West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

Corporate Office
High Street, Greymouth

Telephone 03 768 0499
Fax 03 768 2791

5 August 2020

9(2)(a)
[redacted]

[redacted]

[redacted]

RE Official information request WCDHB 9444

I refer to your email dated 3 July 2020 requesting the following information under the Official Information Act from West Coast DHB. Specifically:

Please may I see the Covid-19 preparedness assessments done on the six West Coast aged care providers.

Please find attached as the following **Appendices** the information you have requested.

Appendix 1 Ziman House – Reefton
Appendix 2 Kahurangi
Appendix 3 Ultimate Care – Allen Bryant Lifecare
Appendix 4 O'Conor Home
Appendix 5 Granger House – Heritage Life Care
Appendix 6 Dixon House

We have redacted information in these appendices pursuant to section 9(2)(a) of the Official Information Act i.e. to protect the privacy of individuals.

Please also note: The Ministry of Health commissioned a report into the COVID-19 clusters in ARC Facilities and the preliminary report (29 May 2020) was published on 17 June 2020.

The West Coast DHB submitted the requested information to the Ministry of Health which was used to help inform this report. The report is publicly available at the following link https://www.health.govt.nz/system/files/documents/publications/independent-review-covid-19-clusters-aged-residential-care-facilities-may20.pdf

Feedback has been sought which will be used to develop and confirm an action plan, based on the recommendations, that will be implemented.

I trust that this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

001

APPENDIX 1

WCDHB - Infection Prevention and Control Service

ARC Quick Environmental Audit

Name of Auditor 9(2)(a)
Facility Zimard House. Reefton.
Nurse Manager 9(2)(a)
Date of Audit 22/04/20
Date of Feedback

SECTION 1: GENERAL ENVIRONMENT

Standard: Clinical areas are visibly clean, uncluttered and maintained appropriately to minimise cross infection.

		C	NC	P	NA
HAND HYGIENE FACILITIES					
1.	Hand washing facilities are clean, available and access is clear	✓			
2.	ABHR is available outside Ens HWB room	✓			
DETERGENTS/DISINFECTANTS					
3.	Detergent or detergent wipes are available for general environmental cleaning of surfaces	✓			
4.	Approved disinfectant (bleach product or other hospital grade disinfectant active against viruses) is available	✓			
5.	Correct dilution/refreshing of disinfectant every 24 hours	✓			
6.	Alcohol impregnated wipes are available for sensitive equipment	✓			
7.	Designated housekeeping staff ISS not noted cleaning frequently touched rails etc	✓			
DIRTY UTILITY/SLUICE ROOM					
8.	The dirty utility or sluice area is visibly clean and tidy	✓			
9.	There is a designated hand wash basin in this room, with soap and paper towels present	✓			
10.	There is a facility to safely sanitize equipment e.g. bedpans/urinals /bowls	✓			
WASTE MANAGEMENT					
11.	There is correct segregation of waste	✓			
12.	Infectious/medical waste bins with foot-controlled lids are available	✓			
13.	Waste bags awaiting collection are stored in a non-public area	✓			
14.	ABHR/HWB is available for use after handling waste	✓			
SOILED LINEN					
15.	Linen bags are secured and stored in a secure area for collection	✓			
16.	Soiled linen from isolation rooms is handled/laundered separately	✓			
17.	Staff working in laundry do not provide patient care due to lav vols		✓		
18.	Dirty and clean linen is segregated	✓			
19.	Personal clothing is laundered separately for each patient/resident			✓	
20.	Hand hygiene and personal protective equipment is available	✓			

Comments Locked + collected x2 weekly r inspected at Grey Base
Laundry is processed by CDS.

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

002

SECTION 2: PATIENT ROOMS

Standard: Facilities and appropriate products are available to ensure effective hand hygiene and standard precautions are undertaken.

		C	NC	P	NA
21.	ABHR is available at each resident's room outside	✓			
22.	Disposable gloves in a range of sizes are available outside	✓			

Comments

SECTION 3: PATIENT CARE EQUIPMENT

Standard: Patient care equipment will be cleaned/decontaminated and stored safely and appropriate resources made available to minimise the risk of cross infection

		C	NC	P	NA
23.	Manual handling sheets, hoist slings and slides are cleaned between patients	✓			
24.	Are commodes used	✓			
25.	Commodes are individually assigned and disinfected between patients	✓			

Comments

SECTION 4: COMMUNAL PATIENT AREAS

Standard: Communal patient areas shall be maintained appropriately to minimise the risk of cross infection.

		C	NC	P	NA
TOILETS & BATHROOMS					
26.	Are bathrooms/toilets shared between residents? cleaned between use	✓			
27.	How are residents in isolation showered/toileted No ensuites.		N/A	✓	
28.	Toilets are visibly clean	✓			
29.	Bathroom areas are free from communal items which may be contaminated e.g. creams, talc				
30.	Showers are clean, intact and free from mould	✓			
31.	Linen is not stored in open shelves in bathroom areas	✓			
32.	Staff have a separate toilet from residents	✓			

Comments residents, either opened or entered in a unsafe area that allocated covid positive pts.. older facility + some bathrooms have access that need attention/maintenance.

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

003

SECTION 5: STANDARD AND TRANSMISSION-BASED PRECAUTIONS

Standard: Care will be planned for individual patients using precautions necessary to prevent the spread of infection, taking into account the needs of the patient and other patients

		C	NC	P	NA
33.	Sufficent PPE stock on hand	✓			
34.	PPE Donning/doffing areas are identified	✓			
35.	Staff have received training in donning/doffing PPE	✓			
36.					
37.	Disposable gloves, aprons and gowns are available/worn	✓			
38.	Surgical masks are available/worn	✓			
39.	Safety glasses/protective eyewear is available/worn	✓			
40.	The correct transmission-based precautions signage is available and used appropriately	✓			
41.	Eye protection is cleaned and disinfected after use	✓			

Comments

SECTION 6: KITCHEN AND FOOD / BEVERAGE FACILITIES

Standard: Kitchen and food handling areas conform to Food Safety Authority guidelines

		C	NC	P	NA
42.	Kitchen staff are not involved in patient cares or laundry	✓			
43.	There are hand hygiene facilities available	✓			
44.	Are there any filtered water units available in facility				✓

Comments On boiled Wate - water cooler's not in use. Buy water in & stored & served to patients.

SECTION 7: COVID-19 OUTBREAK MANAGEMENT

		C	NC	P	NA
45.	COVID-19 Outbreak management plan available need update.	✓			
46.	CDHB Planning and Funding liaison person identified	✓			
47.	Staffing contingency plan available need to review	✓			
48.	Community & Public Health contact details known Follow notifiable disease process.	✓			
49.	Staff know how to launder their uniforms	✓			

⇒ DHB P&P -

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

SAFE STAFFING PLAN

ESCALATION LEVELS

Reefton Integrated Family Health Centre

ESCALATION LEVELS

The Escalation plan is split into five stages. These reflect the current status of the ward or unit for Nursing Service and its ability to accept admissions into the wards or continue with planned electives. The actions described at each level should be completed before moving onto next level.

WHITE
There is capacity to carry on as business as usual, staffing exceeds patient needs

GREEN
Resident ward full, patients discharging today will ease load, Nursing hours available match service needs District Nursing patient load within normal parameters. Medical Centre - Routine

AMBER
Resident/Medical ward full, unable to free up capacity, Unable to accept transfers Service needs exceed nursing hours available, staff are sick Unable to continue with planned daily activities District Nursing patient load – maximum Medical Centre – assess routine appointments at morning huddle, assess need to assist District Nursing and Resident/Medical Wards

RED
Resident/Medical wards full unable to continue with Respites, unable to accept admissions or transfers from other facilities Service needs exceed clinical hours available for all of Reefton Integrated Family Health Centre No Major Incident

BLACK
Resident/Medical ward full unable to continue with planned care, transfers into facility postponed Service needs exceed clinical hours available for all of Reefton Integrated Family Health Centre **Major incident plan enacted**

ESCALATION STATUS – WHITE

STATUS: There is capacity to carry on as business as usual, staffing exceeds patient needs

RESPONSIBILITY	ACTION
Reefton Integrated Family Health Centre Hospital Wing (RN, EN, CG) Medical Centre District Nursing	- Normal service provided for whole of facility, all departments
Clinical Nurse Manager	- Ensures normal staffing levels maintained – 28 days in advance. - MDT meetings x 1 per week.
Northern Integrated Family Health Service Manager	- Meets weekly with Clinical Nurse Manager to support care delivery processes.

ESCALATION STATUS – GREEN
STATUS: There is capacity to accept referrals and provide on-going care

TRIGGERS: Increase in Admissions
Increase in work load due to current occupancy
Higher acuity of patient's received
Increased staff absence e.g. sickness

RESPONSIBILITY	ACTION
Reefton Integrated Family Health Centre Hospital Wing (RN, EN, CG) Medical Centre District Nursing	- Normal Services provided - Teams to review planned workload and re-prioritise as necessary - Teams to review the need for additional staffing hours
Clinical Nurse Manager	- CNM to keep Northern Integrated Family Health Service Manager informed of position daily (as required)
Northern Integrated Family Health Service Manager	- Keeps General Manager informed of position weekly and action taken (as required) - Inform Grey Base of possible problem.

TRIGGERS: No vacancies in Residential Rest Home, Long Term Care, Medical, long wait time for Medical Centre appointments, increased District Nursing caseload Staff absences / sickness within acceptable levels.

ESCALATION STATUS – AMBER
STATUS: Service needs exceed the nursing hours available

TRIGGERS:

All GREEN actions have been taken
Escalated staff sickness / absence e.g. bereavement
No part time or casual staff available
Inability to provide a safe level of care
Ability to provide admission for assessment and care is compromised.

RESPONSIBILITY	ACTION
Reefton Integrated Family Health Centre Hospital Wing (RN, EN, CG) Medical Centre District Nursing	- Action as for Green
Clinical Nurse Manager	- Contact all staff on Leave and Study Leave - Contact Primary Health Wing staff - Casual Staff for availability - Advise NZNO delegate - Liaise with Primary Health Wing regarding status of available staffing to assist
Northern Integrated Family Health Service Manager	- Review provision of hospital and medical centre services with CNM, Senior Administrator and GP/RNS - Ongoing monitoring of situation - Keeps General Manager informed of position weekly and action taken (as required)
General Manager	- Informs the weekly Executive Management Team meetings of position and action taken. Nominates appropriate deputy as required to attend this meeting.

ESCALATION STATUS – RED
STATUS: Service needs exceed the nursing hours available
NO MAJOR INCIDENT

TRIGGERS: All GREEN and AMBER actions have been taken
Unable to match service needs to nursing hours available despite actions taken

RESPONSIBILITY	ACTION
Reefton Integrated Family Health Centre Hospital Wing (RN, EN, CG) Medical Centre District Nursing	- Action as for Green and Amber - Review distribution of work over the number of staff available - Prioritise necessary care - Delegation of non-nursing task more effectively - Cancellation of study leave – where appropriate - CNM and Northern IFHS Manager assists to facilitate safe staffing
Clinical Nurse Manager	- Use of overtime / casual pool staff to cover roster - CNM keeps Northern IFHS Manager informed of position daily - Advise NZNO delegates to complete incident / accident reports
Northern Integrated Family Health Service Manager	- Ongoing monitoring of service continues - Works closely with the Director of Nursing, and People and Capabilities to source additional staff - Ensure liaison with the other community / Primary Health Services
General Manager	- Ensures the Chief Executive Officer is informed of situation and action taken - Updates the weekly executive Management Team meeting of position and action taken. Nominates appropriate deputy as required to attend - Discussions to be had with the General Manager Finance, re the commitment of any additional resources.

ESCALATION STATUS – BLACK
STATUS: Major incident plan enacted
Unable to provide acceptable level of safe care, no additional capacity
Residents/Inpatients at risk despite special care packages
Caseloads are full despite action at previous levels
Services needs exceed nursing hours available

TRIGGERS: As for RED and **MAJOR INCIDENT HAS BEEN ENACTED by Operations Team**

RESPONSIBILITY	ACTION
Reefton Integrated Family Health Centre Hospital Wing (RN, EN, CG) Medical Centre District Nursing	- Action as for GREEN, AMBER and RED - Use Volunteers, Family members, Management staff to assist with care provision of Residents/Inpatients - Inform all Residents/Inpatients families of situation
Clinical Nurse Manager	- Ensure operation debriefing related to major incidents are in place - Assist staff to access EAP and additional support - Review availability of nursing staff, re-allocate as required taking into account designation and experience - Monitor situation ensuring all prioritised patients are seen - CNM to keep Northern IFHS Manager informed of position daily - Last Option: cancel all study and annual leave
Northern Integrated Family Health Service Manager	- Ongoing monitoring of situation - Works closely with Director of Nursing, General Manager and People and Capabilities to source additional staff. - Ensure liaison with other Community Services - Works with Communication Officer re: information bulletin to go out to Health Providers and general media release - Inform General Manager of position and action taken - Keeps partner agencies informed
General Manager	- Ensure CEO is aware of the situation and actions taken - Updates the weekly Executive Management Team meeting of position and action taken. Nominates appropriate deputy as required to attend. - Calls exceptional EMT meetings as required - Discussion continue with the General Manager Finance re: the commitment of any additional resources

POST CRISIS

- Debriefing to be held – minutes taken
- Staff offered EAPS or support as appropriate
- Staff to be thanked (formal acknowledgment e.g. personalised care / letter).
- Escalation plan to be reviewed / updated and sent out for staff input.

Appendix 3

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

APPENDIX 2

WCDHB - Infection Prevention and Control Service

ARC Quick Environmental Audit

Name of Auditor 9(2)(a) [redacted]
Facility Kahurangi
Nurse Manager 9(2)(a) [redacted]
Date of Audit 15/4/20
Date of Feedback

SECTION 1: GENERAL ENVIRONMENT

Standard: Clinical areas are visibly clean, uncluttered and maintained appropriately to minimise cross infection.

		C	NC	P	NA
HAND HYGIENE FACILITIES					
1.	Hand washing facilities are clean, available and access is clear	✓			
2.	ABHR is available	✓			
DETERGENTS/DISINFECTANTS					
3.	Detergent or detergent wipes are available for general environmental cleaning of surfaces	✓			
4.	Approved disinfectant (bleach product or other hospital grade disinfectant active against viruses) is available	✓			
5.	Correct dilution/refreshing of disinfectant every 24 hours	✓			
6.	Alcohol impregnated wipes are available for sensitive equipment	✓			
7.	Designated housekeeping staff	✓			
DIRTY UTILITY/SLUICE ROOM					
8.	The dirty utility or sluice area is visibly clean and tidy	✓			
9.	There is a designated hand wash basin in this room, with soap and paper towels present	✓			
10.	There is a facility to safely sanitize equipment e.g. bedpans/urinals /bowls	✓			
WASTE MANAGEMENT					
11.	There is correct segregation of waste	✓			
12.	Infectious/medical waste bins with foot-controlled lids are available	✓			
13.	Waste bags awaiting collection are stored in a non-public area	✓			
14.	ABHR/HWB is available for use after handling waste	✓			
SOILED LINEN					
15.	Linen bags are secured and stored in a secure area for collection	✓			
16.	Soiled linen from isolation rooms is handled/laundered separately	✓			
17.	Staff working in laundry do not provide patient care	✓			
18.	Dirty and clean linen is segregated	✓			
19.	Personal clothing is laundered separately for each patient/resident	✓			
20.	Hand hygiene and personal protective equipment is available	✓			

Comments

WCDHB, IPC, april 2020 – supplied by CDHB.

C	Compliant
NC	Non Compliant
P	Partial

SECTION 2: PATIENT ROOMS

Standard: Facilities and appropriate products are available to ensure effective hand hygiene and standard precautions are undertaken.

Hand basin in each room

		C	NC	P	NA
21.	ABHR is available at each resident's room			✓	✓
22.	Disposable gloves in a range of sizes are available	✓			

Comments

SECTION 3: PATIENT CARE EQUIPMENT

Standard: Patient care equipment will be cleaned/decontaminated and stored safely and appropriate resources made available to minimise the risk of cross infection

		C	NC	P	NA
23.	Manual handling sheets, hoist slings and slides are cleaned between patients	✓			
24.	Are commodes used	✓			
25.	Commodes are individually assigned and disinfected between patients	✓			

Comments

SECTION 4: COMMUNAL PATIENT AREAS

Standard: Communal patient areas shall be maintained appropriately to minimise the risk of cross infection.

		C	NC	P	NA
TOILETS & BATHROOMS					
26.	Are bathrooms/toilets shared between residents?	✓			
27.	How are residents in isolation showered/toileted	✓			
28.	Toilets are visibly clean	✓			
29.	Bathroom areas are free from communal items which may be contaminated e.g. creams, talc	✓			
30.	Showers are clean, intact and free from mould	✓			
31.	Linen is not stored in open shelves in bathroom areas	✓			
32.	Staff have a separate toilet from residents	✓			

Comments

		016
C	Compliant	
NC	Non Compliant	
P	Partial	

SECTION 5: STANDARD AND TRANSMISSION-BASED PRECAUTIONS

Standard: Care will be planned for individual patients using precautions necessary to prevent the spread of infection, taking into account the needs of the patient and other patients

		C	NC	P	NA
33.	Sufficent PPE stock on hand	✓			
34.	PPE Donning/doffing areas are identified	✓			
35.	Staff have received training in donning/doffing PPE	✓			
36.					
37.	Disposable gloves, aprons and gowns are available/worn	✓			
38.	Surgical masks are available/worn	✓			
39.	Safety glasses/protective eyewear is available/worn	✓			
40.	The correct transmission-based precautions signage is available and used appropriately	✓			
41.	Eye protection is cleaned and disinfected after use	✓			

Comments

SECTION 6: KITCHEN AND FOOD / BEVERAGE FACILITIES

Standard: Kitchen and food handling areas conform to Food Safety Authority guidelines

		C	NC	P	NA
42.	Kitchen staff are not involved in patient cares or laundry	✓			
43.	There are hand hygiene facilities available	✓			
44.	Are there any filtered water units available in facility			✓	

Date tested and not clearly visible.

Comments

unsure when Service,

SECTION 7: COVID-19 OUTBREAK MANAGEMENT

		C	NC	P	NA
45.	COVID-19 Outbreak management plan available	✓			
46.	CDHB Planning and Funding liaison person identified	✓			
47.	Staffing contingency plan available	✓			
48.	Community & Public Health contact details known	✓			
49.	Staff know how to launder their uniforms	✓			

J.L

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Older Persons Health
Kahurangi Dementia Services

SAFE STAFFING PLAN
&
ESCALATION LEVELS

DRAFT 2020

Older Person Health – Kahurangi Dementia Unit, Grey Base Hospital

Kahurangi is a 20 bed facility, 17 of which are dedicated to Aged Residential Psychogeriatric Hospital Specialised Care residents and 3 dedicated beds to Assessment, treatment and rehab of older person's health.

As per the below guidelines there **must** at least one Registered Nurse on duty and all times and the rest of the care staff are made up of both enrolled nurses and healthcare assistants. Kahurangi also has Full Time Diversional Therapists and a Full Time Housekeeper.

Appropriate staffing levels are assessed and influenced by trendcare, safe staffing and CCDM (Care Capacity Demand Management) as well as current ARC resident and ATR patient consideration depending on individual BPSD (behavioural and psychological symptoms of dementia) displayed.

The RN on duty is the shift coordinator completing both RN tasks as well as coordinating the care for the unit. EN and HCA's have allocated workloads and generally work in pairs looking after 2 x groups of 10 residents/patients (this variable depending on acuity of residents/occupancy of beds). There is a 'Float role' assisting across all aspects of the cares as well as being a safety support to help manage BPSD and falls risk element of Dementia.

Oversight of daily Staffing

RN Requirement per shift:

			Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Public Holiday
	No Hours per Shift	Hour Start/Finish	People/Heads							
Morning	8		1	1	1	1	1	1	1	1
Afternoon	8		1	1	1	1	1	1	1	1
Night	8		1	1	1	1	1	1	1	1

EN/HCA Requirement per shift (ideally one EN per shift to cover second checking etc. of medications, if unable to DNM is required to help)**:**

			Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Public Holiday
	No Hours per Shift	Hour Start/Finish	People/Heads							
Morning	8		5	5	5	5	5	6	6	6
Afternoon	8		5	5	5	5	5	6	6	6
Night	8		2	2	2	2	2	2	2	2

In ideal circumstances we also have 2 x FTE Diversional Therapist Mon – Fri, a Housekeeper Mon – Fri as well as support from a 0.2 FTE ACNM and 1.0 FTE CNM.

Quick Guide to Retirement Villages & Aged Residential Levels of Care

Retirement Villages

These people are equivalent as someone living in their own home.
Even if a village has a rest home as part of the complex, the rest home is not responsible for any cares for these people who live in the village. The DHB does not have any contracts with Retirement Village businesses.

Staffing: No staff. People live independently and make their own decisions about what they need
Medical Practitioner: Same as a person living in their own home. (Ring their GP and plan how to get there)

Rest Home level of care

These residents need support at a level that can no longer be delivered in their own home.

Staffing
- May not have a Registered Nurse on duty
- Will have a Registered Nurse on call for clinical advise or decision making. (This could be an Agency RN)
- Most cares provided by Healthcare Assistants. (May only be on on duty in small facilities)

Medications
- Do not have a drug cupboard or supply of medication 'just in case' situations.
- Can have prn prescriptions as part of a care plan
- May not have access to a pharmacy 24/7

Equipment
- Will only have standard equipment

Medical Practitioner support
- A General Practitioner or Nurse Practitioner provide medical care for the residents, so visits or consultations are variable depending on how the general practice operates.
- Residents must be seen by the General Practitioner or Nurse Practitioner within 2 days of admission unless seen by a medical practitioner within the previous 2 days and summary of the examination notes provided.

Many facilities have rest home and hospital levels of care

Hospital level of care

HOSPITAL LEVEL OF CARE DOES NOT MEAN THEY ARE A HOSPITAL. As a rough rule these residents need help with activities of daily living, have physiological symptoms which require frequent input from carers.

Staffing
- Will always have a Registered Nurse on duty. (This could be an Agency RN who is new to the facility)
- Registered Nurse on duty may not be decision maker regarding whether to admit after hours. (They may need to have this approved by the Facility Manager)
- Health Care Assistants will provide most of the residents' care

Medications
- Can have a supply of medications for prn use of any resident
- May not have access to a pharmacy 24/7

Equipment and medical supplies
- May not have access to non standard equipment or medical supplies

Medical Practitioner support
- The General Practitioner or Nurse Practitioner provide medical care for the residents, so visits or consultations are variable depending on how the general practice operates.
- Residents must be seen by the General Practitioner or Nurse Practitioner within 2 days of admission unless seen by a medical practitioner within the previous 2 days and summary of the examination notes provided.

Dementia Rest Home level of care

THIS IS A SECURE ENVIRONMENT so only people approved by an Older Persons Mental Health SMO can be admitted to this facility.

Staffing
- Registered Nurse must have training in care of older people with dementia (This could be an Agency RN)
- Most care provided by Healthcare Assistants with additional training for people with dementia.

Medications
- Do not have a drug cupboard or supply of medication for 'just in case' situations.
- Can have prn prescriptions as part of a care plan
- May not have access to a pharmacy 24/7

Equipment and medical supplies
- May not have access to non standard equipment or medical supplies

Medical Practitioner support
- The General Practitioner or Nurse Practitioner provide medical care for the residents, so visits or consultations are variable depending on how the general practice operates.
- Residents must be seen by the General Practitioner or Nurse Practitioner within 2 days of admission unless seen by a medical practitioner within the previous 2 days and summary of the examination notes provided.

Psychogeriatric Hospital Specialised level of care

THIS IS A SECURE ENVIRONMENT so only people approved by an Older Persons Mental Health SMO can be admitted to this facility. As a rough rule these residents need help with activities of daily living, have psychological symptoms which require frequent input from carers.

Staffing
- One Registered Nurse with training in care of older people with dementia on duty at all times.
- Most care provided by Healthcare Assistants with additional training for people with dementia.

Medications
- Can have a supply of medications for prn use of any resident
- May not have access to a pharmacy 24/7

Equipment and medical supplies
- May not have access to non standard equipment or medical supplies

Medical Practitioner support
- The General Practitioner or Nurse Practitioner provide medical care for the residents, so visits or consultations are variable depending on how the general practice operates.
- Residents must be seen by the General Practitioner or Nurse Practitioner within 2 days of admission unless seen by a medical practitioner within the previous 2 days and summary of the examination notes provided.

Developed by HOP team, Planning & Funding May 2019

ESCALATION LEVELS

The Escalation plan is split into five stages. These reflect the current status of ability to accept referrals for AT&R assessment and long stay dementia care. The actions described at each level should be completed before moving onto next level.

WHITE
There is capacity to accept referrals for assessment and for the provision of long term care

GREEN
All AT&R beds and ARC beds are occupied, No waiting list for ARC admission and/or AT&R admissions. Nursing hours available match service needs

AMBER
All AT&R beds and ARC beds are occupied. There is a waiting list for ARC admissions and/or AT&R admissions. Nursing hours in Kahurangi match the need. Special care packages available outside Kahurangi and needs are met.

RED
All AT&R beds and ARC beds are occupied. There is a waiting list for ARC admissions and/or ATR admissions. Service needs exceed nursing hours. Special care packages available outside Kahurangi and needs are met. Major incident possible

BLACK
All AT&R beds and ARC beds are occupied. There is a waiting list for ARC admissions and/or AT&R admissions. Major incident plan enacted Service needs continue to exceed nursing hours available. No special care packages available outside Kahurangi

ESCALATION STATUS – WHITE
STATUS: There is capacity to accept referrals and provide on-going care

RESPONSIBILITY	ACTION
Kahurangi staff (all staff including RN's, EN's, HCA's, DT's, Housekeeper, ACNM)	• Normal Services provided • Admission and discharge processes as required • Assists IPU as needed
Clinical Manager	• Ensures normal staffing levels maintained • 1 x ARC MDT and 1 x AT&R MDT weekly • Approve annual leave where possible
Operations Manager	• Regular catch ups with CNM as required • Receives updates daily through Operations Meeting

ESCALATION STATUS – GREEN
STATUS: There is no capacity to accept referrals but on-going care is provided. There is no waiting list

TRIGGERS: No Vacancies in Kahurangi
Staff absence / sickness within acceptable levels

RESPONSIBILITY	ACTION
Complex Comminity Care Network (CCCN)	• Normal Services provided • Aware if no vacancies in Kahurangi • Teams to review planned workload and reprioritise as necessary
Clinical Nurse Manager	• Maintains acceptable staffing levels with consideration of replacement nursing hours to cover staff level/sickness, review current roster and flexibility of staff • CNM to keep Operations Manager informed of position daily via staffing meeting • Prioritise discharge planning of AT&R patients with MDT and discharge if appropriate • ACNM to assist with nursing hours if required
Operations Manager	• Keeps General Manager informed of occupancy and staffing situation in Kahurangi daily at morning ops meeting and action taken (as required)

ESCALATION STATUS – AMBER
STATUS: Waiting list exists for inpatient assessment and care
Patients being managed with extra support in their current living environment

TRIGGERS: All GREEN actions have been taken
Ability to provide admission for assessment and care is compromised
Increased level of staff sickness/absence

RESPONSIBILITY	ACTION
Kahurangi Staff	• Action as for Green
Clinical Manager	• Action as for Green • Liaise with the outreach nurse re patients on waiting list, updating MDT • Works with psychiatrist to prioritise waiting list patients and continue discharge planning of existing AT&R patients • Review current ARC residents, consider if there is any individual suitable to be considered for change of level of care and moved to general ARC facility • ACNM to assist with nursing hours
Operations Manager	• On going monitoring of situation • Keeps General Manager informed of occupancy and staffing situation in Kahurangi daily at morning ops meeting and action taken (as required)
General Manager	• Informs the Executive Management Team meetings of position and action taken. Nominates appropriate deputy as required to attend this meeting.

ESCALATION STATUS – RED
STATUS: Service needs exceed the nursing hours available
NO MAJOR INCIDENT

TRIGGERS: All GREEN and AMBER actions have been taken
Unable to match service needs to nursing hours available despite actions taken

RESPONSIBILITY	ACTION
Kahurangi staff	• Action as for Green and Amber • Review distribution of work over the number of staff available • Prioritise care rationing • Delegation of non-nursing task more effectively • Cancellation of study leave – where appropriate • Prioritise use of Housekeeper and Diversional Therapists to assist in day to day operations tasks, ceasing other tasks as required • CNM and/or Ops manager assists to facilitate safe staffing
Clinical Manager	• Use of overtime / casual pool staff to cover roster • Coordinates with other CNM/DNM to see availability of staff from other areas • CNM keeps Operations Manager informed of position daily via staffing meeting
Operations Manager	• On going monitoring of service continues • Works closely with the Nurse Director of Operations, General Manager and Human Resource Department to source additional staff • Ensure liaison with the other Community / Primary Health services
General Manager	• Ensures the Chief Executive Officer is informed of situation and action taken • Updates the Executive Management Team meeting of position and action taken. Nominates appropriate deputy as required to attend. • Discussions to be had with the General Manager Finance re the commitment of any additional resources

ESCALATION STATUS – BLACK
STATUS: Major incident plan enacted
Unable to provide acceptable level of safe care, no additional capacity
Patients at risk despite special care packages
Services needs exceed nursing hours available

TRIGGERS: As for RED and Major Incident Declared

RESPONSIBILITY	ACTION
Kahurangi staff	• Action as for Green and Amber and Red • Use of volunteers, family members, management staff to assist with care provision • Inform families of situation
Clinical Nurse Manager	• Ensure operation debriefing related to major incidents are in place • Assist staff to access EAP and additional support • Review availability of nursing staff, reallocate as required taking in to account designation, experience, gender • Monitor situation, ensuring all priority patients are seen • CNM to keep Operations Manager informed of position daily • Last option cancel all study and annual leave • Support Outreach Nurse with managing patients in the community that need placement in Kahurangi
Operations Manager	• On going monitoring of situation • Works closely with the Nurse Director of Operations, General Manager and Human Resource Department to source additional staff. • Ensure liaison with the other Community services • Works with Communication Officer re information bulletin to go out to Health Providers and general media release. • Inform General Manager of position and action taken • Keeps partner agencies informed
General Manager	• Ensure Chief Executive Officer is aware of the situation and actions taken. • Updates the weekly Executive Management Team meeting of position and action taken. Nominates appropriate deputy as required to attend. • Calls exceptional EMT meetings as required • Discussions continue with the General Manager Finance re the commitment of any additional resource

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

APPENDIX 3

WCDHB - Infection Prevention and Control Service

ARC Quick Environmental Audit

Name of Auditor 9(2)(a)
Facility Allen Byrd Lifecare.
Nurse Manager 9(2)(a)
Date of Audit 23/04/20.
Date of Feedback

SECTION 1: GENERAL ENVIRONMENT

Standard: Clinical areas are visibly clean, uncluttered and maintained appropriately to minimise cross infection.

		C	NC	P	NA
HAND HYGIENE FACILITIES					
1.	Hand washing facilities are clean, available and access is clear	✓			
2.	ABHR is available	✓			
DETERGENTS/DISINFECTANTS					
3.	Detergent or detergent wipes are available for general environmental cleaning of surfaces	✓			
4.	Approved disinfectant (bleach product or other hospital grade disinfectant active against viruses) is available	✓			
5.	Correct dilution/refreshing of disinfectant every 24 hours	✓			
6.	Alcohol impregnated wipes are available for sensitive equipment	✓			
7.	Designated housekeeping staff	✓			
DIRTY UTILITY/SLUICE ROOM					
8.	The dirty utility or sluice area is visibly clean and tidy	✓			
9.	There is a designated hand wash basin in this room, with soap and paper towels present	✓			
10.	There is a facility to safely sanitize equipment e.g. bedpans/urinals /bowls	✓			
WASTE MANAGEMENT					
11.	There is correct segregation of waste	✓			
12.	Infectious/medical waste bins with foot-controlled lids are available	✓			
13.	Waste bags awaiting collection are stored in a non-public area	✓			
14.	ABHR/HWB is available for use after handling waste	✓			
SOILED LINEN					
15.	Linen bags are secured and stored in a secure area for collection	✓			
16.	Soiled linen from isolation rooms is handled/laundered separately	✓			
17.	Staff working in laundry do not provide patient care	✓			
18.	Dirty and clean linen is segregated	✓			
19.	Personal clothing is laundered separately for each patient/resident	✓			
20.	Hand hygiene and personal protective equipment is available	✓			

Comments

↑ cleaning frequently touched surfaces.

WCDHB, IPC, april 2020 – supplied by CDHB.

Sanitizer fluid / validated / monthly checked in Feb 2020. Recod.

infectious / clinical waste - ✓

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

SECTION 2: PATIENT ROOMS

Standard: Facilities and appropriate products are available to ensure effective hand hygiene and standard precautions are undertaken.

		C	NC	P	NA
21.	ABHR is available at each resident's room HRVB.	✓			
22.	Disposable gloves in a range of sizes are available outside Rms.	✓			

Comments

SECTION 3: PATIENT CARE EQUIPMENT

Standard: Patient care equipment will be cleaned/decontaminated and stored safely and appropriate resources made available to minimise the risk of cross infection

		C	NC	P	NA
23.	Manual handling sheets, hoist slings and slides are cleaned between patients	✓			
24.	Are commodes used	✓			
25.	Commodes are individually assigned and disinfected between patients	✓			

Comments Allocated to residents – separate hoists for areas.

SECTION 4: COMMUNAL PATIENT AREAS

Standard: Communal patient areas shall be maintained appropriately to minimise the risk of cross infection.

		C	NC	P	NA
TOILETS & BATHROOMS					
26.	Are bathrooms/toilets shared between residents?	✓			
27.	How are residents in isolation showered/toileted ensuite.	✓			
28.	Toilets are visibly clean	✓			
29.	Bathroom areas are free from communal items which may be contaminated e.g. creams, talc	✓			
30.	Showers are clean, intact and free from mould	✓			
31.	Linen is not stored in open shelves in bathroom areas	✓			
32.	Staff have a separate toilet from residents	✓			

Comments shared by two. Rooms + cleaned 1/L bleach between. left pt + cleaned & present.

C	Compliant
NC	Non Compliant
P	Partial

SECTION 5: STANDARD AND TRANSMISSION-BASED PRECAUTIONS

Standard: Care will be planned for individual patients using precautions necessary to prevent the spread of infection, taking into account the needs of the patient and other patients

		C	NC	P	NA
33.	Sufficent PPE stock on hand	✓			
34.	PPE Donning/doffing areas are identified	✓			
35.	Staff have received training in donning/doffing PPE	✓			
36.					
37.	Disposable gloves, aprons and gowns are available/worn	✓			
38.	Surgical masks are available/worn	✓			
39.	Safety glasses/protective eyewear is available/worn not non currently	✓			
40.	The correct transmission-based precautions signage is available and used appropriately	✓			
41.	Eye protection is cleaned and disinfected after use	✓			

Comments

SECTION 6: KITCHEN AND FOOD / BEVERAGE FACILITIES

Standard: Kitchen and food handling areas conform to Food Safety Authority guidelines ✓

		C	NC	P	NA
42.	Kitchen staff are not involved in patient cares or laundry	✓			
43.	There are hand hygiene facilities available	✓			
44.	Are there any filtered water units available in facility	✓			

Comments checking servicing + date - march 2020.

SECTION 7: COVID-19 OUTBREAK MANAGEMENT

		C	NC	P	NA
45.	COVID-19 Outbreak management plan available	✓			
46.	CDHB Planning and Funding liaison person identified	✓			
47.	Staffing contingency plan available	✓			
48.	Community & Public Health contact details known	✓			
49.	Staff know how to launder their uniforms	✓			

Contingency planning within organisation + then reach out to DHB.
staffing at good levels: staff / residents health monitoring.

Ultimate Care Group

Date	20 April 2020
Provider name	Ultimate care Group
Provider details	Ultimate care Group Ultimate Care Group is a residential aged care provider with nationwide cover in all aspects of residential care as well as independent living or assisted living. These services include rest home care, geriatric hospital level of care, dementia care, palliative and respite care.
Advisor name	9(2)(a) [redacted]
Documents provided	Document 1: UCG Policy & Procedure Guide COVID19 Guidance for admission into facilities – The purpose of this policy is to provide guidance for facility managers and clinical nurse managers during the COVID-19 outbreak and applies to all UCG facilities.  1.B.5 COVID 19 Guidance for admissic Document 2: Guidance for managing residents with dementia on alert level 4  1.B.6 Managing Residents with Demer

		Document 3: Guidance for managing staff/residents with COVID19 infection  1.B7 Management of Staff and Residents wi Document 4: Outbreak plan influenza-like-illness UCG  Outbreak-plan-influe nza-like-illness UCG.p	
Colour key		Finding statements in blue: can only be answered with by onsite or virtual visit/review. Finding statements in red: Not applicable, no answer provided.	
Critical Factor	Component	Evidence	Outcome
Structure for planning and decision making	COVID-19 has been incorporated into emergency management planning for the facility	Yes	Fully demonstrated in information supplied
	A person has been assigned to coordinating planning for COVID-19	Yes 'person responsible'	
	The facility has a written plan for COVID-19 preparedness that encompasses the elements outlined below	Yes	
	A person has been assigned responsibility for communications with staff, residents and their families	Yes – 'person responsible'	
Primary care and nursing cover	Facility has dedicated GP/NP cover	**Still to be determined**	**Still to be determined**

	• If yes, what hours does it cover?		Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Facility's primary GP/NP(s) will provide cover for all residents if required	**Still to be determined**	
	GP/NP has confirmed that they will be able to provide face-to-face assessments (even in the context of Alert Levels 3 and 4)	**Still to be determined**	
	Facility has access to CareConnect eReferrals	**Still to be determined**	
	GP/NP has confirmed they are available to assess +/- test a suspect case within 6 hours	**Still to be determined**	
	Facility registered nurse able/willing to complete COVID-19 testing if required by GP/NP	**Still to be determined**	
Minimise risk of infection being introduced into facility – residents and visitors	Process in place to isolate/quarantine residents on admission, aligned with Ministry of Health advice	Yes	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Visitors restricted in accordance with current Alert Level 4 guidance (no visitors except on compassionate grounds)	Yes	
	Process is in place if visitors are permitted to visit a resident, for example for end-of-life care (IPC requirements stipulated)	Yes Restrict external visitors except for family and friends who are considered essential to the welfare of the resident e.g., end-of-life – manager to approve.	

	Behavioural plans & close monitoring of residents non-complaint with remaining on site	**Still to be determined**	
Minimise risk of infection being introduced into facility – staff	**Staff able to access changing room to allow them to change into uniform at work**	**Still to be determined**	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Staff have access to lockers or other system for storing personal items and street clothing	**Still to be determined**	
	Policy that staff members change into uniforms at work, and back into personal clothes at end of shift.	**Still to be determined**	
	Staff have access to shower, after completing shift before changing into street clothing	**Still to be determined**	
	Policy against cell phone use while on the floor	**Still to be determined**	
	Does the facility have staff that work in settings other than the facility?	**Still to be determined** Non-essential staff are not permitted to enter suspected or confirmed COVID-19 infected resident rooms. Document 4	
	If yes, how are the risks mitigated?	**Still to be determined**	
	If yes, state number and roles	**Still to be determined**	
Staff screening	Documented process in place to routinely screen staff for	**Still to be determined**	**Still to be determined**

	symptoms at the start of each shift		Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	• Process includes screening questions (self-report symptoms)	**Still to be determined**	
	• Process includes recording temperature	**Still to be determined**	
	• Process includes documenting findings and this is evidenced	**Still to be determined**	
	• **Sufficient thermometers available for staff temperatures**	**Still to be determined**	
Management of symptomatic staff	Documented policy/process requiring staff who become symptomatic during their shift to report to CNM/RN and go home immediately.	Staff must advise CSM or manager immediately if they experience symptoms. Add infected staff onto the case log. Infected staff are not permitted to return to the work until 48 hours after last symptom. Staff update the CSM or manager. Staff are made aware specimens can be requested from them. These will need the outbreak number attached. This cost is covered by the facility.	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	• Provided with appropriate advice to contact Healthline or GP and arrange testing if indicated.	Yes	

	• Policy in place with respect to return to work consistent with Ministry of Health guidance.	Staff are required to be symptom free for 48 hours before returning to work. This is followed up by the dedicated Support Office staff member who is also a registered nurse and is documented in our monitoring system.	
	• Documented evidence of implementation	**Could not verify that the processes for staff symptoms management is documented in policy. Please follow up.**	
	Documented system and process for staff to ring and report symptomatic / ill	**System not verified. Still to be determined**	
	• Includes instructions regarding return to work	See notification which went out to staff and the dates on which this was sent. **Could not verify that the processes for staff symptoms management is documented in policy. Please follow up.**	
	• Documented evidence of implementation	**Documented evidence of implementation could not be verified. Please follow up**	
Identification and management of ill residents	**Documented System / process in place to screen residents twice daily (document frequency)**	**Still to be determined**	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Process includes screening for symptoms	**Still to be determined**	
	Process includes recording temperature	**Still to be determined**	
	Process includes documenting findings and this is evidenced	**Still to be determined**	
	Sufficient thermometers available to monitor resident temperatures	**Still to be determined**	
	Documented process for isolating residents with symptoms and obtaining assessment and testing	**Still to be determined**	

	consistent with Alert Guidance document		
Environmental capability to isolate suspected / confirmed COVID 19 resident(s)	**Number of bedroom suitable for Isolation - single bedrooms with single access ensuites**	**To be identified in each facility**	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Do the above rooms have hand-washing facilities, liquid soap dispensers and paper hand towel dispensers?	**Still to be determined**	
	Are there sufficient pedal operated rubbish bins and soiled linen containers for each of these rooms?	**Still to be determined**	
	Can the above rooms be closed off to achieve a secure cohort?	**Still to be determined**	
	Plan in place to manage isolation where residents have significant cognitive impairment (if applicable)	Yes	
Infection prevention and control and personal protective equipment (PPE)	**Alcohol-based hand santiser or hand-washing facilities are available in every resident's room and in other resident care and common areas**	**Still to be determined**	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Posters/signs posted in key areas in the facility reminding staff/residents about hand washing and cough/sneeze hygiene	Place relevant signage on all facility entrance doors advising the facility has restricted access due to an outbreak. Posters advise all visitors must report to reception first. • Display any additional, illness-specific signage e.g., for COVID-19. • Implement a reception sign-in process for all visitors.	

	Evidence of training for staff in the safe use and disposal of PPE, including what PPE is required and how to don & doff correctly	oversee and guide staff on duty regarding PPE use.	
	Posters/signs are available indicating appropriate IPC precautions and required PPE and these are used where appropriate	Yes Ensure all staff are correctly applying and removing PPE each shift. ensure staff use PPE and follow hand hygiene practices correctly education including demonstration at each change of shift.	
	Necessary PPE is available immediately outside the resident's room and in other areas where resident care is provided	Infection control coordinator completes PPE stock audits every day Set up personal protective equipment (PPE) for each resident, print all signage, notify staff of affected. residents in isolation and strict hand hygiene practices and PPE application apply. • Consider feasibility of isolating symptomatic residents to one wing of the facility.	
	Receptacles for disposal of PPE and other clinical waste are positioned appropriately	Do not exit the room with PPE on. Discard cleaning cloths and PPE into the resident's plastic rubbish bag inside the room o wash hands before leaving the room.	
	Process in place for monitoring stocks of PPE, including rate of consumption	RNs ensure PPE is restocked before CSM checks outbreak PPE stock daily when in use and at the end of every shift,	

	Stock control process in place, including security measures for stock	Yes	
	Adequate supplies (sighted, record numbers) • **Hand gel** • **Soap dispensers** • **Surgical Masks** • **Eye protection** • **Gloves** • **Fluid resistant Gowns / Aprons**	Process in place	
Preventing transmission of infection between residents	Residents have been educated about measure to take to protect themselves against COVID-19 (where possible)	**Still to be determined**	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Process in place to support physical distancing of residents (including physical distancing at meal times/staggered meal times)	Request non-symptomatic residents stay in their rooms during the outbreak, to ensure social distancing occurs. Support all residents to remain in their rooms. • Enforce physical distancing including Maintain physical distancing at handovers.	
	Process in place for cleaning and reuse of equipment (including stipulating where equipment should not be shared)	Yes Adjust cleaning and other services provided to village residents to minimise risk of transmission from the facility or alternatively consider risk of transmission from village residents to the facility.	

		Extra cleaning Complete extra cleaning 3 x daily for the following: • touch points, surfaces, communal bench tops, staff areas, doors in communal spaces • phones, walkie talkies and computer keyboards • communal and staff toilets including door handles, taps and doors where hands touch them to open tops of communal rubbish bins, including staff room. Terminal cleaning • Complete once the resident is 48 hours symptom-free. • Launder curtains or steam clean in place. Cleaning staff communicates PPE and cleaning chemical requirements: • Order stock as required.	
Staffing – limiting contact between teams of staff	Care staff are cohorted (without crossover) within specific sections/wings of the facility and cohorting for breaks is considered	Yes	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Cleaning staff are cohorted within specific sections/wings of the facility, and cohorting for breaks is considered	Yes	
	Cohorting also considered for other staff including	Yes	

	management of kitchen staff exposure		
	Physical distancing for staff – including in break rooms, and at handovers	Yes	
Staffing resources for where there are no suspected or confirmed cases of COVID-19	**Roster evidences all shifts covered**	**Still to be determined**	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Coverage considered adequate (meets Ministry of Health guidelines)	**Still to be determined**	
	Facility has capacity to cover staff absences	**Still to be determined**	
	Facility has identified a pool of casual staff available to be used	**Still to be determined**	
	RN coverage for Hospital each shift OR in standalone Rest Homes / Secure Dementia Unit appropriate level of RN onsite	**Still to be determined**	
Staffing resources for where there are suspected or confirmed cases of COVID-19	**Sufficient HCA resources to provide separate staff to care for resident/s in isolation**	**Still to be determined**	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Sufficient RN resources to provide separate staff to care for resident/s in isolation	**Still to be determined**	
	How long could this additional resource be maintained?	**Still to be determined**	

Environmental capability to isolate suspected / confirmed COVID 19 resident(s)	**Number of bedroom suitable for Isolation - single bedrooms with single access ensuites**	**Still to be determined**	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Do the above rooms have handwashing facilities, liquid soap dispensers and paper hand towel dispensers?	**Still to be determined**	
	Are there sufficient pedal operated rubbish bins and soiled linen containers for each of these rooms?	**Still to be determined**	
	Are there sufficient supplies of (working) patient care equipment, including thermometers?	**Still to be determined**	
	Can the above rooms be closed off to achieve a secure cohort	**Still to be determined**	
Care planning preparedness	**Are there specific care plan templates for the management of residents with suspected COVID-19?**	**Still to be determined**	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Resident care plans are up-to-date	**Still to be determined**	
	Residents' advanced care plans are up-to-date and documented	**Still to be determined**	
	All residents have received influenza vaccination this season, or this is scheduled (document date)	**Still to be determined**	

Residential services COVID-19 preparedness- **HealthCERT assessment of provider's national policies** –

Equipment	**Number of sets of clinical equipment for monitoring residents** • **tympanic thermometers** • **blood pressure cuffs** • **pulse oximeters**		**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Are there sufficient consumables for this equipment e.g thermometer covers?	**Still to be determined**	
	Facility has sufficient bins, trolleys for managing clinical waste, laundry and cleaning	**Still to be determined**	
Food Service Equipment, supplies and processes in place to manage food service safely	Are there COVID-19 specific written instructions for food service in place?	Yes Their custom food control plan, that is registered with MPI, covers hygiene, cleaning and infection control. COVID19 related infection policies and procedures apply to the kitchen.	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Food service staff knowledgeable about above instructions	**Still to be determined**	
	If food service staff are involved in serving meals / refreshments directly to residents has this practice been considered / stopped.	Yes	
Cleaning Service Equipment, supplies and processes in place to manage	Protocol in place for routine cleaning, including frequent cleaning of high touch surfaces.	Yes	**Still to be determined**

cleaning service safely	**Are cleaning staff aware of additional requirements for cleaning rooms / facilities following a suspected , probable or confirmed case of COVID-19 (aligned with Ministry of Health guidance)** • **Principles of cleaning top to bottom, clean to dirty.** • **Cleaning order** • **PPE requirements**	**Still to be determined**	Fully demonstrated in information supplied Partially demonstrated in information supplied Not demonstrated in information supplied
	Facility has appropriate cleaning supplies/equipment	**Still to be determined**	
	What chemical cleaning agents are used?	**Still to be determined**	
	Process in place for allocation of cleaning staff if suspected COVID-19 case (e.g. different teams of cleaning staff for area with COVID-19 case vs. not).	Yes	
Laundry Equipment, supplies and processes in place to manage laundry service safely	**Washing machine capabilities** • **Automatic chemical supply with hot water cycles OR** • **Large Domestic washing machine with manual**	Washing machines are capable of automatic supply	**Still to be determined** Fully demonstrated in information supplied Partially demonstrated in information supplied

	detergents, hot or cold washes		Not demonstrated in information supplied
	Process for safe laundry service operation established	Yes	
	Any specific written guidelines for laundering activities, including PPE requirements	Yes	
	Management process for personal dirty items usually taken home by families to launder.	**Still to be determined**	

5. COVI-19 GUIDANCE FOR ADMISSIONS INTO FACILITIES

Purpose

The purpose of this policy is to provide guidance for facility managers and clinical nurse managers during the COVID-19 outbreak and applies to all UCG facilities.

Policy

Admission from the community

The Ultimate Care Group can accept admissions from the community if the person has not had contact with anyone who has been overseas in the last 14 days or been overseas themselves, has not been in contact with anyone with confirmed, suspect or probable COVID-19 and does not have any acute respiratory symptoms (cough, fever, sore throat).

1. All people, prior to admission, must be screened by a General Practitioner/Nurse Practitioner or Community Based Assessment service for COVID-19 to determine if these conditions are met. The screening can be done virtually.

a. Where the person has been overseas, has been in contact with someone who has been overseas, or has had close contact with a confirmed, suspect, or probable case, admission should be **delayed until 14 days since the contact.**

2. New Admission: Suspected COVID-19

a. If COVID-19 is suspected (symptomatic) the Needs Assessment Service, Coordination (NASC) will liaise with community services (e.g., community Nursing and/or Home Support Agencies) to continue to support the resident at home while waiting for test results. They **will not** be transferred to any Ultimate Care Group facility while waiting for the test results.

b. Any potential resident with a negative test result will be admitted to the facility. As a new admission from the community, the resident should spend 14 days in isolation in case they subsequently develop, COVID- 19.

c. The resident should be in a single room with its own dedicated bathroom[1] having meals in their rooms and not visiting common areas. The resident should be monitored daily for 14 days for new or worsening symptoms, for example respiratory symptoms, and assessment sought if this is identified.

[1] Dedicated bathroom can be ensuite rooms or where not available a bathroom allocated for specific use of resident in isolation and cleaned after use.

3. New Admission: COVID-19 not suspected

a. If COVID-19 is not suspected, any Ultimate Care Facility should accept an admission if they have vacancies and are able to offer a single room for at least 14 days. Fourteen days of isolation after admission is required.

b. New or returning admission from the community who are asymptomatic and not suspected of COVID-19 should have symptom checks daily for 14 days, reside in a single room with its own dedicated bathroom, have meals in their rooms and visit common areas.

c. If asymptomatic no PPE is required by staff or visitor (other than that required for standard precautions). If symptoms develop, they should be isolated with contact and droplet precautions and assessment sought.

4. New Admission: Respite

a. All Planned respite is cancelled.

b. Emergency Respite is available only after discussion with GM Clinical and CEO and the DHB's Planning and Funding team and is to be considered case by case with the facility and regional manager.

c. Any new emergency respite must be managed under the same isolation requirements as those residents entering long term care. This should be considered when emergency respite is considered.

d. An exit plan for the return to the community must be discussed with the facility, NASC and the family.

5. New Admission: into a secure dementia unit.

All admissions should be tested COVID-19 if they are symptomatic and meet clinical criteria for suspect COVID-19.

a. If COVID-19 **is not** suspected, Ultimate Care will accept an admission into a secure unit. The unit is then considered to be the person's 'household bubble'. Staff should practice safe distance and hand washing protocols. If close care is required, droplet and contact PPE is appropriate. Facilities should plan this close care and try to do this all at one time, as far as possible, to manage use of PPE.

b. If COVID-19 is suspected the NASC will liaise with the community nursing and or home support agencies to continue to support he person at home while they are waiting for test results and/or 14 days since last exposure with the suspected, probable or confirmed case (whichever is the longer). The resident WILL NOT be transferred into any Ultimate Care Facility.

c. Once a negative test result has been attained, the resident should still wait for the 14 days and **be symptom free before admission into the facility.**

6. **Admissions (transfer) from Hospital**

1. All Ultimate Care facilities will support the return of their residents from hospital once they are medically stable and have been reviewed by a clinician to determine whether the resident meets the clinical criteria for COVID-19, or there is clinical suspicion of COVID-19. If COVID-19 is suspected, testing will be undertaken prior to any re-admission back into the facility.

Ultimate Care Group will not accept any returning resident whilst waiting for the test results.

a. New or returning residents from DHB hospital who are asymptomatic and not suspected of COVID-19 should have symptoms checks daily for 14 days or the balance of the 14 days if there were in isolation in the hospital, reside in a single room with its own dedicated bathroom, have meals in their room and not visit common areas. If asymptomatic no PPE is required by staff or visitors (other than that required for standard precautions). If symptoms develop, they should be isolated with contact and droplet precautions and assessment sought.

7. Transferring of residents to DHB.

NON COVID-19 related transfer.

a. All Clinical Nurse Managers should continue to seek medical advice through their contracted General Practitioner/Nurse Practitioner.

b. The GP or CSM/Nurse Manager (when GP is unavailable) will access specialist advice by telephone (Geriatrician/General Medicine) prior to any transfer to hospital.

c. This advice will seek to support residents in their facility for as long as possible and will approve any transfer to hospital in advance. The Advanced Care Plan of the resident will be considered.

d. If a major medical event or injury has occurred and the, General Practitioner/Nurse Practitioner has been consulted, an ambulance will be called as normal.

8. Transferring of residents to family during the period of lock down.

a. Any request to transfer a resident from the facility bubble to the family household bubble during the COVID-19 Alert level 4 should be determined on an exceptional basis. The family and resident will need to understand that the transfer **is one-way,** and there will be no opportunity to return to the facility until level 4 has ended and there is agreement from the facility manager.

9. Family members visiting the facility

a. Where residents are receiving palliative care, visits will be considered on a case-by-case basis. The facility should be contacted in advance, and contact between family and staff, and family and other residents, should be minimal.

b. Visitor numbers should be limited to one visitor at a time and a maximum number of visits per day can be established on a case by case basis. PPE must be worn as per the guidance on use of PPE on the Ministry's website.

Related Links and References

Guidance for admissions into aged residential care facilities at Alert Leve 4 as of 11 April 2020 Ministry of Health.

Quality Assurance and Safety
Health System Improvement and Innovation
Ministry of Health 11 April 2020

UCG Facility – COVID-19 Preparedness

Facility Name:	UCG Allen Bryant	Phone Number:	9(2)(a)
FMs Name:	9(2)(a)	GP Name:	9(2)(a)
CSMs Name:	As above	Practice Name:	9(2)(a)
Total Residents:	44 ARC	Total Staff:	55
Levels of Care:	Rest Home – 21 Hospital – 23	Roles	Care Givers RNs Household Management Temp Staff –

The following has been prepared for the COVID-19 Pandemic. Given the way this has evolved in NZ over the past couple of months, the Initial Preparedness document was released early March. There have been several updates since with the latest release 8th April.

Daily emails are sent from Head Office to Facility and Clinical Managers ensuring they are across daily developments and appropriate changes required.

Attached are some of the documentation to provide reassurances of what we have in preparation for COVID-19 across all Ultimate Care Group's facilities.

Policy, Plans & Registers		Last Update
Policy: 1. Guidance for Admissions 2. Managing Residents with Dementia during COVID-19 3. Management of Staff & Residents with COVID-19 4. Interim Infection Control Policy in Suspected or Confirmed cases of COVID-19 5. Outbreak Plan Influenzas like Illness UCG	UCG	14th April
Isolation Plan for COVID-19	Site Specific	23rd March
Outbreak Plan for COVID-19		8th April
Short Term Care Plan for Resident with COVID-19		
COVID-19 Register	Site Specific	Daily
Flu Vaccine Register – Staff & Residents		Daily
PPE Register for COVID-19	Site Specific	Daily

ULTIMATE CARE GROUP

FMs Quick Reference Guide to Managing COVID-19		Daily
HR Guide for FMs – Managing Staff during Lockdown		14th April
Education Register for COVID-19 related trainings		Daily
Creating smaller Bubbles within Bubbles	Site Specific	Current
Skeleton Staff Rosters	Site Specific	
Business Continuity Plans	Site Specific	
Check Lists & Cheat Sheets		
Preparedness Checklist	Version 3	
Checklist: Isolating Resident while Testing	Version 2	
Checklist: Positive Test OUTBREAK	Version 1	
Cleaning Room Post COVID-19 Resident	Version 1	
Staff Contact Tracing – Staff Personal Details	Version 1	
Isolated Resident Contact Tracing Register		
Protective Access Register		
Staff Uniform Management		
Respiratory Supplies & Equipment Stock take		
Tangihanga Guidelines	Version 1	
Village Residents		
Meal provisions in ILUs away from Facility		
Supermarket Shopping – provision for home delivery		
Communication with Families		
Weekly Email from UCG to Family & Friends	Early each week (Mon/Tues)	
Weekly Email from each facility to family	Late each week (Thurs/Fri)	
Facebook Private Group Updates	Daily / As Appropriate	
Skype Appointments	Facilitated Face-to-Face	
Supporting Documentation		
Guidelines Govt COVID – Need to Know		
Guidelines Govt COVID – Self-Isloation		
Guidelines Govt COVID – Welfare Info		
Guidelines MoH – Admissions @ Lvl 4		

Guidelines MoH – COVID Cleaning	
Guidelines MoH – COVID in ARC	
Guidelines MoH – Dementia @ Lvl 4	
Guidelines MoH – InterARC Transfer	
Guidelines MoH – PPE	
Guidelines MoH – Tangihanga	
Poster – COVID-19 – PPE Aged Care	
Poster – COVID-19 – PPE Essential Non-Health Worker	
Poster – COVID-19 – PPE Hospital Care	
Poster – COVID-19 – PPE On Off Poster	
Poster – COVID-19 – PPE Swab-Testing	

Attachments:


Cheat Sheet - COVID - Preparedne


COVID - FMs Quick Reference Guide - 2(


Outbreak-plan-infl uenza-like-illness U(


Cheat Sheet - COVID - OUTBREAK.


Checklist - Cleaning Room Post COVID R


Interim Infection Control Policy in Sus


Contact Tracing - Staff Personal Detail


COVID-19 Isolation Plan - SAMPLE SITE.p


1.B7 Management of Staff and Residen


Register - Tracing Staff Work Resident


1.B.5 COVID 19 Guidance for admiss


1.B.6 Managing Residents with Dem

COVID-19 :: Being Prepared

Version 3 as at 1st April 2020

ULTIMATE CARE GROUP

We have developed the following to assist in addressing issues that our staff, residents and families may encounter from the threat of Coronavirus within our sites nationwide.

Resident CHECKLIST

- ☐ Residents understand expectations of staying on site – as cognitive ability allows
- ☐ Residents educated in extra hygiene care
- ☐ Residents aware of PPE – who what when why
- ☐ Flu Vaccine program undertaken
- ☐ Respiratory outbreak plan
- ☐ Visitor management in place and clear
- ☐ Village Independent Residents – Shopping needs communicated and assistance given

Staff CHECKLIST

- ☐ Flu Vaccine program undertaken
- ☐ 12 Hour Shift considerations
- ☐ Educated Staff on Isolation Plan – including their roles and responsibilities
- ☐ Staff contingency plan in case of staff falling ill
- ☐ Plan for cohorting staff in an outbreak
- ☐ Staff education on PPE correctness – HOW, what when who and why
- ☐ Staff understand escalation protocol for suspected Outbreak
- ☐ Short Term Care Plan template understood and distributed

Business CHECKLIST

- ☐ GPs and associated Health Care Providers know your Outbreak Plan
- ☐ Communication with family about Infection Control prevention transmission
- ☐ PPE Stock take – adequate on-site
- ☐ Cleaning supplies stock take
- ☐ Escalation protocol for suspected Outbreak clearly understood
- ☐ Contact List for DHB contact person and other relevant stake holders (Site GP etc) up to date
- ☐ Communications plan during outbreak
- ☐ Increased daily cleaning procedures

COVID-19 :: Quick Reference Guide

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Business

Communication

Doctors

Doctors have been issuing their own statements about access and onsite consultations. Please continue to work with them and let your RM know if we can help or if you have any concerns – or feeling unsupported.

Families Phones / Emails:

We are happy to help where we can – so let us know. We are continuing to take the over-flow at head office and will take messages if we cannot help immediately.

Family FAQ Sheet

You should have all received the first FAQ Sheet for the families & friends of our residents. I am hopeful we will be able to send out in support of any major announcement email that either myself or Ben send from here. These are intended to be sent by each Facility however since we are here to support you, we are very happy to do the mechanics, meaning we'll send on your behalf. If this is the case, please just let Andreea know and she will arrange with the correct personalised information included and then send to FIRST CONTACT on the Resident Register.

Info Email Feedback

We've been having a lot of great support coming through the generic Info@UltimateCare email address. Obviously the complainers as well but it's lovely to see so many genuine comments of support and appreciation for all the great work that is happening in our facilities by your teams.

Keeping Family in Touch

We have had some requests for a device for Residents to Facetime, Skype, WhatsApp, Messenger and so on. Before we work through the logistics of this, we need to know if it's really worth it. We have a solution where we could use a single device however, Points to Consider:

Ongoing Enjoyment

While all our sites are without infection, and we are community-outbreak free, let's keep our resident's enjoying their Happy Hours, activities and gatherings in smaller groups. Protective Access will help minimize the restrictions.

Physio – TBI Health

"The physiotherapists are able to provide their services for your facility skype or similar platform if this is easier for you &/or your residents.

They will make contact with you to discuss your needs at this time. You may consider setting up a weekly telehealth slot for physiotherapist advice, problem solving, providing/progressing residents' home exercise programmes etc.

Finance

Comfort Funds

It came up in our catch-ups today that some of our residents require a little help sourcing some items which they use to be able to collect from the supermarkets. Given they're in lockdown and cannot do so, some sites have been helping out and using the Comfort Fund. Please follow careful protocols as Sharon has sent out earlier – and think ahead. Cashing a cheque is not that easy given banks are on restricted opening hours. Please check your local bank to find out what the hours are. Also, you will need to get the family to input money in first. Just something that may have not crossed your mind yet.

Marketing

Eldernet

Eldernet have been asking about Visitor Status for their website – we have advised them on your behalf that it is No Visitors.

Facebook Family & Friends Community

"Some of our sites are really getting Facebook to work for them and keep in touch with their families. Have a look at the attachment with the love that's being shared. Some great ideas in there for you all. If you're keen for more help with how to use your Facebook page, please contact Andreea and she'll help you.

9(2)(a) has put together some of the interactions around in a PowerPoint which you might like to share with your teams. Click Here for the PowerPoint and hopefully you can share some of the love 😊"

Great Ideas Shared

Please remember to share your brilliant ideas. Sitting inside OneDrive is a place to dump your suggestions. Big and Small.

Miscellaneous

Sharing Great Ideas

Thought it would be a great time to share ideas between you all. Inside FM's Folder on OneDrive is a document where simply you add. Please keep it short 'n sweet but share the full variety of what you are doing to help the "boredom breakers". Big and Small – it's all helpful.

COVID-19 :: Quick Reference Guide

Testing – Test Test Test

The MOH has advised that the case definition to determine testing is being widened to acknowledge that more than 80% of cases in New Zealand have a presenting cough as the main early symptom and so if our residents have these symptoms they will be tested. In addition, staff in aged residential care facilities are recognised as essential health workers, so they will be prioritised for testing. This means any aged care worker with a cough will be prioritised for a COVID-19 test.

Operations

Business as Usual – bit different

We are still infection-free to the best of our knowledge. This means I ask that you please continue communicate well with your Regional Manager regarding any requirements you feel you cannot manage. We need to take each day as it comes however this is not a time for shortcuts.

Food Audits

"Telarc wish to pass on to you their admiration for the work everyone is doing to keep our residents safe. For CHU, MAU, PON, CAM, OAK. ALB & KEN only … MPI are doing "Off-Site Verification Audits" which means:

1. You'll send evidence of records of food storage and temperature
2. Site visit when Level 4 is lifted

Meanwhile, everyone keep doing BAU in the kitchens please."

Isolation Plans:

Once your plan is done, you no longer have to have it clogging up your 'worry brain'. So far, all Midlands & Northern's are done (thank you), so perhaps go in and have a quick read. P:\Operational\All\COVID-19\Isolation Plans - All Sites. Some great ideas have come up and this is about sharing the knowledge!

Management Team Changing Hours

Some of our Management Teams are changing their hours. Given those who are not working now lose track of which day of the week it is – every day is a Saturday – there is more flexibility in their demands at home. As a consequence, some FMs and CSMs have decided they would rather keep a Manager on site 7 Days per week so they've altered accordingly. Have a chat with your Regional Manager if this is something you would like to discuss further. It might help a little bit with some of the anxiety levels with our staff.

Outbreak Conversations

Some of our teams have had the discussion about what they would do if they find out today there site is in Outbreak. This has meant some staff have a bag already packed to stay at work for as long

as required / or isolation to avoid passing this on at home or outside the now smaller bubble to our healthy residents. A reminder to those who haven't got a plan like this in place, how about you have that chat?

PPE – Stolen Product

"Sadly there are several facilities throughout the country where PPE is 'walking'. Obviously stress levels are higher than usual and the use of PPE never been more desirable. I doubt the average NZer even knew what PPE stood for but now it's a household term. Please:

1) Do a stock take

2) Leave appropriate daily numbers of stock available for staff to use if they want / need it

3) Lock away volume of stock

4) Speak to your staff about it not taking it home

5) Educate your staff on what, when & where

Unfortunately, it appears we have some people who are undermining a lot of really good preparatory work that has been done and helping themselves to the PPE stocks. Can you please let your Regional Manager know and they will update the PPE Register on your behalf. We do not want to burden you with another thing to do so your RMs are going to do this one for you."

PPE & PPE Register

"Attached is a Poster prepared by the Ministry of Health for COVID-19 on Personal Protection Equipment. This is specifically for those in AGED RESIDENTIAL CARE. There is a range of feelings surrounding PPE and the more we see the media images from around the world, the more our people believe they need to have full body suits and breathing apparatus. We are taking our guidance from our MoH and ask that you speak to your teams about keeping it real. We will have the PPE Register in OneDrive up 'n running in the next day or so.

We are creating a PPE Register to ensure we can support where the demands come. We have ensured there is plenty being held centrally as back-up. You will receive a link once we have this live. Those who have already done a stock-take will have that information entered. The rest will have to do a stock-take and enter please.

This will be mainly managed by your Regional Managers because we do not want to add to your job list. This is to ensure the right people have what they need and they feel confident they are protected. PPE is important in managing anxiety levels so correct education is vital. Please ensure you refer to the material provided by the MoH which is in the COVID-19 Folder named as Poster. We have a centralised supply and we are aware the DHBs are working to ensure continued supply however they require us to have base levels to 14+ Days."

COVID-19 :: Quick Reference Guide

Preparatory Work

There is a lot of preparatory work going on from requests you have been sending through. Some of what we will come out with in the coming days are around End of Life Plan if with COVID-19, Revised Policy, Revised Tick Sheets, Sky TV Movies and more. We are also seeking advise on Dignified Death and the sensitivities for our Maori people and the requirements from the Funeral Directors. (I know, morbid but better we know!).

Reflection Report

Your Reflection Report has been sent to your Regional Managers for distribution. Remember you can add the Commentary for your staff by using the "Fill & Sign" functionality. It's been a lot of development behind the scene and hopefully they're a useful tool going forward.

Reporting Requirements to Head Office

"Your Regional Manager is in the best position to give you permission on what current expectations can be juggled around depending on the individual site's requirements. I appreciate sometimes it can be challenging however the reporting is our visibility into a site and we need to see what's going on. That said, I also respect we need to find a balance. Your RM knows this better than a blanket yes / no.

As reminded, we are infection-free and let's keep as much of our BAU going at this time – a sense of normality is great. Please have your Monthly Report completed by Close of Business Thursday. If you are unable to meet this, please speak with your Regional Manager."

Tangihanga Guidelines

"Following both the MOH Tangihanga Level 4 Guidelines and our tikanga on tangihanga to ensure the utmost safety and accountability for our workforce and whanau an easy to follow protocol:

1) Consult with whānau pani (bereaved family of the deceased) first on tikanga and level of support and advise according to safety first i.e. physically, mentally and spiritually. Whānau need to be the rangatira of this process as per normal.

2) Contact the Tumu Whakarae Māori immediately.

3) Viewing protocols of the tūpāpaku (deceased) is to be strictly led by the funeral director only who also is required to be present at all times. Staff visitation protocol need to be upon the advisement of your Regional Manager and in consultation with the funeral director.

4) Absolutely NO touching of the tūpāpaku at any time due to possible contamination.

5) Absolutely NO mixing of isolation bubbles.

6) Tūpāpaku cremation can be buried at a later date upon advisement of the whānau pani.

7) Absolutely NO live streaming or providing photos of the service and/or burial in keeping with the wairua of our tangihanga tikanga protocol.

8) Our Māori staff can lead karakia at the beginning i.e. at the home or outside in either English, te reo Māori or both.

9) Absolutely NO kai hākari gathering to prevent the mixing of isolation bubbles.

10) The whānau pani can call our service staff and management, Trauma informed care support or Counselling Centre or any reputable support service to offer additional comfort support during this time.

11) Whānau pani can hold a tangihanga or memorial service after the Alert Level 4 restrictions is eased through MOH. "

Contractors on Site

It is critical that no one arranges to get contractors on site without going through Help Desk. Please log as usual or phone if urgent.

DHB Contacting You

Please speak with your Regional Manager if you are contacted for pressure on anything. We are getting some interesting requests across the variety of DHBs so please don't assume anything.

Ecolab

We have instructed Ecolab not to visit our sites for the monthly service checks. Should there be an equipment failure, they will need access but this will be looked at on a case by case basis should the need arrive. As usual any equipment failure, 24/7 please contact the property help desk 0800 102 865. The Ecolab Territory Managers have been instructed to check in with sites by phone to see how stock is holding up. Keep an eye on the stock levels and please contact the Territory Manager should they be getting low.

Residents

Clinical

ED Admissions

We are seeking advice from the DHB on what they want us to do with ED admissions and will come back to you when we know. It is fair to say that it is expected for us to manage most of these onsite unless it is life-threatening or there has been an accident. In the meantime, please continue to contact 9(2)(a) for advice.

InterRai

"Please continue to complete all InterRai as required. The only part of InterRai that has changed is the Funding Referral which is what the Regional Manager and 9(2)(a) work on together to ensure our financial support matches up with the care we provide. Your RM will manage this process with you.

Please keep your teams updating InterRai. We will sort out the funding behind that in time, but we need accurate data to start with so let's keep that as Business as Usual. Obviously if one of our sites receives a COVID-19 positive test, we'll reconsider but that's under the instruction of your Regional Manager."

Palliative

"For those who are facing the end of their life, having family close can be comforting. During these times we can make exceptions however there are still long periods of time when they will be without them. One of our regions has come up with a great idea to have a device donated by the family that stays connected through a platform of choice, like WhatsApp. Please the device by their pillow and let the family just 'pop in & out' of their day chatting away as they like. Could be lovely and comforting for both parties. Suggestion – no camera operating as the ceiling is infinitely boring after a few minutes as any dentist has proven!

If any exceptions are given for family to visit their loved one in Palliative, please ensure they wear PPE. Public Health have confirmed the PPE required is gloves and surgical masks. They must also meet our current 4 Golden Rules of Entry, along with being a very close relative, (i.e. spouse, son / daughter) in limited numbers. "

Operations

Admissions

We are still not accepting Admissions without our CEO's sign-off for extraordinary instances. MoH advises the 14 day isolation policy remains in place for new resident admissions which is really hard to do!

Admissions of Residents

We are not accepting any new residents. If the DHB are asking you regarding bed availability, please respond with, "We are currently closed to new admissions. We are happy to have a Bed Availability Report to you mid-next week."

Checklist for COVID-19 Preparations

ATTACHED is an update for you to consolidate what we have done in preparations onsite in case we get an Outbreak. Please read the attached and check that you have done what we need to do so far. If you have any gaps, please speak to your Regional Manager. We are not expecting everyone

to have done everything but the checklist completed is a prompting helper – and lets us know where we can assist.

COVID-19 Register

"Thank you to those who are using the Register. The numbers of Affected are obviously increasing (which is what we expect to see!). This lets us also help manage expectations on Staff Shortages etc so please keep this as a daily task for updating. Your RM will help you remember.

We have updated the Register with Testing column, one for Staff, one for Residents. Please select Waiting, Negative or Positive.

Please update when situations change! We've made modifications. The register was designed around the requirements at the time however the government provisions have shifted so we've updated to better reflect what we need. It's a Free text field which I know you all love but No essays please. We are counting Self Isolating and COVID-19 illness (fingers crossed it stays ZERO!) to see the impact on staffing. "

Residents Leaving

"""Please continue to be vigilant during this Lockdown for ALL residents to stay in the facility. Unfortunately we have had a couple of residents who even when confronted by the Manager have defiantly left the facility and it is breaching a very fragile bubble. Some ideas here:

1) Signage – obvious signage on all exit doors the reason they are not allowed out

2) Restrict & barriers – minimize the number of doors that are being used (without fire issues).

a. Place road-cones and barrier arms over doorways.

b. Place a plastic cup over the green button to provide a 'stop / think' measure.

c. Scooters – remove batteries / no recharge

3) At Risk Plans – if there is a resident who usually goes out, you should have an At Risk Plan in place for them to ensure they are being watched."""

Supermarket Help

"There has been a lot of commentary in the media about Supermarkets. Countdown announced two new measures yesterday to try and ease the current burden.

1) Apparently, they will open an hour early for Essential Workers. Check your local Countdown for details as I couldn't see anything online confirming this yet.

2) There is an Online Priority Assistance – which is for those over 70yrs (our residents). They need to sign up, but it means they are being prioritised for delivery. It doesn't guarantee it.

COVID-19 :: Quick Reference Guide

We are still working with BIDFOOD for delivery but this another option if they know what they're doing."

Bidfood Deliveries

Next week with Easter Friday, Bidfood will on the Saturday instead. Monday 13th is also a public holiday for cut off at midday, so can you please ensure the orders are in by Saturday 11th at midday instead.

BIDFOOD Ordering for our Residents – and you!

"This is for your VILLAGE Residents. We have been working with Bidfood to develop a list that we believe will cover almost all the basics of a Lockdown (I note they don't have my fav chocolate though!). Two ways of doing it – through a spreadsheet or paper. We give you the options depending on your resident's preference.

1. Delivery fee is $5.00, with a minimum order of $50.00.
2. Twice weekly deliveries on Wednesday and Friday.
3. Deadlines: Monday 12pm – cut off time for Wednesday delivery & Wednesday 12pm – cut off time for Friday delivery.
4. All resident orders will be charged to us, and we on charge the resident.
5. Each resident order will be delivered to Facility – boxed per resident order.
6. Once checked off, lease have your Admin ADD the name and amount of each order placed and send to the facility Finance person. Finance will provide your Administrator with the spreadsheet.

NOTE: Also Bidfood is trying to source additional products such as Shampoo & Conditioner, Dishwash Liquid, Bodywash, Spray n Wipe, Dishwasher tablets and basic Toiletries. We will modify the form if/when this comes through.

ATTACHED is the form we have put together for them. And a bonus for you as Managers: 😊 Appreciating how well you're doing, we will allow our Managers to place your personal orders for home if your Regional Manager approves. Please note: some products may seem expensive – this is because Bidfood don't have the same buying power as supermarkets on retail lines. "

Flu Vaccine

"If you have any issues with availability of having Flu Vaccine for your staff and residents, please let your Regional Manager know. 9(2)(a) is working with them to have the deployment of resources nationwide.

9(2)(a) has received an update regarding the Flu Vaccine. All pharmacies have been instructed to send Vaccine's to the DHBs. This is obviously causing supply issues. The next shipment arrives April

13th so please ensure that if your GP or pharmacy have any stock, and offering vaccinations, then take this up. If you are still having issues, please contact Shereen directly and she will assist."

Medication Competent

It is a good idea to ensure your Caregivers Level 4 are all medication competent as part of our contingency planning. Just in case we have an outbreak and there are limited staff who are able to work, this will be a solid backup for your RNs.

Human Resource

Government Leave Payments

"The govt has withdrawn the Leave Payment scheme into this scheme so this is no longer an option for our staff. The original leave scheme was designed when few people were in self-isolation, and it is no longer fit for purpose. The govt are working on arrangements for those in essential work who require sick leave due to COVID-19.

Datacom has given us an update. The instructions will come on Friday before you do your pay run so it is fresh in your mind.

We have the option for staff who are receiving the COVID-19 Leave Payment Scheme that they can top it up with either Annual Leave or Sick Leave so they can continue to receive the same amount for the normal hours of work."

Immigration Announcement

"Two decisions concerning those working in aged residential care:

1) Those migrant workers in the aged residential care sector who were subject to a stand down period this year (2020) will now be able to continue working here for another year.

2) Students working in the aged residential care sector part-time will be able to work full time for 3 months."

Leave Payment for Over 70's

"You may be surprised how many of our facilities have staff who are over 70 and with the government announcement for our 70+ yr olds to stay at home, this has been raised a few times already today. In short, It is their choice. Have a chat with them (if you know who they are) and let them know they are very welcome to continue working and supporting our residents – likewise they are able to take advantage of the government payment scheme in place. Also since we are so good at Infection Control – you may find they feel more safe with us than not.

At this point we are not clear if our staff over 70 yrs will be covered because they have been recommended to stay home, but it is not enforced. We are currently seeking clarification on this point."

COVID-19 :: Quick Reference Guide

Payroll Instructions

9(2)(a) sent through your Payroll Instructions on Friday. This is to make sure you have the correct way to indicate the COVID-19 Payment. Otherwise it's business as usual.

Pregnant Staff

People who are pregnant are not considered High Risk however if a site is in Outbreak, we will have another conversation. This means that if they don't come to work, they do not get Leave Payment.

Self-Isolation & COVID-19 Illness Leave

Should any staff be required to self-isolate, or are required to care for dependents who self-isolate, or become unwell with COVID-19, the first step is to register with Healthline. As you will not be able to work from home, we will consult with you directly on how leave entitlements and payments will be allocated. 9(2)(a) is the Facility Manger's point of contact for assistance.

Staff – Minimum Wage Increase

The adult minimum wage will increase $1.20 from $17.70 to $18.90 per hour on 1 April 2020. The new rate equates to an extra $48 per week before tax for employees on a 40-hour working week. As for the questions around relativity to others workers, we at least need to wait until we get the new Rates for 1 July before any decisions can be made for this.

Staff not coming to work

If you have staff that are Willing, Able and Ready to work but for family reasons (as in family not wanting them to work) and therefore are unable to come to work, we cannot pay them, nor support the government package to do so.

Staff with Dependent Children

"To ensure essential workers can access care for their children if needed, the Government has agreed that a range of large home-based providers will provide additional support. If you want to read more about this – click here

Due to us being deemed essential services, they will not be covered for the leave payment. But, the initial strategy proposed for care is to have a buddy (in another house) as part of their self-isolation group so long as they are trusted, and not over 70 yrs. This shares the burden."

Operations

Careerforce

Your regular contacts will all be available via their usual contact details, albeit not via face to face means. If there is anything Careerforce can do to assist and support, please let them know.

COVID-19 :: Quick Reference Guide

Don't Bring it Home

We've had some misinterpreted information for our staff which has heightened their fears. Your staff can continue to live at home if there is a COVID-19 outbreak however there are definitely some routines they will want to adopt to ensure the minimize the issues between 'bubbles'. Attached is the advice on what to do to ensure they "Don't Bring It Home".

Staff ID cards for Essential Worker

9(2)(a) is currently doing up new ID Cards as an "Essential Worker". She's done a great job on them and 9(2)(a) has arranged a courier to delivery lanyards and pouches for the new cards. 9(2)(a) is currently doing up one for each employee which is personalised with name, title and photo. Please print them and hand out as appropriate. See below as an EXAMPLE Only: We are removing the email address and enlarging the phone number.

9(2)(a) is available over the weekend to help with any IDs they need to be done for staff that have missed out. The Police are pulling people over and ask for their IDs. Let's help our staff feel protected. 9(2)(a) is very happy to help get these done for staff.

Remember all staff to carrying their ID Cards coming and going from the facility. You will receive an email from 9(2)(a) or 9(2)(a) who have created all these ID Cards. Please print and insert into the lanyard pouches you have received today; fingers crossed you have them. If not, please laminate and cut up and get your team to carry with them until the pouches arrive."

Staff Purchases through the Facility

We do not provide access to groceries, toilet paper, hand sanitiser, masks or any other items for our Staff to purchase for themselves through our facilities and pay us back. Please do not compromise. I understand how much we like to help our teams however encourage them to use Online Shopping if they are struggling with timeframes.

Two Jobs – Your Staff

Some teams have people who are working two jobs which previously we understood, and were not concerned about. However, given the pandemic and change in requirements, we ask that all your staff now only work for us (or them). This means we ask that you have a conversation with them and yes, they'll need to make the choice. Please feel free to speak 9(2)(a) about this if you need help.

Uniforms

We are all doing our best to uphold the "Bubble" as our PM calls it. Our staff present our highest risk of perforating this and one way is through uniforms. Please have all your staff come to work and home again in mufti – take their uniform home – hot wash and be ready for the next time they need it. Staff now have ID Cards for their commute.

COVID-19 :: Quick Reference Guide

Village

Home Care into Village

Will be coming to you with answers shortly. We cannot allow external care providers to have access to our facilities however so that must cease.

Pharmacy Deliveries for Villas

When this is not provided by the Care Facility's Pharmacy, please speak to Regional Manager.

Village – CFFC Complaints

You are going to receive an extension for the Reporting of the Complaints. This is now open until May however as 9(2)(a) is filling this in for you online, let's just keep note that she will need them at the end of April. The reporting period is from October to April 2020.

Village Managers – for your Village Residents

We understand the pressure which is on our Independent elderly who are not able to go out into the community and their families cannot help. Online Shopping is over-subscribed so we have worked with BIDFOOD to provide a basic shopping list that will provide some relief. This is absolute core products without a lot of variety but it is food and it is delivered – Wednesday and Friday. We will pay the bill and then On-Charge to them. The form will have their signature for payment on it.

Outbreak plan – COVID-19 and Influenza – like illness

Date		Facility		Reported by		Designation	

Key area to manage	Proposed action (how will it be achieved?)	Person/s responsible	By when	Sign & date as completed
SECTION 1 **First response** One or more residents with influenza-like symptoms identified or infection confirmed = **OUTBREAK RESPONSE INITIATED AND FACILITY IS CLOSED** Notes: ▪ Early recognition of potential outbreak is essential. ▪ Staff should report acute symptoms – or a change in condition of the resident. ▪ Immediate elevation to senior UCG management team who will consult with public health for decision to close	▪ Isolate symptomatic residents to their rooms o place signage on their door to highlight restricted access. ▪ Set up personal protective equipment (PPE) for each resident, print all signage, notify staff of affected. residents in isolation and strict hand hygiene practices and PPE application apply. ▪ Consider feasibility of isolating symptomatic residents to one wing of the facility. ▪ Request non-symptomatic residents stay in their rooms during the outbreak, to ensure social distancing occurs. ▪ Stop communal dining and group activities immediately.	▪ Most senior person on duty at the time oversees resident isolation process. **Note:** If not the manager, clinical service manager to be notified of outbreak and ensure registered nurses (RNs) on duty understand all required protocols. Regional Manager must notify GM Operations/GM Clinical immediately. **Note: Notification must be made as soon as possible after isolation has been set up – 24 hours per day/7 days per week.**	Immediately. **Containment becomes the priority.**	
	▪ Notify all staff on shift of the outbreak, including (if not already advised), laundry, housekeeper/cleaner on duty, diversional therapy/activities staff, kitchen staff and those coming in for next shift. ▪ Notify family/whānau of affected resident/s. ▪ Notify regional operations manager. ▪ Notify public health unit (or equivalent).	▪ Most senior person on duty notifies manager and staff. ▪ Manager notifies senior management. ▪ Manager phones the DHB and asks for public health authority, to notify and obtain outbreak number – communicate specific symptoms of affected residents to public health to assist with assessment of potential influenza or other illness (e.g. COVID-19) outbreak.		
	▪ Implement room set-up for infected resident/s: o Clean zone outside room set-up (to put PPE on).	▪ Most senior person on duty communicates process to staff.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person/s responsible	By when	Sign & date as completed
facility and declare outbreak.	o Staff remove their PPE off in room. Set up a yellow bio-hazard rubbish bag for collecting used PPE (in room). o Set up a black rubbish bag (or disposable linen bag) for their linen. Tie this bag off and transport to the laundry each shift, notifying laundry staff the linen is contaminated. o Remove non-essential equipment from affected resident's rooms and clean.	▪ Manager monitors infected resident rooms to ensure protocols are in place. ▪ Manager ensures yellow bio-hazard rubbish bags are collected regularly for turnaround into skips and black bags to the laundry.		
	▪ Use plastic bags for lining general rubbish bins: o dispose of each shift or when full into another yellow bio-hazard rubbish bag o securely tie off, transport to skip bin immediately.			
	▪ Commence outbreak plan. ▪ Commence outbreak case log. ▪ Complete outbreak daily situation report o continue to complete daily for the duration of the outbreak.	▪ Registered nurse (RN) updates log each shift. ▪ Reviewed by the manager daily at a set time e.g., 4pm after handover. ▪ Submit outbreak daily situation report to public health authority as well as regional operations manager who will brief GMs involved.		
	▪ Manager co-ordinates testing as advised by public health authority for suspected COVID-19.	▪ Manager with support from RNs as needed.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
SECTION 2 **Manage a 'facility closure'**	**Facility closure process:** 1. Decision to close is made between CEO/GM Operations/GM Clinical manager, senior management, and public health. 2. Oversee day-to-day management of facility closure and ensure actions are upheld by staff. 3. Convene outbreak management team (OMT).	1. Manager in conjunction with regional operations manager. 2. Clinical Services Manager (CSM) and RNs. 3. Manager and all other senior staff.		
	▪ Place relevant signage on all facility entrance doors advising the facility has restricted access due to an outbreak. Posters advise all visitors must report to reception first. ▪ Display any additional, illness-specific signage e.g., for COVID-19. ▪ Implement a reception sign-in process for all visitors.	▪ Manager or their delegate, change signage over.	Once Facility closure has been decided by CEO and Executive Management team.	
	▪ Notify all impacted parties, as per **SECTION 4: Communication, reporting and documentation**. o Ensure senior management are aware. o Notify public health authority and GP/NP practice. o Update the village resident community via the village resident committee chairperson (as applicable). o **Contact all resident families** by phone, to update on status, to avoid visitors arriving and being disappointed. Maintain a correspondence log. o Contact contractors and service providers where relevant.	▪ Manager notifies public health authority, GP/NP. ▪ Regional manager asks village manager to notify resident committee chairperson. ▪ Receptionist can manage general communication e.g. 'ongoing restricted access due to outbreak'. ▪ Manager, CSM and RNs keep resident family/s informed of their condition, by phone.		
	▪ Record an outbreak event in '1Place' management system. Record all activity pertaining to the facility closure within this record.	▪ Manager oversees this. Other staff and reception to contribute as directed by the manager.	Immediately and ongoing	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	o See **SECTION 4 Communication, reporting and documentation** for details.			
	▪ Support all residents to remain in their rooms. o Enforce physical distancing including **cancellation** of group activities and communal dining.	▪ Manager/CSM to provide direction. ▪ All care staff to support and enforce.		
	▪ Restrict staff access to facility. o Arrange alternatives for non-care staff to access laundry and kitchen access.	▪ Manager arranges and communicates instructions. This can be delegated.		
	▪ Laundry staff are not permitted to deliver clean linen and clothing to any infected resident's room. o Laundry staff leave clothing trolleys for care staff to deliver.	▪ Manager/CSM directs laundry staff. ▪ Manager organise for care staff to deliver infected resident clothing and oversee this practice.		
	▪ Adjust cleaning and other services provided to village residents to minimise risk of transmission from the facility or alternatively consider risk of transmission from village residents to the facility. o Aim to reduce staff working across the village and facility depending on where infected residents are living.	▪ Manager to provide alternative instructions to staff for managing village services.		
	▪ Place facility admissions and transfers on hold until manager deems they are appropriate to resume. o Includes liaising with families, district health board and needs assessment and service coordination (NASC).	▪ Manager. ▪ GM Clinical/CEO	Immediately and ongoing.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Restrict external visitors except for family and friends who are considered essential to the welfare of the resident e.g., end-of-life – manager to approve. ▪ Contractors are only allowed access for urgent services and works. This must be approved by GM Property. The nature of the work must be understood by facility staff. o Supply PPE and instructions where there is risk of transmission to contractors e.g. if working in infected resident's rooms/area. ▪ Supplies must be delivered using a non-contact process where possible unless this poses security or manual handling risk e.g.: o controlled drug deliveries that need to be accepted and signed for o large bulky supplies that require safe stowing – property teams to support as able. ▪ Delay prospect visits and cease all communal social events and outings.	▪ Manager oversees this but may delegate to the CSM, or receptionist. ▪ See **SECTION 4 Communication, reporting and documentation** for more info.	Immediately and ongoing.	
SECTION 3 **Care for affected residents** Goal: ▪ Contain the infection and reduce the spread.	▪ Confine symptomatic residents to their rooms until cleared by public health authority – generally 48 hours symptom-free but could be longer depending on the illness e.g., 14 days for COVID-19. ▪ Have a plan for residents with cognitive impairment: o cohort into small groups during the day with a staff member assigned to supervise all movements. o use sensor mats when in bed to alert resident is moving o ensure holistic needs are met to avoid behaviour developing that increases risk to them and others o wash the resident's hands frequently o clean surfaces continuously.	▪ Manager/CSM ensures RN on duty: o directs care o reviews chart/s every shift o ensure staff use PPE and follow hand hygiene practices correctly o education including demonstration at each change of shift.	Immediately and in response to new cases.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Cohort staff = a key step to reducing infection spread. o One group of staff care for infected residents – ensure equipment such as iPads/tablets do not enter affected resident's rooms and are not shared between staff cohorts. o The other group care for non-infected residents. o Aim to maintain this for night duty which can be a challenge during outbreaks – spread occurs easily at night if staff cohorts are not maintained. o Set up separate areas for each group of staff including break rooms, toilets/showers if possible. ▪ Avoid group gatherings of staff including meetings, shared meals and food. ▪ Maintain physical distancing at handovers. ▪ Ensure all staff are correctly applying and removing PPE each shift. ▪ Supply staff rooms with refreshments for staff to support them in their work.	▪ RNs on duty.		
	▪ Monitor resident's clinical condition: o check vital signs **four-hourly** while resident symptomatic o report any decline in condition to GP/NP or seek additional medical and clinical assistance for the resident. Note: refer to Frailty Care Guides where relevant o consider transfer to hospital if clinically indicated: follow hospital transfer procedure.: Policy: ***1.B5 COVID-19 Guidance for admissions*** ▪ Advocate for resident's clinical care needs as indicated. ▪ Keep family/whānau informed.			

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Commence the following documentation for each infected resident: o chart/s, as directed by the CSM including food and fluid charts, turning charts, output charts o short term care plan (STCP) evaluated by RN each shift.			
SECTION 4 **Communication, reporting and documentation**	▪ Notify senior management of the outbreak and cease access for visiting.	▪ Manager/or regional manager. ▪ Follow specific guidelines for notifying ARC Infection Control Team at DHB as well as funding and planning manager	Within 24 hours of outbreak being suspected. Ongoing for duration of outbreak.	
	▪ Notify primary care team – GP practice or NP.	▪ Manager or CSM.		
	▪ Update the village resident communit *(if applicable to your facility)*	▪ Manager.		
	▪ Notify relevant contractors, service providers, volunteers as relevant. i.e. Pharmacy Services, Physio etc.; All building contractors will be notified by GM Property	▪ Manager delegates to appropriate staff member/s.		
	▪ Enter an event in the incident management system, i.e 1Place as soon as reasonably practical: o record all outbreak-related information, 'running commentary' and documentation relating to the outbreak via the event record.	▪ Manager enters an outbreak event in the incident management system. ▪ Manager/CSM and/or RNs manage the record-keeping for the duration of the outbreak.	Within 24hrs of outbreak being confirmed. Update daily.	
	Complete these records for each infected resident: ▪ case log and/or	▪ Manger, CSM or RN manage individual infection event records in 1Place	For each new case.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ resident infection event in the incident management system: o record information, running commentary and documentation relating to the event.		Update every duty.	
	▪ Notify families of outbreak (with infected resident's families as a priority), by phone: o suggest they call the office daily for an update, otherwise the nursing team will call if there are concerns, or the resident's condition changes. o encourage co-operation with restricted visiting. ▪ Record phone calls via each person's resident correspondence log.	▪ Manager and/or RN for initial phone call. ▪ Manager, CSM or RN for ongoing updates.	For each new case. Update with changes in condition.	
	▪ Hold daily meetings with OMT to discuss status of outbreak: o document all meetings.	▪ All essential staff: manager, CSM, kitchen manager, laundry, housekeeping. ▪ All to attend daily meeting at an agreed time in the morning: o Manager records the meeting minutes. o Attendees disseminate information back to their respective teams. o Send completed report to public health contact daily.	Daily.	
	▪ Enter an event in 1Place for each infected staff member (not resident).	▪ Manager.	As required.	
	▪ Keep the case log up to date. ▪ Email to public health daily or as instructed	▪ Manager.	Daily.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
SECTION 5 **Kitchen / food service management and staff**	**Staff movements:** ▪ Only kitchen staff are permitted in the kitchen. **No** access is given for other staff. ▪ Kitchen staff are not permitted in residents' rooms. ▪ Kitchen staff are only permitted in the non- affected staff cohort staffroom for their break during an outbreak.	▪ Manager directs kitchen manager and reviews daily, to identify any issues. ▪ Kitchen manager directs all other kitchen staff. ▪ CSM/RN oversee care staff in the facility.	Immediately and ongoing. Actions do not cease until advised otherwise by manager.	
	Food service: ▪ Prepare all food in the kitchen. ▪ Transport to the facility in a hot box and/or staff collect trays from a given point. o Staff caring for infected residents deliver meals to rooms of those residents. o Non-affected residents continue to receive normal meal service in their rooms unless otherwise directed by the manager. ▪ Meals are served on disposable dinner ware, which are placed on top of plates/dishes located in their room, unless the resident can safely manage food and fluids from the disposable dinner ware. o Hold infected residents' dishes in their room for the duration of the outbreak.	▪ Manager directs kitchen manager and reviews daily, to identify any issues. ▪ Kitchen manager directs all other kitchen staff. ▪ CSM / RN oversee care staff in the facility.		
	Dishwashing ▪ Wash infected resident dishes in their room. o Dispose of infected resident disposable dinner ware in the rubbish – dishes and cutlery remain in their room. ▪ Non-symptomatic residents have their dishes collected by staff using PPE. Leave trolley outside the kitchen.	▪ Manager oversees the process and ensures staff understand the process well and the rationale. ▪ Staff caring for residents take allocated trolley to agreed area for kitchen staff to collect. ▪ Staff caring for infected residents ensure their dinner ware and crockery is properly cleaned in their room.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Kitchen staff wear PPE for dishwashing and ensure gloves are changed when moving from dirty dishes to handling clean dishes. ▪ **Dementia care:** Staff should wash dishes before they leave the unit to return dishes to the main kitchen.			
	Food choices ▪ Depending upon the infection type, the menu may require adjustment. ▪ If so: the CSM discusses and agrees alternatives with the kitchen manager.	▪ CSM oversees the menu, with the kitchen manager and ensures alternatives are available.	Immediately and ongoing. Actions do not cease until advised otherwise by manager.	
	Communication ▪ Provide daily status update to kitchen team.	▪ Kitchen manager attends daily outbreak management meetings and reports back to kitchen staff.		
SECTION 6 **Laundry service management and staff**	**Staff movements** ▪ Laundry staff are not permitted to enter or deliver clean linen and clothing to infected resident's rooms. o Laundry staff leave clothing trolleys for care staff to deliver.	▪ Manager directs laundry staff. ▪ Manager organise for care staff to deliver infected resident clean clothing and oversee this practice.	Immediately and ongoing. Actions do not cease until advised otherwise by manager.	
	Launder clothing and linen ▪ Infected resident's laundry is placed in black rubbish bags which are kept inside the resident's room. Alternatively use disposable linen bags where possible: o care staff seal this bag securely before transporting to the laundry. ▪ Launder non-infected residents' laundry as per normal process.	▪ CSM / RN ensure care staff manage laundry as per plan. ▪ CSM: o check each shift the correct cycle for infected linen is used by laundry staff. ▪ Laundry staff manage laundering.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	o Wash and dry first ***before*** infected residents' laundry is washed and dried. ▪ PPE must be worn by laundry staff when handling soiled linen. This should include gloves, goggles, apron and face mask if the soiled linen is from an infected resident.			
	Clean the laundry area ▪ Thoroughly clean and disinfect the laundry area (bench tops and commonly touched surfaces) at the end of each shift. o Use detergent in warm water and disposable cloth followed by disinfectant solution. o Leave to air dry.	▪ Laundry staff clean and disinfect laundry area.	End of each shift.	
	Laundry effort and hours ▪ Monitor and assess the need to add additional laundry hours during an outbreak. ▪ Where an outbreak becomes protracted or is difficult, consider outsourcing laundry services: o if an external laundry service is used, they must be informed about the outbreak, so they know to take necessary precautions to avoid infection.	▪ CSM.	If required.	
SECTION 7 **Housekeeping management and staff**	**Chemicals and PPE** ▪ Make up disinfectant solution every 24hrs, o Refer to the manufacturer instructions for dilution, o Ensure bottles have a date and time sticker and are replenished every 24 hours, ▪ Housekeeper checks stock daily and advises manager of order requirements e.g., o gloves, hand sanitiser, disposable cloths, disinfectant solution	▪ Night staff make up the solution. ▪ Housekeeper ensures product is stocked on the trolley. o Discard all bottle contents at the end of the outbreak. ▪ Manager arrange replacement stock orders. o See **SECTION 7: Manage outbreak supplies** for details	Daily.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	Housekeeping procedure ▪ Housekeeper cleans communal areas first, including public toilets, handrails, door handles. ▪ Housekeeper cleans non-infected resident rooms. ▪ Caregiver assigned to the infected residents cleans infected resident's rooms: o Wear disposable long sleeve plastic apron, gloves and mask. Change between each resident's room clean. ▪ Cleaning trolley is not to be taken into the infected resident rooms. Instead: o take in materials you require i.e., detergent and warm water in a bucket, disposable cloths/paper towels o clean first, then disinfect o do not exit the room with PPE on. Discard cleaning cloths and PPE into the resident's plastic rubbish bag inside the room o wash hands before leaving the room. ▪ Pay special attention to soap dispensers and hand sanitisers to ensure these are well stocked.	▪ CSM directs all housekeeping. ▪ RN ensures care staff follow cleaning procedures. ▪ Housekeeper checks stock daily and alerts manager to what needs to be ordered: o e.g., gloves, hand sanitiser, disposable cloths, bleach tablets.	Immediately and ongoing. Actions do not cease until advised otherwise by the CSM.	
	Extra cleaning ▪ Complete extra cleaning 3 x daily for the following: o touch points, surfaces, communal bench tops, staff areas, doors in communal spaces o phones, walkie talkies and computer keyboards o communal and staff toilets including door handles, taps and doors where hands touch them to open o tops of communal rubbish bins, including staff room.	▪ PM and night shift care staff clean these areas once during their shift.	Daily.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	Carpets ▪ Vacuum and steam clean carpets as and when directed by the CSM.	▪ CSM decides whether to outsource or use housekeeping staff.	As directed.	
	Soft furnishings ▪ Clean with detergent and warm water and if possible, steam clean, as and when directed by the CSM or manager.	▪ CSM decides whether to outsource or use housekeeping staff.	As directed.	
	Terminal cleaning ▪ Complete once the resident is 48 hours symptom-free. ▪ Launder curtains or steam clean in place.	▪ CSM directs housekeeper and care staff.		
	Housekeeping hours ▪ Monitor and assess the need to add additional Housekeeping hours during an outbreak o Additional hours will be needed to ensure Terminal cleaning is thoroughly carried out	▪ CSM manages this.	When required.	
SECTION 8 **Manage outbreak supplies**	▪ Store outbreak equipment in a central location, easily accessible by all staff. o Minimum of six plastic buckets is required, containing all outbreak PPE. o Infection control coordinator completes PPE stock audits every day.	▪ Infection control coordinator. ▪ Infection control coordinator and RNs oversee and guide staff on duty regarding PPE use.	Every day. Immediate and ongoing during outbreak.	
	▪ CSM checks outbreak PPE stock daily when in use and at the end of every shift, to ensure there is enough: o Order stock as necessary.	▪ CSM oversees stock and order/reorder. ▪ RNs ensure PPE is restocked before the next shift comes on.	When required. Ongoing during outbreak.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ CSM reviews all other outbreak stock requirements for the infection as per outbreak kit audit tool, e.g. barrier cream, medication: o Order stock through the relevant supplier.	▪ CSM.		
	▪ Cleaning staff communicates PPE and cleaning chemical requirements: o Order stock as required.	▪ Cleaner advises manager and/or CSM.		
SECTION 9 **Resident visitors, outings and appointments**	▪ Display outbreak signage as directed by manager on all facility entrance doors – these advise visitors and other residents of the outbreak. ▪ Display any additional, illness-specific signage e.g. for COVID-19.	▪ CSM or infection control coordinator, or their delegate, put signage up once 1 or more cases confirmed.	Immediately with 1 or more cases.	
	▪ Postpone all non-essential services, such as hairdresser, podiatrist until after the outbreak.	▪ Manager.		
	▪ Postpone all non-essential care resident outings and appointments, as assessed, and directed by the CSM.	▪ CSM assesses appointments and outings. ▪ CSM, manager or postpone.		
	▪ Visitors are permitted as agreed with CSM and/or manager but must wear PPE when visiting an infected resident. ▪ Staff should: o provide basic education to incoming visitors, including use of PPE o remind visitors they are not permitted to visit multiple residents.	▪ Manager or receptionist, or any other staff member that greets the visitor	Ongoing until otherwise notified by CSM	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Resident transfers to other facilities should be avoided. o If the transfer is essential, notify the receiving facility of the infection type that the resident and facility has/had. If COVID 19 suspected please refer to Policy Guidelines for managing admissions, transfers, and discharges.	▪ RNs manage any transfers. ▪ RNs advise hospital of outbreak should any acute admission be required for a resident.		
SECTION 10 **Manage staff education, infection and rostering**	▪ Display outbreak staff information in the staffroom. ▪ Display any additional, illness-specific signage e.g., for COVID-19. ▪ Discuss the following outbreak-related information at each handover, and with other key people: o vigorous focus on handwashing and use of PPE. o update on outbreak status. o other relevant infection control education information.	▪ CSM ensures all signage is in place. ▪ CSM/infection control coordinator ensure education for staff is in place and provide oversight daily. ▪ CSM / RNs oversee outbreak information at handovers. ▪ CSM liaises with team daily to update outbreak status.	Immediately and ongoing. Immediately and ongoing.	
	▪ Non-essential staff are not permitted to enter suspected or confirmed COVID-19 infected resident rooms.	▪ CSM/RNs oversee this.		
	▪ Staff must advise CSM or manager immediately if they experience symptoms. o Add infected staff onto the case log. ▪ Infected staff are not permitted to return to the work until **48 hours** after last symptom. o Staff update the CSM or manager. ▪ Staff are made aware specimens can be requested from them. o These will need the outbreak number attached. o This cost is covered by the facility.	▪ All staff report any symptoms to the RN on duty. o RN on duty updates the case log. ▪ CSM may request specimen and will provide staff with the outbreak number.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Review roster daily, including planning for managing infected staff. ▪ Bureau staff may be called in but must be advised prior to agreeing to work and **will not** be asked to care for infected residents.	▪ CSM reviews rosters daily. Assess bureau needs at the same time. ▪ Manager, CSM or RN book bureau staff, and advise of status upon booking.		
SECTION 11 **Outbreak debrief meeting** After an outbreak has ended, a staff meeting is arranged to discuss and debrief the event	▪ Decision to open the facility is made between the manager, regional manager CSM and public health. ▪ Organise the debrief meeting; include all clinical staff. o Run the meeting over several days if required, to capture key people. o Document the meeting and attendance. ▪ Discuss and reflect upon the outbreak. Cover: o what went well o identify opportunities for improvement.	▪ CSM organises and facilitates the debrief meeting.	Within two weeks of the outbreak ending.	
	▪ Record findings and a summary of the outbreak, including learning and improvement opportunities.	▪ Manager and CSM.		
	▪ Retain all information pertaining to the outbreak, including an outbreak summary report in the infection control folder under the month it occurs and recorded against the incident management system.	▪ CSM and infection control coordinator.		

Resident TESTING for COVID-19 – Now What?

ULTIMATE CARE GROUP

If a resident is being TESTED for COVID-19, they should be in isolation until the results of the test are known.

Resident Isolation

The Resident and their Room

- ☐ Resident remains within their room
- ☐ Encourage residents to wash their hands regularly – support to do so
- ☐ Clean frequently touched surfaces often
- ☐ Keep the windows open and door closed as much as possible in their room
- ☐ Wash towels, bed linen and clothing separately in a dissolvable laundry bag – only take to laundry once full. Otherwise leave in room
- ☐ If no ensuite provide a designated bathroom and clean it after every use. If not possible, place commode in room. Cover any bodily fluids when taking to the sluice and sterilise.
- ☐ Cutlery and Crockery must be handwashed and wiped with chlorwhite before leaving the room to be sterilised in the kitchen. It returns to general circulation after this process
- ☐ Ensure chlorwhite spray is available in each isolated room.
- ☐ Ensure PPE required is set up outside room.
- ☐ Monitor and document symptoms
- ☐ Report any unmanaged/behavioural issues to Regional Manager

Staff

Communication

- ☐ Place sign on door for Contact isolation
- ☐ Time Target messaging
- ☐ Handovers
- ☐ Nursing notice boards
- ☐ Resident notes
- ☐ With FM approval, CSM or RN notifies the family, giving reassurance
- ☐ Non-punitive support for staff who do not feel confident – provide reassurance and education

Personal Protection Equipment

PPE

- ☐ Follow the guidelines below. Printable Sheet in COVID-19 on P: Drive: PPE Aged Care Poster
- ☐ Stock-take to ensure you have enough and lock away stock other than a daily allowance
- ☐ Check understanding and adherence of correct on / off, and disposing of PPE
- ☐ Clean and sterilise goggles for re-use.
  a. Warm hot soapy water and then wipe down with pure chlorwhite.
  b. Allow to dry.

For people in self-isolation due to recent travel or contact with someone with confirmed, probable or suspected COVID-19; standard precautions still apply.
Ask the patient to wear a mask, if possible, when providing cares

	Hand Hygiene ‡	Surgical Mask	N95/P2 Mask	Eye Protection*	Gloves	Fluid Resistant Gown or Plastic apron
Providing care not involving contact with body fluids or oral mucosa	✓	✗	✗	✗	✗	✗
Providing cares that will have contact with blood, body fluids, secretions, excretions, touching oral mucosa, or medication assistance	✓	✗	✗	✗	✓	✓

POSITIVE Test Result for COVID-19 – Now What?

ULTIMATE CARE GROUP

If a resident has a POSITIVE Test Result for COVID-19, they should already be in self-isolation from the Testing Phase. All appropriate measures from the Testing Phase page are to remain active unless superseded below.

Isolation

The Resident

- [ ] All actions from "Testing" (above) remain
- [ ] Resident MUST always remain within their room at all times
- [ ] CSM (RN by delegation) to co-ordinate staff allocation to unwell residents.
- [ ] Refer to Isolation Plan
- [ ] Resident must avoid any situation where they come into face-to-face contact with anyone for more than 15 minutes.
- [ ] CSM/FM or RN briefs staff on ICP requirements.
- [ ] CSM to seek DHB ICP advice as required.
- [ ] Commence COVID Short Term Care Plan
- [ ] PPE is checked and ready on ICP trolley or similar
- [ ] Keep all infection control processes in place until advised by a medical practitioner to remove.

Communication

Internal

- [ ] Communicate with Regional Manager immediately
- [ ] Update COVID-19 Register
- [ ] Head Office to advise as to notifications
- [ ] Place sign on door for COVID-19

External

- [ ] With approval, contact FAMILY, and others as directed by Head Office
- [ ] Remind staff of their Privacy responsibilities
- [ ] Do not communicate with media. Refer to your RM who will refer to GM / CEO

Personal Protection Equipment

PPE Expectations

- [ ] Printable Sheet in COVID-19 Folder on P: Drive: PPE Hospital Care Poster

Challenges

Reduced Staff

- [ ] Clearly identify staff unwilling to continue working on Time Target (non-punitive)
- [ ] Revert to pre-prepared rosters for reduced staff: 30% / 50% / 70%

Refuse to Stay in Room

- [ ] If the Resident is challenging isolation, please speak with your Regional Manager

Family Requests to Visit

- [ ] No visiting, even with full PPE. If the resident is critical, they are likely to be in an ICU not with us.
- [ ] For exceptions, please refer to your Regional Manager

Post COVID 19 Room Cleaning Checklist

Version 1 as at April 2020

ULTIMATE CARE GROUP

Please use the following to assist in safe cleaning of a resident's room after COVID-19. **Each box must be ticked before a new resident can reside in the room**

Room Number

- ☐ Clear room wearing PPE: mask, gloves, plastic apron
- ☐ Remove all linen into dissolvable washing bag. Remove rubbish into biohazard bag.
- ☐ Wash linen and towels using the "Infection Wash" cycle on the washing machine following normal outbreak precautions
- ☐ Pull curtains to air in the breeze for 24 hours and put fabric furniture near the windows. Fabrics are not dense so less likely to absorb the virus for a long period of time.
- ☐ Leave room empty for 24 hours with windows wide open and a "Do Not Enter" sign on door with timing:
  - ☐ Start Time: _____
  - ☐ Finish Time: _____

Please note: Please ONLY use CHLORWHITE cleaner. Other cleaners will not kill the virus.

- ☐ Wash down all fabric surfaces with soap and water and allow to dry
- ☐ Replace all soap and sanitizer dispensers with new products
- ☐ After 24 hours PPE: mask, gloves, plastic apron
  Clean all hard surfaces with CHLORWHITE
- ☐ Steam /deep clean the carpet if you have a machine in your facility

Clean with CHLORWHITE the following:

0 Floor	0 Call bell & cord
0 Bed	0 Rails
0 Sinks	0 Commode
0 Taps	0 Toilets if Ensuite
0 Tables	0 Door frames
0 Windowsills	0 Chair hardware
0 Door handles	0 Soap dispensers
0 Light fittings	0

- ☐ Replace toilet paper
- ☐ When completed, leave windows open, close door and remove sign
- ☐ Leave completed checklist in room

Name & Sign

Date

Infection Prevention and Control Interim Policy for Suspected or Confirmed Coronavirus (COVID-19) **(this policy and its contents is subject to change as directed by Ministry of Health)**

Next Review	To be updated as required
Effective Date	26 March 2020

UCG Policy & Procedures Guide

8. Infection Control

A. Infection Control Interim - Management

It is the policy of Ultimate Care Group to minimize exposures to respiratory pathogens and promptly identify residents with Clinical Features and an Epidemiologic Risk for the COVID-19 and to adhere to Ministry of Health recommendations (to include, for example: Admissions, Visitation, Precautions: Standard, Contact, Droplet and/or Airborne Precautions, including the use of eye protection).

To address the greater risk of transmission of COVID-19 within our facilities the following steps will be put in place:

If one of your residents is suspected or has a confirmed case of COVID-19 managers will need to notify Healthline on **0800 358 5453 as well as your local DHB Funding and Planning manager.**

For suspected or confirmed cases of COVID-19 the resident should be isolated on the premises if admission to hospital is not required.

If one or more confirmed COVID-19 cases have occurred within a residential care facility, an outbreak management team should be convened. For more information see Interim Advice contact GM Clinical Services.

Transmission of COVID-19 is considered to occur primarily through respiratory droplets and secretions.

The virus is most likely to spread from person to person through:

- direct contact with a person while they are infectious
- contact with droplets when a person with a confirmed infection coughs or sneezes
- touching objects or surfaces that were contaminated by droplets (like those from a cough or sneeze) from a person with a confirmed infection and then touching your mouth or face.

COVID-19 transmission is similar to that of the influenza virus and it is recommended that standard droplet and contact precautions are used when managing a resident with suspect COVID-19 infection

The symptoms of COVID-19 are:

- cough
- fever
- shortness of breath
- sneezing or a runny nose.

All UCG Residential facilities

- Stop all non-essential services
- Stop all family visits except for families with residents receiving palliative care – subject to public health direction and in consultation with the facility manager.
- Any admission requests from any external referral sources such as NASC or direct from DHB must be approved at senior management level. i.e. GM Clinical GM Operations and CEO. All admission requests will be considered on a case by case basis

Isolation of suspected and known cases

- For residents, isolate on premises if admission to hospital is not required. Symptoms may vary and if mild resident will not require transfer to hospital.
- If the resident does not require a higher level of care, the facility should adhere to the infection prevention and control practices for isolation procedures for managing 'outbreaks' the same principles should apply.
- For staff, isolate at home, or on premises if possible.
- Daily monitoring of **ALL** residents must be put in place (refer to attached monitoring form)
- Short term care plan for COVID-19 must be put in place (see attached).
- Once a resident has been identified as positive there must be a consistent assignment of caregivers for that resident/s.

Procedure for residents that develop more severe symptoms that require transfer to the public hospital for higher level of care.

- Prior to transfer, emergency medical services (ambulance) and the receiving DHB ED department should be alerted to the resident's diagnosis.
- Pending transfer, the resident must have a facemask in place and remain in isolation in bedroom with the door closed until the paramedics arrive.

Supporting residents who are more at risk of COVID-19

Extra precautions are needed to ensure residents receiving care in our facilities are safe, particularly those who are more at risk of infection and severe illness. Residents who are more at risk of COVID-19 infection include:

- residents who have conditions that compromise their immune systems or have compromised immune systems as a side effect of taking certain medications, such as chemotherapy
- residents who have chronic medical conditions such as liver disease, heart disease, kidney disease, diabetes mellitus, lung disease or other long-term conditions
- residents with a disability and co-existing long-term conditions
- residents who have medical devices that enter the body (e.g., a catheter, tracheostomy, ileostomy, feeding tube)
- residents with large pressure injuries or open wounds
- all residents older than 70 years of age.

Please ensure staff:

- Cover coughs and sneezes with disposable tissues or the inside of the elbow
- Wash hands for at least 20 seconds with soap and water and dry them thoroughly:
    - before starting work in a new setting
    - before eating or handling food
    - after using the toilet
    - after coughing, sneezing, blowing your nose or wiping noses
    - after caring for sick people
    - and at the end of their shifts
- If soap and water are not available, clean hands with an alcohol-based hand sanitiser that has at least 60 percent alcohol, covering all surfaces of the hands and rubbing them together until they feel dry
- Avoid touching eyes, nose or mouth if your hands are not clean

Guidance for Cleaning

***Always wear disposable gloves when cleaning. When finished, place used gloves in a rubbish bin. Wash your hands immediately after handling these items**

- Wash items such as dishes, drinking glasses, cups and eating utensils in the dishwasher (you should use a commercial cleaner if you have one) or use soap/detergent and water to wash them thoroughly.
- Clean all 'high-touch' surfaces such as desks, counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards and bedside tables every day with antiseptic wipes or disinfectant, including bleach solutions.
- Clean toilets with a separate set of cleaning equipment (disposable cleaning cloths, mops, etc).
- Clean floors with disinfectant or bleach solution, starting from one end of the premises to another (from the exit inwards) every day.
- Wash laundry items such as bedding, towels, tea towels, cushion covers and other fabrics and dry thoroughly outside or with a dryer. Wear disposable gloves while handling soiled items. Wash hands immediately after removing gloves or after handling these items.
- Read and follow directions on the labels of laundry or clothing and detergent. In general, wash and dry laundry and clothing with the warmest temperatures recommended on the label.
- you should read all cleaning product labels and follow the recommendations provided on them. Product labels contain instructions for safe and effective use of the cleaning product, including precautions you should take when applying the product, such as wearing gloves or aprons and making sure you have good ventilation (e.g., open windows) while you use i

Clean your hands

Regardless of whether you wore disposable gloves while cleaning, you should wash your hands regularly. You should wash your hands thoroughly with soap and water for at least 20 seconds, making sure you dry them thoroughly. You can use hand sanitiser (containing at least 60 percent alcohol) if soap and water are not available and if your hands are not visibly dirty. If using hand sanitiser, cover all surfaces of your hands and rub them together until they feel dry. Avoid touching your eyes, nose and mouth with unwashed hands

Stay home. Save lives. New Zealand Government Find out more Unite against COVID-19

ULTIMATE CARE GROUP

Contact Tracing – Staff Personal Details

Name:	Date:
Role:	
Address:	Phone:

People Living in your Bubble:	Occupation	Been overseas in last 30 Days? Yes / No
1)		
2)		
3)		
4)		
5)		
6)		

Does anyone in your Bubble work in another Aged Care Facility or DHB?	If YES, Where?

Have any of the people in your Bubble been unwell over the last 10 Days. If YES, Who? (sore throat, temperature, cough, shortness of breath, etc)	What are the Symptoms?

Thank you for completing this form. I appreciate your honesty and cooperation.
Facility Manager

I declare the above information is true and correct.

Staff Name: _____ Signature: _____ Date: _____

COVID-19 Oakland Isolation Plan

ULTIMATE CARE GROUP

The Isolation Plan for COVID-19 Outbreak in conjunction with UCG's Pandemic Plan. This plan is subject to periodic review and changes appropriate to prevailing conditions and resources.

OAKLAND	
Infected: < 5	**Isolation in Rooms:** Notifications directing people to Reception, no entry to any Isolation area unless authorised by FM or senior person in charge. Rimu board room will immediately become our isolation area – residents move in and dedicated staff assigned. Staff notified through Time Target, Notice Boards, handover, face to face from management. All non-essential visitors stopped, all doors continue to be locked from the outside. Contractors only allowed into area with PPE in place for urgent requirements as directed by FM or senior person in charge.
Infected: Between 5-50%	**Isolation Red Zone:** Isolate as appropriate to facility lay out in the Rimu wing expansion of initial isolation zone through to Rimu wing rooms, including lounge, activities, small lounge and surrounding spaces. Lock back door so that no one can come in or out through this. Only laundry staff to use Rimu/Pohutukawa lift, notice to be put up on lift doors. Labelling directing people to Reception. Staff notified through Time Target, Notice Boards, handover, face to face from management. No visitors permitted to any of the building. Contractors only allowed into area with PPE in place for urgent requirements. Tea and coffee making facility in area.
Infected: Over 50%	Back to individual rooms, try to continue to isolate by using Rimu, then Pohutukawa in the same block, moving through to Puriri and Patersonnii if required.
Medications / Pharmacy	Move medicines and clinical supplies into isolated area. Drug cupboard is already in place in Rimu, CSM has the responsibility to move supplies around and ensure that adequate stock is in place. Arranged with 9(2)(a) [redacted] to do drop-offs at Reception for distribution without entering the facility further. CSM to be advised when drop-offs occur
Food Service	All dining to be undertaken in residents' rooms, dining rooms will be closed. Dedicate kitchen to two sides. Hot boxes to be used for each area no cross over. • Catering staff not to enter isolation room. • No special requirements of eating utensils and crockery. • All items must go through dishwasher at a temp of above 60° and 82° for rinsing. • Catering staff must wear gloves when handling residents' trays and utensil etc.
Cleaning	Dedicated staff to infected and non-infected areas. Cleaning staff to wear PPE (gloves, long sleeved impermeable gown, goggles and masks) when cleaning isolation rooms. Two step cleaning process: neutral detergent followed by disinfectant. Increase cleaning to at least twice a day in isolation rooms, common areas, frequently touched surfaces (telephones, handrails door handles etc) and staff rooms.

	Yellow cleaning equipment; change mop heads immediately, bag and launder, discard or launder cleaning cloths when cleaning isolated rooms. Re-usable or shared equipment: to be cleaned with two step cleaning process after each use if unable to be dedicated to the isolated room. (Bug Control Influenza Outbreak Cleaning information)
Laundry	Place into leak proof bags and (disposable bags) in isolation room prior to transport to laundry. • No non infected laundry to be in the area when the infected laundry is being laundered. • Launder in hot water greater than 65° for not less that 10min or greater than 71° for not less than 3 minutes. • Laundry staff must wear PPE: Heavy duty gloves, long sleeve waterproof gowns, masks, eye protection wen handling linen from isolation rooms. ASNZ4146:2000 Laundry Practice must be followed (Bug Control Influenzas Laundry protocols)
Sluice	Rimu sluice for infected residents. Other sluices for non-infected residents
PPE	**28 Days Supply:** Currently holding 14 Days supply on site, plus Head Office holding a further 14 Days Emergency Supply for distribution nationwide. • PPE is recommended for primary care staff who cannot maintain at least 1 metre of contact distance from people with COVID-19 symptoms. • PPE includes gloves, gown, medical/surgical mask and eye protection. • The wearing of PPE must be done correctly, along with the safe removal and disposal of PPE adhered to.
Staffing Contingency	Identify staff that will work in the infected area and assign to 12-hour shifts. (based on number of residents with infection). All other staff to continue to work in other wings. Use casual staff to fill into non infected areas. Dedicated agency staff have been identified to work with us if outbreak occurs. Utilise volunteers for non-direct resident care for meal delivery, resident entertainment, movement, moving clean laundry, meal preparation etc etc

Management Oversight

If the Facility has an outbreak, daily contact through Regional Manager with GM Ops & GM Clinical and updates to CEO. If the Facility Manager or CSM are unable to be onsite:

1. FM: Remote from Home – skype / email / mobile
2. CSM: Remote from Home – skype / email / mobile
3. Backed up by: Regional Manager and Administrator

Onsite Staff

Only staff who will be in contact with the resident for more than 15 minutes, and within 1 metre, need to wear PPE. As a result, reception staff do not need to wear a face mask or any other PPE.

Tracing – Staff with Isolated Residents

Self-isolation

094

ULTIMATE CARE GROUP

Please enter the name of all staff who have been with this Resident each shift.

Resident Name:

Room Number:

Day – Date	AM Shift	PM Shift	Night Shift	Registered Nurse	Cleaning	Laundry	Other
1)							
2)							
3)							
4)							
5)							
6)							
7)							
8)							
9)							
10)							
11)							
12)							
13)							
14)							

Thank you, Facility Manager

5. COVI-19 GUIDANCE FOR ADMISSIONS INTO FACILITIES

Purpose

The purpose of this policy is to provide guidance for facility managers and clinical nurse managers during the COVID-19 outbreak and applies to all UCG facilities.

Policy

Admission from the community

The Ultimate Care Group can accept admissions from the community if the person has not had contact with anyone who has been overseas in the last 14 days or been overseas themselves, has not been in contact with anyone with confirmed, suspect or probable COVID-19 and does not have any acute respiratory symptoms (cough, fever, sore throat).

1. All people, prior to admission, must be screened by a General Practitioner/Nurse Practitioner or Community Based Assessment service for COVID-19 to determine if these conditions are met. The screening can be done virtually.

a. Where the person has been overseas, has been in contact with someone who has been overseas, or has had close contact with a confirmed, suspect, or probable case, admission should be **delayed until 14 days since the contact.**

2. New Admission: Suspected COVID-19

a. If COVID-19 is suspected (symptomatic) the Needs Assessment Service, Coordination (NASC) will liaise with community services (e.g., community Nursing and/or Home Support Agencies) to continue to support the resident at home while waiting for test results. They **will not** be transferred to any Ultimate Care Group facility while waiting for the test results.

b. Any potential resident with a negative test result will be admitted to the facility. As a new admission from the community, the resident should spend 14 days in isolation in case they subsequently develop, COVID- 19.

c. The resident should be in a single room with its own dedicated bathroom[1] having meals in their rooms and not visiting common areas. The resident should be monitored daily for 14 days for new or worsening symptoms, for example respiratory symptoms, and assessment sought if this is identified.

[1] Dedicated bathroom can be ensuite rooms or where not available a bathroom allocated for specific use of resident in isolation and cleaned after use.

3. New Admission: COVID-19 not suspected

a. If COVID-19 is not suspected, any Ultimate Care Facility should accept an admission if they have vacancies and are able to offer a single room for at least 14 days. Fourteen days of isolation after admission is required.

b. New or returning admission from the community who are asymptomatic and not suspected of COVID-19 should have symptom checks daily for 14 days, reside in a single room with its own dedicated bathroom, have meals in their rooms and visit common areas.

c. If asymptomatic no PPE is required by staff or visitor (other than that required for standard precautions). If symptoms develop, they should be isolated with contact and droplet precautions and assessment sought.

4. New Admission: Respite

a. All Planned respite is cancelled.

b. Emergency Respite is available only after discussion with GM Clinical and CEO and the DHB's Planning and Funding team and is to be considered case by case with the facility and regional manager.

c. Any new emergency respite must be managed under the same isolation requirements as those residents entering long term care. This should be considered when emergency respite is considered.

d. An exit plan for the return to the community must be discussed with the facility, NASC and the family.

5. New Admission: into a secure dementia unit.

All admissions should be tested COVID-19 if they are symptomatic and meet clinical criteria for suspect COVID-19.

a. If COVID-19 **is not** suspected, Ultimate Care will accept an admission into a secure unit. The unit is then considered to be the person's 'household bubble'. Staff should practice safe distance and hand washing protocols. If close care is required, droplet and contact PPE is appropriate. Facilities should plan this close care and try to do this all at one time, as far as possible, to manage use of PPE.

b. If COVID-19 is suspected the NASC will liaise with the community nursing and or home support agencies to continue to support he person at home while they are waiting for test results and/or 14 days since last exposure with the suspected, probable or confirmed case (whichever is the longer). The resident WILL NOT be transferred into any Ultimate Care Facility.

c. Once a negative test result has been attained, the resident should still wait for the 14 days and **be symptom free before admission into the facility.**

6. **Admissions (transfer) from Hospital**

1. All Ultimate Care facilities will support the return of their residents from hospital once they are medically stable and have been reviewed by a clinician to determine whether the resident meets the clinical criteria for COVID-19, or there is clinical suspicion of COVID-19. If COVID-19 is suspected, testing will be undertaken prior to any re-admission back into the facility.

Ultimate Care Group will not accept any returning resident whilst waiting for the test results.

a. New or returning residents from DHB hospital who are asymptomatic and not suspected of COVID-19 should have symptoms checks daily for 14 days or the balance of the 14 days if there were in isolation in the hospital, reside in a single room with its own dedicated bathroom, have meals in their room and not visit common areas. If asymptomatic no PPE is required by staff or visitors (other than that required for standard precautions). If symptoms develop, they should be isolated with contact and droplet precautions and assessment sought.

7. Transferring of residents to DHB.

NON COVID-19 related transfer.

a. All Clinical Nurse Managers should continue to seek medical advice through their contracted General Practitioner/Nurse Practitioner.

b. The GP or CSM/Nurse Manager (when GP is unavailable) will access specialist advice by telephone (Geriatrician/General Medicine) prior to any transfer to hospital.

c. This advice will seek to support residents in their facility for as long as possible and will approve any transfer to hospital in advance. The Advanced Care Plan of the resident will be considered.

d. If a major medical event or injury has occurred and the, General Practitioner/Nurse Practitioner has been consulted, an ambulance will be called as normal.

8. Transferring of residents to family during the period of lock down.

a. Any request to transfer a resident from the facility bubble to the family household bubble during the COVID-19 Alert level 4 should be determined on an exceptional basis. The family and resident will need to understand that the transfer **is one-way,** and there will be no opportunity to return to the facility until level 4 has ended and there is agreement from the facility manager.

9. Family members visiting the facility

a. Where residents are receiving palliative care, visits will be considered on a case-by-case basis. The facility should be contacted in advance, and contact between family and staff, and family and other residents, should be minimal.

b. Visitor numbers should be limited to one visitor at a time and a maximum number of visits per day can be established on a case by case basis. PPE must be worn as per the guidance on use of PPE on the Ministry's website.

Related Links and References

Guidance for admissions into aged residential care facilities at Alert Leve 4 as of 11 April 2020 Ministry of Health.

Quality Assurance and Safety
Health System Improvement and Innovation
Ministry of Health 11 April 2020

6. GUIDANCE FOR MANAGING RESIDENTS WITH DEMENTIA ON ALERT LEVEL 4

Managing residents with dementia while on Alert Level 4

This advice provides information that may help to:

i. Reduce transmission of COVID-19 from resident to resident in aged residential care.
ii. Maintain care and quality of life for residents with dementia or cognitive impairment.

Preventing COVID-19 in residents with dementia

COVID-19 is highly contagious. As an organisation we recognise that social distancing for residents with dementia may be difficult to maintain and may heighten their anxiety and agitation.

Creating bubbles within your facility

1. You may like to think about creating small bubbles of residents within your facility. You could try to:

- Organise activities and mealtimes around the bubbles.

- Keep the same care staff within each bubble.

- Maintain a regular schedule with meaningful activities for your residents with dementia.

Caring for residents with dementia and COVID-19

Person-first – keep to basic principles of dementia care

- Know your residents: their likes, dislikes and triggers to behaviours that challenge.
- Understand the person's dementia type (e.g., Alzheimer's, Vascular, Lewy Body, Frontotemporal), as this may help you manage and understand their behaviours and distress.
- Even during this difficult time, focus on good care and quality of life.
- Create opportunities for residents with dementia to experience 'good moments' including keeping connected with whānau, while minimising the risk of transmission of COVID-19 to other residents.
- Consider increasing Diversional Therapy/Activity Coordination hours where possible as residents may need more one to one psychosocial support.
- Establish and/or facilitate regular communication with whānau from the facility and whānau member so they are kept informed about what is happening and how their whānau member is.

- Call on local experts to help you and/or support families, such as the local Dementia/Alzheimer's organisations, Nurse Practitioners (NP), general practice, geriatrician or psychogeriatrician.

Identifying residents with dementia with confirmed or suspected COVID-19

- Residents with mild dementia are likely to be able to tell you how they feel.
- Residents with moderate to severe dementia may show signs of illness through changes in behaviours, such as increased agitation, sleepiness, or increased falls.
- Notify your general practice of changes in health status of residents.

Isolation and notification of suspected and known cases

- If one of your residents is suspected or has a confirmed case of COVID-19 you need to notify your district health board (DHB) and Regional Public Health as COVID-19 is a notifiable disease or Healthline on 0800 358 5453.
- For suspected or confirmed cases of COVID-19 the resident should be isolated on the premises if admission to hospital is not required.
- If one or more confirmed COVID-19 cases have occurred within a residential care facility, an outbreak management team should be convened. For more information see Interim Advice for Health Professionals at health.govt.nz/covid-19 or Healthline on 0800 358 5453.
- Contact your Needs Assessment Service Coordination (NASC) to discuss options if needs change.
- For staff, isolate at home, or on premises if possible.
- If the above are not possible, contact your DHB and Regional Public Health to identify alternative quarantine options.

Develop a short-term care plan to maintain expert cares for residents with dementia and COVID-19

- Maintain good fluid intake, nutrition, and hygiene.
- Record daily observations, e.g., temperature, blood pressure, heart rate, respiratory rate, and O_2Sats.
- Closely monitor underlying conditions that could put people with dementia at greater risk, e.g. residents with diabetes should have regular blood sugar levels recorded.
- Residents' medications may need to be adjusted if underlying conditions are destabilised by COVID-19.
- Liaise closely with the resident and family for informed consent about what you are doing and why.
- Information for Hospice and Palliative Care facilities is available on **health.govt.nz/covid-19.**

Recognising delirium in residents with dementia

- If a resident with dementia exhibits any sudden change to normal behaviours and/or in level of alertness, consider delirium. More information

Caring for residents with dementia and COVID-19

Person-first – keep to basic principles of dementia care

- Know your residents: their likes, dislikes and triggers to behaviours that challenge.
- Understand the person's dementia type (e.g., Alzheimer's, Vascular, Lewy Body, Frontotemporal), as this may help you manage and understand their behaviours and distress.
- Even during this difficult time, focus on good care and quality of life.
- Create opportunities for residents with dementia to experience 'good moments' including keeping connected with whānau, while minimising the risk of transmission of COVID-19 to other residents.
- Consider increasing Diversional Therapy/Activity Coordination hours where possible as residents may need more one to one psychosocial support.
- Establish and/or facilitate regular communication with whānau from the facility and whānau member so they are kept informed about what is happening and how their whānau member is.
- Call on local experts to help you and/or support families, such as the local Dementia/Alzheimer's organisations, Nurse Practitioners (NP), general practice, geriatrician or psychogeriatrician.

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- Residents with moderate to severe dementia may show signs of illness through changes in behaviours, such as increased agitation, sleepiness, or increased falls.
- Notify your general practice of changes in health status of residents.

Isolation and notification of suspected and known cases

- If one of your residents is suspected or has a confirmed case of COVID-19 you need to notify your district health board (DHB) and Regional Public Health as COVID-19 is a notifiable disease or Healthline on 0800 358 5453.
- For suspected or confirmed cases of COVID-19 the resident should be isolated on the premises if admission to hospital is not required.
- If one or more confirmed COVID-19 cases have occurred within a residential care facility, an outbreak management team should be convened. For more information see Interim Advice for Health Professionals at health.govt.nz/covid-19 or Healthline on 0800 358 5453.
- Contact your Needs Assessment Service Coordination (NASC) to discuss options if needs change.
- For staff, isolate at home, or on premises if possible.
- If the above are not possible, contact your regional manager as well as DHB and Regional Public Health to identify alternative quarantine options.

Develop a short-term care plan to maintain expert cares for residents with dementia and COVID-19

- Maintain good fluid intake, nutrition, and hygiene.
- Record daily observations, e.g., temperature, blood pressure, heart rate, respiratory rate, and O_2Sats.

- Closely monitor underlying conditions that could put people with dementia at greater risk, e.g. residents with diabetes should have regular blood sugar levels recorded.
- Residents' medications may need to be adjusted if underlying conditions are destabilised by COVID-19.
- Liaise closely with the resident and family for informed consent about what you are doing and why.
- Information for Hospice and Palliative Care facilities is available on **health.govt.nz/covid-19.**

Recognising delirium in residents with dementia

- If a resident with dementia exhibits any sudden change to normal behaviours and/or in level of alertness, consider delirium. For further information see **here** or alternative New Zealand-specific advice if available.

Related Links and References

health.govt.nz/covid-19.

https://www.hqsc.govt.nz/our-programmes/aged-residential-care/publications-and-resources/publication/3975/

7. Guidance for managing staff/residents with COVID-19 infection

Managing residents/Staff with COVID-19 infection

These guidelines are interim and may be amended as the COVID-19 outbreak evolves. Aged care facilities are residents' homes where they are cared for by staff. There are multiple contact points between residents and staff daily, which increases the risk of transmission of COVID-19. If a staff member or resident is suspected of having COVID-19, the person has likely had contacts with multiple staff, residents, and visitors.

Guidelines:

Management of staff with suspected, probable, or confirmed COVID-19 infection (including close or casual contacts)

- It is critical that staff who are unwell, even with mild respiratory symptoms or a fever do not come to work.
- All staff with suspected, probable, or confirmed COVID-19 infection should isolate at home immediately.
- Staff who meet the criteria for a suspect case (symptoms of an acute respiratory infection however mild) should phone Healthline or their GP/ nurse practitioner, specify where they work, and arrange to get tested. If the test is negative, then unless advised otherwise by their GP/ nurse practitioner, provided they have been symptom free for 48 hours, they can return to work.
- Staff who are close contacts of probable or confirmed cases should not be at work. They should be quarantined at home for 14 days since last exposure with the case. Should they develop symptoms, they should phone Healthline or their GP and arrange to be tested.
    - If the test is negative, they should remain in quarantine until they have completed their 14 days and have been symptom free for 48 hours.
    - If the test is positive, then thee person is considered a confirmed case. If they are a confirmed case or meet the criteria for a probable case (refer to **COVID-19 case definition**) then they cannot be released from isolation unless advised by the health professional responsible for daily monitoring of their health and well- being. This is usually based on the following criteria: at least 10 days since onset of symptoms and at least 48 hours since resolution of symptoms (whichever is longer).
- Staff should follow advice from appropriate health care professionals, e.g., general practitioner, public health unit, contact tracing team or Healthline regarding clinical assessment, testing for COVID-19, self-isolation and release from isolation or hospital admission.

Management of residents with suspected, probable, or confirmed COVID-19 infection (including close or casual contacts)

- All residents with suspected, probable, or confirmed COVID-19 infection, **should be isolated immediately.** This will reduce risk of further transmission to other residents.
- Residents with clinical symptoms consistent with COVID-19 should be reviewed by their GP/nurse practitioner to determine whether they should be tested and/or whether there is another underlying cause for their symptoms that may require investigation or treatment. A resident who is being tested for COVID-19 should remain in isolation until test results are available.
- Unless in an outbreak situation, most people meeting the suspect case definition will NOT have COVID-19.
- Standard precautions and contact and droplet precautions should be undertaken by all staff when interacting with the resident as per the Facilities Pandemic Plan and infectious disease protocols for management of COVID-19. If the resident has probable or confirmed COVID-19, a clinical and risk assessment will need to be undertaken to establish the best place of care for the resident.
- Seek medical guidance on use of nebulisers for residents with COVID-19 as this is an aerosol generating procedure.
- When a facility is notified of a probable or confirmed case, the facility should work with their local public health unit, follow the Ministry of Health's online **Updated advice for health professionals: novel coronavirus (COVID-19)** to start identifying and isolating all other residents and staff who may be close or casual contacts, and convene their outbreak management team. All communications must be done in conjunction with the regional manager and GM Operations and Clinical.
- If a resident test positive for COVID-19, and medically do not need to be transferred to hospital, it is expected that the facility will continue to care for the resident if they can be appropriately isolated. The resident will require daily monitoring and symptom checks, especially looking for signs of deterioration which may require hospital admission. Monitoring may be undertaken by phone or in person depending on the health status of the resident. The facility should liaise with the DHB to ensure they receive the PPE needed for the duration of care whilst the resident is isolated for COVID-19.
- Please refer to the **Advice for Aged Care Providers – residents with dementia on Alert Level 4**.
- If isolation on premises is not possible, contact the local public health unit to identify alternative isolation options.
- Residents in isolation should have symptom checks daily, reside in a single room with own dedicated bathroom (This can be ensuite rooms or where not available a bathroom allocated for specific use of resident in isolation and cleaned after use), have meals in their room. Movement to other common areas of the residential home

is not permitted during isolation, however, thought must be given to how residents who are isolated can be escorted for a walk around garden, and how their cultural needs are met.

- The decision to 'release' a resident from isolation will be made by the health practitioner responsible for monitoring them and in line with the current **Updated advice for health professionals: novel coronavirus (COVID-19)** about release from isolation of confirmed or probable COVID-19 cases.

Related Links and References

health.govt.nz/covid-19 or **covid19.govt.nz**

Outbreak plan – COVID-19 and Influenza – like illness

Date		Facility		Reported by		Designation	

Key area to manage	Proposed action (how will it be achieved?)	Person/s responsible	By when	Sign & date as completed
SECTION 1 **First response** One or more residents with influenza-like symptoms identified or infection confirmed = **OUTBREAK RESPONSE INITIATED AND FACILITY IS CLOSED** Notes: ▪ Early recognition of potential outbreak is essential. ▪ Staff should report acute symptoms – or a change in condition of the resident. ▪ Immediate elevation to senior UCG management team who will consult with public health for decision to close	▪ Isolate symptomatic residents to their rooms o place signage on their door to highlight restricted access. ▪ Set up personal protective equipment (PPE) for each resident, print all signage, notify staff of affected. residents in isolation and strict hand hygiene practices and PPE application apply. ▪ Consider feasibility of isolating symptomatic residents to one wing of the facility. ▪ Request non-symptomatic residents stay in their rooms during the outbreak, to ensure social distancing occurs. ▪ Stop communal dining and group activities immediately.	▪ Most senior person on duty at the time oversees resident isolation process. **Note:** If not the manager, clinical service manager to be notified of outbreak and ensure registered nurses (RNs) on duty understand all required protocols. Regional Manager must notify GM Operations/GM Clinical immediately. **Note: Notification must be made as soon as possible after isolation has been set up – 24 hours per day/7 days per week.**	Immediately. **Containment becomes the priority.**	
	▪ Notify all staff on shift of the outbreak, including (if not already advised), laundry, housekeeper/cleaner on duty, diversional therapy/activities staff, kitchen staff and those coming in for next shift. ▪ Notify family/whānau of affected resident/s. ▪ Notify regional operations manager. ▪ Notify public health unit (or equivalent).	▪ Most senior person on duty notifies manager and staff. ▪ Manager notifies senior management. ▪ Manager phones the DHB and asks for public health authority, to notify and obtain outbreak number – communicate specific symptoms of affected residents to public health to assist with assessment of potential influenza or other illness (e.g. COVID-19) outbreak.		
	▪ Implement room set-up for infected resident/s: o Clean zone outside room set-up (to put PPE on).	▪ Most senior person on duty communicates process to staff.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person/s responsible	By when	Sign & date as completed
facility and declare outbreak.	o Staff remove their PPE off in room. Set up a yellow bio-hazard rubbish bag for collecting used PPE (in room). o Set up a black rubbish bag (or disposable linen bag) for their linen. Tie this bag off and transport to the laundry each shift, notifying laundry staff the linen is contaminated. o Remove non-essential equipment from affected resident's rooms and clean.	▪ Manager monitors infected resident rooms to ensure protocols are in place. ▪ Manager ensures yellow bio-hazard rubbish bags are collected regularly for turnaround into skips and black bags to the laundry.		
	▪ Use plastic bags for lining general rubbish bins: o dispose of each shift or when full into another yellow bio-hazard rubbish bag o securely tie off, transport to skip bin immediately.			
	▪ Commence outbreak plan. ▪ Commence outbreak case log. ▪ Complete outbreak daily situation report o continue to complete daily for the duration of the outbreak.	▪ Registered nurse (RN) updates log each shift. ▪ Reviewed by the manager daily at a set time e.g., 4pm after handover. ▪ Submit outbreak daily situation report to public health authority as well as regional operations manager who will brief GMs involved.		
	▪ Manager co-ordinates testing as advised by public health authority for suspected COVID-19.	▪ Manager with support from RNs as needed.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
SECTION 2 **Manage a 'facility closure'**	**Facility closure process:** 1. Decision to close is made between CEO/GM Operations/GM Clinical manager, senior management, and public health. 2. Oversee day-to-day management of facility closure and ensure actions are upheld by staff. 3. Convene outbreak management team (OMT).	1. Manager in conjunction with regional operations manager. 2. Clinical Services Manager (CSM) and RNs. 3. Manager and all other senior staff.		
	▪ Place relevant signage on all facility entrance doors advising the facility has restricted access due to an outbreak. Posters advise all visitors must report to reception first. ▪ Display any additional, illness-specific signage e.g., for COVID-19. ▪ Implement a reception sign-in process for all visitors.	▪ Manager or their delegate, change signage over.	Once Facility closure has been decided by CEO and Executive Management team.	
	▪ Notify all impacted parties, as per **SECTION 4: Communication, reporting and documentation**. o Ensure senior management are aware. o Notify public health authority and GP/NP practice. o Update the village resident community via the village resident committee chairperson (as applicable). o **Contact all resident families** by phone, to update on status, to avoid visitors arriving and being disappointed. Maintain a correspondence log. o Contact contractors and service providers where relevant.	▪ Manager notifies public health authority, GP/NP. ▪ Regional manager asks village manager to notify resident committee chairperson. ▪ Receptionist can manage general communication e.g. 'ongoing restricted access due to outbreak'. ▪ Manager, CSM and RNs keep resident family/s informed of their condition, by phone.		
	▪ Record an outbreak event in '1Place' management system. Record all activity pertaining to the facility closure within this record.	▪ Manager oversees this. Other staff and reception to contribute as directed by the manager.	Immediately and ongoing	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	o See **SECTION 4 Communication, reporting and documentation** for details.			
	▪ Support all residents to remain in their rooms. o Enforce physical distancing including **cancellation** of group activities and communal dining.	▪ Manager/CSM to provide direction. ▪ All care staff to support and enforce.		
	▪ Restrict staff access to facility. o Arrange alternatives for non-care staff to access laundry and kitchen access.	▪ Manager arranges and communicates instructions. This can be delegated.		
	▪ Laundry staff are not permitted to deliver clean linen and clothing to any infected resident's room. o Laundry staff leave clothing trolleys for care staff to deliver.	▪ Manager/CSM directs laundry staff. ▪ Manager organise for care staff to deliver infected resident clothing and oversee this practice.		
	▪ Adjust cleaning and other services provided to village residents to minimise risk of transmission from the facility or alternatively consider risk of transmission from village residents to the facility. o Aim to reduce staff working across the village and facility depending on where infected residents are living.	▪ Manager to provide alternative instructions to staff for managing village services.		
	▪ Place facility admissions and transfers on hold until manager deems they are appropriate to resume. o Includes liaising with families, district health board and needs assessment and service coordination (NASC).	▪ Manager. ▪ GM Clinical/CEO	Immediately and ongoing.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Restrict external visitors except for family and friends who are considered essential to the welfare of the resident e.g., end-of-life – manager to approve. ▪ Contractors are only allowed access for urgent services and works. This must be approved by GM Property. The nature of the work must be understood by facility staff. o Supply PPE and instructions where there is risk of transmission to contractors e.g. if working in infected resident's rooms/area. ▪ Supplies must be delivered using a non-contact process where possible unless this poses security or manual handling risk e.g.: o controlled drug deliveries that need to be accepted and signed for o large bulky supplies that require safe stowing – property teams to support as able. ▪ Delay prospect visits and cease all communal social events and outings.	▪ Manager oversees this but may delegate to the CSM, or receptionist. ▪ See **SECTION 4 Communication, reporting and documentation** for more info.	Immediately and ongoing.	
SECTION 3 **Care for affected residents** Goal: ▪ Contain the infection and reduce the spread.	▪ Confine symptomatic residents to their rooms until cleared by public health authority – generally 48 hours symptom-free but could be longer depending on the illness e.g., 14 days for COVID-19. ▪ Have a plan for residents with cognitive impairment: o cohort into small groups during the day with a staff member assigned to supervise all movements. o use sensor mats when in bed to alert resident is moving o ensure holistic needs are met to avoid behaviour developing that increases risk to them and others o wash the resident's hands frequently o clean surfaces continuously.	▪ Manager/CSM ensures RN on duty: o directs care o reviews chart/s every shift o ensure staff use PPE and follow hand hygiene practices correctly o education including demonstration at each change of shift.	Immediately and in response to new cases.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Cohort staff = a key step to reducing infection spread. o One group of staff care for infected residents – ensure equipment such as iPads/tablets do not enter affected resident's rooms and are not shared between staff cohorts. o The other group care for non-infected residents. o Aim to maintain this for night duty which can be a challenge during outbreaks – spread occurs easily at night if staff cohorts are not maintained. o Set up separate areas for each group of staff including break rooms, toilets/showers if possible. ▪ Avoid group gatherings of staff including meetings, shared meals and food. ▪ Maintain physical distancing at handovers. ▪ Ensure all staff are correctly applying and removing PPE each shift. ▪ Supply staff rooms with refreshments for staff to support them in their work.	▪ RNs on duty.		
	▪ Monitor resident's clinical condition: o check vital signs **four-hourly** while resident symptomatic o report any decline in condition to GP/NP or seek additional medical and clinical assistance for the resident. Note: refer to Frailty Care Guides where relevant o consider transfer to hospital if clinically indicated: follow hospital transfer procedure.: Policy: ***1.B5 COVID-19 Guidance for admissions*** ▪ Advocate for resident's clinical care needs as indicated. ▪ Keep family/whānau informed.			

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Commence the following documentation for each infected resident: o chart/s, as directed by the CSM including food and fluid charts, turning charts, output charts o short term care plan (STCP) evaluated by RN each shift.			
SECTION 4 **Communication, reporting and documentation**	▪ Notify senior management of the outbreak and cease access for visiting.	▪ Manager/or regional manager. ▪ Follow specific guidelines for notifying ARC Infection Control Team at DHB as well as funding and planning manager	Within 24 hours of outbreak being suspected. Ongoing for duration of outbreak.	
	▪ Notify primary care team – GP practice or NP.	▪ Manager or CSM.		
	▪ Update the village resident communit *(if applicable to your facility)*	▪ Manager.		
	▪ Notify relevant contractors, service providers, volunteers as relevant. i.e. Pharmacy Services, Physio etc.; All building contractors will be notified by GM Property	▪ Manager delegates to appropriate staff member/s.		
	▪ Enter an event in the incident management system, i.e 1Place as soon as reasonably practical: o record all outbreak-related information, 'running commentary' and documentation relating to the outbreak via the event record.	▪ Manager enters an outbreak event in the incident management system. ▪ Manager/CSM and/or RNs manage the record-keeping for the duration of the outbreak.	Within 24hrs of outbreak being confirmed. Update daily.	
	Complete these records for each infected resident: ▪ case log and/or	▪ Manger, CSM or RN manage individual infection event records in 1Place	For each new case.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ resident infection event in the incident management system: o record information, running commentary and documentation relating to the event.		Update every duty.	
	▪ Notify families of outbreak (with infected resident's families as a priority), by phone: o suggest they call the office daily for an update, otherwise the nursing team will call if there are concerns, or the resident's condition changes. o encourage co-operation with restricted visiting. ▪ Record phone calls via each person's resident correspondence log.	▪ Manager and/or RN for initial phone call. ▪ Manager, CSM or RN for ongoing updates.	For each new case. Update with changes in condition.	
	▪ Hold daily meetings with OMT to discuss status of outbreak: o document all meetings.	▪ All essential staff: manager, CSM, kitchen manager, laundry, housekeeping. ▪ All to attend daily meeting at an agreed time in the morning: o Manager records the meeting minutes. o Attendees disseminate information back to their respective teams. o Send completed report to public health contact daily.	Daily.	
	▪ Enter an event in 1Place for each infected staff member (not resident).	▪ Manager.	As required.	
	▪ Keep the case log up to date. ▪ Email to public health daily or as instructed	▪ Manager.	Daily.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
SECTION 5 **Kitchen / food service management and staff**	**Staff movements:** ▪ Only kitchen staff are permitted in the kitchen. **No** access is given for other staff. ▪ Kitchen staff are not permitted in residents' rooms. ▪ Kitchen staff are only permitted in the non- affected staff cohort staffroom for their break during an outbreak.	▪ Manager directs kitchen manager and reviews daily, to identify any issues. ▪ Kitchen manager directs all other kitchen staff. ▪ CSM/RN oversee care staff in the facility.	Immediately and ongoing. Actions do not cease until advised otherwise by manager.	
	Food service: ▪ Prepare all food in the kitchen. ▪ Transport to the facility in a hot box and/or staff collect trays from a given point. o Staff caring for infected residents deliver meals to rooms of those residents. o Non-affected residents continue to receive normal meal service in their rooms unless otherwise directed by the manager. ▪ Meals are served on disposable dinner ware, which are placed on top of plates/dishes located in their room, unless the resident can safely manage food and fluids from the disposable dinner ware. o Hold infected residents' dishes in their room for the duration of the outbreak.	▪ Manager directs kitchen manager and reviews daily, to identify any issues. ▪ Kitchen manager directs all other kitchen staff. ▪ CSM / RN oversee care staff in the facility.		
	Dishwashing ▪ Wash infected resident dishes in their room. o Dispose of infected resident disposable dinner ware in the rubbish – dishes and cutlery remain in their room. ▪ Non-symptomatic residents have their dishes collected by staff using PPE. Leave trolley outside the kitchen.	▪ Manager oversees the process and ensures staff understand the process well and the rationale. ▪ Staff caring for residents take allocated trolley to agreed area for kitchen staff to collect. ▪ Staff caring for infected residents ensure their dinner ware and crockery is properly cleaned in their room.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Kitchen staff wear PPE for dishwashing and ensure gloves are changed when moving from dirty dishes to handling clean dishes. ▪ **Dementia care:** Staff should wash dishes before they leave the unit to return dishes to the main kitchen.			
	Food choices ▪ Depending upon the infection type, the menu may require adjustment. ▪ If so: the CSM discusses and agrees alternatives with the kitchen manager.	▪ CSM oversees the menu, with the kitchen manager and ensures alternatives are available.	Immediately and ongoing. Actions do not cease until advised otherwise by manager.	
	Communication ▪ Provide daily status update to kitchen team.	▪ Kitchen manager attends daily outbreak management meetings and reports back to kitchen staff.		
SECTION 6 **Laundry service management and staff**	**Staff movements** ▪ Laundry staff are not permitted to enter or deliver clean linen and clothing to infected resident's rooms. o Laundry staff leave clothing trolleys for care staff to deliver.	▪ Manager directs laundry staff. ▪ Manager organise for care staff to deliver infected resident clean clothing and oversee this practice.	Immediately and ongoing. Actions do not cease until advised otherwise by manager.	
	Launder clothing and linen ▪ Infected resident's laundry is placed in black rubbish bags which are kept inside the resident's room. Alternatively use disposable linen bags where possible: o care staff seal this bag securely before transporting to the laundry. ▪ Launder non-infected residents' laundry as per normal process.	▪ CSM / RN ensure care staff manage laundry as per plan. ▪ CSM: o check each shift the correct cycle for infected linen is used by laundry staff. ▪ Laundry staff manage laundering.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	○ Wash and dry first ***before*** infected residents' laundry is washed and dried. ▪ PPE must be worn by laundry staff when handling soiled linen. This should include gloves, goggles, apron and face mask if the soiled linen is from an infected resident.			
	Clean the laundry area ▪ Thoroughly clean and disinfect the laundry area (bench tops and commonly touched surfaces) at the end of each shift. ○ Use detergent in warm water and disposable cloth followed by disinfectant solution. ○ Leave to air dry.	▪ Laundry staff clean and disinfect laundry area.	End of each shift.	
	Laundry effort and hours ▪ Monitor and assess the need to add additional laundry hours during an outbreak. ▪ Where an outbreak becomes protracted or is difficult, consider outsourcing laundry services: ○ if an external laundry service is used, they must be informed about the outbreak, so they know to take necessary precautions to avoid infection.	▪ CSM.	If required.	
SECTION 7 **Housekeeping management and staff**	**Chemicals and PPE** ▪ Make up disinfectant solution every 24hrs, ○ Refer to the manufacturer instructions for dilution, ○ Ensure bottles have a date and time sticker and are replenished every 24 hours, ▪ Housekeeper checks stock daily and advises manager of order requirements e.g., ○ gloves, hand sanitiser, disposable cloths, disinfectant solution	▪ Night staff make up the solution. ▪ Housekeeper ensures product is stocked on the trolley. ○ Discard all bottle contents at the end of the outbreak. ▪ Manager arrange replacement stock orders. ○ See **SECTION 7: Manage outbreak supplies** for details	Daily.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	Housekeeping procedure ▪ Housekeeper cleans communal areas first, including public toilets, handrails, door handles. ▪ Housekeeper cleans non-infected resident rooms. ▪ Caregiver assigned to the infected residents cleans infected resident's rooms: o Wear disposable long sleeve plastic apron, gloves and mask. Change between each resident's room clean. ▪ Cleaning trolley is not to be taken into the infected resident rooms. Instead: o take in materials you require i.e., detergent and warm water in a bucket, disposable cloths/paper towels o clean first, then disinfect o do not exit the room with PPE on. Discard cleaning cloths and PPE into the resident's plastic rubbish bag inside the room o wash hands before leaving the room. ▪ Pay special attention to soap dispensers and hand sanitisers to ensure these are well stocked.	▪ CSM directs all housekeeping. ▪ RN ensures care staff follow cleaning procedures. ▪ Housekeeper checks stock daily and alerts manager to what needs to be ordered: o e.g., gloves, hand sanitiser, disposable cloths, bleach tablets.	Immediately and ongoing. Actions do not cease until advised otherwise by the CSM.	
	Extra cleaning ▪ Complete extra cleaning 3 x daily for the following: o touch points, surfaces, communal bench tops, staff areas, doors in communal spaces o phones, walkie talkies and computer keyboards o communal and staff toilets including door handles, taps and doors where hands touch them to open o tops of communal rubbish bins, including staff room.	▪ PM and night shift care staff clean these areas once during their shift.	Daily.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	Carpets ▪ Vacuum and steam clean carpets as and when directed by the CSM.	▪ CSM decides whether to outsource or use housekeeping staff.	As directed.	
	Soft furnishings ▪ Clean with detergent and warm water and if possible, steam clean, as and when directed by the CSM or manager.	▪ CSM decides whether to outsource or use housekeeping staff.	As directed.	
	Terminal cleaning ▪ Complete once the resident is 48 hours symptom-free. ▪ Launder curtains or steam clean in place.	▪ CSM directs housekeeper and care staff.		
	Housekeeping hours ▪ Monitor and assess the need to add additional Housekeeping hours during an outbreak o Additional hours will be needed to ensure Terminal cleaning is thoroughly carried out	▪ CSM manages this.	When required.	
SECTION 8 **Manage outbreak supplies**	▪ Store outbreak equipment in a central location, easily accessible by all staff. o Minimum of six plastic buckets is required, containing all outbreak PPE. o Infection control coordinator completes PPE stock audits every day.	▪ Infection control coordinator. ▪ Infection control coordinator and RNs oversee and guide staff on duty regarding PPE use.	Every day. Immediate and ongoing during outbreak.	
	▪ CSM checks outbreak PPE stock daily when in use and at the end of every shift, to ensure there is enough: o Order stock as necessary.	▪ CSM oversees stock and order/reorder. ▪ RNs ensure PPE is restocked before the next shift comes on.	When required. Ongoing during outbreak.	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ CSM reviews all other outbreak stock requirements for the infection as per outbreak kit audit tool, e.g. barrier cream, medication: o Order stock through the relevant supplier.	▪ CSM.		
	▪ Cleaning staff communicates PPE and cleaning chemical requirements: o Order stock as required.	▪ Cleaner advises manager and/or CSM.		
SECTION 9 **Resident visitors, outings and appointments**	▪ Display outbreak signage as directed by manager on all facility entrance doors – these advise visitors and other residents of the outbreak. ▪ Display any additional, illness-specific signage e.g. for COVID-19.	▪ CSM or infection control coordinator, or their delegate, put signage up once 1 or more cases confirmed.	Immediately with 1 or more cases.	
	▪ Postpone all non-essential services, such as hairdresser, podiatrist until after the outbreak.	▪ Manager.		
	▪ Postpone all non-essential care resident outings and appointments, as assessed, and directed by the CSM.	▪ CSM assesses appointments and outings. ▪ CSM, manager or postpone.		
	▪ Visitors are permitted as agreed with CSM and/or manager but must wear PPE when visiting an infected resident. ▪ Staff should: o provide basic education to incoming visitors, including use of PPE o remind visitors they are not permitted to visit multiple residents.	▪ Manager or receptionist, or any other staff member that greets the visitor	Ongoing until otherwise notified by CSM	

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Resident transfers to other facilities should be avoided. o If the transfer is essential, notify the receiving facility of the infection type that the resident and facility has/had. If COVID 19 suspected please refer to Policy Guidelines for managing admissions, transfers, and discharges.	▪ RNs manage any transfers. ▪ RNs advise hospital of outbreak should any acute admission be required for a resident.		
SECTION 10 **Manage staff education, infection and rostering**	▪ Display outbreak staff information in the staffroom. ▪ Display any additional, illness-specific signage e.g., for COVID-19. ▪ Discuss the following outbreak-related information at each handover, and with other key people: o vigorous focus on handwashing and use of PPE. o update on outbreak status. o other relevant infection control education information.	▪ CSM ensures all signage is in place. ▪ CSM/infection control coordinator ensure education for staff is in place and provide oversight daily. ▪ CSM / RNs oversee outbreak information at handovers. ▪ CSM liaises with team daily to update outbreak status.	Immediately and ongoing. Immediately and ongoing.	
	▪ Non-essential staff are not permitted to enter suspected or confirmed COVID-19 infected resident rooms.	▪ CSM/RNs oversee this.		
	▪ Staff must advise CSM or manager immediately if they experience symptoms. o Add infected staff onto the case log. ▪ Infected staff are not permitted to return to the work until **48 hours** after last symptom. o Staff update the CSM or manager. ▪ Staff are made aware specimens can be requested from them. o These will need the outbreak number attached. o This cost is covered by the facility.	▪ All staff report any symptoms to the RN on duty. o RN on duty updates the case log. ▪ CSM may request specimen and will provide staff with the outbreak number.		

Outbreak plan – COVID-19 and Influenza – like illness

Key area to manage	Proposed action (how will it be achieved?)	Person responsible	By when	Sign & date as completed
	▪ Review roster daily, including planning for managing infected staff. ▪ Bureau staff may be called in but must be advised prior to agreeing to work and **will not** be asked to care for infected residents.	▪ CSM reviews rosters daily. Assess bureau needs at the same time. ▪ Manager, CSM or RN book bureau staff, and advise of status upon booking.		
SECTION 11 **Outbreak debrief meeting** After an outbreak has ended, a staff meeting is arranged to discuss and debrief the event	▪ Decision to open the facility is made between the manager, regional manager CSM and public health. ▪ Organise the debrief meeting; include all clinical staff. o Run the meeting over several days if required, to capture key people. o Document the meeting and attendance. ▪ Discuss and reflect upon the outbreak. Cover: o what went well o identify opportunities for improvement.	▪ CSM organises and facilitates the debrief meeting.	Within two weeks of the outbreak ending.	
	▪ Record findings and a summary of the outbreak, including learning and improvement opportunities.	▪ Manager and CSM.		
	▪ Retain all information pertaining to the outbreak, including an outbreak summary report in the infection control folder under the month it occurs and recorded against the incident management system.	▪ CSM and infection control coordinator.		

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

APPENDIX 4

WCDHB - Infection Prevention and Control Service

ARC Quick Environmental Audit

Name of Auditor 9(2)(a)
Facility Oldcastle Home
Nurse Manager 9(2)(a)
Date of Audit 17/04/20
Date of Feedback

SECTION 1: GENERAL ENVIRONMENT

Standard: Clinical areas are visibly clean, uncluttered and maintained appropriately to minimise cross infection.

		C	NC	P	NA
HAND HYGIENE FACILITIES					
1.	Hand washing facilities are clean, available and access is clear	✓			
2.	ABHR is available	✓			
DETERGENTS/DISINFECTANTS					
3.	Detergent or detergent wipes are available for general environmental cleaning of surfaces	✓			
4.	Approved disinfectant (bleach product or other hospital grade disinfectant active against viruses) is available	✓			
5.	Correct dilution/refreshing of disinfectant every 24 hours	✓			
6.	Alcohol impregnated wipes are available for sensitive equipment	✓			
7.	Designated housekeeping staff	✓			
DIRTY UTILITY/SLUICE ROOM					
8.	The dirty utility or sluice area is visibly clean and tidy	✓			
9.	There is a designated hand wash basin in this room, with soap and paper towels present	✓			
10.	There is a facility to safely sanitize equipment e.g. bedpans/urinals /bowls	✓			
WASTE MANAGEMENT		x1 Domestic x1 nursing x1 catering			
11.	There is correct segregation of waste	✓			
12.	Infectious/medical waste bins with foot-controlled lids are available	✓			
13.	Waste bags awaiting collection are stored in a non-public area	✓			
14.	ABHR/HWB is available for use after handling waste	✓			
SOILED LINEN					
15.	Linen bags are secured and stored in a secure area for collection	✓			
16.	Soiled linen from isolation rooms is handled/laundered separately	✓			
17.	Staff working in laundry do not provide patient care	✓			
18.	Dirty and clean linen is segregated	✓			
19.	Personal clothing is laundered separately for each patient/resident		✓		
20.	Hand hygiene and personal protective equipment is available				

Comments

Both in case handy access.

WCDHB, IPC, april 2020 – supplied by CDHB.

C	Compliant	123
NC	Non Compliant	
P	Partial	

SECTION 2: PATIENT ROOMS

Standard: Facilities and appropriate products are available to ensure effective hand hygiene and standard precautions are undertaken.

		C	NC	P	NA
21.	ABHR is available at each resident's room	✓			
22.	Disposable gloves in a range of sizes are available	✓			

Comments

SECTION 3: PATIENT CARE EQUIPMENT

Standard: Patient care equipment will be cleaned/decontaminated and stored safely and appropriate resources made available to minimise the risk of cross infection

		C	NC	P	NA
23.	Manual handling sheets, hoist slings and slides are cleaned between patients	✓			
24.	Are commodes used	✓			
25.	Commodes are individually assigned and disinfected between patients	✓			

Comments pt own slings cleaned between

SECTION 4: COMMUNAL PATIENT AREAS

Standard: Communal patient areas shall be maintained appropriately to minimise the risk of cross infection.

		C	NC	P	NA
TOILETS & BATHROOMS					
26.	Are bathrooms/toilets shared between residents?	✓			
27.	How are residents in isolation showered/toileted	✓			
28.	Toilets are visibly clean	✓			
29.	Bathroom areas are free from communal items which may be contaminated e.g. creams, talc	✓			
30.	Showers are clean, intact and free from mould	✓			
31.	Linen is not stored in open shelves in bathroom areas	✓			
32.	Staff have a separate toilet from residents	✓			

Comments Resident lock shared bathroom. 27. separate toilet/shower.

C	Compliant
NC	Non Compliant
P	Partial

SECTION 5: STANDARD AND TRANSMISSION-BASED PRECAUTIONS

Standard: Care will be planned for individual patients using precautions necessary to prevent the spread of infection, taking into account the needs of the patient and other patients

		C	NC	P	NA
33.	Sufficent PPE stock on hand	✓			
34.	PPE Donning/doffing areas are identified	✓			
35.	Staff have received training in donning/doffing PPE	✓			
36.					
37.	Disposable gloves, aprons and gowns are available/worn	✓			
38.	Surgical masks are available/worn	✓			
39.	Safety glasses/protective eyewear is available/worn	✓			
40.	The correct transmission-based precautions signage is available and used appropriately	✓			
41.	Eye protection is cleaned and disinfected after use	✓			

Comments plastic aprons - shortage / personal cares. no masks
➡ . noted by CDHB IPC

SECTION 6: KITCHEN AND FOOD / BEVERAGE FACILITIES

Standard: Kitchen and food handling areas conform to Food Safety Authority guidelines

		C	NC	P	NA
42.	Kitchen staff are not involved in patient cares or laundry	✓			
43.	There are hand hygiene facilities available	✓			
44.	Are there any filtered water units available in facility	✓			

Comments Dedicated unit last serviced. note cares.

SECTION 7: COVID-19 OUTBREAK MANAGEMENT

		C	NC	P	NA
45.	COVID-19 Outbreak management plan available	✓			
46.	CDHB Planning and Funding liaison person identified	✓			
47.	Staffing contingency plan available	✓			
48.	Community & Public Health contact details known	✓			
49.	Staff know how to launder their uniforms				

NCDHB

Overhead manual collated.
forms included - + contacts.

staff & residents check daily -
4 1
Temp questions temp.
medimap.

POLICY: OUTBREAK MANAGEMENT

[NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standards
Refer: Contact Isolation, Infection Prevention and Control Procedures, Infection Prevention and Control Policy]

An outbreak may be described as an epidemic or an increase in the normal or expected level of healthcare associated infection within a facility. The goal of managing an outbreak is to prevent further infection to other residents or staff of the facility and to identify factors which may have contributed to the outbreak. This allows for the development and implementation of measures to prevent further outbreaks. The most common outbreaks to occur in O'Connor Home will be viral gastroenteritis, respiratory tract infections and scabies.

When an outbreak occurs, it is imperative that ***immediate action*** is taken to prevent further transmission to resident and staff. The action required is dependent on the nature and severity of the infection; however, some basic principle must be followed.

Step 1 – Recognise the outbreak and prepare to investigate

Determine the existence of an outbreak. The background occurrence of the infectious disease must be known to judge whether this new information is a normal variation in rates or is the onset of an outbreak. Determine the need for immediate control measures and notify and communicate to all the healthcare workers, management and the local Public Health Unit if necessary.
At this time, it will be important to mobilise the outbreak management team.

Step 2 – Verify the diagnosis and confirm that an outbreak exists

Once the background rate of infection has been determined, comparison can be made with the current infection rate to decide if an outbreak has occurred or is occurring. Review each case and ensure there are no discrepancies between diagnosis and laboratory findings. Confirm cases and identify the infectious agent when possible.

Step 3 – Establish a case definition and find cases

Establish a set of standard criteria to decide whether or not a person has the disease of concern.

In the case of gastroenteritis or food borne illness, two or more cases of vomiting and diarrhoea (not related to disease process or medication) among residents and staff in an institution constitute an outbreak in a 24-hour period.

Influenza like illness is defined as three or more cases of influenza like illness in a facility during a period of 72 hours.

An outbreak of influenza may be defined by three cases of acute respiratory tract illness in the facility during a period of 72 hours with at least one of these being laboratory confirmed as a pathogen i.e. influenza.

Once a case definition is developed it is important to review all residents and staff to find cases which meet this definition, then list (line list) all the cases and update the list with new cases as they are identified.

Step 4 – Characterise the outbreak by person, place and time

Documentation must be compiled by a designated staff member regarding all affected residents, staff and visitors. The following information is required:

- person's name

- date of birth
- date of admission
- location of resident in facility
- date and time of onset of symptoms
- presenting symptoms
- date of resolution of symptoms (if available)
- specimens sent for pathology analysis and results if available

Examination of the data regarding person, place and time provides information about the agent, the source or reservoir, the means of transmission and host factors. From this information, a tentative hypothesis or explanation for this particular disease transmission and its probable source can be identified.

Step 5 – Determine who is at risk

Identify the risk groups and the number of people ill or who may become ill and initiate precautionary measures such as:

- Use of standard precautions and appropriate transmission based precautions
- Increase frequency and efficiency of environmental cleaning using appropriate products
- Prophylactic treatment/immunisation
- Antibiotic restrictions
- Exclusion of cases from high risk activities
- Isolation and/or cohorting of residents
- Restricting movement of residents, staff and visitors
- Screening of patients with isolation of residents and cohorting of contacts
- Provision of health information and advice to all residents, staff and visitors

Step 6 – Develop an hypothesis of how and why this may have occurred

Develop hypotheses from the information gathered on the potential source of infection, the vector, the pathogen and/or the route of transmission.

The type of outbreak should be identified as:

- *Common source outbreak*: exposure to a common or harmful substance e.g. food borne illness.
- *Propagated outbreak*: direct or indirect transmission of an infection from an infected person to a susceptible person e.g. person to person transmission by a vector such as mosquitoes. These cases usually occur over a longer period than in common source outbreaks. Determine if the hypothesis explains the situation for the majority of cases.

Based on the hypotheses, plans should be developed for the care of the sick, control of transmission and prevention of illness.

Step 7 – Test the hypothesis with the established facts

Analyse the data and compare risk factors among ill (cases) and those not ill and identify the attack rates. Determine if the hypothesis explains the situation for the majority of cases.

Step 8 – Carry out further studies if necessary

This may involve testing faecal specimens, sputum specimens, environmental samples, food samples or environmental screening in some situations (e.g. Legionella, or Pseudomonas outbreaks)

Step 9 – Implement ongoing infection prevention and control measures

Standard precautions and appropriate transmission based precautions will need to be implemented to prevent further illness to:

- Restrict spread from the case
- Interrupt chain of infection
- Interrupt transmission or reduce exposure
- Reduce susceptibility to infection
- Assessment of policy, regulations, standards

Step 10 – Communicate findings

Document the type and time of implementation of infection control measures. Monitor factors contributing or affected by the outbreak and any changes noted**.**

Notification

Notification of an outbreak must be ***prompt*** and initially be made to the person in charge of the facility. It is the responsibility of the person in charge to notify the Manager/Nurse Manager or designate who will assess the situation and advise the following members of staff:

- Outbreak Coordinator
- Medical Officer in charge of the resident's care
- Manager/Nurse Manager
- Chief Executive Officer
- Consulting Microbiologist (as required)
- DAA (Designated Auditing Agency), Janice McEwen – 03 329 6477

Initial notification to these personnel must be made 7 days a week. Early notification will enable determination of isolation requirements and institution of an outbreak management plan.

Infectious Diseases notification should be directed to the local District Health Board/ Medical Officer of Health and should be initiated within 24 hours of diagnosis. To maintain confidentiality, notification **must not** be made by facsimile.

Immediate action is aimed at preventing the spread of the infection.

- Any resident suspected of having the infection is to be isolated using appropriate additional transmission based precautions (airborne, droplet or contact).

- Staff who may be affected must stay home until clinically recovered.

- Any staff returning from work after this infection or staff known to be immune should nurse clinical cases.
- Staff will be reminded/educated about protective effects of hand hygiene and Standard precautions. (Include education for visitors)

- In the event of an epidemic outbreak, the District Health Board carries responsibility to provide Personal Protective Equipment.

Appropriate specimens will be submitted to the laboratory on each newly identified case so the causative agent is defined and sub typed if necessary. Line listing/reporting requirements will be followed. (Page 131).

An investigation will be carried out by Management and the Infection Prevention and Control Officer as required to identify possible source of infection

The Infection Prevention and Control Officer will liaise with medical staff, laboratory staff and if necessary Infection Prevention and Control consultant to ensure that correct procedures for identifying, controlling and treating the outbreak are followed.

After consultation with relevant medical personnel and consultants, the Infection Prevention and Control Officer will provide feedback and education as required to management, staff, residents and if necessary, visitors. Any new control measures or procedures will then be put in place.

If the infection is notifiable, the Medical Officer of Health will be contacted.

A detailed written report will be made by the Infection Prevention and Control Officer, covering all aspects of the outbreak from initial notification that an outbreak has occurred to the final resolution. Feedback to staff will occur through regular staff meetings.

In service education, will be developed using the above information to prevent / limit further outbreaks.

Outbreak Related Activities:

If an outbreak of infection is identified or suspected the following infection prevention and control actions will immediately be implemented

Standard and additional Transmission Based precautions (airborne, droplet or contact) will need to be implemented.

Emphasis of the importance of thorough hand hygiene before and after direct resident care, together with the use of protective apparel, must be made to all staff. It is necessary to carry out all of the following measures:

- During an outbreak of infection an alcohol based hand rub should be located within the room of each affected resident to ensure staff clean their hands as the last task carried out before moving to another task.

- Staff entering the room must wear appropriate personal protective apparel of medical examination gloves, impervious long sleeved gown or apron and appropriate fluid repellent masks

- Isolation or cohorting of infected residents is essential to contain the further spread of the outbreak. Isolation must remain in force until the resident is symptom free

- If several residents have the same symptoms then cohort (grouped) nursing may be appropriate. Cohort nursing involves one carer or group of carers who exclusively look after the infected group of residents whilst other carers look after the uninfected residents.

- Restriction of allied health personnel, non-essential staff and visitors entering the ward/unit may be necessary to confine and contain the outbreak.

- Relatives and visitors should be advised not to offer any nursing assistance to their relative or to other residents in the same facility. Small children and babies should not visit during the outbreak and visitors should be advised to wash hands before leaving the area.

- Staff working within the facility should not be relocated to other areas until the outbreak has ceased.

- Where appropriate, pathology specimens must be taken for culture and identification of organisms, from all affected persons both residents and staff.

- The Manager/Nurse Manager/Infection Prevention and Control coordinator should monitor staff pathology results and liaise with the infection control consultant or consultant microbiologist.

- Facility closure to further admissions may be necessary during an outbreak where there is a risk of severe illness or even death.

- Determination of facility closure will be made by the Manager/Nurse Manager or delegate in liaison with the resident's Medical Officer and other members of staff already notified.

- Where closures and isolation restrictions are implemented residents, relatives and staff must be informed of reasons and procedures for isolation.

During an outbreak, the frequency of cleaning will need to be increased. After the initial clean with neutral detergent, a second clean with a disinfectant may be warranted depending of the type of organisms. The cleaning process must involve either:

  - Physical cleaning using detergent followed by a chemical disinfectant (2-step clean) i.e. clean with detergent, then clean with a disinfectant
  - Physical cleaning using a detergent and chemical disinfectant (2-in-1 clean) i.e. a combined detergent/disinfectant wipe or solution could be used if this process involves mechanical/manual cleaning (NHMRC 2010)

- Rooms of well residents should be cleaned first. Attention must be paid to the cleaning of bathrooms, toilets, door handles, handrails, commode chairs and other areas frequently touched by affected residents.

- Rooms of residents in isolation should be cleaned with yellow colour coded cleaning equipment.

- Staff assigned to cleaning duties should not have access to the kitchen during an outbreak.

- The Outbreak Coordinator must report to the Manager/Nurse Manager on a daily basis during the period of outbreak of infection.

O'Conor Home

Staff Contingency Policy

H&DSS 2.8.1(c)

Rationale: To cover the shortfall in staffing in the advent of an emergency situation, such as Covid-19, where staff numbers are depleted through emergency sickness, annual leave or family demands.

Specific staffing requirements are outlined within the Ministry of Health contract. The ratio of staff per resident numbers must be adhered to so the provision of services meets their needs.

In the case O'Conor Home finds it has a large number of rostered staff unavailable our staff contingency plan includes the following steps to meet contracted requirements:

Step 1: All rostered staff hours will be increased

Step 2: Staff working under a casual contract will go to full time hours

Step 3: Staff working under a part time contract will go to full time hours

Step 4: Diversional therapists will move into the role of carers

Step 5: Registered nurses will undertake caring roles

Step 6: The Clinical Managers will perform the duties of registered nurses

Step 7: The Service Manager, Quality Manager and General Managers will support the overall business ensuring correct practices and procedures are adhered to during an emergency situation

Step 8: The rosters will be completed by the General Manager, freeing up the Team Leader for full shifts as a carer. All leave will be cancelled to further supplement rostered staff numbers. If there is a necessity shift hours will be increased to 12 hours per shift per staff. Previous staff who may be called back as they have indicated.

Weekly meetings will be undertaken to review and revise the emergency situation, assess staffing levels and availability, discuss national developments and implement strategies put in place by the Ministry of Health or District Health Board.

Cross Reference:

Policy 2.8	Staff Numbers & Skill Mix
Policy 2.3.9	Health & Safety
Policy 2.7.4	Staff Wellness
Policy 2.8.1(f)	Sick Leave
Policy 2.8.1(f)	Contingency Plan in the Event of Unplanned Leave

Form:

HRF-04-01 Leave Application Form

Templates:

HRT-04-14 Unplanned Event – Contingency Plan for Unplanned Leave

Revision History	Version:	1
	Developed By:	Quality Manager
	Authorised By:	General Manager
	Date Authorised:	April 2020
	Date Last Reviewed:	New
	Date of Next Review:	April 2022

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

APPENDIX 5

WCDHB - Infection Prevention and Control Service

ARC Quick Environmental Audit

Name of Auditor 9(2)(a)
Facility Gorge House
Nurse Manager 9(2)(a)
Date of Audit 20/04/20.
Date of Feedback

SECTION 1: GENERAL ENVIRONMENT

Standard: Clinical areas are visibly clean, uncluttered and maintained appropriately to minimise cross infection.

		C	NC	P	NA
HAND HYGIENE FACILITIES					
1.	Hand washing facilities are clean, available and access is clear	✓			
2.	ABHR is available Good supplies	✓			
DETERGENTS/DISINFECTANTS					
3.	Detergent or detergent wipes are available for general environmental cleaning of surfaces	✓			
4.	Approved disinfectant (bleach product or other hospital grade disinfectant active against viruses) is available	✓			
5.	Correct dilution/refreshing of disinfectant every 24 hours	✓			
6.	Alcohol impregnated wipes are available for sensitive equipment	✓			
7.	Designated housekeeping staff new cleaning schedules. Yarka cleaning refrigerator checklist	✓			
DIRTY UTILITY/SLUICE ROOM					
8.	The dirty utility or sluice area is visibly clean and tidy	✓			
9.	There is a designated hand wash basin in this room, with soap and paper towels present	✓			
10.	There is a facility to safely sanitize equipment e.g. bedpans/urinals /bowls	✓			
WASTE MANAGEMENT					
11.	There is correct segregation of waste	✓			
12.	Infectious/medical waste bins with foot-controlled lids are available	✓			
13.	Waste bags awaiting collection are stored in a non-public area	✓			
14.	ABHR/HWB is available for use after handling waste	✓			
SOILED LINEN					
15.	Linen bags are secured and stored in a secure area for collection	✓			
16.	Soiled linen from isolation rooms is handled/laundered separately	✓			
17.	Staff working in laundry do not provide patient care	✓			
18.	Dirty and clean linen is segregated	✓			
19.	Personal clothing is laundered separately for each patient/resident			✓	
20.	Hand hygiene and personal protective equipment is available	✓			

Comments In progress of purchasing a second sanitizer. Buns/fuel. validated yearly.

WCDHB, IPC, april 2020 – supplied by CDHB.

Bulk purchase bins on way

clinical waste - bio hazard -

C	Compliant
NC	Non Compliant
P	Partial

SECTION 2: PATIENT ROOMS

Standard: Facilities and appropriate products are available to ensure effective hand hygiene and standard precautions are undertaken.

		C	NC	P	NA
21.	ABHR is available at each resident's room on walls HWB in each room	✓		✓	
22.	Disposable gloves in a range of sizes are available	✓			

Comments

SECTION 3: PATIENT CARE EQUIPMENT

Standard: Patient care equipment will be cleaned/decontaminated and stored safely and appropriate resources made available to minimise the risk of cross infection

		C	NC	P	NA
23.	Manual handling sheets, hoist slings and slides are cleaned between patients	✓			
24.	Are commodes used	✓			
25.	Commodes are individually assigned and disinfected between patients	✓			

Comments Shop designated for isolation pts c

SECTION 4: COMMUNAL PATIENT AREAS

Standard: Communal patient areas shall be maintained appropriately to minimise the risk of cross infection.

		C	NC	P	NA
TOILETS & BATHROOMS					
26.	Are bathrooms/toilets shared between residents?	✓			
27.	How are residents in isolation showered/toileted no ensuites sponged			✓	
28.	Toilets are visibly clean	✓			
29.	Bathroom areas are free from communal items which may be contaminated e.g. creams, talc own residents items	✓			
30.	Showers are clean, intact and free from mould some showers needs refurbishing	-			
31.	Linen is not stored in open shelves in bathroom areas		✓	✓	
32.	Staff have a separate toilet from residents	✓			

Comments commode / + bed baths for pts in bath.

Some bathrooms non compliant from being mould + free from mould because of age of facility.

C	Compliant
NC	Non Compliant
P	Partial

SECTION 5: STANDARD AND TRANSMISSION-BASED PRECAUTIONS

Standard: Care will be planned for individual patients using precautions necessary to prevent the spread of infection, taking into account the needs of the patient and other patients

		C	NC	P	NA
33.	Sufficent PPE stock on hand	✓			
34.	PPE Donning/doffing areas are identified	✓			
35.	Staff have received training in donning/doffing PPE	✓			
36.	- Practical training - notices, video -	✓			
37.	Disposable gloves, aprons and gowns are available/worn	✓			
38.	Surgical masks are available/worn	✓			
39.	Safety glasses/protective eyewear is available/worn	✓			
40.	The correct transmission-based precautions signage is available and used appropriately	✓			
41.	Eye protection is cleaned and disinfected after use	✓			

Comments MoH - guidelines. -

SECTION 6: KITCHEN AND FOOD / BEVERAGE FACILITIES

Standard: Kitchen and food handling areas conform to Food Safety Authority guidelines

		C	NC	P	NA
42.	Kitchen staff are not involved in patient cares or laundry	✓			
43.	There are hand hygiene facilities available	✓			
44.	Are there any filtered water units available in facility	✓		N/A	

Comments going to check some date. & regular servo

SECTION 7: COVID-19 OUTBREAK MANAGEMENT

		C	NC	P	NA
45.	COVID-19 Outbreak management plan available	✓			
46.	CDHB Planning and Funding liaison person identified	✓			
47.	Staffing contingency plan available	✓			
48.	Community & Public Health contact details known	✓			
49.	Staff know how to launder their uniforms	✓			

HERITAGE LIFECARE

Granger Management Plan Covid-19 Response

GM Operations: 9(2)(a) [redacted]

Date: 1 April 2020

Document Version: 1.0

1 Management Plan Document History

1.1 Document Location

The source of the document will be found at this location – 9(2)(a) 9(2)(a)

1.2 Revision History

Date of this revision:
Date of next revision:

Revision date	Previous revision date	Summary of Changes	Changes marked
		First issue	

1.3 Approvals

This document requires the following approvals.

Name	Signature	Title	Date of Issue	Version
9(2)(a)		CEO		
9(2)(a)		GM Operations		

1.4 Distribution

This document has been distributed to: [Project Steering Group before approval, Strategic Program of Work Steering group upon approval]

Name	Title	Date of Issue	Version

2 Table of Contents

3 Introduction

The purpose of this document is to develop a plan for Granger to support our Care Homes, staff and residents should there be a Covid-19 outbreak in Granger, with 25% of Heritage Lifecare's Homes being in this region.

4 Care Home Contact Details and Location

Care Home Name	Address	Contact Phone Number	Care Levels	Number of Beds
Granger	117 Shakespeare Street, Greymouth	03 768 6091	Rest Home Hospital	18 52

5 Heritage Lifecare Key Staff Contacts

5.1 Regional Operation Managers

Below is a list Granger Operations Managers

Staff Name	Title	Location	Mobile Number
9(2)(a)	9(2)(a)	Granger	9(2)(a)
9(2)(a)	9(2)(a)	Granger	9(2)(a)

5.2 Key Care Home Staff

Below is a list of Heritage Lifecare staff members who are key contacts.

Care Home	Name	Title	Mobile Number
Granger	9(2)(a)		
	9(2)(a)		

5.3 Key Support Contacts

Below is a list of Heritage Lifecare executive members who are key contacts.

Support Area	Name	Title	Mobile Number
CEO	9(2)(a)		
Clinical and Quality	9(2)(a)		
Operations	9(2)(a)		
Finance	9(2)(a)		
People	9(2)(a)		
Marketing & Communication	9(2)(a)		

5.4 Key Contacts External Providers e.g. DHB Portfolio, Nasc, Union

Below is a list external providers who are our key contacts in Granger

Provider Name	Staff member Name	Title	Relationship	Mobile Phone Number
Xx DHB		HOP Portfolio Manager	Contract Manager for ARC	
Xx District Health Board	9(2)(a)			
Public Health Unit			Outbreak Advisor	9(2)(a)
Hospice	9(2)(a)			
E-TU	9(2)(a)			
NZNO		9(2)(a)		
Home care Provider	9(2)(a)			

6 Compliance with Level 4 Alert Lockdown

6.1 Visitors

In light of the Governments directive to limit all contacts between the population of NZ, our Care Homes are locked to all visitors. We can arrange phone calls, Facebook or Zoom for family and friends to use in order to stay in contact with our residents.

If a resident reaches the time when they become in need of palliative care, we will try our hardest to ensure that family can visit them in person. Any visitors over that time will be required to follow the instructions of the clinical team with regards to infection control, for their safety, as well as for the safety of all the other residents in our home

6.2 Communal Areas

Care and housekeeping employees need to be designated to certain wings/areas of the care home and cannot rotate through to other wings – this is so that it is easier to trace and isolate residents and employees in the event of either residents or employees becoming unwell and requiring testing or possible isolation.

Employees breaks must also now be taken wing by wing, so that employees working in one wing are not taking breaks with employees working in other wings. Where possible it would be preferable for employees to have a designated break area within the wing they are working in.

Employees handovers must also be conducted separately in the wing – rather than as a group in the nurses station.

6.3 Meals

Currently 9(2)(a) are supplying food to Granger in a contactless form. This requires our kitchen chefs and cooks to produce meals from recipes provided.

In the event that we can no longer provide chefs or kitchen staff, then we will look to provide ready made meals through an external supplier. 9(2)(a) are able to provide frozen meals and a contact has been made. 9(2)(a)

9(2)(a)

6.4 Activities

Activities will need to be given to residents to complete independently, according to social distancing protocol. The Heritage marketing team have developed a set of activities ideal for isolation, and these will be available on the Monday dashboard.

Additionally, when not in use for GP consultations, residents may use the Care Home tablets to contact their family and friends. There is also a gallery feature which allows residents to be photographed with messages, to be uploaded to an online gallery for their loved ones to see.

6.5 Cleaning

We do not need to change the cleaning products that Heritage Lifecare uses but we do need to increase the frequency of cleaning. The scientific evidence confirms that COVID-19:

- Is spread by droplets. This means that when an infected person coughs, sneezes or talks, they may generate droplets containing the virus.
- These droplets are too large to stay in the air for long, so they quickly settle on surrounding surfaces.
- In summary 'The things that you have your hands on all the time', for example: handrails, benches, tables, chairs, doorknobs, furniture, handrails, basins, pens, scissors, our uniforms, trolleys, toilets, showers, bed levers and bedrails, windowsills.

When cleaning:

- Remember to wear your PPE
- Remember to start cleaning cleaner areas first and progress to dirtier areas
- If surfaces look visibly dirty, they should be cleaned first. Remember it is not enough to swipe clean, the surface needs to be scrubbed. Then the disinfectant/chemical is applied and left to dry
- If your home has residents that are isolated please be guided by your senior RN on duty at the time

Remember no matter how busy you get it is important to use and store cleaning products safely including personal protection. It is important that you continue to follow the guidelines of the safety data sheets provided by eco lab. Please print and display the eco lab information sheets for your Care Home if you haven't already done so.

6.6 Essential Maintenance and Safety Checks

As a result of the COVID-19 pandemic and with the welfare of our residents in mind, it is necessary to stop all non-essential property work from being undertaken in our care homes and villages. This is necessary in order to reduce the volume of people coming into our care homes and thereby in contact with our vulnerable residents. This means that for the next few weeks at least, please do not engage contractors to come on-site to undertake non-essential property work, including for the purposes of scoping work to provide a quote. Non-essential work includes

building projects, painting, carpeting, non-essential compliance checks such as washing machine/dryer 6 monthly preventative maintenance checks etc.

You will need to call on tradespeople for essential plumbing and electrical work as normal, and practice the infection control guidelines with anyone who has to attend to essential maintenance.

We have been advised by MBIE and the Fire Association that fire alarm and sprinkler system routine checks are able to be suspended over this lockdown period. The fire alarm system and sprinkler systems are monitored, so if they go into fault the fire company is alerted and then they will obviously need to go to site and repair the fault to keep the facility safe.

Please visit the 'Monday' Dashboard for an information sheet explaining the differences between essential and non-essential services from a Fire Security Services perspective.

7 Covid-19 Response

7.1 Covid-19 Action Plan

The Covid-19 Action Plan has been developed for Care Homes to execute when they have a suspected Covid-19 patient.

P:\HILMS\COVID-19 (Novel Coronavirus)\Action Plan\COVID-19 Action Plan - Final.pdf

7.2 Flu Vaccinations

To be updated by 9(2)(a) [redacted]

7.3 Care Home and Village Preparedness Checklist

Heritage Lifecare have developed a preparedness planning checklist for each Village to ensure we are ready for Covid-19. The checklist for each Care Homes is stored P:\HILMS\COVID-19 (Novel Coronavirus)\Prepareness checklist\Care Home

7.4 Village Site by Site Plans

Site by Site plans are being developed for each village. This includes:

- An overall plan
- A contact spreadsheet
- A preparedness Checklist
- A Covid-19 Action Plan (Clinical / Infection Control)

The link to the file is P:\HILMS\COVID-19 (Novel Coronavirus)\Village\Village Plans

7.5 Education and Training

There is compulsory education on COVID-19 for all care home employees, which includes guidelines on the correct use of PPE.

Heritage has requested that Care Homes confirm this training has been provided for all their employees in the Preparedness Checklist (see 'Monday' dashboard for more information).

8 Plan for Granger Outbreak

8.1 Response Team and Responsibility

Role	Name	Title	Responsibility	Mobile Number
Incident Controller	9(2)(a)			
Team Leader	9(2)(a)			
Clinical Lead	9(2)(a)			
Operations Lead - Heritage	9(2)(a)			
Logistics Support	9(2)(a)			
Communication – All communication including Media	9(2)(a)			

Other information:

- Operations Manager to update status on 8.15am call
- Operations Manager to contact DHB and Public Health representatives
- Emails cc'd to Team Leader, CHM, Clinical Lead, Operations manager and CEO for information group sharing

8.2 Granger Response Team Meeting

Meeting Name	Frequency & Time	Purpose	Attendees	Minutes taker and location
Daily Heritage Covid-19	8.15am	All of Heritage Covid-19 Response team. To go through Incident Action plan and have updates from Regional Managers	Executive, Programme Manager, Quality Team, Regional Operations Team, IT Manager	Executive Assistant Monday Dashboard
On-Site Daily Meeting Co-ordinated by the Response Team Clinical Lead	9.30am	On-site – Review actions that have put in place. Ensure action plan is being followed. Monitor situation.	CH Manager, Laundry, Chef, Household Cleaner, Unit Co-ordinator, Administrator, Village Co-ordinator	Administrator
Response Team Meeting	2pm Daily	Monitor situation Action plan.	CEO, Team Leader, Clinical Lead, Operations Manager	Team Leader
GM Ops and GMCQ Meeting with Regional Managers	12 noon Monday, Wednesday, Friday	Share Information, Raise Issues and ask questions.	GM Ops, GMCQ, Regional Managers	Senior Administrator
Regional Managers Meeting	Daily 10am – 12 noon	Share Information from the daily 8.15am meeting. Raise issues and ask questions.	Regional Managers, Care Home Managers	

8.3 Response Team Communication Process

8.3.1 Reporting

Report	Purpose	Location	Responsibility	Distribution
Incident Action Plan	To provide a daily update on the situation, including actions and completed and plans	Monday. Dashboard	Programme Manager	Executive, Operations Group, Quality Team, IT Manager, Board
Response Team Reporting	To provide an update for the Incident Action Plan after the 2pm meeting.	Email. Saved in Incident Action Plan on Monday Dashboard	Operations Manager.	Executive, Operations Group, Quality Team, IT Manager, Board
Verbal – Update to Care Home Managers - Incident Action Plan	To update care Homes on relevant items from the 8.15am meeting	Monday. Dashboard	Regional Manager	Care Home Managers
CEO Update to Board	To provide an update for the board after the 2pm meeting.	Verbal	CEO	Board

8.3.2 Communications and Media

The Covid-19 communication plan outlines the communication strategy. The plan is stored at the following file location:

P:\HILMS\COVID-19 (Novel Coronavirus)\Communication Plan\Covid19 Communication Strategy v2.0.docx

All media enquiries to the CEO.

8.4 New Admissions

8.4.1 Rules on New Admissions

- Where there is a positive case of COVID-19 in our care home, that care home will be closed to further admissions until further notice.
- In homes where there is no known or probable cases of COVID-19, admissions can be accepted subject to adherence to the flowchart and admissions questions guidelines provided to all Care Home Managers in the daily update on Monday 13 April 2020.

8.5 Rules Regarding Moving Residents

If there is suspected Covid-19 in a Care Home, it is recommended well residents are not to be moved into another Care Home. Recent medical literature suggests that Covid-19 is difficult to detect in tests with a-symptomatic people, therefore moving residents between facilities increases the risk of spreading the infection.

Each decision to move a resident must be made by the Infection Control team and the with approval of the CEO.

8.6 When to move Residents to Hospital

The Hospital will take the confirmed cases if a GP admits them, under the approval of the geriatrician. All concerns to be escalated to the Infection Control team for support.

8.7 Covid-19 Patients Isolation Wings

Daily occupancy reports provided will provide up to date information on bed capacity per home. At 3 April 2020, the following capacity exists.

GRANGER

Granger:

- There are 9 empty rooms at Granger

These numbers will change each day. The daily occupancy report will provide an up-to-date report on available beds.

Heritage Lifecare floor plans are stored here:

P:\HILMS\99. Heritage - company\Property\Property Reports\A. Facility Floor Plans

8.8 Logistics and Supplies

8.8.1 Key Responsibilities

Task	Responsibility	Support	Contact Number
Monitoring of Clinical Equipment Levels	9(2)(a) [redacted]		
Ordering New Clinical Equipment			
Moving Stock			
Food			
Furniture / Capex			

8.8.2 Supplier Details

Product (s)	Supplier	Contact Name	Contact Number
DHB PPE Supply	9(2)(a) [redacted]		
Food Services			
Food Services			
Chemicals			
Medical Consumables			
Toilet paper and gloves			
Toilet Paper			
Medical Equipment – beds, hoists, wheelchairs, shower chairs etc.			
Bedroom and Care home furniture			
Gloves			

8.9 Payroll & Finance Business Continuity Plans

Business continuity plans (BCP) have been developed for key support office functions to ensure we continue our core functions.

The payroll and Finance BCP are stored in the following file location: P:\HILMS\COVID-19 (Novel Coronavirus)\BCP

8.10 Staff Management Plan

- A new Support Worker role has been developed that is solely for the period of COVID-19 and is essentially a catch all of all non-clinical work for you to direct on tasks wherever you need on the day. A support worker who is on kitchen duty that shift, cannot also work cleaning bathrooms on the same shift.
- All care homes have the clearance to place one 3 month fixed term Support Worker. HR will manage all the logistics The CHM does need to approve the appointment following a quick phone conversation with the recommended candidate.
- If there is a permanent vacancy, the CHM has the flex to recruit at 1.25 the FTE for the role if it is a Caregiver or RN role.
- If the care home is short of RNs or assess there is more challenge at your site, contact Ellie to discuss and troubleshoot ideas.

Here is how the process will work for the Support Worker role:

- HR will place ads on local community sites where possible with a link to the careers page on our website for more detail of how to apply, (please email any known links to the email address to help the team or if you know of people already let us know via email)
- HR will screen candidates by video interview, undertake reference checks on recommended candidates before forwarding information to you as the manager on site
- Once you confirm comfort to proceed HR will commence all the documentation set up for you including TimeTarget and Affinity
- We are likely to also recruit casual people on the books as reserves and will always be keen for volunteers.

8.11 Task or Care Reduction Plan (based on reducing numbers of staff)

Delegate:	Reduce Cares:	Reduce Other Duties:	Human Resources Management	STOP
Bed making: Could be done by cleaners	Showers: Each resident will have 1-2 shower(s) per week.	Kitchen: Use disposable items such as plates, cups, cutlery etc.	Request recently resigned staff return as a casual as some may not have employment during the lockdown period.	Application of Resident Makeup (lipstick etc.)
Meal Times: All Staff can assist with feeding (i.e. managers, DT, Admin, RN's (after meds given) Alter staff breaks to ensure all staff are available to assist with residents who require assistance with feeding or are a choking risk. Stagger the meal times and simplify the meals eg finger food	Body wash: Twice daily body wash and as needed.	Centralise resident documentation in Progress notes, STCP and BC, instead of multiple forms.	Redeploy staff to different tasks, depending on where the shortage is and on skill sets (e.g. staff could pick up cleaning, kitchen laundry, CHM & CSM could work on floor as RN or caregiver, RN can do cares, etc).	**Consider stopping admissions if clinically the risk is too great**
	Grooming: Shaving, finger nails – will be provided on an as needed basis.	Care Plans and six-monthly interRAIs could be put on hold – but progress notes need to continue as do SLOC Change InterRAI.	Ongoing recruitment of Caregivers and Nurses, or utilisation of agency staff if available	
Afternoon staff to do cares/shower of other residents who has not been showered during the morning.	Getting residents up every second day with pressure care implemented.	Designate areas that only need one staff member.	Commence completion of care competencies for untrained staff.	
Night staff to do the cares of at least 9-10 residents for both departments (At least 3 residents per wing)	Getting residents into their night attire before evening meal		Offer empty rooms and empty village units for staff to stay/sleep over if required. Need to consider payment to outgoing resident if using the Village	
			Firm guidance and support from RN / senior staff will be required to ensure all essential tasks are completed	

ACTION PLAN

Staff and Resident with respiratory symptoms, or suspected coronavirus or resident with positive result for coronavirus

FACILITY ……

DATE ……

NAME AND SIGNATURE OF PERSON COMPLETING

……

DATE	CORRECTIVE ACTION (what is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Staff member: if they have been in close contact with a person known to have COVID-19 Or Have recently travelled from an area or country with COVID-19 such as Mainland China, Iran, Italy and Republic of Korea Or Suspect they have COVID-19	The staff member must call the dedicated Healthline on **08003585453** Staff must phone ahead before visiting a GP clinic or hospital Staff member to contact the CHM or CSM and inform them of Healthline's recommendation.	Manager completes the Self-Isolation Employee Register (Appendix One) and returns it to 9(2)(a) [redacted]	Immediately	
	Recognition by staff of acute respiratory symptoms in another staff member	Staff member to inform the most senior person on duty. Provide the staff member with a facemask and advise them to keep this on while in the facility and on their way home or if they are going to seek medical attention Staff member is to self-isolate at home. Staff members who are placed under active monitoring or facilitated self-monitoring should follow instructions provided by the Healthline	Most senior staff member on duty at the time oversees the staff member's 'isolation' away from others. Notify CHM/CSM and take instructions from them Most senior staff member on duty at the time must contact the CSM and/or the CHM CHM is to contact their ROM as soon as possible	Containment becomes the priority	

	First Response: **Resident** with acute respiratory symptoms (cough, runny nose, fever) or suspected of COVID-19 symptoms: The following symptoms may appear 2-14 days after exposure - Sore throat - Cough - Body aches - Fever (at least 38òC) - Shortness of breath - Fatigue - Sometimes vomiting and diarrhoea NB: use of N95 masks are to be worn by staff caring for residents with symptoms consistent with pneumonia, coughing which is more likely to generate infectious droplets. Staff who have direct care with infected residents must wear N95 masks including when administering medications via nebulisers or high flow oxygen	Isolate symptomatic resident to their room immediately Collect bucket/container containing PPE and set up i.e. **droplet and airborne based precautions** in addition to standard precautions, i.e. use of N95 masks, gloves, gowns, face and eye protection outside of the residents room on a small table or trolley. Make up Actichlor (5,000pm, i.e. 5 tablets in 1 litre of water in Ecolab Disinfectant bottle) Appendix Two or use Chlor-white solution (Appendix Three). Used to clean surfaces in the resident's room. Cleaning to be completed by the staff member assigned to the infected resident. Make up fresh each day. (Signage on symptomatic resident door/ restricted access and use of Airborne Precautions (Appendix Four) Keep the resident's door closed at all times **Strictly no visiting under any circumstances to this resident until they come out of isolation** Set room up with a yellow biohazard rubbish bag for collecting infectious medical waste as well as continence products. Use black rubbish bags for	Most senior staff member on duty at the time must contact the CSM and/or the CHM CHM is to contact their ROM as soon as possible who will inform GM CHM or CSM will contact the Medical Public Health Officer through their DHB contact number. When informing Public Health, please inform them who the GM Clinical and Quality is Most senior person in charge notifies all staff, laundry, housekeeper/cleaner on duty + CHM/CSM of suspected resident with COVID-19 and those incoming for next shift.	CHM or CSM to notify GM Clinical and Quality asap	

		infectious clothing and linen **(in room).** Take **PPE** off in room and complete hand hygiene. (Appendix 10)This bag is to be tied off and transported to the laundry each shift. Laundry staff are to be notified that this linen is contaminated and requires a separate hot wash once all other laundry has been completed. Use plastic bags for lining general rubbish bins which are to be disposed of each shift or when full into another black rubbish bag. These are to be securely tied off and transported to the waste skip immediately Obtain respiratory specimens if requested to by Medical Officer from Public health to send to lab Commence outbreak log (Appendix Five)	Log is updated each shift by the RN and reviewed by the CSM/UC daily.		

DATE	CORRECTIVE ACTION (what is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Second Response: Care of affected residents with COVID-19 Nominated point of contact Mobilising provisions: PPE and staff to respond to symptomatic resident	Residents with symptoms are confined to their rooms until cleared by Medical Officer from Public health Cohort staff, i.e. one group of staff to care for infected resident (s) and the others for non-infected residents. Implement the 12-hour staff shifts to reduce contact with infected residents. Move resident to isolation ward/end of wing/or area identified to manage these residents. (NB: the resident must wear a N95 mask when transferring to another room). The resident must be transported on their bed or wheelchair covered with a clean sheet. All arms and legs must be tucked in. Staff are to wear full PPE when transferring the resident. All residents located in the same wing are to be in their rooms with their doors closed until the resident has been moved Staff assigned to the resident are to limit their time with the affected resident and	RN on duty to direct care until the implementation of the 12hour shifts by the CHM/CSM can be introduced. Contact the named staff prepared to work 12hour shifts, i.e. 3 on 3 off. These staff will not leave the care facility/village during this isolation period. In advance, the CHM/CSM to ensure a separate area is set up for when staff are not on their 12-hour shift such as use of an empty villa/apartment.	Immediately and in response to new cases CHM/CSM to complete and oversee these shifts implementations. CHM/CSM to inform ROM when these 12hour shifts commenced	

		are not to be more than 15 minutes and within 1 metre of the resident unless completing hands on clinical cares for the resident. Hand hygiene is essential to prevent infection following contact with infectious secretions. Encourage residents to practice good hand hygiene (i.e. use of soap and water or alcohol hand sanitizer) and to wear a face mask (N95) when staff are in the resident's room. Each infected resident will have a STCP commenced (Appendix Six). This STCP shall be evaluated by the RN **each shift** and an entry into the resident's progress notes including any discussion with the resident's family members shall reflect this plan	The CSM/UM shall review the STCP and residents general condition daily with the RN assigned to the infected resident		

DATE	CORRECTIVE ACTION (what is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Third Response: Reporting Facility-wide reporting Families Transferring and receiving residents Daily management meetings	ROM and GM, Clinical and Quality will be notified of a suspected resident with COVID-19 symptoms as soon as practical Public Health at DHB and GP practice will be notified Initially, the families of those infected residents will be notified by the CSM/UC There after a daily communication to the NOK or EPOA will be communicated and **recorded in the residents notes by a staff member.** This will occur no later than 1300hrs daily as evidence of communication. Daily meetings are held with essential key facility staff to discuss status of the isolation process, resources required and infected residents. Information is disseminated back to their respective teams	CHM or CSM to notify their ROM CHM or CSM will notify GP practice and contact Public health. Confirm notification via email to GM, Clinical and Quality Essential staff: CHM/CCM/UM, AC, DT, kitchen manager, laundry, housekeeper & Maintenance personal to attend daily meetings at time agreed in morning. These daily meetings are to be recorded using the Daily Management template. This template and ongoing meetings to be captured by the CHM/CSM using Appendix Seven	Within 24 hours of suspected symptoms and ongoing	

		All unwell residents that are required to be transferred to a DHB hospital for further assessment and treatment must include both verbal and written information including the dates and results of any relevant clinical observations and culture results. The hospital and ambulance service must be notified in advance of the infected resident's status so that they can be properly prepared. The resident must put on clean clothing and wear a N95 mask for transporting.	CHM/CSM/RN in collaboration with the residents gp will make the decision to transport the resident to the hospital		

DATE	CORRECTIVE ACTION (what is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Kitchen: Chef Kitchen staff	Only kitchen staff are permitted in the kitchen. **Kitchen staff must stay within the confines of the kitchen and dining area.** That is, they are not permitted in the staff room for their break until all residents with respiratory symptoms, or suspected of having COVID-19 or are positive COVID-19 have come out of isolation. Alternative staff room areas for kitchen staff are to be allocated by CHM/CSM	CHM will direct kitchen manager and identify any issues at the daily meeting Kitchen manager will direct all other kitchen staff CHM/CSM will inform Kitchen manager when kitchen staff can resume going to the staff room	Immediately and ongoing Actions do not cease until advised otherwise by CHM	

	A 'Given Point' is a set location or junction where food delivered by a non-kitchen staff member cannot go beyond. The food is left at this junction to be collected by the caregiver looking after the infected residents. The bain marie given point is at the lift entrance.	Where Bain Marie's or Hot boxes are used, these are to be taken to the lift and second floor or given point by a non-kitchen staff member. This non-kitchen staff member will deliver the Bain Marie or Hot Box back to the kitchen when the meal has been completed. Non-kitchen staff will serve the food from the Bain Marie The bain marie shall be cleaned in the normal manner, i.e. before and after use In other instances, where food is delivered on trays directly from the kitchen to infected residents, these are to be delivered by a non-kitchen staff member to a given point. Staff caring for infected residents will deliver meals from this given point to rooms of those residents infected and return trays to the given point for collection by a non- kitchen staff member Infected resident dishes and trays are collected on a separate trolley, with signage that this is the allocated trolley. This trolley is not to enter the kitchen area. This trolley is to be cleaned with warm soapy water followed by Actichlor or chlor-white solution after every use.	CHM/CSM to identify what the 'given point' is. CHM/CSM to inform staff of the 'given point' The staff working the 12hour shifts are not to mix with other staff, nor go to the staff room. All meals will be eaten in a dedicated area. CSM is to ensure trolley for transporting and collecting infected residents dishes and trays is well labelled.		

		Meals are to be supplied to the staff completing the 12-hour shifts caring for infected residents. Food prepared for night staff must be left in the staff room area Non affected residents can continue normal service unless decided otherwise by the CHM/CSM Resident's dishes will be managed as per the normal process. Trays and plates will be delivered back to the nominated point. **NB: You do not need to use disposable plates, knives and forks** Infected resident's dishes will be washed separately in the commercial dishwasher from other crockery and utensils Kitchen manager will ensure that there is plenty of available alternatives of food for the infected residents Daily update to kitchen staff will be given following the daily Management Meeting	Trays and dishes are to be collected by staff allocated to infected residents. Trolley is then taken to the kitchen and left in an agreed area for kitchen staff to collect trays from. CHM/CSM will oversee the menu and ensure alternatives are available Kitchen manager to attend daily meetings and report back to kitchen staff		

DATE	CORRECTIVE ACTION (what is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Laundry Management of Laundry Waste Management	All infected resident's laundry is placed in black rubbish bags which are kept **inside** the resident's room Seal bag securely before transporting to the laundry The practice of sluicing clothing and linen prior to laundering is strictly prohibited Use of laundry chutes is prohibited to transport infected rubbish bags. Infected resident's clothing and linen to be washed and dried last at the end of each shift. Laundry staff to wear full PPE, untie the rubbish bag and tip the clothing directly into the washing machine. Wash on the hottest cycle and follow up with drying in the clothes dryer. If an external laundry service is used, they should be informed about the respiratory, suspected or confirmed COVID 19 resident so they can take necessary precautions to avoid infection	CHM will direct laundry staff CSM/UM/RNs will ensure care staff are managing laundry appropriately for infected residents CHM/CSM to inform staff that sluicing of any linen or clothing is strictly prohibited and is not evidence based best practice CHM/ CSM will assess need to add additional hours to the laundry during this period and until all residents are out of isolation CHM/CSM: Where an outbreak becomes protracted or is difficult, consideration should be given to outsourcing laundry	Immediately and ongoing Actions do not cease until notified by CHM	

	Waste Management: New Zealand Standards for Management of Healthcare Waste (NZS 4304:2002)	Laundry staff are not permitted to enter any area containing infected residents. Laundry staff are not permitted to deliver clothing to rooms. Clothing trolleys will be left at the start of each wing for care staff to deliver Clean linen will be put away by the care staff in these wings. All infected clothing and linen is washed using the 'soiled' washing cycle and dried in the clothes The laundry area (bench tops and commonly touched surfaces) must be thoroughly cleaned and disinfected at the end of each shift. Use detergent in warm water + disposable cloth followed by Ecolab 'Actichlor Plus'. Leave to air dry. Medical waste includes emptied urine bags, subcut tubing and bags, catheter tubing, used dressings, used and emptied specimen containers, used PPE equipment Disposable equipment that has been used to examine the resident e.g. spatulas, thermometer covers should also be disposed of in the yellow biohazard bag. Handling and disposal of Sharps: use sharps container and do not overfill Dispose of medical and sharps by an appropriate waste contractor	CSM to organise for assigned care staff to deliver clean clothing to infected resident's rooms CSM/UM to oversee this practice CSM/UC to ensure the correct cycle is used for infected clothing and linen Laundry staff every shift. CSM/UM to check this practice is occurring. CHM/CSM to organise collection of medical/sharps waste		

DATE	CORRECTIVE ACTION (what is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Housekeeping management of cleaning	House keeper will clean communal areas first including staff and public toilets, handrails, door handles every day. Clean all 'high' touch surfaces such as desks, counters, table tops, doorknobs, phones, keyboards etc. every day Clean toilets and bathrooms with a separate set of cleaning equipment every day. Clean with soap and water followed by Actichlor or Chlor-white. Housekeeper will not clean down the infected residents wing or in any of the infected resident's rooms. Cleaning of the infected residents wing shall be carried out by the caregivers assigned to that wing. Caregivers assigned to the infected residents shall clean their rooms only and will use full PPE When cleaning carried out by caregivers for residents in the same wing but are not isolated, they are to use disposable plastic apron and gloves. These must be changed between each resident's room	CHM will direct house keeping RN will ensure care staff are following cleaning aspects of CAP House keeper will check stock daily, gloves, hand sanitiser, disposable cloths and bleach tabs and alert OM as to what needs to be ordered CHM will assess need to add additional hours for cleaning during outbreak. Additional hours will be needed to ensure terminal cleaning is thoroughly carried out Housekeeper to refill each day (**first thing in the morning**) the Actichlor or Chlor white bottles for cleaning	Immediately and ongoing Actions do not cease until notified by CHM	

		A cleaning bucket containing plastic bags (liners for rubbish bins, Ecolab all-purpose cleaner and a hospital grade disinfectant such as Actichlor solution or Chlor-white and disposable rags are to be kept in the nearest sluice room to allow 'clean' staff to access. Clean first followed by disinfecting by using Ecolab Actichlor Plus or Chlor-white which is made up fresh each day. Infected resident's rooms are cleaned only by their designated care givers. Actichlor or Chlor-white solution is to stay in the infected resident's rooms and is made up fresh each day. Use paper towels for cleaning and drying and discard into the rubbish bin within the resident's room. Actichlor: use 5 tablets to 1 litre of cold water Chlor-white: use 20mls to 1 litre of cold water Already made up in the resident's room. You cannot exit the room with PPE on. Discard cleaning cloths and PPE into the resident's plastic rubbish bag. Wash hands before leaving the room. Ecolab 'Actichlor Plus' disinfectant solution is to be made up at the commencement of the shift as this will last for 24hours. Refer to the Instructions on the Ecolab plastic bottle for the Actichlor solution.	Housekeeper is to take the Ecolab Actichlor Plus tablets on the trolley as this is made up in the Ecolab plastic bottle which is kept in each infected residents room. At the end of the outbreak, this bottle is discarded. Housekeepers PM staff and night staff All staff Housekeeper CSM/UC to organise		

	Cleaning up vomit or faeces: vomit can produce aerosols. If vomit occurs in a public area, remove residents/people and the clean the area immediately.	House keeper to pay special attention to soap dispensers, hand sanitisers to ensure these are well stocked Extra cleaning of touch points, surfaces, communal bench tops, staff areas, phones, and computer keyboards is needed at least a minimum of twice daily. Care staff on the PM shift clean these areas once on their shift Wear PPE. Clean the area with detergent and warm water using disposable cloths and discard into plastic rubbish bag. Disinfect using Ecolab Actichlor Plus (if not subjected to damage by bleach) **Do not use the vacuum cleaner as this has the potential to recirculate the virus**			

DATE	CORRECTIVE ACTION (what is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Outbreak Supplies Management	Outbreak equipment is stored in central positions and is easily accessible by all staff. The minimum of 6 plastic buckets, ready to go buckets containing all of the PPE is required as per the Outbreak Audit checklists (Appendix eight). These buckets are checked against the PPE audit PPE for residents in isolation are to be restocked as needed when in use and at the end of every shift CSM will check supplies daily during an outbreak and order/ replace stock in advance via EBOS	Infection Control Nurse is to complete PPE audit every 3 months to ensure resources are available. In advance the CHM/CSM is to ensure large buckets with lids or containers are available to contain all of the necessary PPE in for staff to grab and go. Ensure these are clearly labelled. CHM/CSM/UC to oversee stock and order/ reorder RN's will oversee and guide staff on duty in relation to use of PPE. **Every handover, a practical demonstration by the RN as to how to put on and take off PPE will occur plus reminder about good hand hygiene practices** RN's will ensure PPE is restocked in the central positons before the oncoming shift comes on	Immediate and ongoing Actions do not cease until notified by CSM	

DATE	CORRECTIVE ACTION (what is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Communication Monday.com Medications	**All media approaches are to be directed to the CEO, Norah Barlow. Heritage Lifecare Ltd will release all communications to the media. Staff are not to make any comment to the media.** Situational reports are to be provided to the relevant public health unit. Isolation Reports (Appendix One) are to be sent to RQM (one source of truth) Daily review of the COVID-19 Comms board to review updates, general information, printable letters, posters, templates and clinical support. This is to be disseminated out to the various departments, staff, residents etc. as appropriate In advance: as soon as infected residents have been identified, ensure you communicate to the GP and have appropriate medications charted on Medimap such as oxygen usage via nasal prongs or Hudson mask, nebulizers, oxygen concentrators etc Consider end of life medication early to control shortness of breath due to pneumonia when no longer reversible as symptom relief becomes the main objective of therapy	CEO: 9(2)(a) GM, Clinical and Quality: 9(2)(a) ROM: 9(2)(a) 9(2)(a) CHM CSM/UC/RNs CSM/UC/RNs		

Date	CORRECTIVE ACTION (What is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Care of deceased residents Use the Mortech Body Bag to place the resident into. Fold the excess under the feet or tie off securely with string or a zip tie. These bags are made of heavy duty polyethylene and are impervious to body fluid leakage	As there is an increased risk of leakage of body fluids in those who are deceased, full PPE shall be used when handling all human remains. As this resident had been categorised as a high risk, no washing of the deceased is to occur. The deceased must be placed in a body bag immediately after death Use of body bags for transporting the deceased is mandatory Any wounds should be left covered and all drains, catheters and sub cut lines should be removed It is imperative that the funeral director is informed that the body poses a significant health risk, i.e. has been in isolation for suspected of having coronavirus or confirmed coronavirus	Body bags x 3 are to be kept in the treatment room cupboard		

DATE	CORRECTIVE ACTION (what is to be achieved)	PROPOSED ACTION (How will it be achieved)	PERSON RESPONSIBLE	BY WHEN	SIGNED AS COMPLETED
	Visitors: strictly no admittance to the care facility (Appendix Nine)	All entrances into the care facility are to be secured to limit people from gaining access to the building. Ensure one main entry point for staff to enter and leave by Signage will be placed on all entrances into the care facility building advising that there is no visiting allowed This signage is to identify contact details for visitors to call Palliative residents: Full cessation of resident visits unless approved by ROM If permitted, the visitor will need to be screened and wear full PPE when visiting an infected resident. They are not permitted to visit multiple residents All non- essential services such as hair dresser, podiatry, communal gatherings by residents will be postponed until after the isolation is over	Signage will go up at all entrance ways into the care facility (Appendix Nine) A Heritage staff member will advise and provide basic education to incoming visitors(once approved) including use of PPE CHM will liaise with non-essential service providers	Immediately Ongoing until otherwise notified by CHM/CSM	

After an outbreak there will always be a scheduled staff meeting to discuss/ debrief the event.

Appendix One

Self-Isolation Employee Register

We are working on updating Affinity and TimeTarget with a process for recording employees that are in self-isolation. It is important we capture this information so we can ensure eligible employees receive the COVID-19 Leave Payment Subsidy. Please record any employees that are currently in Self-Isolation below, and send to 9(2)(a) [redacted]. If any further employees go into Self-Isolation, please add them and resend to 9(2)(a) [redacted] on a daily basis.

Employee Name	Employee Number	Location	Date of Birth	When did the employee register with HealthLine?	Did HealthLine recommend the Self-Isolation?	What is their reason for Self-Isolating? *	Date Self-Isolation Began	Date Self-Isolation Ends

*Reasons for Self-Isolating options, please choose one of the following:

A. Tested Positive (employee was tested and results came back positive)
B. Awaiting Test Results (employee was tested and awaits test results)
C. Family living with employee, has or, is suspected to have COVID-19
D. Arrived back in the country and Self-Isolating as per Government Regulations
E. Probable exposure to someone with COVID-19
F. Employee is aged 70+
G. Employee has a pre-existing condition
H. Employee is pregnant

TimeTarget

While we are busy configuring TimeTarget with new Self-Isolation leave types, please make use of any leave type with a leave balance, as mentioned in the Employee Management & HR Processes FAQ Document. This includes 'Unpaid' if an employee does not have a leave balance available. By doing this, we can match the dates of Self-Isolation against TimeTarget leave, and easily identify and pay the COVID-19 Leave Payment Subsidy to impacted employees.

If you have any questions regarding your employees and Self-Isolation, please refer to the daily COVID-19 updates on the COVID-19 Comms Dashboard https://heritagecommunications.monday.com/, or speak with your Operations Manager.

ACTICHLOR® PLUS
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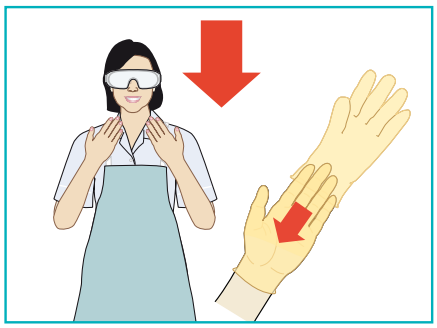
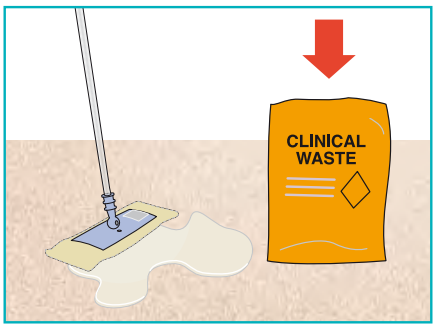
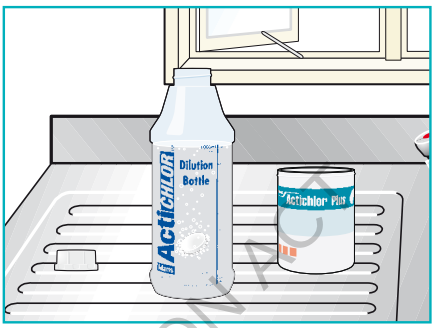


1 Wear utility gloves and apron. If risk of splashing wear eye protection.

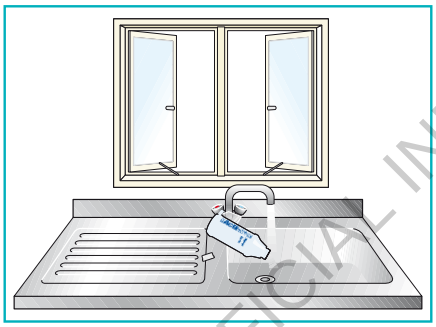


2 Remove any gross contamination before applying actichlor® Plus, including urine, vomit, faeces.

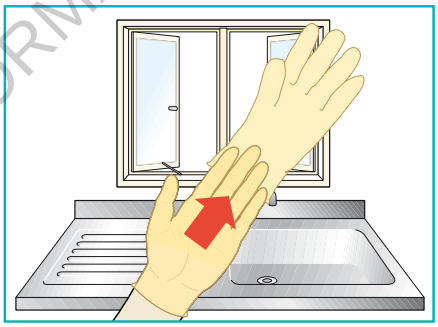


3 Dissolve Actichlor® Plus tablets (according to dilution instructions below) in solution bottle or bucket in cold water to make your solution.

4 Use solution according to your hospital policy. Rinse commodes and mattresses after use.



5 Dispose of remaining solution in bottle or bucket into drain with cold running water.



6 Wash your hands after removing gloves.

DILUTION INSTRUCTIONS

Actichlor® Plus Formulation		3.25g Tablets
Environmental Situation	Required amount of available chlorine	Number required per litre of water
Single step cleaning and broad spectrum disinfection under dirty conditions	2,000ppm	2
Outbreak disinfection to kill MRSA, VRE	1,000ppm	1
Outbreak disinfection Clostridium Difficile (ASID/AICA Position)	ASID/AICA recommend minimum 1,000ppm	1
Outbreak disinfection Norovirus (CDC Guideline)	CDC recommends minimum concentration 1,000ppm up to 5,000ppm on resistant surfaces	1 - 5
Outbreak disinfection Influenza Department of Health and Aging (June 2006)	Department guideline 1,000ppm	1

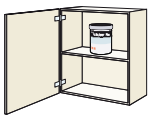
WARNINGS AND PRECAUTIONS

DON'T take internally, **AVOID** eye and direct skin contact

DON'T mix with acids* or other detergents *eg. urine, vomit

AVOID PROLONGED contact with stainless steel or clothing

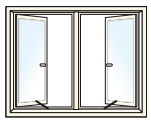
ALWAYS dispose used materials as clinical waste



ALWAYS replace lid after use and store in a secure dry place

ALWAYS keep out of the reach of children

ALWAYS make up a fresh solution for each use/refer to Ms Ds and your hospital policy



WHENEVER POSSIBLE ensure good ventilation when using all chlorine products

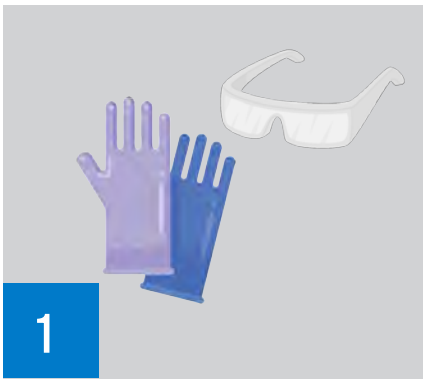
Worldwide Headquarters
370 Wabasha Street N
St Paul, MN 55102
+1 800 35 CLEAN
www.ecolab.com

Australia
6 Hudson Ave
Castle Hill NSW 2154
Ph: 1800 022 002
Fax: 1800 655 679

New Zealand
2 Daniel Place
Hamilton 3241
Ph: 0508 732 733
Fax: 07 958 2361

ISG-00062 08/12

Chlorwhite - Outbreak Control



1

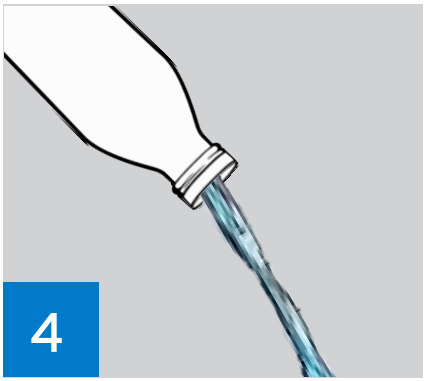
Wear utility gloves, eye protection and an apron.

2

Remove any gross contamination before applying Chlorwhite.

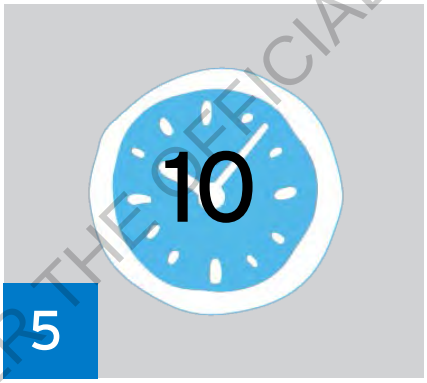
3

Measure 20ml of Chlorwhite into solution bottle or bucket in 1L cold water = 1000ppm.



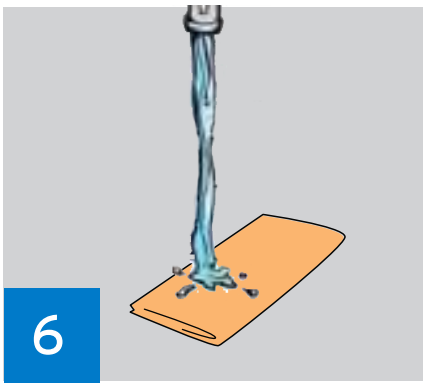
4

Apply solution to area to be cleaned using clean cloth.



5

Allow 10 minutes contact time.

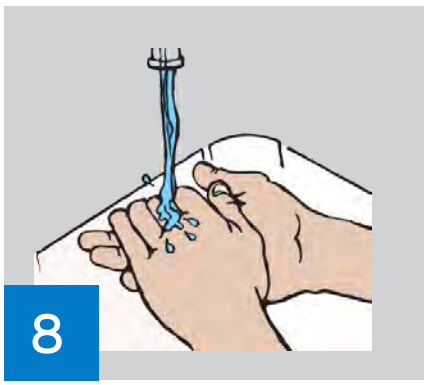


6

Rinse off with clean cloth & cold water.

7

Dispose of remaining solution into drain with cold running water & dispose of or launder cleaning cloth.



8

Wash hands after removing gloves.

AUS 1800 022 002
NZ 0508 732 733
FIJI 3361 744

STOP

AIRBORNE PRECAUTIONS

STOP

EVERYONE MUST:

Clean their hands, including before entering and when leaving the room.

Put on a fit-tested N-95 or higher level respirator before room entry.

Remove respirator after exiting the room and closing the door.

Door to room must remain closed.

CS19-306149-A

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Appendix Five – COVID19 Infection Log

Care Home: _____ Start Date: _____ End Date: _____ # of Days: _____

Case Identification					Symptoms											Swab			Outcome		
Name and NHI	Resident	Staff	Date of Birth	Flu Vaccine & Date	Onset Date	End Date	Fever or Temp > 38°C	Cough	Sore Throat	Runny Nose	Shortness of Breath	Myalgia	Malaise	Lethargy	Headache	Other, Specify	Nasopharyngeal Swab	Date Swab Taken	Swab Result	Hospitalised	Deceased	Other details e.g. travel overseas or contact with COVID-19 case

Case Identification					Symptoms											Swab			Outcome		
Name and NHI	Resident	Staff	Date of Birth	Flu Vaccine & Date	Onset Date	End Date	Fever or Temp > 38°C	Cough	Sore Throat	Runny Nose	Shortness of Breath	Myalgia	Malaise	Lethargy	Headache	Other, Specify	Nasopharyngeal Swab	Date Swab Taken	Swab Result	Hospitalised	Deceased	Other details e.g. travel overseas or contact with COVID-19 case

HERITAGE LIFECARE

SHORT TERM CARE PLAN One STCP per short term need. Add details to the STCP register	RESIDENT NAME LABEL
Date Commenced:	**STCP Commenced by (RN Name and signature):**

Describe the short term issue	**Ineffective Airway Clearance as evidenced by:** • **Shortness of breath** • **Tachypnea / >20 breaths per minute** • **Oxygen Saturation less than normal** • **Ineffective cough / cough without sputum production**

The Goal:

_____ will maintain patent airway with breath sounds clearing as evidenced by effectively clearing secretions (cough with sputum production).

Planned Action / Support / Interventions:

- **RN to do the following: *(or caregiver in a rest-home only facility)***
  - **and caregivers are to ensure that they wear correct PPE before attending to _____'s needs.**
  - commence full vital signs monitoring (Temp, Resps., O2Sats, HR, BP) a minimum of once per shift or more frequently as clinically required and document
  - assess rate, rhythm, and depth of respiration, and document in progress notes. (e.g. 24 breaths/minute, irregular, shallow breathing)
  - assess cough effectiveness and productivity and document (e.g. no sputum production after coughing)
  - auscultate lungs and document breath sounds (e.g. decreased airflow on upper right lung, crackles heard on inspiration)
  - observe sputum colour and document in progress notes
  - ensure head of bed is elevated. (This lowers diaphragm and expands lungs – resident will breath better)
  - provide nebulizer treatment as prescribed by the GP (This humidifies airway and thins secretions) and administer medications as required.
  - caregiver to assist in oxygen therapy as prescribed by the GP (assists resident to breathe better)
  - request GP to prescribe PRN oxygen and medications for dyspnoea, pain and discomfort on Medi-map.
  - Commence fluid balance chart / hydration chart, monitor every shift, and commence subcutaneous fluids if needed.
  - Evaluate and update this short term care plan at least once a day.
  - **Contact GP urgently if there are signs of pneumonia or respiratory distress: Oxygen Saturation is slowly dropping, develops fever, increase in coughing, very unwell and is not improving to medications prescribed. RN to document GP's instructions, inform EPOA/NOK/family and document conversation in progress notes.**
  - **Report to EPOA/NOK/family member every shift.**
  - **Strictly ensure no visitors are allowed – consult with CHM and CSM if needed.**

- **Caregiver to do the following:**
  - document fluid intake per shift and perform mouth cares regularly
  - ensure head of bed is elevated. (This lowers diaphragm and expands lungs – resident will breath better)
  - observe sputum colour and document in progress notes
  - **activate call bell / report to RN urgently if resident shows the following:**
    1. **Cyanosis (bluish colour – blue lips, blue nail beds, grunting when breathing)**
    2. **If the resident is looking pale, sweating, looks unwell, and feels like fainting**
  - report to RN for any questions and concerns about the resident's care.

Date	Review / Comment	Signature

Appendix Seven

Daily Management Meeting Minutes

Care Home		**Meeting Date**		**Meeting Time**	
Staff Present					
Date of First Case		**Number affected currently**	**_____ total**	**Wings / units / areas affected currently**	
Current length of Outbreak	**____ days**		**_____ Residents** **_____ Staff**		

Item	Action Required	By Whom	When
Public Health Service Notified			
Outbreak Management Checklist commenced			
Outbreak Infection Log commenced / updated			
Incident Forms completed per infected case			
Signage in place *Main entrance, doors of affected resident rooms, nurses station, staff room*			
Adequate supplies of PPE *Gowns, gloves, yellow rubbish bags,, alcohol gels, face shields*			

Appendix Seven

Adequate Cleaning Equipment Available E.g. Bleach solution, Actichlor, disposable cloths				
Areas / residents currently in isolation				
Staff illness / replacement				
Are there problems / challenges for the following teams – agree actions *Laundry/Kitchen / Cleaning / Nursing / Caregiving*				
Restricted Access – what steps need to be taken				
Admissions / discharges / transfers *Name of resident and details*				
Additional items				
Provide daily update to OM and RQM by 4pm daily *Cover each of these items*	• New affected residents ☐	• New affected staff ☐		
	• Number of staff off-duty due to symptoms ☐	• Number of residents in isolation ☐		
	• Update on outbreak management processes implemented, and support required ☐	• Additional measures in place to contain outbreak ☐		

Personal Protective Equipment (PPE) & Outbreak Kit

Aim: PPE is equipment worn to reduce the chance of touching, being exposed to, and spreading germs and is a key component of Heritage's Infection Prevention & Control Programme. Types of PPE Used in Heritage include:

- Gloves – protect hands
- Gowns/aprons – protect skin and/or clothing
- Masks – protect mouth/nose
- Goggles – protect eyes
- Face Shields – protect face, mouth, nose and eyes

Compliance entails having sufficient PPE available for everyday use and having 'Outbreak Kits' prepared in case of an outbreak, i.e. Gastroenteritis/Respiratory etc.

Method:

- Check to ensure Standard Precautions of disposable PPE is readily available
- Outbreak Kit is prepared, checked regularly & stored appropriately
- Staff are aware of the location of the Outbreak Kit

Yes = 1 No = 0

Anything deemed partial should be noted as a no

Audit Questions:

Standard Precautions: Disposable PPE for everyday use	
Is there sufficient stock of disposable gloves for resident cares?	/1
Is there sufficient stock of disposable plastic aprons for resident cares?	/1
Is there sufficient stock of masks for resident cares?	/1
Is there goggles or a face shield in every sluice room?	/1
Is there disposable gloves in every sluice room?	/1
Is there disposable aprons in every sluice room?	/1
Are there rubber gloves for general cleaning? Are there disposable gloves on the cleaner's trolley? Is there disposable aprons on the cleaner's trolley?	/3
Is there a stock of disposable gloves (blue) in the kitchen? Is there a stock of linen aprons for kitchen staff to wear?	/2
Subtotal	**/ 11**

Personal Protective Equipment (PPE)
& Outbreak Kit Audit Tool
(Appendix Eight)

Outbreak Kit: contains all of the essential items staff will need in a quick response when a resident needs to go into isolation due to respiratory symptoms or suspected of having coronavirus or has coronavirus. The outbreak kit brings everything together, staff will need to 'grab and go'.	
Are the outbreak kits stored in an easily accessible location?	/1
Do all staff know where this location is?	/1
Outbreak Kits x 6 (Clearly labelled) and contains the following disposable items:	/1
Gloves - 1 carton	/1
KC Thumbs Long Sleeved Aprons - 20	/1
N95 Respirator Face Mask - 10	/1
Surgical masks - 10	/1
Halyard Face Shield Full Length - 5	/1
Vomit Bag 1500ml - 10	/1
Over boots Polythene Clear - 10	/1
Black rubbish bags and Yellow Hazard Bags (small) - 5 of each	/1
Small plastic bags to line the rubbish bin inside the resident's room - 5	/1
Ecolab Plastic Spray Bottle labelled for Bleach - 1	/1
Bleach tablets ('Actichlor Plus' or Chlor-white from Ecolab) - 1 container	/1
Disposable cleaning cloths (Yellow) - 1 roll	
Documentation required in the Outbreak Kit:	/1
Site specific cleaning leaflet describing high risk areas & frequently touched items e.g. bathroom/toilet, hand basin, rubbish bin, door handles, taps, switches, telephone, handrails/bed gates, over bed tray tables, call bell, window sill and any other hard surface in the resident room	/1
Leaflet describing two step cleaning process: use soap and water followed by Ecolab bleach (Actichlor or Chlor-white)	/1
Leaflet describing frequency of cleaning in an outbreak, i.e. once every duty in the infected residents room	/1
Bleach solution instructions: make up fresh every 24 hours	/1
Signs and Alerts for Staff and Visitors	
Subtotal	**/ 20**

Compliance Rate

Standard Precautions PPE Supplies	/11
Outbreak Kit Supplies	/20
Total	**/31**
Total correct divided by 33 x 100	_____%

Name of auditor: _____

Designation: _____ Date of audit: _____

Personal Protective Equipment (PPE)
& Outbreak Kit Audit Tool
(Appendix Eight)

HERITAGE LIFECARE

Corrective Action Plan

Audit Name:	
Date:	
Results: _____ %	
Key Problems Identified	
1	6
2	7
8	9
4	9
5	10
Area of Focus:	

Improvement Action Recommended	Time Frame	Person Responsible
1		
2		
3		
4		
5		
6		
7		

Comments:
These issues were discussed at the staff meeting and are included in the minutes. Date of the meeting:
The issues have now been resolved:
Time frame for Unresolved Issues:
Care Home Manager Sign Off:

STOP
NO ADMISSION

In light of the Governments directive to limit all contacts between the population of NZ, our home is locked to all visitors. We apologise for any inconvenience this causes to you, which is totally out of our control.

OUR CONTACT DETAILS ARE

First Name Last Name #1 Phone 021 000 0000 or (00) 000 0000

First Name Last Name #2 Phone 021 000 0000 or (00) 000 0000

We can arrange phone, facebook or zoom for you to use. Please contact us to arrange. We are here to look after your loved ones, and will be totally focussed on this over this time. Thank you for your ongoing cooperation and patience.

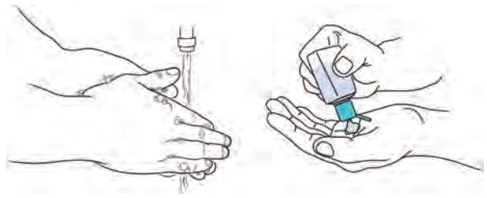
<Type your name here>

Care Home Manager, <your site name> Lifecare

HERITAGE LIFECARE

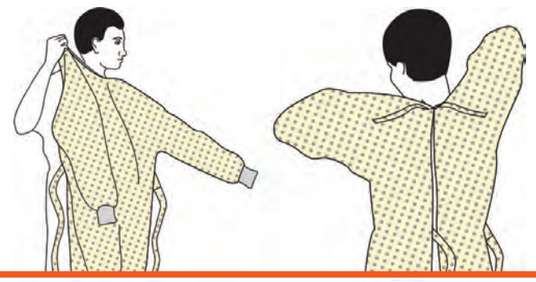
How to PUT ON personal protective equipment (PPE)

1 WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITISER IMMEDIATELY BEFORE PUTTING ON ALL PPE



2 GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back.
- Fasten at back of neck and waist.



3 SURGICAL MASK

- Secure ties or elastic bands at middle of head and neck.
- Fit flexible band to nose bridge.
- Fit snug to face and below chin.

4 EYE PROTECTION

- Place over eyes and adjust to fit.

5 GLOVES

- Extend to cover wrist of gown.

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face.
- Limit surfaces touched.
- Change gloves when torn or heavily contaminated.
- Perform hand hygiene.

Content: Department of Health & Human Services, USA and Centres for Disease Control & Prevention

NORTHLAND DISTRICT HEALTH BOARD · AUCKLAND DISTRICT HEALTH BOARD · Waitematā District Health Board Best Care for Everyone · COUNTIES MANUKAU HEALTH

Version 2.

Approved Northern Region Health Coordination Centre 27/02/2020

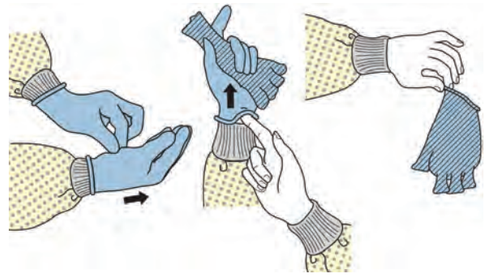
Content: Department of Health & Human Services, USA and Centres for Disease Control & Prevention

How to safely REMOVE personal protective equipment (PPE)

Move away from the patient as far as possible before removing PPE.

1 GLOVES

- The outside of your gloves are contaminated! If your hands get contaminated during glove removal, immediately wash them or use an alcohol-based hand sanitiser.
- Use one gloved hand to grasp the palm area of the other gloved hand. Peel off first glove.
- Hold removed glove in gloved hand.
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove.
- Discard gloves in a clinical waste container.
- Perform hand hygiene.



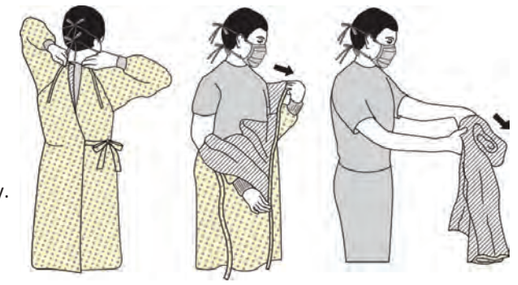
2 EYE PROTECTION*

- The outside of your eye protection is contaminated! If your hands get contaminated during removal, immediately wash them or use an alcohol-based hand sanitiser.
- Remove eye protection from the back by lifting ear pieces.
- If the eye protection is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a clinical waste container.

** If using integrated mask/eye protection, skip step 2.*

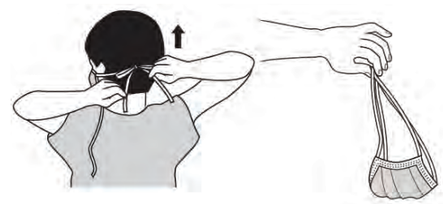
3 GOWN

- The outside of your gown front and sleeves are contaminated! If your hands get contaminated during gown removal, immediately wash them or use an alcohol-based hand sanitiser.
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties.
- Pull gown away from neck and shoulders, touching inside of gown only.
- Turn gown inside out.
- Fold or roll into a bundle and discard in a clinical waste container.
- Perform hand hygiene.



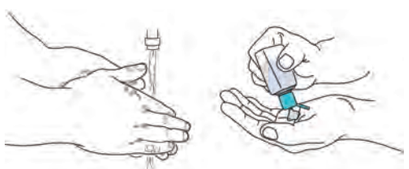
4 SURGICAL MASK

- The front of your mask is contaminated — **DO NOT TOUCH!** If your hands get contaminated during mask/respirator removal, immediately wash them or use an alcohol-based hand sanitiser.
- Grasp bottom ties or elastics of the mask, then the ones at the top, and remove without touching the front.
- Discard in a clinical waste container.



5 WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITISER IMMEDIATELY AFTER REMOVING ALL PPE

- Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE.



6 DISINFECTION OF ROOM

- Leave room closed and vacant after patient has left.
- Wear gown and gloves and wipe down all hard surfaces with virucidal disinfectant.
- Reusable eye protection should be cleaned with virucidal disinfectant.
- Medical equipment that has touched the patient must be wiped down with a virucidal disinfectant.
- Dispose of wiping agent in clinical waste container. Perform hand hygiene.

COVID-19 LAUNDRY MANAGEMENT ACTION PLAN

Date		Care Home		Reported By		Designation	

Key Area to Manage	Proposed Action	Person Responsible	By When	Sign & date as Completed
Laundry	• **"Full gear" (Mask, face shield, thumbs-up gown, gloves) PPE is worn during handling of soiled linen** to prevent skin and mucous membrane exposure to blood and body substances. During an outbreak, laundry staff are to use "full gear" PPE when handling linen and clothes from identified residents in isolation. • **No one is to enter the laundry room except the laundry staff.** Likewise, the laundry staff cannot enter the staff room or go to any of the care home wings. Laundry staff are to have a designated toilet/rest area if possible to avoid cross-contamination. • The CHM or CSM is to ensure that laundry staff will receive a list of residents in isolation; the laundry staff is expected to receive a new list whenever a new resident is added to the infection log. • **All linen and clothing from isolated residents is to be treated as infectious**; whether the residents are under investigation or a diagnosis has been confirmed.	• CHM/CSM directs laundry • CHM/CSM to ensure all staff are aware that only laundry staff are allowed in laundry room/area • RN on duty to give up to date list to laundry staff • CSM to ensure all staff treat linen from isolated residents as being infectious	Immediately.	

	• **Linen soiled with body substances is to be placed into leak-proof black rubbish bags for safe transport to the laundry.** Used linen is 'bagged' at the location of use into black rubbish bags. When a care home / facility is experiencing an outbreak, all linen is to be bagged in black plastic bags. These black plastic bags are to be tied off when the bag is ¾ full, clearly labelled as infectious, before transportation to the laundry room. • **No manual sluicing is to be done in an outbreak**. Manual sluicing increases the risk of both care staff and laundry staff to aerosol-transmitted infections. Soiled linen must not be rinsed or sorted in resident-care areas or washed in domestic washing machines. • **The black rubbish bags are to be untied carefully or cut open with scissors and tipped straight into the washing machine** – no sorting before laundry. Sorting is to be done prior to transport by care staff. Wash on the hottest cycle and follow up with drying in the clothes dryer. All infectious linen are to be washed last, after all other linen have been washed. • **Hand hygiene is performed following the handling of used linen**. • **Soiled linen should not pass through food preparation or food storage areas.** If this cannot be prevented due to building architecture, the soiled black rubbish bags are to be placed inside a designated "dirty" trolley which is covered and secured before transport. The laundry staff is to clean the trolleys before sending back to the	• Care staff assigned to isolated residents • Laundry Staff • Laundry Staff • Laundry Staff • Care Staff • CHM/CSM to direct all staff		

	wings. • **Laundry staff should be notified by phone when there is linen from an isolation room to be processed.** • **For residents placed in contact isolation a black rubbish bag is to be kept covered immediately inside the resident's room, tied securely when ready to be sent to the laundry.** • **The black rubbish bags must never be more than two thirds full** to avoid creating a manual handling hazard for laundry staff. • Staff Uniforms - Care should be taken to check that pockets of uniforms are empty and name badge removed before sending uniforms to the laundry. (There should be a designated box in a staff room, or in the "dirty section" of a laundry room) • Aprons and tea towels are not to be washed with any other items. Staff to engage in correct manual handling techniques when carrying out laundry duties.			

COVID-19

DON'T BRING IT HOME

No wallet.
Put car keys and drivers licence in a ziplock bag.

Leave pen at work
Frequently wipe with alcohol wipes.

Minimalist clothes.
Separate shoes to be left at work, preferably plastic/ washable.

Avoid eating in communal spaces.
Bring a drink bottle.
No keep cups at café.

Bring your own food in a re-usable shopping bag to wash.

No case on your phone, wipe down with alcohol wipe. Leave in scrub pocket, consider using a ziplock bag.

Don't use your hands where possible - open doors with your feet doors. Use gel

End of the day wash hands and arms.
Alcohol wipe phone, leave pen behind.

When you get home:

– take your shoes off outside
– no hugs
– take clothes off, and wash separately from family washing, hot wash, tumble or line dry, iron
– shower
– enjoy your family

Hauora
Tairāwhiti

20.03.2020

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora o Waitaha

C	Compliant
NC	Non Compliant
P	Partial

APPENDIX 6

WCDHB - Infection Prevention and Control Service

ARC Quick Environmental Audit

Name of Auditor [redacted] CNS IPC.
Facility Eden House.
Nurse Manager [redacted]
Date of Audit 20/4/20.
Date of Feedback

SECTION 1: GENERAL ENVIRONMENT

Standard: Clinical areas are visibly clean, uncluttered and maintained appropriately to minimise cross infection.

		C	NC	P	NA
HAND HYGIENE FACILITIES					
1.	Hand washing facilities are clean, available and access is clear	✓			
2.	ABHR is available	✓			
DETERGENTS/DISINFECTANTS					
3.	Detergent or detergent wipes are available for general environmental cleaning of surfaces	✓			
4.	Approved disinfectant (bleach product or other hospital grade disinfectant active against viruses) is available	✓			
5.	Correct dilution/refreshing of disinfectant every 24 hours	✓			
6.	Alcohol impregnated wipes are available for sensitive equipment	✓			
7.	Designated housekeeping staff	✓			
DIRTY UTILITY/SLUICE ROOM					
8.	The dirty utility or sluice area is visibly clean and tidy	✓			
9.	There is a designated hand wash basin in this room, with soap and paper towels present	✓			
10.	There is a facility to safely sanitize equipment e.g. bedpans/urinals /bowls	✓			
WASTE MANAGEMENT					
11.	There is correct segregation of waste	✓			
12.	Infectious/medical waste bins with foot-controlled lids are available	✓			
13.	Waste bags awaiting collection are stored in a non-public area	✓			
14.	ABHR/HWB is available for use after handling waste	✓			
SOILED LINEN					
15.	Linen bags are secured and stored in a secure area for collection waste	✓			
16.	Soiled linen from isolation rooms is handled/laundered separately	✓			
17.	Staff working in laundry do not provide patient care	✓			
18.	Dirty and clean linen is segregated	✓		NA	
19.	Personal clothing is laundered separately for each patient/resident	NA		✓	
20.	Hand hygiene and personal protective equipment is available	✓			

Comments WCDHB, IPC, april 2020 – supplied by CDHB.

double bagging skip sharps bins hospital. pathway for clinical waste.

sanitizer disinfectant NW product Rhino.

recessed cleaning following - cleaning / disinfects rails hard surfaces tables + shower & door handles.

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

SECTION 2: PATIENT ROOMS

Standard: Facilities and appropriate products are available to ensure effective hand hygiene and standard precautions are undertaken.

		C	NC	P	NA
21.	ABHR is available at each resident's room outside. WB inside.	✓			
22.	Disposable gloves in a range of sizes are available	✓			

Comments

SECTION 3: PATIENT CARE EQUIPMENT

Standard: Patient care equipment will be cleaned/decontaminated and stored safely and appropriate resources made available to minimise the risk of cross infection

		C	NC	P	NA
	Residents have own bathing equip no sharing				
23.	Manual handling sheets, hoist slings and slides are cleaned between patients	✓			
24.	Are commodes used	✓			
25.	Commodes are individually assigned and disinfected between patients	✓			

Comments

SECTION 4: COMMUNAL PATIENT AREAS

Standard: Communal patient areas shall be maintained appropriately to minimise the risk of cross infection.

		C	NC	P	NA
TOILETS & BATHROOMS					
26.	Are bathrooms/toilets shared between residents?			✓	
27.	How are residents in isolation showered/toileted	✓			
28.	Toilets are visibly clean	✓			
29.	Bathroom areas are free from communal items which may be contaminated e.g. creams, talc	✓			
30.	Showers are clean, intact and free from mould	✓			
31.	Linen is not stored in open shelves in bathroom areas	✓			
32.	Staff have a separate toilet from residents	✓			

Comments 2 mop shared toilet/bathrooms. 4 people share 1 used by CMW residents

West Coast – District Health Board – Te Poari Hauora a Rohe o Tai Poutini

Canterbury District Health Board Te Poari Hauora ō Waitaha

C	Compliant
NC	Non Compliant
P	Partial

SECTION 5: STANDARD AND TRANSMISSION-BASED PRECAUTIONS

Standard: Care will be planned for individual patients using precautions necessary to prevent the spread of infection, taking into account the needs of the patient and other patients

		C	NC	P	NA
33.	Sufficent PPE stock on hand	✓			
34.	PPE Donning/doffing areas are identified	✓			
35.	Staff have received training in donning/doffing PPE	✓			
36.					
37.	Disposable gloves, aprons and gowns are available/worn as restocked. Please Ask.	✓			
38.	Surgical masks are available/worn	✓			
39.	Safety glasses/protective eyewear is available/worn	✓			
40.	The correct transmission-based precautions signage is available and used appropriately	✓			
41.	Eye protection is cleaned and disinfected after use	✓			

Comments Video - from CDHB IPC rep.

SECTION 6: KITCHEN AND FOOD / BEVERAGE FACILITIES

Standard: Kitchen and food handling areas conform to Food Safety Authority guidelines

		C	NC	P	NA
42.	Kitchen staff are not involved in patient cares or laundry	✓			
43.	There are hand hygiene facilities available	✓			
44.	Are there any filtered water units available in facility	✓		✓	

Filtered water - date / starting.

Comments

SECTION 7: COVID-19 OUTBREAK MANAGEMENT

		C	NC	P	NA
45.	COVID-19 Outbreak management plan available	✓			
46.	CDHB Planning and Funding liaison person identified	✓			
47.	Staffing contingency plan available	✓			
48.	Community & Public Health contact details known			✓	
49.	Staff know how to launder their uniforms	✓			

Shot x1 RN-

COVID-19 Pandemic Plan

Contents

If you have concerns, you can contact the dedicated Ministry of Health COVID-19 Healthline for free on 0800 358 5453.

WHITE ALERT
Planning for a Potential COVID-19 Pandemic

1. Aims and Objectives of the Pandemic Plan

This pandemic plan aims to manage the impact of COVID19 Pandemic on employees, residents and Dixon House via two main strategies

1. Containing the disease by minimising spread within the facility; and
2. Maintaining essential services if containment is not possible.

2. Definitions

a) **Influenza** – Illness caused by viruses that infect the respiratory tract. Influenza viruses are divided into three types, designated A, B and C.

b) **Contact** – In this context, a contact is any person who has had close physical (less than one metre) or confined airspace contact with an infected person, within four days of that person developing symptoms. Note that this definition may change during a developing pandemic based on epidemiological evidence from the pandemic.

c) Incubation period - means the time between catching the virus and beginning to have symptoms of the disease. Most estimates of the incubation period for COVID-19 range from 1-14 days, most commonly around five days. These estimates will be updated as more data becomes available.

d) **Pandemic** – An epidemic occurring over a very wide area, crossing international boundaries and usually affecting a large number of people – a global epidemic.

e) **Virus** – A microorganism smaller than a bacteria, which cannot grow or reproduce apart from in a living cell. A virus invades living cells and uses their chemical machinery to keep itself alive and to replicate itself. It may reproduce with fidelity or with errors (mutations) – this ability to mutate is responsible for the ability of some viruses to change slightly in each infected person, making treatment more difficult.

3. Background Information on COVID19 Pandemic

Coronavirus Pandemics with novel viruses are recurring events, are unpredictable and result in serious health effects to large proportions of the population, causing significant disruption to social, economic and security concerns of the community.

A Coronavirus Pandemic is a global outbreak of a new virus that is very different from current and recently circulating human seasonal influenza A viruses. Pandemics happen when new (novel) viruses emerge which are able to infect people easily **and** spread from person to person in an efficient and sustained way.
Because the COVID-19 virus is new to humans, very few people will have immunity against the pandemic virus, and a vaccine might not be widely available. The new virus is likely to impact a lot of people, with older adults and those with reduced immunity being at higher risk of contracting the related viral infection. How sick people get will depend on the characteristics of the virus, whether or not people have any immunity to that virus, and the health and age of the person being infected. With seasonal flu, for example, certain chronic health conditions are known to make those people more susceptible to serious flu infections.

Coronaviruses are a family of viruses that can cause illnesses such as the common cold, Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). In 2019, a new virus called the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) caused a disease outbreak in China. The disease is called coronavirus disease 2019 (COVID-19).

Public health groups, such as the World Health Organization (WHO) and the U.S. Centers for Disease Control and Prevention (CDC), are monitoring the situation and posting updates on their websites. These groups have also issued recommendations for preventing and treating the illness.

As at the time of publishing this document mortality rates were:

WHO states Covid-19 mortality rate increased to 3.4%

- WHO has stated that the mortality rate of Covid-19 coronavirus stands at 3.4% globally, which is higher than the previous estimate of 2%.
- WHO director general stated that Covid-19 'spreads less efficiently than flu' and is a results in a severe illness compared to flu. There are no vaccines or therapeutics for it and it is possible to contain it.

Potential Effects:

- Widespread disruption to business: 20-60% of working population unable to work for 2-4 weeks at the height of a severe COVID-19 Pandemic wave. Each wave may last approximately 8 weeks depending on containment.
- Significant death rate.
- Reduction of emergency services – fire, police, health services, air traffic controllers.
- Reduction of other services – retail, transport, government departments, etc.

Effects on Business:

- Reduction of people to operate the business (either temporary or permanent).
- Reduction of services and supplies from suppliers.
- Operations (e.g., production) and support (e.g., IT) will be affected.
- Travel will be affected.

4. COVID-19 Vaccine

The development of a vaccine for pandemic COVID-19 has begun however is not available. Staff and residents are encouraged to get the annual Influenza vaccination as soon as it becomes available to them.

New Zealand does not have the capacity to manufacture vaccines. The Ministry of Health will provide the government with advice on priority groups for vaccination.

It may take significant time after the declaration of a pandemic by WHO before vaccine is generally available for use in New Zealand.

5. Pandemic Information Sources and Implementation of the Plan

The Ministry of Health national pandemic management strategy has identified 5 stages of a pandemic, as well as alert codes that will signal a shift from one stage to the next. These stages and alert codes are shown in the table below.

Stage	New Zealand Strategy	MOH/DHB Alert Code
1	**Plan for it** (Planning)	**WHITE** (Information/advisory)
		YELLOW (Stand-by)
2	**Keep it out** (Border Management)	**RED** (Activation) – **FULL STATE OF EMERGENCY AND LOCKDOWN IN NZ DECLARED 26TH MARCH 2020**
3	**Stamp it out** (Cluster Control)	
4	**Manage it** (Pandemic Management)	
5	**Recover from it** (Recovery)	**GREEN** (Stand down)

This pandemic plan will come into operation on the instruction of the Facility Manager at such time as the risk of COVID-19 entering the local community is regarded as high **(YELLOW ALERT)**.

Information on the spread of COVID-19 Pandemic will be obtained from – 1 and 2 below are the key sources and should be used in preference to other sources of information.

1. Ministry of Health website www.moh.govt.nz and https://covid19.govt.nz/ for current status, fact sheets and FAQ's, and general information on vaccines, medication and treatment guidelines.
2. Access up to date information from https://nzaca.org.nz/covid-19/
3. Ministry of Economic Development website www.med.govt.nz
4. Information communicated to contracted providers from the Chief Medical Officer of the local DHB.
5. Media releases from official sources including communication through Eldernet.
6. The World Health Organisation www.who.int/

Escalation of the Plan - Steps for the escalation of the Pandemic Plan (from white to yellow to red to green) will originate with the Ministry of Health, who will provide notification via their website and through the media.

YELLOW ALERT -
Pandemic Overseas, but has Not Reached New Zealand

6. Required Actions

At the stage where risk of COVID-19 entering New Zealand is regarded as high **(YELLOW ALERT)**, the Facility Manager will implement the following:

a) **Check Supplies Levels** - Check that stock levels of all essential products are sufficient to meet needs should supply be disrupted. This includes supplies of personal protective equipment, cleaning chemicals and foodstuffs.

Where any stocks are below a level regarded as necessary to meet requirements in the event of a disruption in supply, supplies are to be immediately ordered.

b) **Educate Staff** – Ensure that all staff are educated and are aware of their responsibilities during the pandemic. This will include ensuring that all staff are fully familiar with this plan and have received adequate training and education.

c) **Educate Residents and Families** – Education on the COVID-19 Pandemic will be provided to able residents, including how to minimise the risks of contracting and transmitting COVID-19.

d) **Manage Anxiety** - It is likely that there will be anxiety among staff and residents regarding the COVID-19 Pandemic and this is likely to contribute to increased work absence and/or increased distress to staff. This will be minimised by:

- Ensuring this plan is communicated to staff prior to any pandemic.

- Communicating this plan to residents and families.
- Providing staff with education on how to manage their own and their family's health during the COVID-19 Pandemic.
- Providing clear, thorough and timely information to staff throughout the implementation this plan.
- Providing back-up assistance for counseling staff through the Employee Assistance or staff wellness programmes.

Under no circumstances are other staff endorsed to speak to the Media unless this is requested by the most senior Manager in writing. Likewise, posting information in relation to our quarantine status on social media site is not permitted

RED ALERT
Declaration of National State of Emergency – DECLARED ON 26TH MARCH 2020

7. Immediate Steps on Notification of COVID-19 in Local Community

When it is confirmed that COVID-19 is in the local community **(RED ALERT)**, the Facility Manager will implement the following:

a) **Entry Notices** - Instruct that notices are set up prominently at all entry points into Dixon House, instructing all persons (staff and visitors) not to enter if they have symptoms of COVID-19.

b) **Restrict Site Access** – Access to the buildings will be restricted by keeping all external access doors locked to prevent unauthorised entry. All entry to Dixon House will be through the front door.

c) **Provide Required Hygiene Information** – Give instructions that infection prevention and control notices be set up around Dixon House covering basic hygiene and hand hygiene, and also required cleaning procedures.

d) **Provision of Community Care –** We are not a general community care provider. The responsibility of Dixon House is for the care of the residents and the health and safety of staff. We will not therefore undertake any form of direct care for other members in the community during a pandemic. This includes those in external independent living dwellings in Retirement Village settings (where applicable).

e) Persons calling Dixon House seeking assistance from staff will not be admitted into the facility unless able to be admitted as **hospital level of care** into 14 day strict isolation while infection status is ascertained. Others will not receive direct assistance other than remotely via video like communication or phone. A notice to this effect will be placed at the front door of Dixon House. **Hospital level of care for isolation period indicates the need for increased clinical input during this time and funding for this should be confirmed prior to admission.**

f) Staff may provide advice to such callers on alternative locations where assistance can be obtained.

8. External Communications

The Facility Manager or their delegated authority is responsible for liaising with appropriate agencies and other healthcare providers regarding the quarantine status of the facility in the event of an outbreak or a suspected case or cases of COVID-19.

9. Workplace Precautions to Minimise COVID-19 Spread

Implement Physical distancing

During the COVID-19 Pandemic, staff and residents should minimise the risk of contracting the virus by use of physical distancing. Physical distancing refers to strategies to reduce the frequency of contact between people. Generally, it refers to mass gatherings, but the same strategies can be used in the workplace setting. These strategies include:

a) Except for resident care where direct contact is required, staff should wherever possible avoid meeting people face-to-face.

b) This particularly applies to administration staff who can maximise physical distancing by using phones and the internet for most communications and can, for much of the time at least, work from home (see below).

c) Cancel or postpone any booked travel.

d) Cancel all non-essential meetings and training.

e) Wherever possible, residents are to be instructed not to go out into the community or visit high-risk densely populated areas during the COVID-19 Pandemic.

f) Residents may need to be fed in their rooms to avoid close contact in the dining rooms. Activities will be assessed for risk and will be cancelled if the risk is unacceptable. Residents will be encouraged to avoid close contact with others where possible.

g) Staff should avoid use of public transport – staff should walk, cycle or drive to work wherever possible.

h) Staff should avoid congregating in the staff room during breaks. Breaks will be staggered so that numbers in the staff room at any one time will be minimised.

i) Office based staff will be encouraged to eat at their desks where appropriate, or at a location away from others.

j) Where face-to-face meetings are necessary, the following rules should apply –
- Meet in a large **ventilated** room if possible
- Avoid shaking hands or hugging
- Sit at least 1 metre apart from other meeting participants
- Minimise meeting times
- Ensure lidded receptacles are available for disposal of tissues in case of use by any participant during the meeting.

k) Staff should avoid activities away from work which brings them into unnecessary contact with other people.

Workplace Ventilation

There is scientific and medical evidence that influenza or COVID-19 can spread in inadequately ventilated internal spaces. The Ministry of Health and Worksafe recommend that all internal spaces be well ventilated.

This facility does not have mechanical ventilation systems that pose a potential threat for the transmission of viruses. The air conditioning units in this facility (if applicable) and the air extraction systems in the bathrooms and toilets are required to be in properly maintained condition at all times. Filters must be cleaned and signed off on the schedule to verify this has been completed. Those performing these cleaning duties must wear the appropriate PPE during these tasks.

Wherever possible, windows are to be kept open to allow fresh air to circulate in the building and air conditioning units / heat pumps should not be used, unless absolutely necessary for temperature control.

Working from Home
Non-essential and administration staff should work from home where possible:

1. The accounting systems have been set up so that accounting staff can access the accounts from their home computer.
2. Other administration/quality/support services staff should work from home wherever possible.

Reception Window (if applicable)
The nature of the workplace does not allow for most staff to be separated by screens to prevent close contact. However, the Reception window should be kept closed at all times to minimise the risk of contact across the reception counter.

10. Educate and Implement Personal Infection Prevention and Control Precautions

All staff during their orientation to work as from the 10th May 2020 will undertake familiarisation with the use (donning and doffing) of PPE.

Personal infection prevention and control precautions are required to be taken by all staff, residents and visitors to minimise the spread of COVID-19. These precautions relate to the general workplace only. Infection prevention and control precautions that care staff are required to take while providing direct resident care are covered in section 12 below.

1. Emphasis needs to be made of the importance of thorough hand washing. Instructions on hand washing and on the use of alcohol-based hand gel are to be given verbally to residents, with notices placed prominently around Dixon House as a reminder for all staff, residents and visitors.

2. Adequate supplies of hand washing soap and paper towels are to be maintained at all sinks. Check supplies each shift and replenish as necessary.

3. Alcohol hand gel dispensers are to be available in common areas where there are no hand basins for hand washing. These areas are to include the lounges, dining room, reception, and the staff room. Ensure these are checked each working duty to verify they contain gel for use.

4. Staff and residents are to be instructed to report any symptoms of respiratory illness, and notices are to be placed around the workplace repeating these instructions.

5. Tissues are to be available in common areas, along with lidded non-touch (foot operated) waste receptacles for the disposal of these.

6. Tissues and face masks are to be provided to any person who is coughing or sneezing so that they can cover their mouth and nose. **Remind mask wearers NOT to touch** the mask as each hand contact could contaminate the mask.

7. Staff, residents and visitors need to be encouraged to implement physical distancing and to cough into their inner elbows - not their hands. See Cough Etiquette.

11. Management of Staff illness at Work

Introduction – The Ministry of Health advises that businesses should plan for up to 50% absences for periods of about two weeks at the height of a pandemic wave and lower levels of staff absence for a few weeks either side of the peak. Furthermore, a pandemic could last many months and may contain several peaks. These absences may be due not only to illness to staff members, but also due to staff who need to stay home to look after ill family or to look after school age children (as schools are likely to be closed).

Annual Influenza Vaccination –

All staff and residents are encouraged to be vaccinated annually for common influenza strains.

Although this will not prevent a staff member from contracting COVID-19, it will enable a sick staff member to know that the virus strain that they have contracted is the pandemic strain and not a normal strain. Additionally, it will assist the workplace if staff are not ill with a normal influenza strain, at the same time that COVID-19 is prevalent.

COVID-19 or Cold? - All staff are to be educated to recognise the difference between COVID-19 and the common cold. These differences are shown on the table below.

SYMPTOM	COVID-19	COMMON COLD
Loss of sense of smell and / or taste	Common	Rare
Fever	Common, sudden onset 38° - 40° C and may last only a period of hours before returning without intervention to afebrile	Rare
Headache	Common and can be severe	Rare
Aches and pains – reports of back pain and joint pain in particular	Common and can be severe	Rare
Fatigue and weakness	Common and can last 2-3 weeks or more after acute illness	Sometimes but mild
Debilitating fatigue	Common, early onset can be severe	Rare
Nausea, vomiting, diarrhoea (highly offensive smelling)	Evident in a number of older adults	Rare
Watering of the eyes	Rare	Usual
Runny, stuffy nose	Rare	Usual
Sneezing	Rare in early stages	Usual
Sore throat	Common	Usual
Chest discomfort / Shortness of breath	Common and can be severe	Sometimes, but mild to moderate
Complications	Respiratory failure; can worsen a current chronic condition; can be life threatening	Congestion or earache
Fatalities	Older adults are at extreme high risk of death from COVID-19	Not reported
Prevention	**Strict and consistent PPE use in outbreak situations,** Non-outbreak - frequent hand washing; cover your cough/sneeze (inner elbow cough etiquette	Frequent hand washing; cover your cough

Procedure for Staff Reporting Illness –

Staff may either phone in to report that they have symptoms of COVID-19, or they may report symptoms while at work. In either case, they should be screened by a Registered Nurse or the senior staff member on duty, using the instructions and flowchart below.

1. Registered Nurses and senior staff should avoid close contact with the unwell staff member / suspected case. Wherever possible, it is preferable to carry out the screening by phone.

2. The staff member / suspect (probable) case should be immediately asked to wear a surgical mask if they are not already doing so, in order to protect others from possible contamination.

3. The Registered Nurse or senior staff member should check the symptoms outlined in the table above.

4. If the staff member does not have any of the symptoms listed, they are very unlikely to have COVID-19 and should be reassured and advised to check with the Registered Nurse or senior staff member again later, or contact Healthline on 0800 358 5453 if they have concerns.

5. An employee who does report any of the symptoms listed should be treated as a suspect case. The Registered Nurse or senior staff member should complete and add the employees details into an Outbreak Log, and gather details in relation to any staff and/or visitors that the staff member has been in close contact with. This information will allow the Facility Manager to monitor staff whereabouts and wellbeing during the pandemic.

6. The suspect case will be asked to leave work immediately and be advised to contact a health professional by telephone for a review. They should not use public transport if at all possible, or drive if they have become acutely unwell. Management will, if required due to no other safe option, pay for a taxi.

7. Other necessary staff should be informed that the staff member has left work.

8. The Registered Nurse or senior staff member is responsible for advising contacts that the staff member has been in contact with that they have been in contact with a person suspected of having COVID-19 (see Contact Management page 13).

9. Where practical, contacts should be sent home and asked to stay at home until advised otherwise.

10. The suspect case's work area should be cleaned and disinfected in accordance with the cleaning instructions included in this document.

11. The Facility Manager, Clinical Nurse Manager or their delegated authority is responsible for monitoring the suspect case and their contacts during their absence.

    This responsibility includes –

    - Advising the staff member how long they should stay away from work for (the Ministry of Health website should have advice regarding this on their website once the characteristics of the pandemic are known).

- Checking the staff member during his or her absence from work. This will facilitate treatment, contact tracing, etc., if they become ill.

- Staff should have confirmation from their GP that they are well prior to their return to work.

12. The information is to be held by the Facility Manager or their delegated authority responsible for rostering of staff.

Staff Screening Flowchart

Ask the staff member if they have any of the following symptoms:

- High fever (<38 degrees Celsius, or feel feverish or hot)
- Loss of taste or smell
- Headache
- Fatigue and weakness
- Sore throat, cough, chest discomfort, Shortness of breath or difficulty in breathing
- Muscle aches and pains
- Been overseas recently or living with someone who has been overseas recently
- Been in contact with someone diagnosed with COVID-19

Yes, two or more symptoms as described above

Staff member should be considered as a possible case of COVID-19 – may need to stand down from duty - isolate

Seek testing and Take names of contacts (those working within 2 metres or in an enclosed place for more than 15 minutes)

Isolate pending test result

Full PPE for cleanup – Arrange cleanup of staff members work area or areas that may have been potentially infected by staff member.

No symptoms as described above

Unlikely to be COVID-19

- Reassure
- Monitor for onset of any symptoms
- Advise to call again if concerned or visit their GP

Advise contacts that they may have been in contact with suspect case.

Contact Management –

Physical distancing and Hand hygiene are the primary infection transmission precautions. These are likely to include family and/or other living companions, some work colleagues. People who have not been in close proximity nor share a combined airspace with a sick person within four days of that person developing symptoms are not considered to be a contact.

The Health Act (1956) classes both highly pathogenic avian influenza (HPAI) and influenza as infectious diseases. In addition, HPAI is a notifiable disease meaning that some additional provisions of the Health Act apply, over and above the provisions that apply to influenza. All probable and confirmed cases of COVID-19 are being notified.

To minimise the spread of infection, contacts will be expected to stay home and avoid contact with others for a recommended period that will be set by the Ministry of Health. **As at 26th March 2020, NZ has declared a State of Emergency and is under a National Lockdown.**

Healthcare and medical support workers and health professionals are classed as part of essential services. Letters should be provided to each staff member to carry with them for transiting to and from work to verify they have a valid reason for leaving their home.

Physical distancing and use of PPE when working with residents in 14 day isolation, or probable or confirmed cases is the key focus during the LOCKDOWN which commenced on the 26th March, 2020. This applies to level 4, 3 and 2 of lockdown.

Treatment of COVID-19

Symptoms management with detailed monitoring and frequently (more than once per shift if necessary) updating of resident progress notes. Remote medical consultations are now being advised to limit risk of infection transmission. Doctors and Nurse Practitioners to have their own individual logins for access to HCSL Software for remote diagnosis support and treatment planning.

12. Management of Staff Shortages and Rosters

Roster management is based on a Ministry of Health guideline that states that at the peak of the pandemic wave, up to 50% of staff may be unavailable for work. Staff may be unavailable for work either because they are sick themselves, because they are required to look after sick family members, or because they have been bereaved.

At the peak of the pandemic wave, staff unavailability will require that non-essential work duties be left so that staff working can concentrate on essential duties (see 12. below). In addition, some staff may be asked to assist in areas unfamiliar to them if staff shortages make this a necessity.

Responsibility for Management - Management of staff rosters will become the responsibility of the Facility Manager or their delegated authority, who will coordinate staff rosters in conjunction with the departmental Manager.

Sick Leave Policy – The Employment Agreement should include a clause that gives the Facility Manager the authority to grant staff discretionary sick leave over and above the standard entitlement in circumstances that the Facility Manager believes warrants this being granted.

Use of Family/Whanau/Volunteers – If staff are unavailable to provide full necessary cares for all residents, resident's family/whanau or other resident representatives will be used wherever they are willing and able to assist in looking after their relative. Prior to doing so, it will be determined that they have no symptoms and have not come in to contact with suspected COVID-19 sufferers. Volunteers will also be used wherever possible.

Family members/ non-clinical staff volunteers will not be used to support staffing / fill gaps in the roster in the event of an Outbreak.

13. Cancellation of Non-essential Services

Non-essential services will be cancelled for the duration of the pandemic outbreak, or at least for that portion of the outbreak which makes the provision of non-essential services impractical or poses increased risks of COVID-19 spread. Essential repairs etc., will be done only by pre-arrangement with the manager and service providers will wear full PPE for each individual service.

Services that will need to be cancelled will include:

1. All or most activities which require communal areas and socialising.
2. Non-essential allied services, including physiotherapy and podiatrist, (consultations may be conducted virtually using video / phone or other electronic device methods).
3. Hairdresser
4. Church services – phone and video will be used where possible to support meeting spiritual and cultural needs of residents
5. Non-essential internal services e.g., ironing of clothes, cleaning of drawers, some non-essential maintenance.
6. Non-essential resident appointments will be cancelled.
7. **Non-essential staff in accounts, Human Resources or Operations, if able, should work from a dedicated space at home. Ensure privacy of information and security of any company records / information.**

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-health-advice-general-public/covid-19-essential-services-health-and-disability-system

14. Provision of Resident Care and Isolation / PPE Guidelines

Refer to the organisations Infection Prevention and Control policies and procedure manual.

Advise from NZACA Nursing Leadership Group regarding use of PPE: https://nzaca.org.nz/covid-19/

Isolation during Alert Level 4 and Level 3 – Eliminate Practice Advice:

- A risk-based approach means the same precautions for ALL admissions including returning residents from ED or OPA who have 'broken the facility lock down bubble'.
- ARC cares for the most frail and vulnerable population with the highest fatality rates from COVID-19. There must be strict isolation adherence across the sector.
- The preference is where able, testing of all new admissions to reduce the time in isolation for vulnerable residents and decrease unnecessary cost and waste of PPE.
- The only difference in PPE use is whether the resident is asymptomatic vs suspect case, symptomatic, or COVID-19 positive.
- All usual infection prevention and control / isolation standards apply in terms of cohorting, minimising staff exposure, grouping cares.
- **Isolation continues for 14 days from: commencement of symptoms; admission or re-entry to the facility, or until a negative COVID-19 test returned and asymptomatic.**

Refer to the below table for all probable or confirmed cases:

Transmission-based precautions are required for all suspected or confirmed COVID-19—Contact and droplet precautions.

Contact and airborne procedures for aerosol generating procedures[1]

Before entering patient rooms	Single room	Cohorted room (bay of two or more people)
Always perform hand hygiene*. ABHR or soap and water	✓ Hand hygiene as per 5 moments for hand hygiene	✓ Hand hygiene as per 5 moments for hand hygiene
Don a long sleeve impervious gown	✓ For close patient contact, single use	✓ For close patient contact, single use
Use a Surgical Mask	✓ For all patient interactions	✓ Keep mask on until mask becomes damp. Change as per PPE doffing guidance
N95/P2[1] Mask	✓ Wear N95 mask[1^] for Aerosol generating procedures **only**.	✗ Nebulised medications should not be performed in cohort bay
Wear eye protection[1]	✓	✓
Don non- sterile Gloves	✓ Single patient use	✓ Single patient use.

Please refer to guidance on donning and doffing of PPE and Ministry information on COVID-19.
www.health.govt.nz/covid19-hp-resources

- Dementia residents may be isolated as a whole community. Use your current procedures for isolation for norovirus, influenza etc. The preference is for dementia admissions to be tested negative for COVID-19 and be asymptomatic prior to admission.

15. Food Service

Food Services is as per the Food Control Plan. Attention needs to be paid by staff handling used plates, cups, cutlery, etc, with particular attention being paid to hand washing.

Meal service may be staggered if all residents dine in the dining room to allow for more space eg; physical distancing. Consideration could be given to two sittings for example with those who need support to eat their meal are served first and then when they've finished, the more independent residents can dine. Alternatively more residents may dine in their room however this is reliant on increasing staffing support to ensure safe monitoring and assistance to residents.

Moving to use of disposable plates, cups and cutlery may be an option which is undertaken in the early stage of a Pandemic. Staff segregation so **care staff do not enter kitchen** areas is recommended.

Outsourcing meal service may also be part of pandemic outbreak planning for continuation of services. Meals will be supplied in disposable lidded or otherwise sealed containers.

16. Laundry

For the laundry industry, there are no recommended changes in normal laundry processing of textiles from the CDC, as the current textile processing standard of appropriate time, high temperature **(thermal treatment)** and chemicals should kill the virus.

Ensure clear demarcation of green (clean) area and red (dirty) areas in the laundry is evident through taped off areas or other marking and labelling.

For employee exposure risk on the sorting side, the CDC has made no recommended changes in textile handling procedures at this time. Viruses usually do not live outside a live host for long periods, especially on porous surfaces like textiles, limiting the potential exposure risk to laundry personnel who will be handling the laundry hours or days after use.

According to the CDC, there is a higher risk of exposure with close direct person-to-person contact than with indirect contact of potentially contaminated objects. Since laundry personnel are not providing direct care to ill residents, PPE requirements per blood borne pathogen standards and following good hand hygiene practices should limit the exposure risk of handling contaminated textiles. Based on current infection prevention and control practices, laundries should include the use of standard / universal precautions when handling textiles.

Sorting practices of contaminated healthcare linens should include the use of gloves and frequent hand hygiene, at a minimum.

All items from isolation rooms should be kept separate from other laundry and laundered separately after all other laundry (using thermal treatment) or outsourced to a commercial laundry service.

Gowns, masks and eye protection can also be worn if the laundry worker is concerned about splashing or aerosolisation of microorganisms. As long as staff processing laundry utilise standard precautions, the risk of exposure should be reduced to very low.

(*See Linen handling and processing policy/procedures to be used in conjunction with this document).*

Personal Protective Equipment:

Laundry staff are to wear personal protective equipment at all times when working in the dirty laundry area:

1. Disposable aprons – different aprons for clean and dirty laundry processing.
2. Gloves - to be changed and discarded, and hands washed before going into clean laundry area.
3. Sleeve protectors should be worn if the staff member is wearing long sleeved clothing.
4. Surgical masks for all handling and sorting of dirty laundry.

Masks: **: (DO NOT WEAR FROM MORE THAN 2 HOURS AND CHANGE IF BECOMES MOIST PRIOR TO 2 HOURS)**

How to wear a mask:

- wash hands with soap and water or use hand sanitiser
- place over nose, mouth and chin
- fit flexible nose piece over nose bridge
- secure on head with ties or elastic
- adjust to fit – secure on your head, fitting snugly around your face with no gaps
- avoid touching or adjusting your mask during use.

How to remove a mask:

- wash hands with soap and water or use hand sanitiser
- avoid touching the front of the mask
- if the mask has ties, untie the bottom, then top tie
- remove from face hanging forward to avoid contact with body of mask
- discard, do not use again
- wash hands with soap and water or use hand sanitiser immediately.

Hand Hygiene: Proper use of hand washing procedures are critical to minimise the transfer of viral disease. Hands are to be washed regularly and thoroughly at the time and in accordance with the instruction provided in the Infection Prevention and Control Manual, Hand Hygiene.

Laundry Procedures: Usual procedures for processing laundry will apply with the following exceptions –

1. Hot water temperatures ALONE in the laundry are generally NOT sufficient to kill the virus, therefore this must be done by using a SPECIFIED SANITISING AGENT in the wash cycle. This will be added by the Chemical supplier or manually during the Yellow Alert phase of the COVID-19 Pandemic.

2. Unauthorised persons are not to be permitted entry into the dirty laundry work area

3. The separation of dirty and clean laundry, and staff hygiene practices when moving from the dirty into the clean laundry required as a part of normal infection prevention and control procedure must be strictly enforced.

17. Household Cleaning

COVID-19 may be able to live for up to three days on hard surfaces such as doorknobs, handrails, cups, utensils and telephones. Rigorous, thorough and frequent cleaning is required to minimise the spread of the virus.

Remove Unnecessary Items: COVID-19 can live on hard surfaces for up to three days, all unnecessary items in common areas that might be handled by different residents and/or staff should be removed and stored for the duration of the pandemic. Examples of such items are books and magazines, display items, etc.

Personal Protective Equipment: Cleaning staff are to wear personal protective equipment for all cleaning and:

1. Disposable apron.
2. Rubber gloves can be worn in non-isolation areas as usual. However, if worn in isolation areas, these should be removed and replaced or disposable gloves used instead. Gloves are to be changed and hands washed and sanitised between cleaning different rooms/areas.
3. Sleeve protectors should be worn if the staff member is wearing long sleeved clothing.
4. Surgical mask for normal cleaning.
5. N95 mask for cleaning in isolation areas.

Isolation rooms: The general facility cleaner will not enter each isolation unit where there are multiple isolation units. Care staff will touch point clean using Clinell Universal Wipes or similar products. Rubbish will be placed in a Hazardous Waste bag, sealed and disposed of as Medical Waste. Cleaning will be done by care staff in this instance after support with clinical and hygiene / grooming cares.

Hand Hygiene: Proper use of hand washing procedures are critical to minimise the transfer of viral disease. Hands are to be washed regularly and thoroughly at the time and in accordance with the instruction provided in the Infection Prevention and Control Manual, Hand Hygiene.

Cleaning Supplies: Chemical stocks required for a pandemic are not held in stock.

The regular chemical supplier will supply the required products when required. These stocks, and detailed instructions and safety precautions for the use of them, are to be obtained when the pandemic is at the Yellow Phase or at the first confirmed infectious case is noted.

Ensure close communication with supply companies for supply of hand-towels, toilet paper, hand soap and sanitisers. Review of hand soap dispensers should occur to determine if more are needed in an outbreak situation.

Cleaning Procedures:

Cleaning needs to be increased during a pandemic wave.

1. Particular attention needs to be paid to hard surfaces that receive regular hand contact e.g., sinks and taps, cisterns, handrails, doorknobs, telephones, counters and benches.

2. Influenza / COVID-19 viruses are inactivated by chlorine and by alcohol. Hard surfaces are to be cleaned using a multi-purpose detergent, followed by a wipe down using a solution of Chlorowhite at the chemical suppliers recommended concentration, and allowed to air dry.

3. For surfaces that may be damaged by bleach (eg. Drain grates in sinks, door handles), an alcohol based cleaner should be used, and allowed to air dry.

4. Communal areas should be cleaned first and isolation areas last.

18. Building Services

Maintaining building services is dependent on:

1. The availability of staff and maintenance contractors during the pandemic wave.
2. The ongoing provision of community infrastructure e.g., electricity, LPG, telephone communications.
3. The availability of supplies e.g., fuel, oil, gas, waste disposal skips, medical waste removal, access to serviceman for essential repairs.

The management of building services is to be carried out in accordance with instructions in other relevant site specific Emergency Management Plans.

Any fuel, oil tanks or gas cylinders are to be kept at maximum stock levels prior to the commencement of the pandemic wave to guard against supply being disrupted during the pandemic wave. Ensure alternative access points are available if service is usually done through an area that becomes non-accessible due to outbreak management processes in case of outbreaks.

GREEN
Stand Down

19. Review of Pandemic Plan

A **COVID-19 Pandemic** may occur in waves, with a period of respite between each wave. Of the pandemic waves, the second wave is likely to be the most virulent. Between each wave, the management of the pandemic wave is to be evaluated against the Pandemic Plan.

This review, which should include input from residents, their families / whanau / representatives, and staff, is to include -

1. A review of any changes to the work force caused by the pandemic wave
2. The management of staff sickness and staff availability during the pandemic wave
3. The management of resident care and support services during the pandemic wave
4. The management and availability of necessary supplies during the wave

The reviewed plan is to be amended where gaps and/or opportunities for improvement are identified, and preparations undertaken for the following pandemic wave.

This policy does not constitute medical advice and further information should be sought for individual suspected cases.

https://www.covid19.govt.nz/ - information and resources

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-resources#posters

https://nzaca.org.nz/covid-19/

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-health-advice-general-public/covid-19-essential-services-health-and-disability-system