., once over the course of each 12 hour shift). If the tester recorded 'Yes' to any questions, the next stage was undertaken by a RN.

The answers in the tool informed whether further action was required, including whether the provider needed to seek the support of an in-reach service to assess the resident. Responses were also analysed to identify any patterns and were discussed at daily meetings with Alfred Health. The Alfred team would combine the screening tool results with other information such as nutrition (weight loss) and cognitive assessments to determine a course of action.

The provider described this tool as key for clinical assessment of residents.

"We have a series of questions people must respond to when they sign into the service, and thermal screens in place."

Similarly, many providers have adopted structured processes for monitoring the health of residents.

Some providers have noted that now residents have returned to going out into the community more regularly, they will have to adopt procedures to mitigate risks associated with this.

"When residents go out into the community now, we're looking at risk-management protocols such as hand sanitiser, hand-washing, recording where they're going, when and who with, whether they're going into areas with lots of people or smaller groups."

Providers had variable experiences with their local public health unit or testing service representative, with some taking on responsibility for coordinating testing and contact tracing and others requiring providers to manage this themselves. Some providers described significant delays in testing (in some cases waiting up to five days for test results), which delayed decisive action. A number of providers waited for test results before they cohorted or isolated residents (given the physical and emotional stress of this task) so any delays in test results could have had a significant impact on the extent of the outbreak experienced at different services.

Some of the more proactive and better prepared providers organised testing themselves, using their existing connections with pathology services to procure swabs and develop a testing regime.

> "We instigated COVID swabs on-site by our own nurses for quicker results."

Some providers noted that in the future, if community transmission was evident in their area, they would start their own testing regime immediately and pre-emptively cohort residents (and staff) even where they are not displaying symptoms.

Isolating and cohorting residents

Cohorting residents (and all staff involved in service delivery to those residents) was a challenge for providers and residents alike. Providers noted that some residents found being physically relocated confusing and distressing and highlighted the need for early communication around the impacts of cohorting. Providers expressed the need to manage moves sensitively, including to discuss security of tenure issues with residents and their representatives and to manage residents' belongings with care.

Some providers described being unprepared for the time, resources and logistical challenges involved in cohorting. Moving residents' furniture, belongings and equipment and deep cleaning rooms, belongings and furnishings were particularly physically challenging and time consuming.

> "On-site cohorting is complex, slow to enact and always evolving. It requires careful planning, resident and family consent, packing, relocating and unpacking furniture and possessions, terminal cleaning and ongoing reassurance and emotional support for residents and families. A dedicated team is required to enact room moves."

Given the average demographic/profile of aged care staff, providers did not have access to a ready workforce that could easily and safely manage the physical strain of moving large objects at short notice.

Providers noted that understanding the service layout is paramount, including identifying cohort 'zones', entry and exit points, access for external amenities, staff rooms, donning and doffing stations, waste management, delivery of food and laundry services and maintaining access to outside areas for all residents. One provider noted that it now maintains a floor plan at the reception of each service that identifies cohorting zones, donning and doffing stations, etc.

Providers used coloured tape and clear signage to demarcate different zones within the service.

Each provider and each service had its own challenges and opportunities in terms of cohorting. For example:

- some providers noted that common areas had to be rapidly closed or heavily restricted and sanitised after each use
- some providers found that shared rooms and bathrooms presented a particular challenge
- providers with multiple services nearby were able to repurpose certain services (or certain areas within services) to help with cohorting
- providers consistently identified the challenges of cohorting residents with cognitive impairments or wandering behaviours. Some providers noted that an inability to isolate such residents contributed to the spread of COVID-19 at their service. Some providers noted the additional resources required to care for these residents.

"We had cleaners allocated to walk behind residents with wandering behaviours (in the dementia ward) and follow them around to wipe down everything they touched."

A number of providers created designated areas within which COVID positive residents could wander safely. Some providers removed furniture from services to create more space and enable ease of movement.

Personal protective equipment

Securing sufficient, suitable PPE, as well as storing PPE and ensuring all staff use PPE appropriately was identified as fundamental by all providers interviewed. Many providers found it challenging to determine how much PPE they would need and the impact of donning and doffing on staff time.

> "We calculated that staff would don and doff up to 30 times a day per resident so needed double the staff to provide sufficient care."

Some providers stated they were given conflicting advice regarding PPE requirements, and some noted they were constantly worried about the supply and demand for PPE. A number of providers noted the logistical challenges around receiving, unpacking and storing PPE.

Some providers with multiple services maintained a central supply of PPE that could be quickly deployed to services when needed. Some providers now have an allocated area to store PPE.

Training staff in the correct use of PPE and ensuring routine adherence to donning and doffing practices was an ongoing priority for providers.

CASE STUDY

Unpacking and storing PPE

"One day we had 37 pallets of PPE delivered on our doorstep, and the logistics of unpacking it was immense."

"We got creative – we employed a whole lot of students who couldn't get Jobkeeper, gave them training on PPE and their sole job was to initially restock PPE all day."

We were later able to use the students to provide companionship for residents who were feeling lonely (e.g., by doing a puzzle with them) and to provide support with technology (such as charging residents' phones and helping them call their families). This new workforce didn't need to be highly skilled, but they needed to be the right personality type."

"The correct application and removal of PPE is key. If we had any outbreak in the future (including gastro or flu) we would immediately ensure that every employee (including contractors) received daily and shift-by-shift instruction and checking of PPE application and removal. We were doing this regularly but not every single shift, and implementing this was key to the transmission within our home decreasing significantly."

Providers noted the reality of using PPE in a crisis situation was different from doing it in a classroom environment and that ongoing monitoring and reinforcement was required. Most providers required staff to demonstrate their competence in donning and doffing PPE prior to being allowed to work. Some providers undertook refresher training at the beginning of every shift. Many providers implemented the use of a skilled, highly trained 'PPE buddy' or spotter to observe donning and doffing.

"We continually reminded people of little things like 'you can't pull your mask up to take a drink.'"

CASE STUDY

Hygiene stations

One provider used small trolleys provided by the Victorian Department of Health and Human Services to set up mobile hygiene stations throughout the service. The trolleys had space for different PPE items, hand sanitiser, etc., were compact and easy to restock and clean. Trolleys were placed at strategic locations throughout the service.

The provider found that these little trolleys were "important in maintaining good infection control".

"We needed to utilise highly skilled, clinical staff to just walk up and down to monitor use of PPE. That's all they did, they spent all day monitoring whether people were doing it properly."

CASE STUDY

PPE refreshers

One provider undertook formal PPE education and training with staff prior to an outbreak occurring but, over the course of an outbreak, identified the need to provide regular refreshers and reminders.

"We found during an outbreak, staff may become tired and potentially not as diligent with PPE. A service in outbreak will also have agency staff, new staff or staff performing different roles requiring strict adherence with PPE."

At the beginning of each shift during an outbreak, the Senior Clinician conducted a demonstration of donning and doffing full PPE, including hand hygiene and the correct disposal of used PPE. The provider found this served as a useful reminder for staff, who felt supported and comfortable to ask questions and discuss specific scenarios.

Cleaning and waste management

Most providers reported they were not prepared for waste disposal issues that emerged during outbreaks at their service(s). Many providers were also surprised by the extent of cleaning required and the impact of this on rosters.

"In terms of the cleaning, the number of people required tripled."

Some providers noted that their procedures for increased cleaning were inadequate, missing critical details such as what type of disinfectant to use, how often staff should change cloths and whether curtains needed to be cleaned.

Many providers described being unprepared for the huge amount of clinical waste generated during an outbreak (predominantly from used PPE) and the challenges in disposing of waste. Most providers significantly underestimated the space required to store waste and the ability of their regular waste management providers to keep up with increased demand.

"We didn't have a plan A, B and C, particularly when waste management businesses were struggling. Over the weekend was a problem. Have suppliers that are on call. You should have three reputable suppliers to deal with this type of issue."

Providers noted the need to be flexible and to update their practices to align with conditions set by waste management contractors. A number of providers now have contingency arrangements in place for secondary waste management providers.

Communications

Providers consistently emphasised the importance of effective, regular and consistent communication throughout an outbreak. This includes with residents and their loved ones, staff and external service providers, and with government agencies supporting and coordinating the service's response to an outbreak.

Providers that established central communications teams and had prepared communications strategies, tools and templates found it easier to manage the "overwhelming" communications needs of different stakeholders and to act quickly and proactively.

Communicating with residents and their representatives

Providers highlighted the importance of ensuring contact details (and in some cases, "complex family dynamics") were documented and up to date. Many providers invested in technology to enable virtual communication between the residents and their loved ones and between the service and resident representatives. Some providers noted in hindsight that it is important to test communications systems prior to an outbreak occurring.

"Communication technologies needed to be up and working before a crisis arises to be quickly leveraged to accommodate a lockdown."

Many providers established a team or tasked an individual with sole responsibility for communicating key information to residents and their families. Some of the different strategies adopted included:

- having a dedicated person with an iPad to support two-way communication between residents and their loved ones
- coordinating a daily call between families and residents (based on what the resident wants)
- for families who were concerned about the residents eating, taking photos after meals were finished, and showing them videos of their family member being fed
- purchasing SMS technology to rapidly communicate with families
- sending a daily email update to families and residents.
  - One provider noted that 98% of families opted to use this form of communication, families were grateful for the regular updates and it was an extremely time-efficient way to communicate
- setting up a dedicated number/call centres or email address that families could contact, and preparing FAQs and templated emails in advance
- undertaking regular video meetings to update families on the situation
- sequencing messaging to families:
  - For example, sending a templated text message to the resident's representative as soon as the resident is confirmed COVID-19 positive, advising the provider would call within six hours and assigning a staff member close to the resident to talk to their family.

"Families expect regular, clear and transparent information from the home especially around measures being taken to protect their loved one, and how team resourcing is being managed."

In many cases, communications were managed by staff who were furloughed to enable them to continue to support the service remotely. Providers emphasised that it was critical to get reliable, detailed information out quickly to "prevent chaos".

The Commission noted the providers that proactively and consistently communicated with residents' families were less likely to have complaints. It was also observed that discussing potentially sensitive matters (such as the possible need for residents to move rooms to enable cohorting) before an outbreak occurred enabled providers to act quickly and decisively when they needed to.

Providers found that families generally wanted:

- a single, consistent point of communication
- to understand the detail of how the service was managing the outbreak (including details such as testing regimes, rates of infection and outcomes for those with the virus)
- to speak with someone with clinical knowledge
- to speak with someone on site who had "eyes on" their loved one and could ensure any specific requests were acted on
- transparency and open disclosure when things weren't necessarily going to plan.

Overall, providers described the importance of honest and transparent communication about case numbers, deaths and what residents and families should be prepared for during the outbreak. One provider found that families felt more reassured by knowing the minutiae of how they were managing the outbreak, including details such as how the service was managing waste.

"The more you communicate, the less the anxiety spreads amongst the staff and residents."

Providers with multiple services also had to manage questions from the families of residents in unimpacted services.

"We were honest with the families and where the situation was up to and we didn't shy away from bad news. Families asked good, detailed questions. We think it was successful because we were honest, and families shared in the problem solving."

Many providers noted that their communications and relationships with residents and families have improved as a result of experiencing an outbreak and are looking to be more proactive in their engagement into the future.

Communicating with staff and other service providers

Providers emphasised that clear and consistent communication with staff was critical to set expectations, communicate responsibilities and remind staff of new/changing processes.

"Clear communication is required to set expectations regarding safety outside of work – accommodation, travel and uniforms."

The Commission found that some providers underestimated the level of detail and specificity required in communications and guidance to staff. It was observed that providers that undertook detailed task analysis and set out exhaustive, step-by-step procedures for all key tasks were less likely to experience an error or breakdown in their infection prevention and control processes.

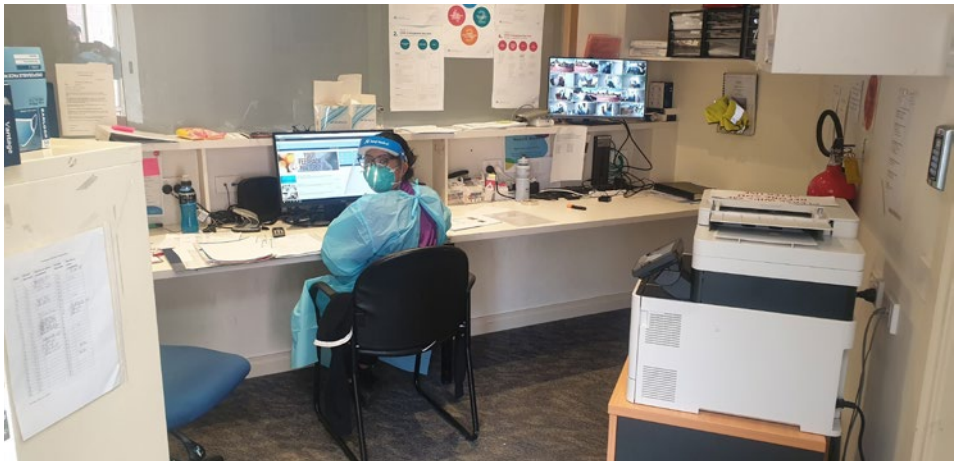
Some providers highlighted the importance of ensuring proactive communication with staff, including to notify of an outbreak at a service "so they knew what they were coming into". Providers used video conferences, phone calls, text messages, emails and app notifications to keep staff informed of the status of the outbreak, notify any changes to procedures and remind staff of key infection control requirements.

Providers found that the new communication systems established to prepare for (or in response to) an outbreak have provided new ways for them to communicate with staff in the future.

"Usually, it's challenging coordinating staff meetings and training as we would have to hold several sessions to accommodate everyone's schedule to come in and many people wouldn't attend. But now we can do these by Zoom and there's flexibility for everyone to attend."

Communication with furloughed and COVID-19 positive staff was vital to ensure the wellbeing of staff and maintain connection with a critical workforce.

"Keeping furloughed team members connected to the home is critical during the outbreak. We held Zoom meetings and sent regular text message communications to keep the team informed."



Liaising with government agencies

All providers interviewed reported varying degrees of difficulty in dealing with multiple government agencies during an outbreak, citing delays in receiving responses to questions, having to wait for clinical advice or instructions, and receiving conflicting advice from different agencies.

> "Following advice, we put in place flip-top bins, the outbreak team then arrived and advised that we should be using open bins. All new bins were purchased. However, on their arrival, AUSMAT advised that we should have closed bins."

Some providers indicated they believed a delay in response from an outside agency contributed to the spread of the virus and some felt PHU contact tracing efforts were not timely or adequate and initiated their own contact tracing efforts.

Some providers found that government representatives did not introduce themselves, their role/agency and sought information without explaining why it was required.

Many providers expressed frustration at a lack of clarity regarding the "ultimate source of truth" and the role of each government agency in relation to the role of the provider.

> "We worked hard to clarify messaging from government to ensure clarity and consistency."

Providers also reported that it became time consuming and burdensome for them to provide information and regular updates to multiple agencies, with some suggesting a centralised point and set time to provide updates would have assisted greatly.

Many providers reported that the establishment of the Victorian Aged Care Response Centre initiated by the Commonwealth Government had led to significant improvements with coordination by government agencies.

The Commission observed that the providers that took responsibility for making decisions and acting assertively managed outbreaks more effectively. While some providers waited to check things or clarify queries with government agencies, quick, decisive action generally stood providers in good stead.

> "We managed the virus first and politics second."

Despite challenges dealing with government agencies, many providers found their support valuable, including the access to skills, expertise, helpful tips and examples of systems implemented by other providers that they would not otherwise have had. One provider noted that infection control spot checks undertaken by various agencies were a good opportunity to identify gaps in their systems that they were not aware of.

Media management

Providers generally found the media attention to be distracting and unhelpful, noting that negative media reports were distressing for residents, their families and staff, and that additional resources were required to manage media presence on-site. Some providers established centralised media management teams to prepare media statements, ensure consistent and accurate information was provided to the media, and to ensure that on-site staff were free to focus on caring for residents. One provider noted:

> "Property and team presentation is important. Be deliberate in keeping all areas of the home that are visible to the public free from anything that may attract the attention of photographers, e.g., waste bins, staff gathering in groups."

One provider hired security to protect staff and families from media representatives with cameras and microphones outside the service.

Several providers noted that the staff at aged care facilities were heroes just like others in health care.

The end of an outbreak

All providers interviewed had commenced (or were planning to undertake) formal reviews and evaluations of their outbreak management.

“We’re employing a storyteller to capture the impact of events for residents and staff.”

Many providers reported undertaking ongoing improvements even prior to getting the outcomes of formal reviews. Changes to governance and work health and safety considerations were consistent themes coming out of reviews.

Providers noted the ongoing impacts for residents and staff dealing with trauma and loss. Residents and staff alike are still working through varying levels of anxiety and grief.

Many providers are offering additional support for residents and staff, including hiring counsellors, social workers and psychologists and engaging with OPAN. One service noted they are planning a service for the residents they lost to COVID 19.

“Residents began to improve when regular faces returned to work.”

Key messages

The Commission asked providers to identify their key "take out" messages that they wanted to share with providers that hadn't experienced an outbreak or were looking to improve their preparedness for a potential outbreak.

- Providers emphasised the **value of keeping a detailed outbreak management plan** specific to each service and trialling the service's outbreak response, including by testing it with local service providers, government agencies and providers that have experienced outbreaks.
- Many highlighted the **value of strong and decisive leadership** and found that a command and control structure was more effective in an emergency situation.
- **Knowing your staff**, their domestic arrangements and their ability/willingness to work on site during an outbreak was considered crucial. Providers also said they would make emotional and mental health support available to staff early, noting that they were working under conditions of extreme stress and were susceptible to burnout.
- Providers found that **contingencies were critical** – contingency staffing and contingency service providers (particularly to support PPE procurement and clinical waste management).
- Some providers said they would be prepared to do their own testing and **start testing immediately** at the onset of an outbreak. Many also said they would more closely consider the layout of each service and how this enables cohorting in the future.
- A number of providers highlighted the need to **think through processes** in explicit detail (rather than just jumping at the first idea) to minimise possible breaches in infection control.
- In general, providers felt **you could not overprepare** as, once an outbreak occurs, there is little time to spare.
- **Communication that was early, inclusive, transparent and frequent** was a hallmark of managing an outbreak well and to the satisfaction of the residents, families and staff.

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