Auckland DHB

Aged Residential Care

Covid-19

Outbreak Plan

Authored date	19 August 2020	Version	V1.3 05.03.2021
Owner	Nurse Director Community and Long Term Conditions		

Prepared By:	Sheri-Lyn Purdy, Nurse Director – Community and Long-Term Conditions
Input Provided By:	Dr Jane Walton, Service Clinical Director, Reablement Bryan Agnew, Programme Manager, HOP Planning Funding and Outcomes Jackie Robinson, Lead Nurse Practitioner, Community and Long Term Cond. Beth Rogers, Service Clinical Director – Adult Community Services Sharon Mildon, Quality Nurse Leader, HOP Planning Funding and Outcomes Dr Maree Todd, SMO, Health of Older Adults Samantha Titchener, Director of Community and Long Term Conditions Jackson Cutting, General Manager, Community and Long Term Conditions Anna McRae, Allied Health Director, Community and Long Term Cond. Infectious Disease SMO's
Approval required from:	IMT Auckland DHB HOP Programme Manager
Document status	DRAFT
Glossary	ARC Aged Residential Care ARPHS Auckland Regional Public Health Service CLTC Community and Long Term Conditions COVID-19 Disease caused by the novel coronavirus SARS-CoV-2 GP General Practitioner IMT Incident Management Team PHO Primary Health Organisation RACF Residential Aged Care Facility RN Registered Nurse

Version control (to be completed each review date)	V 1.0 17 August 2020 V 1.1 28 August 2020 V 1.2 15 February 2021 V 1.3 5 March 2021 V 1.4 25 August 2021

Contents

1. Background 4
2. Principles 4
3. Scope 5
4. Governance 6
5. COVID-19 Outbreak Plan 7
   - 5.1 Auckland ARC Outbreak and Response Team Scope and Membership 8
   - 5.2 Function of the On-Call Response Team 9
   - 5.3 Critical Functions of the ARC Outbreak Management Team 10
   - 5.4 Supporting staffing surges 13
   - 5.5 Transition plan 14
6. Risks and Issues 15
7. Appendices 19
   - 7.1 Preventing and managing COVID-19 across long-term care services – WHO policy brief 19
   - 7.2 COVID-19 and long-term care in Aotearoa New Zealand 21
   - 7.3 Structure of the Outbreak Management Team 22

1. Background

According to the World Health Organisation (WHO) "Preventing and managing COVID-19 across long-term care services" policy brief (24 July 2020), (see Appendix 1) the COVID-19 pandemic has affected older people disproportionately, especially those living in long-term care facilities. Evidence shows that more than 40% of COVID-19 related deaths have been linked to long-term facilities. Furthermore, in long-term care facilities, the case fatality for residents with COVID-19 may be higher than in the population of the same age living outside long-term care facilities.

According to the authors of "COVID-19 and long-term care in Aotearoa New Zealand" (see Appendix 2) as of the 22nd July 2020, there had been 153 COVID-19 cases linked to five Aged Residential Care (ARC) clusters accounting for 10.2% of all cases in New Zealand. Cases consisted of 39 residents and 78 health care workers, with a further 36 linked to the health-care workers. There were 16 COVID-19 related deaths in residents of ARC facilities, the majority occurring in hospital.

Coronaviruses are a large and diverse family of viruses that cause illnesses such as the common cold. In January 2020 a new coronavirus COVID-19 was identified and has subsequently undergone genetic mutations over time as it adapts to humans, leading to the development of new variants of the virus. The Delta variant has become the dominant variant globally.

It is the most transmissible variant, and it is estimated that on average, one person infected with Delta may infect 5 or 6 other people resulting in rapid outbreaks and is a greater threat to the health of individuals who contract the infection and a greater challenge to contain the spread of the virus in an outbreak. For example:

- Delta can cause people to develop more serious COVID-19 illness than other variants of the virus.
- People with a Delta infection are at higher risk of needing hospitalisation.
- The time from exposure to the virus until first symptoms is shorter for the Delta variant. Some people may have no symptoms (asymptomatic) when infectious.

This plan outlines the response from Auckland DHB to support an Aged Residential Care facility, in the event of an outbreak, to continue to safely operate and provide necessary clinical care for all residents. This plan is a living document and will be updated whenever there are changes in practice or process for CoviD-19 management, by the Community and Long Term Conditions Directorate Leadership team.

2. Principles

The plan is based on the following principles:

- Where relevant the national and regional guidance applies insert new link; however previous experience tells us that a level of support and intervention beyond what is outlined may be needed.
- ARC facilities have participated in COVID-19 Preparedness Assessments (insert link) as a baseline assessment in understanding individual facility support needs in the event of an outbreak.

Noting these assessments were completed in 2020; there could be changes in management, reconfigurations etc. There may also be recent audit information. It is important to supplement this information by obtaining updated current state from the HOP Programme and Quality Managers.

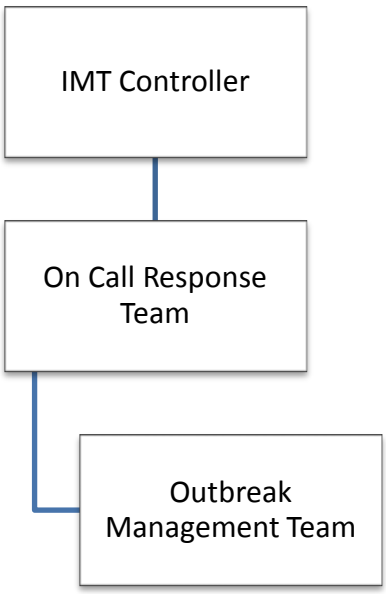
- ARC baseline assessments have resulted in the development of action plans where required and will be referenced in the link above re implementation of those plans and what remains outstanding.
- A period of 14-day quarantine is required for all new admissions and re-admissions to ARC occurs at Alert Level 3 and 4
- The DHB response will be tailored to meet the needs of the Facility
- Working in partnership with Auckland DHB, ARPHS and the ARC Facility is required using clear and streamlined communication
- The Facility will be provided with the support it needs to continue to operate as a residential care facility responsible for providing a home and care support for their residents.
- Residents will be transferred to the hospital immediately if their condition warrants it and on the advice of the resident's GP/NP and receiving clinicians.
- Consideration is to be given to COVID positive residents being transferred from their facility to Auckland City Hospital following the approved COVID admission pathway including escalation pathway when at capacity.
- The wishes of the resident and their family will be considered in terms of hospitalisation.

- Apart from transfer of residents to hospital, all transfers of residents into or out of the facility should be avoided until the outbreak is declared over.
- Staff working within the facility are not to work across any other site
- Clinical care will continue to be delivered by the facility unless the workforce is required to stand down and self-isolate. In the first instance the facility's staffing pool will be utilised before external and DHB workforces.
- The provision of primary care services will continue to be delivered by the contracted Facility GP/NP unless they are required to standing down and self-isolate. In the first instance the facility's locum pool will be utilised before external and DHB workforces

3. Scope

In Scope	Out of Scope
• All ARC facilities in the Auckland DHB catchment area providing one or more of the contracted levels of care (rest home, private hospital, dementia unit, psycho geriatric care).	• Retirement/ lifestyle villages, other than aged care facilities situated within those villages. • Mental Health and Disability Residential care facilities.

4. Governance



The ARC COVID-19 Outbreak Management Team will maintain oversight of processes, outcomes and reporting during a COVID-19 outbreak in an ARC facility.

5. COVID-19 Outbreak Plan

This plan covers a COVID-19 Outbreak in an ARC facility and reflects the capacity that varies between standard business hours and after-hours operations.

If one or more cases of COVID-19 are confirmed within an ARC facility this meets the criteria for a COVID-19 outbreak. Refer to the case classification resources from the Ministry of Health for more information.

The confirmed case may be in:

- A resident
- A staff member who has had close contact with residents or staff when they were symptomatic, or during the 48 hours prior to onset of symptoms
- A visitor who has had close contact with residents or staff when they were symptomatic, or during the 48 hours prior to onset of symptoms

A probable case is a person where there is a high degree of suspicion of COVID-19 but no laboratory confirmation. A probable case may be sufficient to declare an outbreak in some circumstances. This decision will be made by the ARC facility in conjunction with ARPHs. This decision will be confirmed as per the DHB/ARC Facility Escalation Process (insert link).

This plan will cover the support that will be provided by Auckland DHB in the following areas:

- Clinical assessment and on-going review of the facility and residents
- Infection prevention and control e.g. environmental assessment
- Infectious Disease advice
- Psycho-social support for staff, residents and their whānau
- Palliative care supports as and when appropriate
- Support for advanced care plans and goals of care discussions
- Support for swabbing
- Staffing support for daily clinical care: RN, HCA, cleaning and laundry Administrative/ Unit leadership support
- Provision of training and education e.g. PPE use
- Situation reporting process, including daily situation reports and key decision log
- Communication (media, family)support if required
- PPE provision/supply support as required
- Equipment audit and emergency provision of identified equipment needs
- Support provided by Maori and Pacific advisors to ensure any decisions made in relation to residents and whānau have been considered within a cultural safety context.
- Transition plan

5.1 Auckland ARC Outbreak and Response Team Scope and Membership

On-Call Response Team:	Outbreak Management Team: (see appendix 3) (as required)
• IMT Controller On Call (O/C) or SMOC • Infectious Diseases (ID) SCD and/or on-call ID Physician • Reablement SCD and/or on-call Geriatrician • Health Older People (HOP) Programme Manager • Lead Charge Nurse Manager	• IMT Controller/SMOC (briefing only) • Director of CLTC • Resource Management Lead • Infectious Diseases Consultant (as allocated) • Quality Nurse Leader – F&P HOP team • Nurse Director – CLTC • Logistics Lead • IMT Administrative support • Reablement Senior Medical Officer (SMO) • Gerontology Nurse Specialists • Health of Older People (HOP) Programme Manager • ADHB Nurse Practitioner • Communications Representative • Human Resources • Allocated Auckland Regional Public Health Service representative • ARC facility Manager / Clinical Manager / Area Manager / CEO • Facility GP / Nurse Practitioner (NP)/Primary Care Director if GP/NP not available

5.2 Function of the On-Call Response Team

The On-call Response Team's primary focus in this critical period (6 hours) is to ensure processes are put in place with urgency to reduce risk of further spread COVID-19 in facility to staff and residents. It requires a swift and definitive response.

Action	Critical information requirement
A. Convene first meeting within two hours of notification and establish meeting/huddle frequency, to continue until the ARC Outbreak Management Team is established. **B.** Connect with ARC facility, establish facility key contact, positive/probable case details and outline provisional plan for resident(s) **C.** Stand up ARC Outbreak Management Team and handover daily management of outbreak when team fully operational. **D.** Initiate preparation process for designated ward at ACH to receive residents(s) if required **E.** Review strengths and vulnerabilities of the specific ARC facility to continue to provide safe care during outbreak. **F.** Determine whether there is a need to commence surveillance swabbing of all residents and staff, in consultation with ARPHS **G.** Determine potential for number of residents who may need to be transferred to hospital. **H.** Support the ARC Outbreak Management Team process outside the team's standard operating hours.	To meet Actions **B – H** the following information is essential: • Immediate review of ARC Facility COVID-19 Preparedness Action plan. (insert link) and provision of an updated status by the HOP Programme Manager. • HOP Manager needs to establish early contact with ARC Facility Manager and complete an assessment of: - PPE - Equipment – environmental and clinical - Staffing - Environment - Cleaning - Laundry - Food • The team needs to determine the facility's capacity to isolate and monitor residents, develop resident / staff cohorts and increase staffing as needed to ensure isolation and clinical monitoring. • The team (ARPHS lead) needs to commence contract tracing to identify staff and residents at risk of exposure to COVID-19. • A lower level of DHB support may be considered in cases where contact tracing suggests limited exposure and the facility can meet all of the following criteria: - All single rooms with full en-suite bathroom - Capacity to manage all residents in isolation rooms with no risk of mixing - Daily stand up meeting between ARPHS/Facility and Auckland DHB OMT lead - Facility has capacity to meet surge in staffing demands - Staff meet all PPE and IPC controls and have access to adequate supplies of same

5.3 Critical Functions of the ARC Outbreak Management Team

The Outbreak Management Team's primary focus is to provide support and management to the ARC facility throughout the outbreak until such time as it is declared over. The Outbreak Management Team is activated by the ARC On-Call Response Team.

Item	What needs to be done	Who/Lead
Team activation	Convene ARC Outbreak Management Team • Contact team members • Set up first meeting • Confirm administration support • Confirm location of daily huddle/meeting • Create a daily zoom meeting series (note that meetings may be needed more frequently than daily in the case of a complex outbreak) • Generate Situation Report (Sit Rep) details for daily reporting • Generate decision logs • HOP Programme Manager to consider sending ARC Facility Preparedness Plan to team members ahead of first meeting; request each team member review risks and likely support needs relevant to their area of expertise • Establish link with ARC facility manager • Establish line with ARC Facility GP/NP • Establish link with ARPHS lead and expected testing updates	IMT Controller Health Older People (HOP) Programme Manager
Isolation	• Consider information handed over from ARC On-call response team; determine if further assessment is required to support isolation process. • Determine if assessment can be done remotely or onsite. • Confirm current isolation capabilities • Obtain ARC floor plan and information regarding delivery points and contacts that are entering the facility • Identify support needed to create further isolation capacity e.g. equipment, policy, staff, signage, hygiene and waste management • Identify any residents undergoing AGP's, for potential transfer to inpatient setting if deemed close contact/probable/confirmed. E.g. Bipap • Need a list of all residents Names, NHI, room number forwarded to ARPHS and Geriatrician	HOP Programme Manager ARC Facility Manager IPC Lead Nurse Director HOP Programme Manager

Staffing	• Establish link with ARC facility lead Manager and lead RN and ARPHS • Identify any need to stand down facility staff, consideration to be given to supporting staff in remaining in the facility with the use of PPE while developing staffing contingency plan • Check Facility staff who are stood down can safely isolate at home /are not working in other sites or sharing a house with other care home workers • Confirm that symptom checking and temperature checks are occurring (and documented) for everyone entering the facility • Discuss daily information needs to help determine support requirements and planning for potential surge in staff demands: cover all staffing groups e.g. RN, HCA, cleaners, medical, and kitchen. • Confirm daily staff levels per shift, for all staff groups for current day, 48 hours ahead and expected issues for week ahead. • Identify any staff education needs to meet onsite requirements during the outbreak • Identify and agree on facility plans to cover staff absence • Confirm agreement and process to restrict staff movement between teams/pods and other facilities during the outbreak • Identify and agree the threshold decision point and provisional plans for needing to deploy any staff from the DHB to provide direct patient care or support services • Staffing matrix should reflect higher staffing ratios that will be needed to deliver care during an outbreak. There are many more tasks including donning and doffing PPE, increased cleaning frequency, and more clinical and social care of residents.	HOP Manager ARC Facility Manager Nurse Director ARPHS Lead
DHB staff redeployment to facility	• Identify the current and projected demand on acute hospital sites and potential capacity to provide staff for redeployment • Confirm required skill mix for redeployment (HCA, RN, senior nursing/ administrative/ other) • Access the list of staff who have self-identified as being agreeable to working in an ARC facility in the event of an outbreak • These staff should have received: appropriate IPC and PPE training and participated in ARC regional simulation • If the DHB is unable to safely provide the required number or skill mix of staff, escalate to NRHCC/Northern Regional Authority (NRA) to determine regional capacity	CLTC Nurse Director/PMS Nurse Director Director of Provider Healthcare Services (DOPHS) IMT Controller IPC Lead
Resident Wellness	• Establish early link to support a strong primary care / GP response, ensure GP knows how to access further clinical advice and support • Develop a contingency plan if primary care provider is unavailable for on-going medical review of residents • Identify the facility's capacity to meet increased clinical care demands for monitoring and review of unwell residents • Determine approach to maintaining resident continuity of care when	Reablement SCD and/or on-call Geriatrician Nurse Practitioner

	significant numbers of facility staff are stood down or residents are transferred and historical/personal knowledge of resident is lost. • Identify any equipment needs • Understand and document resident premorbid level of function, resident / family expectations of health care/treatment/ advanced care plans/ powers of attorney/ key contacts • Ensure current care plans are in place (work with programme manager to liaise with facilities.) For electronic systems ensure a printed care plan is available • Support (or implement if not already in place) utilisation of the "STOP/WATCH" tool to escalate subtle changes in resident health to registered staff • Use of Zoom/teleconference to be utilised to connect with staff, residents, and families/whānau. Telehealth can be utilised for Primary Care Consultation, virtual rounds with established care facility staff that may have been stood down.	Facility Manager Facility Lead RN Nurse Educator
IPC and PPE	• Confirm staff confidence and skill with use of PPE, and on-going training and support requirements • Implement Auckland DHB guidelines around going to and from work • Determine the need to undertake an IPC onsite assessment within 24-48 hours to ensure support with correct IPC control measures in place and correct use of PPE • Recommend implementation of a buddy/check system for PPE • Confirm Personal Protective Equipment (supply chain process) - Availability - Current PPE stock - Emergency PPE ordering process - Restock capacity - Signage / posters available for isolation	Quality Nurse Leader – HOP IPC Lead HOP Programme Manager Nurse Director Nurse Ed.
Swabbing	• Confirm ARPHS notification • Determine staff capacity to undertake nasopharyngeal swabbing of residents. • Consider requirement for staff training to undertake NPS • Confirm facility has supplies of nasopharyngeal swabs • Confirm swab test ordering process • If the mobile teams are not available, determine the need to use a hospital team.	ARC Facility Manager Facility GP / NP ADHB NP ID Lead
Non-clinical support services	• Determine extra non-clinical support needs and supply chain process to maintain safe service. • Identify any requirements around cleaning equipment, chemicals and storage capacity for increased stock • Confirm correct waste disposal process, frequency of collection and storage of increased waste volume • Confirm correct laundry equipment, chemicals and capacity to manage resident laundry in place (whānau will not be able take items	GM CLTC Quality Nurse Leader HOP

	home) • Ensure food service and appropriate food handling process are in place to reduce risk of contamination, • Confirm staff capacity to deliver increased cleaning, waste and laundry opportunities and reduction in whānau presence to support meal times	
Staff Welfare/ Wellbeing	• Determine staff welfare needs • Identify risk to staff and how these can be mitigated/managed including staff vulnerabilities • Identify risk of staff fatigue and implement measures to address • Ensure effective hazard identification and control measures are in place • Consider periodic surveillance testing for staff working in areas where there is a risk of exposure to COVID-19 • Confirm Facility staff who are stood down can safely isolate at home /are not working in other sites or sharing a house with other care home workers	HR Nurse Director

5.4 Supporting staffing surges

Actions prior to deploying staff to an ARC facility	Steps required to complete
Selection	• Selected staff for secondment to ARCs (as identified in Section 5.3 of this document) will be notified to the Occupational Health and Safety Service • **NOTE:** staff cannot be working in any other site • The staff's Pre-Employment Screening (PES) documentation will be reviewed by the Occupational Health to ensure no physical/psycho-social contraindications prior to deployment • Pre-deployment wellbeing checks with manager including offer to available support networks. This discussion must include shift rosters/fatigue management • Consideration of pre deployment COVID-19 swabbing (regardless of symptoms)
Training	• Cannot be redeployed unless Mandatory online training related to COVID-19 is completed • Infection, Prevention, Control (IPC) Training completed- with particular emphasis on donning/doffing • Stop and Watch tool training • Participation in ARC regional simulation activities • Incident, Hazard and Risk Assessment and reporting training • Nasopharyngeal swabbing training, including ARPHS notification process • Ensure all staff are aware to stay home if unwell and to follow the current "I'm Sick, What Should I Do?" guidelines
Environment	• Local induction to the new area reviewed/started

	• ARC site check/ floor plans reviewed. Health and Safety advisor to visit site with IPC representative to scope ward setup, donning/doffing sites, review on site safety plans, identify any potential risks/hazards to staff, etc.

Actions during deployment	Steps required to complete
1st day of deployment	• To be orientated to the area, complete local area induction training if possible • Ensure correct PPE are available for staff • Liaise with Nurse Director about any concerns/ identified risks/hazards or welfare concerns • Key Contacts and Escalation pathways provided to staff for any concerns/issues
Daily	• Workers must report to their hiring manager if they are unwell prior to being expected at work and follow the current guidelines • Staff to have a start of shift wellness check and to review PPE donning/doffing video from IPC • Briefing with Senior Nurse • Ensure buddy system in place for safe donning/doffing of Personal Protective Equipment (PPE), disposal of soiled equipment/clothing/bagging
Weekly checks	ARC and ADHB/Bureau managers to link with staff to ensure: • Staff understand and follow the guidance around sickness and reporting of symptoms (as above) • Provide opportunity for welfare check/ to provide psychological support for staff • Discuss any review potential risks/hazards identified by staff on site

5.5 Transition plan

ARPHS will determine when an outbreak is considered "closed"

What needs to be done	Action	Who
Establish resident repatriation process and timeline	• Transport requirements • Frequency and safe transfer timing • GP/NP engagement for resident arrival • Medicine reconciliation with designated GP and allocated pharmacy • Set up process for supporting	• Nurse Practitioner

	resident and whānau through repatriation process and integration back to ARC facility • Adhere to regional guidelines around repatriation of COVID residents	
Establish staffing transition process and timeline	• Coordinate with ARPHS and ARC Facility to identify dates of returning staff • Ensure transition period where staff surge overlap BAU to handover residents • Infection, Prevention, Control (IPC) Training completed- with particular emphasis on donning/doffing for returning staff	• Nurse Leader • Nurse Director
Confirm completion of final documents and file storage	• Confirm document storage location • Check for outstanding item completion • Write close out report • Debrief and learning with ARC facility, ARPHS, ADHB and HOP Funding and Planning	• HOP Programme Manager

6. Risks and Issues

Risk	Impact	Mitigations
Lack of current (ARC facility) preparedness or business continuity plan	Low visibility of facilities ability to effectively manage an outbreak of COVID-19	• Regular review and continuous involvement of HOP programme manager and locality GNS to build a longstanding partnership with facility staff and management.
ARC facility resistance to DHB support/ involvement	Low visibility of risks with in facility (staffing, potential admissions), delayed information as to status of outbreak	• On-going involvement of HOP programme manager and facility • GNS to ensure longstanding relationship with facility.
Unable to access timely and appropriate primary care	Limited support for swabbing and wellness checks	• Establish early link to support a strong primary care /GP/NP response • Ensure GP/NP knows how to access further clinical advice and support • Arrange alternative GP/NP if contracted GP/NP

		unable to provide care
Potential DHB staff exposure to COVID-19 if facility requires on-site response	Personal stress and requirement to monitor and/or stand down staff Staff member may contract COVID-19	• Pre-identification of DHB staff who are willing to provide on-site support • Review welfare options for accommodation for staff who are unable to return to their homes due to exposure or infection
Facility environment not suited to isolation of COVID possible and positive residents; dementia residents may not comply with isolation requirements	Spread of COVID 19 within facility	• Participation in COVID-19 preparedness assessment • Onsite assessment by Outbreak Management Team • Surveillance swabbing of staff and residents to identify any new cases • OMT will continually review optimum strategy to minimise transmission risk given environmental and resident characteristics
Inability to maintain infection control processes in facility due to lack of PPE, IPC knowledge, training and support	Potential to spread COVID-19 Staff anxiety, low morale, absenteeism, negative media coverage	• Immediate review of ARC Facility COVID-19 Preparedness Action plan at start of outbreak • Immediate assessment of: PPE, IPC practices, equipment, staffing, environment, cleaning, laundry and food • Implementation of a buddy/check system for PPE • DHB to provide support (PPE +/- training) to whatever level required by the facility
Potential for staff to be stood down at one facility but continue working at another facility, or casual staff working across multiple sites may continue to do so	Contamination of second facility, spread of outbreak	• Facilities to identify all sites where staff work and minimise use of casual staff • Facilities to document prior work history of casual staff • Identify staff who have the ability to work at one preferred facility
Staff attending work when unwell with respiratory symptoms	Minimum: Complicate outbreak response via spread of other respiratory infections even if not COVID (staff need to be stood down until test results negative)	• Symptom checking occurring (and documented) for everyone entering the facility • Staff stood down as soon as they become unwell • All staff have access to welfare support .

	Worst case: Spread of COVID-19	
ARC facility unable to staff the facility to the required levels to meet residents' increased care /monitoring needs	Staff working long hours or reliance on bureau / agency Inadequate care	• ARC facility is reliant on bureau, agency or other facility to provide staff. Regional DHBs might have some staff. • OMT to provide support to identify extra staff
Substitute staff who are not familiar with residents may not recognise deterioration from usual status	Undetected deterioration in mental or physical condition	• Understand and document resident premorbid level of function • Ensure up to date care plans are in place and accessible • Utilisation of the STOP/WATCH tool • Zoom/teleconference to connect with facility staff on stand down who are not unwell, to support continuity of care conversations
DHB unable to redeploy staffing to facility/ unable to source external staff (bureau, other DHBs)	Facility cannot be staffed at safe levels Not all resident cares provided and patient may need to be relocated to another facility/DHB	• Pre-identification of staff willing to work in a facility should an outbreak occur • Contingency plan for support from other DHBs and agencies to support facility if ADHB unable to meet demand • Prioritise resident care/care rationing
Auckland DHB hospitals are at capacity and unable to admit residents from the ARC facility	Potential spread of COVID-19 within facility if positive cases cannot be removed	• Auckland DHBs 'C0VID-19 Readiness Plan' contains an escalation pathway if multiple admissions are required.
An outbreak will result in significant cost to the facility in terms of additional staffing, equipment and PPE, and smaller facilities may not be able to absorb cost.	Facilities may not have ability to meet extra costs. Potential for facility to go into liquidation or receivership; if so the DHB will be required to find alternative accommodation at short notice which could be very challenging if a facility has had an outbreak and	• DHB to support the facility until the outbreak is officially closed ameliorating any financial impact. • If a facility does cease operation post an outbreak the DHB will follow the ARC Closure Guidelines that are well tested and cover all components of transferring residents to new facilities. • All staff have access to welfare support

	residents are not "clear".

7. Appendices

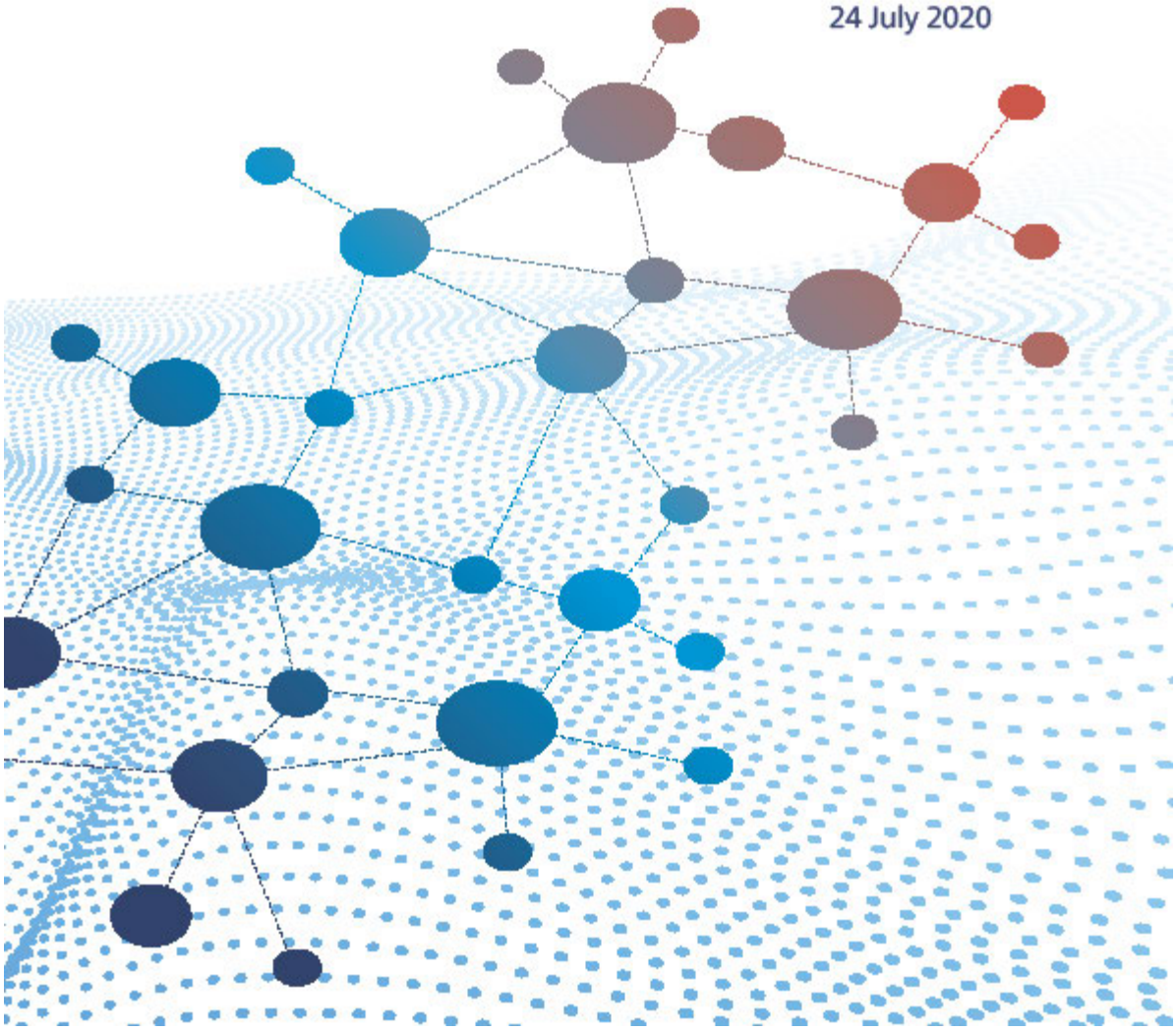
7.1 Preventing and managing COVID-19 across long-term care services – WHO policy brief

World Health Organization

Preventing and managing COVID-19 across long-term care services

Policy brief

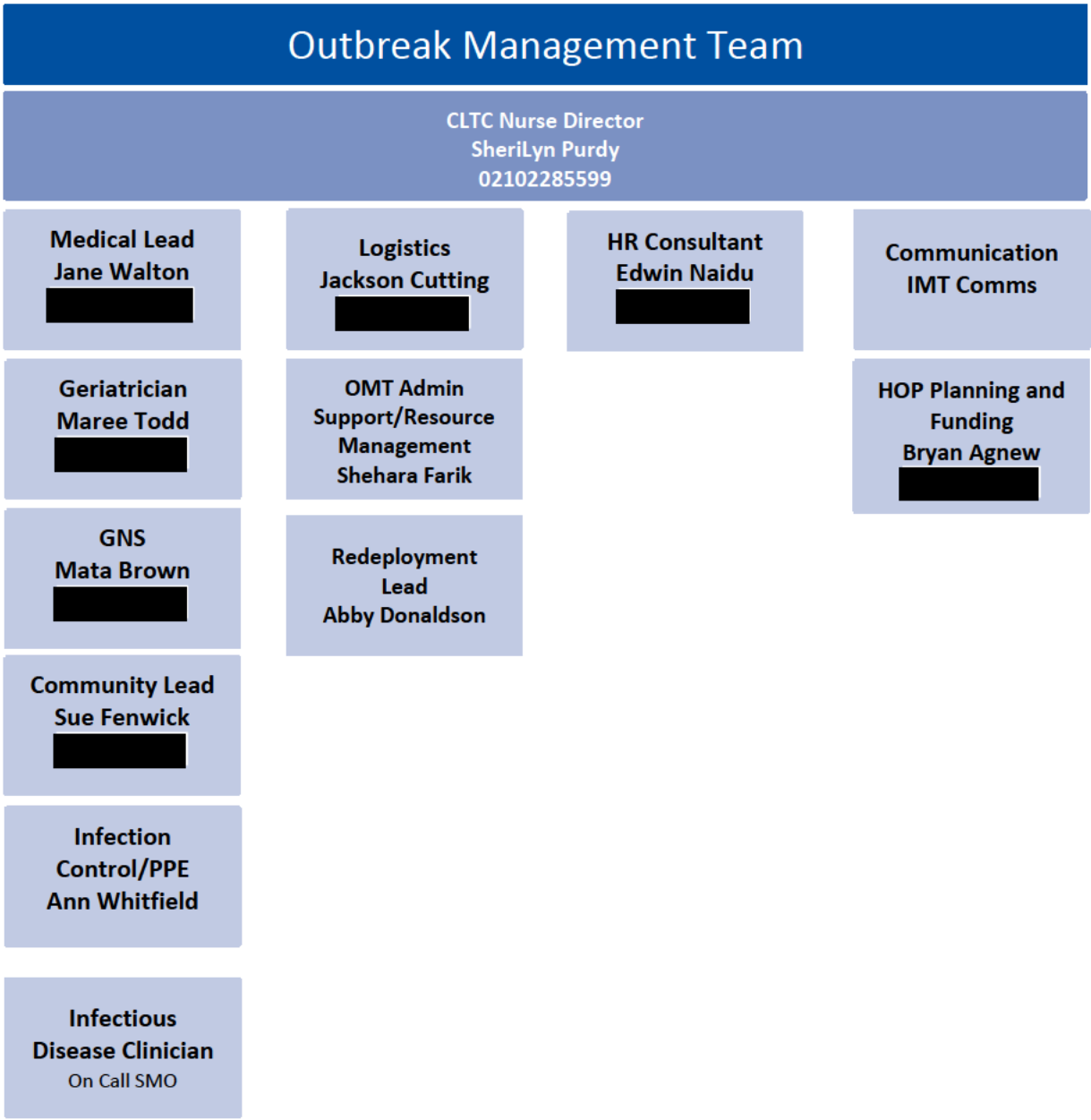
24 July 2020



Authored date	19 August 2020	Version	V1.3 05.03.2021
Owner	Nurse Director Community and Long Term Conditions		

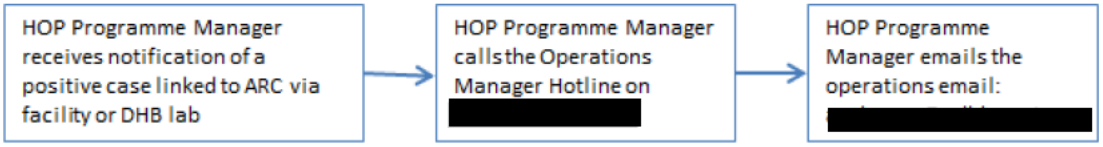
7.2 COVID-19 and long-term care in Aotearoa New Zealand

7.3 Structure of the Outbreak Management Team

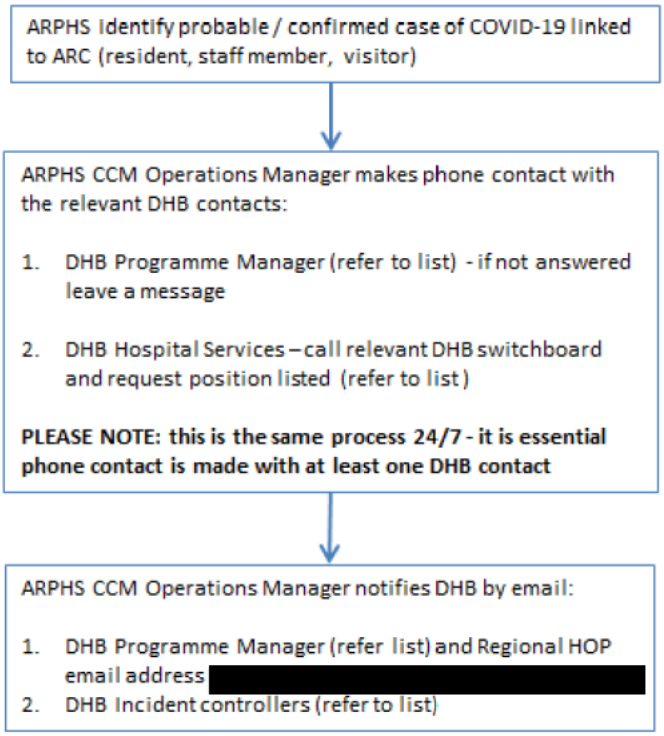


7.4 DHB/ARC Facility Notification Process

DHB / ARC Facility (Via HOP Programme Manager) to ARPHS



ARPHS to DHB/ARC



DHB	Contact	Contact information
Waitemata DHB HOP Programme Manager Or HOP Funding Manager	Karla Powell Kate Sladden	[redacted]
Waitemata DHB	Call switchboard and ask for 'Executive on call' or 'Incident Controller'	[redacted]
Auckland DHB HOP Programme Manager Or HOP Funding Manager	Bryan Agnew Kate Sladden	[redacted]
Auckland DHB	Call switchboard and ask for 'Senior Manager on call' or 'Incident Controller'	[redacted]
Counties Manukau DHB HOP Programme Manager	Berta Nicoll Angela Moorcroft	[redacted]
Counties Manukau DHB	Call switchboard and ask for 'Manager on call' or 'Duty manager of Middlemore Central (MMC)'	[redacted]