5 Health and Welfare

Section approver: Public Health Commander.

Last review date: 8 May 2020

5.1 Purpose

The health and welfare of persons in detention is the highest priority under Operation Soteria.

The Health and Welfare arrangements are based on a set of Public Health Standards for care of returned travellers in mandatory quarantine and a Policy for managing COVID-19 in this setting.

Clinical governance framework

The clinical governance framework for Operation Soteria will ensure that returned passengers in mandatory quarantine receive safe, effective and high-quality care that is consistent with best practice.

This framework integrates existing public health and operational oversight of the nursing, welfare, medical and mental health care provided to people in mandatory quarantine.

The framework ensures that risk from quarantine for individuals, families and the entirety of the passenger group in mandatory quarantine is proactively identified and managed. Information from welfare, nursing, mental health and medical providers will be provided in a secure digital tool which protects passengers' confidentiality and privacy.

This information will be available in real-time to Public Health Command and to Operational Command. Additionally, a daily clinical governance report will identify compliance with Health and Welfare Standards. The daily clinical governance report will also identify and address individual health and welfare issues to ensure that passengers are receiving the right care in the right place at the right time, and that health and welfare staff are able to work safely and effectively to deliver care.

5.2 Standards

The Public Health Standards for care of returned travellers in mandatory quarantine have been developed to ensure that ADEQUATE, APPROPRIATE and TIMELY measures are established and delivered to care for the health and welfare of quarantined persons.

Each standard is composed of a series of criteria to underpin the care of quarantined persons and a suite of indicators to monitor and evaluate the delivery of services. These standards, in **Annex 2**, include:

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Criterion 1.2 Diverse groups

Criterion 1.3 Use of interpreters

Criterion 1.4 Feedback and complaints process

Standard 2. Screening and follow up of health and welfare risk factors

Criterion 2.1 Health and welfare risk factors

Criterion 2.2 Schedule for screening

Criterion 2.3 Methods of screening

Annex 2 – Health & Wellbeing

Standards for healthcare and welfare provision

Standard 1. Rights of people in mandatory quarantine

Criterion 1.1 Charter of Human Rights and Responsibilities

Policies and practices guiding decisions made about people in mandatory quarantine under Operation Soteria must consider the Victorian Charter of Human Rights and Responsibilities.

The Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter) contains twenty basic rights that promote and protect the values of freedom, respect, equality and dignity. The Charter requires the Victorian Government (state and local) to consider human rights when they make decisions about people. While some of these rights may be restricted for quarantined people, consideration of these rights must underlie all decisions made by Operation Soteria staff in relation to people in mandatory detention.

- Relevant Charter of Human Rights that must be considered by Operation Soteria staff when making decisions in relation to people in mandatory detention include:
  - Right to life
  - Right to protection from torture and cruel, inhumane or degrading treatment
  - Freedom from forced work
  - Right to freedom of movement
  - Right to privacy and reputation
  - Freedom of thought, conscience, religion and belief
  - Freedom of expression
  - Right to protection of families and children
  - Cultural rights
  - Property rights
  - Right to liberty and security of the person
  - Right to humane treatment when deprived of liberty

  Noting section 19(2) outlines the distinct cultural rights of Aboriginal persons.

- Quarantined persons should be provided with a notice of detention, information on the terms and nature of the mandatory quarantine period and opportunity to seek exemption or review of the current detention order

Criterion 1.2 Diverse groups

- All persons in mandatory quarantine should be treated with dignity and respect.
- Providers of health and welfare services must meet the care needs of quarantined persons on an individual basis.
- Consideration should be given to the special needs of Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse (CALD) backgrounds; lesbian, gay, bisexual, trans, gender diverse and intersex people; people with disabilities, and others.

- Quarantined persons should be screened on arrival to identify those persons who are of Aboriginal or Torres Strait Islander heritage
- The care provided to Aboriginal and Torres Strait Islander peoples should fulfil the six actions of the National Safety and Quality Health Service Standards that focus specifically on meeting the needs of Aboriginal and Torres Strait Islander people (for further details see https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf).
- Quarantined persons should be screened on arrival to identify those with physical, sensory, psychosocial or intellectual disabilities.
- Quarantined persons with a disability should be provided with the services and supports they require. Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities, which sets out human rights for people with disabilities which include accessibility, personal mobility and access to healthcare.

Criterion 1.3 Use of interpreters

- Quarantined persons should be screened on arrival to identify those who require interpreters
- Interpreters must be used for quarantined persons where English is not their first language and translation would normally be required for interaction with the health or welfare systems
- Language requirements should be recorded in the quarantined person's record and hotel staff advised.

Criterion 1.4 Feedback and complaints process

A feedback and complaints process can provide unique information about quarantined persons needs and the quality of care provided by Operation Soteria. Openly discussing feedback and concerns helps staff to understand strengths in their service, potential problems, and how to make improvements.

- Processes for assessing satisfaction and receiving and addressing complaints should be established.

Potential indicators

Program delivery

- Number of people seeking exemptions from mandatory quarantine
- Number of Aboriginal and Torres Strait Islander peoples in quarantine
- Number of people with a disability in quarantine
- Number of people in quarantine requiring interpreter services
- Number of adverse events arising from failure to address the needs of a person with disability
- Nature of adverse events (de-identified) arising from failure to address the needs of a person with disability
- Number of adverse events arising from failure to use an interpreter
- Nature of adverse events (de-identified) arising from failure to use an interpreter
- Number of complaints related to detention, health and welfare services
- Nature of complaints (de-identified) related to detention, health and welfare services

Outcomes

- Number of people receiving exemptions from mandatory quarantine
- Reasons for exemptions granted (de-identified)
- Outcomes of adverse events (de-identified) arising from failure to use an interpreter

- Outcomes of adverse events (de-identified) arising from failure to address the needs of a person with disability
- Resolution of complaints related to on-site staff, mandatory detention processes and health and welfare services

Reporting frequency

- Significant adverse events (major incidents): as soon as possible after occurrence
- All other adverse events: daily
- Formal complaints: weekly

Standard 2. Screening and follow up of health and welfare risk factors

As part of the duty of care towards people in mandatory detention under Operation Soteria, it is essential that appropriately qualified staff screen quarantined individuals for health and welfare risk factors, so that appropriate services are made available to those who require them.

Criterion 2.1 Health and welfare risk factors

- Returned travellers will be screened for risk factors related to the following:
  - current or potential infection with COVID-19 including
    - temperature
    - symptoms including fever, cough, shortness of breath, chills, body aches, sore throat, headache, runny nose, muscle pain or diarrhoea
  - potential complications or adverse events arising from
    - current or previous physical health conditions
    - current or previous mental health conditions
    - current or previous disabilities
  - allergies and food sensitivities, with particular note of anaphylaxis
  - need for ongoing medication, contact with usual treating health professionals, and other support services
  - family violence or child abuse
  - drug and alcohol use and/or dependence
  - current stressors or factors that will make quarantine particularly difficult, such as small children, bereavement, etc
  - needs or fears expressed by the quarantined person
  - vulnerability due to age (children or people over 65) or pregnancy

Criterion 2.2 Schedule for screening

- Returned travellers should be screened for COVID-19 at the following times:
  - On arrival at airport: screening to include temperature and symptoms of COVID-19
  - Day 3 and Day 11: voluntary routine testing
- Returned travellers will be screened for other health and welfare concerns at the following times:
  - On day of arrival using the initial welfare self-reported survey XXX hyperlink to document

  - Nurse health assessment within the first 24 hours, documented in the nurse health record
  - Regularly throughout detention as determined by risk factors (Criterion 2.5), including welfare checks and checks by nurses or other appropriate staff.

Criterion 2.3 Methods of screening

- Screening tools (online or paper-based surveys, interview questions and prompts) that have been validated to assess health and welfare risk factors should be used where available.
- If appropriate validated tools are unavailable, any tools created for this purpose should be developed by professionals with expertise in survey development.
- It is essential that the initial screening assessment includes identification of Aboriginal and/or Torres Strait Islander status.

Criterion 2.4 Staff undertaking screening

- Staff undertaking health screening should have appropriate qualifications to conduct the tasks they are allocated, including understanding of Aboriginal cultural safety.
- Assessment of current or potential infection with COVID-19 should be undertaken by medical or nursing staff
- Assessment of all other risk factors should be undertaken by staff who have:
  - an understanding of the issues likely to be raised and their implications
  - knowledge of the circumstances that would require escalation or referral to health or mental health professionals
  - training and experience in handling conversations:
    - on sensitive topics, such as family violence
    - with disturbed or fearful people
- It should be noted that health, education and other professional groups have mandatory requirements to report suspected child abuse. CART should be notified, and the individual practitioners are required to make a notification through child protection intake.
- Health or welfare phone calls to Aboriginal or Torres Strait Islander people should be undertaken by people who have undertaken Aboriginal cultural safety training.

Criterion 2.5 Risk assessment and follow up of persons ‘at risk’

The self-screening survey and health assessment needs to identify any of the following risk factors to allocate an appropriate risk Tier. This must be completed in the first 24 hours and documented in the nurse health record and/or welfare application. Each quarantined person could be triaged into three tiers of risk based on identified risk factors as per the example table below.

Risk Tier	**Risk factors**	**Follow up by appropriate health or welfare professionals**
Tier 1	• Persons with suspected or confirmed COVID-19 • Families with children < 18 years • Persons aged > 65 years • Aboriginal and Torres Strait Islander peoples	Phone call daily

	• Persons with underlying physical comorbidities (e.g. respiratory or cardiac conditions) • Persons with a disability • Persons with a history of mental illness • Allergies and food sensitivities, with particular note of anaphylaxis • History of family violence or child abuse • Drug and alcohol use and/or dependence • Current stressors or factors that will make quarantine particularly difficult, such as small children, bereavement, etc. • Those with needs or fears expressed by the quarantined person • Pregnant women	
Tier 2	• Persons who indicate they require a phone call but do not have any other risk factors. • Persons who are by themselves.	Phone call every second day
Tier 3	• Persons with none of the factors above	Tailored contact

- Relevant plans for follow up of identified risks should be developed
- Protocols for communicating follow up plans to relevant health and welfare staff should be documented
- At the discretion of the on-site clinical staff, quarantined persons with currently active physical or mental health issues should be
  - managed on-site if within the capacity, capability and credentialing of attending medical and nursing staff
  - referred to the appropriate health services (e.g. mental health services, specialist medical services, hospital, etc) or other support services as required.
- Notification to the DHHS team leader and escalation to Emergency Operation Centre as appropriate.

Potential indicators

Program delivery

- Number of returning passengers arriving in Victoria
- Number and percentage of returning passengers screened for COVID-19 at the airport
- Reasons for COVID-19 screening not completed at the airport (e.g. passenger refused screening, insufficient staff, etc)
- Number and percentage of quarantined persons receiving health assessment (including risk assessment) in the first 24 hours of arrival
- Reasons for initial health assessment not completed on day of arrival (passenger refused screening, insufficient staff, etc)
- Number and percentage of quarantined persons receiving initial health assessment (including risk factors) after the first 24 hours (e.g. 20% on Day 2)
- Number and percentage of quarantined persons receiving subsequent screen for risk factors during detention period (i.e. screening survey or interview, follow up of identified risk factors)

Outcomes

- Number and percentage of screened passengers with known COVID-19 based on documentary evidence
- Number and percentage of screened passengers with known COVID-19 based on self-report
- Number and percentage of screened passengers with suspected COVID-19 based on signs and symptoms
- Number and percentage of quarantined persons with identified risk factors at initial health assessment
- Number and percentage of quarantined persons with identified risk factors at subsequent health assessment
- Nature of risk factors (de-identified)
- Number and percentage of quarantined persons referred to Operation Soteria health or support services by service (e.g. 10 [2%] referred to on-site doctor, 5 [1%] referred to NorthWestern Mental Health Services)
- Number and percentage of quarantined persons with identified risk factors referred to external services (e.g. one referred to Aboriginal community-controlled health services)

Reporting frequency

- All: Daily
- A daily report will be collated from the AO database, nurse health record and welfare application.

Standard 3. Provision of health and welfare services

The needs of quarantined individuals vary widely and Operation Soteria must have a flexible on-site system for the provision of health and welfare services that can accommodate urgent, non-urgent, complex, planned chronic care and preventive health needs.

Criterion 3.1 Meeting the needs of people in mandatory quarantine

The following principles should be followed in meeting the health and welfare needs of quarantined persons:

- All reasonable requests for medical care from quarantined persons should be facilitated within an appropriate timeframe depending on the acuity of the issue or request, and in a culturally appropriate manner.
- Provision of health or welfare services should not be deferred or delayed because a person is in quarantine.
- Any request for medical review should be carefully considered to determine whether telemedicine or in-person consultation is the most appropriate approach. Telemedicine should not be used if an in-person review or physical examination is clinically indicated. However, if an in-person review is not required, telemedicine is appropriate to reduce risk of infection to health providers and quarantined persons.
- Quarantined persons should be supported in accessing care through their usual general practitioner (GP), medical specialist, Aboriginal community-controlled health organisation, or other health professional via telehealth arrangements where possible. They should also be asked to request that the health professional consulted provides information regarding any ongoing health or welfare issues to the on-site clinical team if appropriate.

Criterion 3.2 Provision of on-site clinical services

- Safeguarding of the health and welfare of quarantined persons is paramount.
- Medical, nursing and other clinical services should be engaged at each hotel/facility to enable ADEQUATE, APPROPRIATE and TIMELY and culturally safe delivery of regular health assessment, acute clinical and support services. This should be determined by those commissioning/operating the health and welfare services in consultation with the Clinical Lead. It should correspond to the workload and burden of illness/needs of the population in mandatory quarantine at any time.
- Given the risk of mental health issues for people in isolation, mental health primary care services should also be available at a ratio proportionate to the burden of disease emerging from the quarantined cohort. Linking Aboriginal and Torres Strait Islander clients to culturally safe and trauma informed mental health and wellbeing services is essential.
- Medical, nursing and other clinical staff should practice within the requirements of their professional registrations, level of experience, codes of conduct and professional standards.
- Medical and nursing clinical practices, record-keeping and correspondence with other health professionals should meet the expectations and usual standards of high-quality primary care.
- Medical and nursing staff should have appropriate training, experience and credentials to:
  - identify physical and mental health emergencies
  - manage acute physical and mental health conditions by providing treatment or arranging appropriate referrals/ escalate care appropriately
  - provide support to quarantined persons who are distressed.
- Clinical governance arrangements should be in place to ensure that:
  - staff have appropriate training, experience and credentials
  - clinical practice is consistent with the best available evidence and follows applicable professional standards
  - clear and consistent escalation pathways are clearly communicated to all clinical staff
  - adequate, appropriate, well-maintained and calibrated clinical equipment is available to deliver primary care services
  - suitable arrangements are in place to enable comprehensive and secure medical record keeping.
- Provision should be made for both on-site in-person clinical consultations and telehealth consultations
- On-site clinical staff should be provided with mobile phones to facilitate rapid access by quarantined persons, operational and administrative staff, and external healthcare providers
- Processes for ensuring continuity of care through accurate and comprehensive medical record keeping and communication of medical information between providers engaged to provide on-site health care should be established.
- It is the responsibility of the doctor who orders any test (COVID-19 or otherwise) to follow up on the result and notify the patient in a timely manner. If they are not able to do so, they must handover this task to the next doctor on-call, inform the nurse, and record this in the medical record.
- Requests for medical care must be actioned in keeping with the acuity of the issue. Where staffing allows, the doctor may see patients before the nurse, particularly if the request is deemed urgent. An example of appropriate response times is included below.

Acuity of issue	**Time frame for response**
Emergency/life-threatening issue	Immediate – any person present to call 000 ASAP without waiting for nurse or doctor to attend
Urgent physical health concerns	Nurse to review ASAP (within 30 minutes) Doctor to review within 1 hour

Urgent mental health issue	Doctor or nurse to review within 1 hour
Urgent mental health issue accompanied by suicidal intent	Doctor to review ASAP (within 30 minutes)
Minor health issue (physical or mental) requiring review, non-urgent	Nurse to review within 4 hours Doctor to review (if required) within 12 hours
Prescription requests (urgent)	Doctor to action within 8 hours
Prescription requests (non-urgent)	Doctor to action within 24 hours

- At the discretion of the on-site clinical staff, quarantined persons with currently active physical or mental health issues should be
  - managed on-site if within the capacity, capability and credentialing of attending medical and nursing staff
  - referred to the appropriate health services (e.g. mental health services, specialist medical services, hospital, Aboriginal community-controlled health organisation, etc.) or other support services as required
- In the case of a physical health emergency in a quarantined person (e.g. heart attack, stroke, anaphylaxis, etc.) an ambulance should be called immediately by any person in attendance. There is no need to wait for attendance of medical or nursing staff in this situation, but they should be called for review as soon as practical after an ambulance has been called.
- In the case of a mental health emergency in a quarantined person (e.g. acute suicidal ideation, thoughts of self-harm, psychosis, etc.) the quarantined individual should be reviewed by the doctor on call as a matter of urgency, particularly if suicidal intent is present. The doctor should then determine if transfer to hospital via ambulance is required for urgent psychiatric assessment or if psychiatric advice or assessment can be appropriately obtained over the phone. If the quarantined individual is deemed as needing urgent psychiatric review and is not willing to be transferred for assessment, the doctor on call will need to decide if enacting provisions within the Mental Health Act 2014 is required.
- Documented protocols related to provision of on-site health services should include:
  - Processes for follow up of physical and mental health risk factors identified through screening
  - Clear instructions for:
    - quarantined persons on how to contact medical and nursing staff
    - clinical staff on responsibilities for first point of contact, triage, escalation and referral pathways
    - clinical staff on actions to be taken in response to acute physical and mental health emergencies
    - clinical staff on continuity of care and handover of outstanding tasks and concerns
    - agreed method of documentation of outstanding tasks/ physical or mental health issues needing follow up.
- Documentation should also include contact numbers for
  - Hotels and other facilities being used for quarantine
  - Medical and nursing contacts at each facility
  - Health service emergency departments, mental health services, Aboriginal community-controlled health services, liaison officers related to this operation (including Aboriginal hospital liaison officers)
  - Other resources including, but not limited to, local health and welfare services, psychiatric triage team (1300 TRIAGE), Crisis Assessment and Treatment Teams (CATT), DHHS Complex Assessment and Referral Team (CART), telephone advice lines, online services, etc.

- Emergency operations centre and DHHS teams.

Prescribing benzodiazepines/anxiolytics

When considering initiating prescription of benzodiazepines for short term management of anxiety or other mental health issues (such as claustrophobia, panic attacks, PTSD etc) in mandatory detention, doctors should exercise a high degree of caution, and implement other strategies to manage these conditions where possible. Doctors initiating prescriptions for benzodiazepines, opioids, anxiolytics and antipsychotics should only do so after a careful history and risk assessment has been conducted. Psychiatric input should be sought where necessary. Care should be taken to ensure that benzodiazepines are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications. Prescriptions should also be limited to small quantities of tablets at a time, with appropriate follow up review arranged to assess response and re-evaluate need for medication.

Initiation of sleeping tablets (including benzodiazepines, zolpidem, zopiclone etc.) in mandatory quarantine should only be considered after a thorough assessment by a healthcare professional. Those on sleeping tablets regularly should have their dose confirmed with their usual GP prior to prescriptions being provided in mandatory quarantine. Care should be taken to ensure sleeping tablets are not prescribed to individuals who are consuming alcohol, or who have other contraindications to these medications.

A protocol for the safe keeping of prescription medications such as Benzodiazepines can be found at XXX (link to operation protocol)

- On-site doctors should be informed of these specific considerations for prescribing benzodiazepines and anxiolytics to quarantined persons.

Criterion 3.3 Provision of welfare services

- Safeguarding of the health and welfare of quarantined persons is paramount
- All quarantined persons should have access to communication services such as phone (local calls) internet and wi-fi so that they can stay in regular contact with family and friends.
- All quarantined persons should have access to entertainment and news services such as television and radio.
- Arrangements for quarantined persons to receive care packages of personal items from family and friends should be established.
- Appropriate professionals should be engaged at a ratio proportionate to the number of quarantined persons at each hotel/facility to enable ADEQUATE, APPROPRIATE, culturally safe and TIMELY delivery of welfare services. This should be determined by those commissioning/operating the health and welfare services. It should correspond to the workload and burden of illness/needs of the population in mandatory quarantine at any time.
- Welfare professionals should practice within the requirements of their professional registrations, level of experience, codes of conduct and professional standards.
- Welfare practices, record-keeping and correspondence with other health and welfare professionals should meet the expectations of high-quality welfare services.
- Welfare staff should have appropriate training, experience and credentials (including Aboriginal cultural safety) to:
  - identify and deal with significant welfare issues by providing advice or arranging appropriate referrals
  - provide support to quarantined persons who are distressed.

- Governance arrangements should be in place to ensure that welfare staff have appropriate training, experience and credentials.
- Provision should be made for both on-site in-person welfare consultations and telehealth consultations.
- Welfare staff should be provided with mobile phones to facilitate rapid access by quarantined persons, operational and administrative staff, and external healthcare providers.
- Regular welfare checks should be conducted, at a minimum, based on the three risk tiers noted above or more frequently to meet the needs of quarantined individuals as determined by clinical or welfare staff.
- Requests for welfare assistance from quarantined persons or clinical staff should be actioned in keeping with the urgency and significance of the issue (usually within 24 hours).
- Processes for managing, escalating and referring incidents of family violence or child abuse should be established, including provision of safe accommodation and referral to Victoria Police where appropriate.
- Processes for assessing satisfaction and receiving and addressing complaints should be established
- Documented protocols related to provision of welfare services should include, but not be limited to:
  - Processes for follow up of risk factors related to welfare issues identified through screening
  - Clear instructions for:
    - quarantined persons on how to contact welfare staff
    - quarantined persons on the arrangements for care packages
    - on-site clinical staff on how to contact welfare staff
    - welfare staff on responsibilities for first point of contact, triage, escalation and referral pathways
    - welfare staff on continuity of care and handover of outstanding tasks and concerns
    - welfare staff on management, escalation and referral of reports of family violence or child abuse
- Documentation should also include, but not be limited to contact numbers for
  - Welfare staff
  - Welfare agencies for referral
  - Family violence and child abuse services
  - Services and programs for Aboriginal and/or Torres Strait Islander people
  - Appropriate Victoria Police departments

Criterion 3.4 Provision of pharmacy and pathology services

- Pharmacy services should be provided to allow for
  - prompt procurement of necessary medications (prescriptions or over-the-counter products) and equipment for quarantined persons
  - delivery to the relevant hotel/facility
  - prescriptions to be emailed to the pharmacy by the quarantined person's usual doctor or the on-site doctor
- Processes for COVID-19 swabs should follow the COVID 19 instructions for testing. (hyperlink) Pathology tests required by the treating clinician (on-site doctor or person's own GP) should be undertaken by the on-site medical or nursing staff. Equipment for taking bloods should be available at (or available to be transported to) the hotel/facility. These specimens should be labelled as per the protocol for labelling COVID-19 swabs (same requirement for identifiers)
- Routine pathology tests should be deferred until after the quarantine period if possible.

Criterion 3.5 Public health policy for COVID-19 in mandatory quarantine

- All staff should follow the COVID-19 policy for mandatory quarantine detailed in Annex 3 (hyperlink).

Potential indicators

Program delivery

- Number of quarantined persons followed up as per their risk screening follow up plan
- Number of Aboriginal and Torres Strait Islander people followed up as per their risk screening follow-up plan
- Number of referrals to external health and welfare providers
- Number of adverse events arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- Nature of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- Number of serious physical or mental health incidents not related to protocols for health and welfare
- Nature of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare
- Number of COVID-19 swabs
- Number of calls related to family violence or child abuse
- Number of emergencies requiring 000 calls
- Number of emergency transfers to hospital
- Number of non-emergency transfers to hospital
- Nature of emergency and non-emergency transfers to hospital (de-identified)

Outcomes

- Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for health and welfare or failure to follow relevant protocols
- Outcomes of serious physical or mental health incidents (de-identified) not related to protocols for health and welfare
- Outcomes of emergency transfers to hospital
- Outcomes of non-emergency transfers to hospital
- Number of COVID-19 swabs with positive results
- Action taken as a result of positive COVID-19 swab
- Action taken as a result of response to calls related to family violence or child abuse

Reporting frequency

- Adverse events, serious incidents and COVID-19 positive swabs: as soon as possible after occurrence
- All others: daily

Standard 4. Health promotion and preventive care

While in mandatory quarantine, health promotion and preventative care should be made available to all quarantined individuals. This includes access to fresh air and promotion of exercise where possible.

Criterion 4.1 Smoking

- Smoking is not permitted in most hotels
- Quarantined persons who are smokers should be provided with information and actively encouraged to quit using validated methods such as:
  - Nicotine Replacement Therapy
  - Quitline telephone counselling (phone 13 78 48)
  - Contacting their regular GP via telehealth
- Where feasible, smoking breaks may be permitted in some circumstances for individuals who do not have access to a smoking area or balcony, where it can be safely and practically implemented at the hotel (weather permitting), taking into account infection control and physical distancing precautions.

Criterion 4.2 Fresh air

- Individuals in mandatory quarantine should have access to fresh air where possible.
- If the room has a balcony or windows that open, quarantined persons should be advised to use them for fresh air and ventilation.
- Individuals in mandatory quarantine should be allowed one hour of suitable exercise (or leisure time) in open air daily, where it can be safely and practically implemented at the hotel (weather permitting), taking into account infection control and physical distancing precautions.
- Only people who are well, and who are staying in the same room, should go outside to exercise at the same time.

Criterion 4.3 Exercise

- Exercise is important for physical and mental health, particularly in the mandatory quarantine environment
- In-room exercises should be encouraged and resources to support this should be facilitated if possible

Criterion 4.4 Alcohol and drugs

- Alcohol is permitted within hotels
- Excessive alcohol consumption should be discouraged.
- Alcohol should not be provided to persons under 18 years of age (including in the hotel room minibar)
- If there are concerns about potential alcohol or other substance abuse or withdrawal:
  - Request nurse or medical review.
  - Provide numbers for support services.
- If there are concerns about acute alcohol withdrawal, confusion, deteriorating mental state, or mental illness:
  - Escalate for urgent medical review
  - Consider calling 000

Potential indicators

- Number of incidents related to nicotine, alcohol or other drugs (withdrawal or intoxication)
- Number of people taking fresh air breaks

Standard 5. Infection control

Infection control procedures in the mandatory quarantine hotels are essential to protect on-site staff and quarantined individuals from COVID-19 and other pathogens. The foundation of good infection control is to assume everyone is potentially infectious, and therefore proper procedures have to be followed at all times.

Criterion 5.1 Personal protective equipment (PPE)

- Appropriate personal protective equipment (single-use face masks, P2/N95 masks, gowns and eye protection) should be available to all staff and quarantined individuals for use when indicated
- PPE stocks should be maintained at each hotel/facility, monitored through regular stocktake and a mechanism to rapidly obtain additional stock in place. Hotels should not run out of stock
- Biohazard bags for waste disposal, hand sanitizer, paper towels, and other necessities for hand hygiene stations should also be available in hotels
- PPE, hand hygiene stations, and waste disposal facilities should be situated at the donning/doffing areas in each hotel
- Appropriate PPE protocols (for droplet and contact precautions) should be available to all staff working in the hotels with clear instruction on what type of PPE to wear in what circumstances, how to don and doff it, and how to dispose of it (see the department's website for further information on PPE usage: https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19#personal)
- Additional training and educational resources should be made available to staff who require it.

Criterion 5.2 Cleaning and waste disposal

- Quarantined individuals should have safe and clean rooms
- Housekeeping services should not be provided routinely in the interest of infection control
- Fresh linen, towels and additional amenities should be left outside rooms for quarantined individuals to collect
- Terminal cleaning is required on vacation of each room. This should follow the processes outlined in the DHHS document 'Cleaning and disinfecting to reduce COVID-19 transmission'
- Rooms that have been vacated should not be repurposed during the quarantine period
- Quarantined individuals may not be able to upkeep their rooms for various reasons, which may affect their physical and mental health. Efforts should be made to assist a quarantined person with cleaning their room if they are not capable of doing so themselves. Any persons for whom there is a concern about room hygiene and safety should be flagged to the team leader.

Criterion 5.3 Laundry

- Quarantined individuals should place dirty linen in biohazard bags which are left outside rooms for collection
- Hotel staff should wear appropriate PPE when handling dirty laundry
- Handling of dirty linen should be minimised; it should be put straight into the washing machines if possible
- Laundry should be washed on the highest possible temperature setting and thoroughly dried before use
- Staff should follow hand hygiene protocols after handling dirty linen.

Criterion 5.4 Isolation protocols

- All staff should follow the 'Public health policy for COVID-19 in mandatory quarantine' (bearing in mind a trauma informed approach is essential for Aboriginal people in isolation).
- Suspected cases of COVID-19 should be separated/isolated from people they share a room with as soon as they become symptomatic if consent is given.
- If this has not already occurred, confirmed cases should be isolated from people they share a room with as soon as the positive result is known. All people who are COVID-19 positive are to be moved the designated COVID-19 hotel. Appropriate signage, PPE and other consumables should be available at the entrance to this area of the hotel.
- Where there are large numbers of confirmed cases arriving on a flight, a COVID-19 hotel is a more appropriate arrangement. Where the infrastructure allows, suspected cases should also be moved to an area of the hotel away from well individuals.

Potential indicators

Program delivery

- Number of adverse events arising from absent or inadequate protocols for infection control or failure to follow relevant protocols
- Nature of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols.

Outcomes

- Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for infection control or failure to follow relevant protocols

Reporting frequency

- Significant adverse events: as soon as possible after occurrence
- All others: daily

Standard 6. Allergies and dietary requirements

As part of the duty of care towards people in mandatory detention, it is essential that appropriately qualified staff document and have processes for managing quarantined individuals' allergy and dietary requirements, as failure to do this can have life-threatening consequences.

- Information on allergies should be collected from all quarantined individuals.
  - Allergen (e.g. name of medication, type of food, etc)
  - Allergic reaction (e.g. rash, gastrointestinal disturbance, etc)
  - History of severe allergic reactions or anaphylaxis
  - Use of antihistamines, corticosteroids or EpiPens
- Clinical staff should ensure that quarantined persons have adequate supplies of allergy medications. If required, urgent prescriptions should be filled and delivered to the hotel/facility
- Mechanisms should be put in place to avoid/limit quarantined individual's contact with allergens
- Dietary requirements should be collected from all quarantined individuals
  - Food allergy (as above, e.g. cow's milk allergy)
  - Food intolerance (e.g. lactose intolerance)
  - Clinical diet (e.g. low salt diet for kidney disease)
- Screening tools that have been validated to collect details of allergies and dietary requirements should be used. If appropriate validated tools are unavailable, any tools created for this purpose

should be developed by professionals with methodological expertise in survey development and content knowledge of allergy and dietary requirements

- Clinical staff identifying allergies and dietary requirements should escalate this information to appropriate operations staff to ensure that details are provided to catering providers:
- An ambulance should be called for anyone who develops a severe allergy whilst in mandatory quarantine, without needing approval from clinical staff, authorised officers or hotel staff etc. On arrival, paramedics should be given clear access to the person for whom the ambulance was called
- Documented protocols related to provision of appropriate services to meet allergy and dietary requirements should include, but not be limited to:
    - Processes for dealing with food allergies, intolerances and other requirements
    - Clear instructions for:
        - clinical and operations staff on how to communicate allergy and dietary requirements to catering providers
        - catering providers on how to address allergy and dietary requirements
        - quarantined persons on how their allergy and dietary requirements will be met
- Documentation should also include, but not be limited to contact numbers for next of kin of the person with an allergy
- As a safeguard, some form of door marking or sign should be used to indicate that a person in the hotel room has a significant allergy or specific dietary requirements.

Potential indicators

Program delivery

- Number of adverse events arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols
- Nature of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols.

Outcomes

- Outcomes of adverse events (de-identified) arising from absent or inadequate protocols for allergies and dietary requirements or failure to follow relevant protocols

Reporting frequency

- Significant adverse events: as soon as possible after occurrence
- All others: daily

Standard 7. Information and data management (including medical records)

Criterion 7.1 Confidentiality and privacy of personal information (including medical records)

Operation Soteria has a systematic approach to maintaining the confidentiality and privacy of a quarantined person's personal and health information.

The *Privacy Act 2001 (Cth)* states that a patient's personal health information includes a person's name, address, account details and any health information (including medical or personal opinion) about the person.

Medical, nursing, clinical and allied heath staff have requirements relating to confidentiality in their professional registration and codes of conduct.

- Quarantined persons should be informed that their health information will be treated as private and confidential and will only be released to third parties with their consent or in compelling circumstances (e.g. concern for the patient's safety or the safety of others) as required by law
- Mechanisms should be in place to ensure that information is shared between on-site staff when necessary but within the bounds of the law. Any transfer of information to a third party without the consent of the quarantined person needs to be documented in their medical record
- Patient information in hotels/facilities should not be stored or left visible in areas where non-health services staff have unrestricted access, or where constant staff supervision is not easily provided
- Devices used to access the information management systems are only accessible to authorised clinical staff
- Screensavers or other automated privacy protection devices are enabled
- Documented protocols related to the confidentiality and privacy of personal and health information of quarantined persons should include, but not be limited to:
    - Informing newly quarantined people about the information collected about them, the use of that information, the range of people (e.g. doctors, nurses, psychologists) who may have access to their medical records and the scope of that access, privacy arrangements and how they can gain access to their personal and health information
    - Gaining consent from quarantined people before disclosing personal and health information to third parties
    - Providing health information to another health professional if requested by the quarantined person
    - Maintaining the security of information held at the hotel/facility, on private external servers or on government servers
    - Retaining medical records as required by law.
- Documentation should also include, but not be limited to:
    - the type of personal health information that may need to be relayed to DHHS when assessing special needs of a quarantined person
    - how confidentiality can be maximised if a third party is present in the consultation without the consent of on-site clinical staff or patient.

Criterion 7.2 Information security (including medical records)

It is paramount that the security of confidential data on quarantined persons is maintained.

- The security of patient information (including medical records) in electronic or paper formats should be maintained through the use of secure-access information management systems
- A minimum number of secure databases should be used to prevent fragmentation of records management and reduce the risk of critical information not being available to DHHS, health or welfare staff providing for the health and welfare needs of quarantined persons
- Different staff members should have different levels of access to quarantined person's information (for example, administrative staff should not have access to the patient's medical records). In relation to medical records, the principles of patient confidentiality should be maintained unless required by law
- These records should not be accessed by anyone not providing care for the person. Specifically, these medical records must only be accessed or viewed by an AHPRA-registered health practitioner employed by DHHS to provide services to people in detention.

- On-site staff have personal passwords to authorise appropriate levels of access to health or other personal information.
- If medical notes are recorded on paper, these should be stored securely and uploaded to the information management system as soon as is practicable and within 72 hours at most
- If an on-site doctor completes an assessment, they must provide a written record of this to the on-site nursing staff, either on paper or via email, if an electronic medical record system is not available. This must be securely stored as soon as possible
- Inactive records must also be also be kept and stored securely. An inactive record is generally considered to be a record of a person who is no longer detained in mandatory detention
- An information disaster recovery plan for use in an emergency such as device failure or power failure should be established.
    - Back-ups of electronic information are performed at an appropriate frequency
    - Back-ups of electronic information are stored in a secure offsite environment
    - Antivirus software is installed and updated
- All internet connected devices have firewalls installed
- Documented protocols related to information security should include, but not be limited to processes for:
    - Collection, storage and transfer to electronic storage
    - Back-up and recovery of digital information
- Documentation should also include, but not be limited to:
    - Record of which staff are authorised to access different levels of information about a quarantined person (e.g. Personal details, contact details, medical record, COVID-19 status, etc).

Criterion 7.3 Transfer of personal information (including medical records)

On request from a quarantined individual, in an emergency, or to support a referral for health or welfare reasons, a summary or a copy of personal information (including the patient health record) may be transferred to the patient, another medical practitioner, health service provider or health service.

- Transfer of patient information in these situations should be facilitated
- Consent of the quarantined person should be obtained before transferring information, except in an emergency when they are unable to give consent and failure to transfer the information will prevent optimal care. Consent may be given for the release of some information beyond an individual consultation
- On-site staff record any requests by quarantined individuals or other reasons for transfer of health information in the medical record. This note should include details of where the information was sent and who authorised the transfer
- Any electronic data transmission of patient information over a public network must be encrypted.

Criterion 7.4 Retention of personal information (including medical records)

The *Privacy Act 1988 (Cth)* requires personal health information to be destroyed or permanently de-identified once it is no longer needed for any authorised use or for disclosure under the legislation.

The *Health Records Act 2001 (Vic)* recommends that individual patient health records be retained for a minimum of 7 years from the date of last contact, or until the patient has reached the age of 25 years, whichever is the longer. In the case of patient health information collected for the purpose of providing

medical advice or treatment, it may be appropriate to retain this information indefinitely so that it is available, if necessary, to assist with the patient's future diagnosis and treatment.

- A protocol for the retention and destruction of personal health information for people in mandatory quarantine consistent with the *Privacy Act 1988 (Cth)* and *Health Records Act 2001 (Vic)* should be established and communicated to all relevant staff

Potential indicators

Program delivery

- Incidents of breach of privacy related to medical information
- Incidents related to failure to maintain adequate medical records

Outcomes

- Adverse events arising from breach of privacy or failure to maintain adequate medical records

Reporting frequency

- Significant adverse events: as soon as possible after occurrence
- All others: daily

Standard 8. Health and welfare reporting to the Public Health Commander

A series of potential indicators to measure program delivery and outcomes are presented for each Standard and a suggested reporting frequency is provided. These indicators were developed systematically to address all the issues contained within these Standards. However, it may not be feasible, or even desirable, to collect and report on them all. They remain as a comprehensive list in this document to inform current decision-making for Operation Soteria and potential measures that may be taken to address future public health emergencies.

- Final decisions on the reporting structure; content, format and frequency of reports; and methods of data collection and analysis should be determined through deliberations with all stakeholders including, but not limited to, Public Health, Compliance, Intelligence and Operations.
- Decision-making criteria should include, but not be limited to:
  - information priorities of each stakeholder group
  - risk assessment and mitigation strategies
  - program monitoring and evaluation questions
  - feasibility of, and resources required for, data collection, analysis and reporting
- Data should be assessed for accuracy (reliability and validity) and completeness. Appropriate measures should be instigated to enable and facilitate easy and accurate capture, entry and transmission of data.
- Minimum datasets for urgent, daily and weekly reporting should be established.

OPERATION SOTERIA
PPE Advice for Hotel-based Healthcare Workers Contact with COVID-19 Quarantined Clients

Annexure B

Approved
Date: 1 May 20 By: M Bamert – Dir EM

Purpose

This document provides advice on the PPE requirements for hotel-based healthcare workers (HCW) for dealing with COVID-19 quarantined clients.

Note: P2 or N95 masks are only recommended for use when aerosol generating procedures are being undertaken or will occur. In all other instances don a surgical face mask for direct client contact.

Recommended HCW PPE

For use according to type of activity and client COVID-19 symptomology

Setting	Activity	HCW PPE required	Client PPE required
Hotel quarantine floor Not entering the client/s room or having direct contact with client/s.	Telephone or online triage to check for recent change in condition or development of symptoms. No direct client contact e.g. walking room hallways.	• No PPE	• No PPE
Doorway indirect contact by HCW Clients **without** symptoms suggestive of COVID-19 (e.g. cough, fever, shortness of breath) **Perform hand hygiene before and after every client contact**	Any doorway visit: • Able to maintain physical distance of at least 1.5 metres (e.g. second HCW accompanying primary HCW)	• Surgical mask • Hand hygiene	• No PPE
	Any doorway visit: • 1.5 metre physical distance is **not feasible**	• Surgical mask • Hand hygiene	• Client to wear surgical face mask if tolerated • Hand hygiene
Doorway indirect contact by HCW Clients **with** symptoms suggestive of COVID-19 (e.g. cough, fever, shortness of breath) **Perform hand hygiene before and after every client contact**	Any doorway indirect contact by HCW	• Surgical mask • Gown • Gloves • Protective eyewear	• Client to wear surgical face mask if tolerated • Hand hygiene

Setting	Activity	HCW PPE required	Client PPE required
Entering the client/s room Clients **with or without** symptoms suggestive of COVID-19 (e.g. cough, fever, shortness of breath) **Perform hand hygiene before and after every client contact**	Providing direct care or any close contact in the **absence** of aerosol generating procedures (AGP) NOTE Naso pharyngeal swab is not classified as an AGP.	• Surgical mask • Gown • Gloves • Protective eyewear	• Client to wear surgical face mask if tolerated and appropriate to procedure (e.g. not for naso-pharyngeal swab) • Hand hygiene
	Providing direct care or any close contact in the **presence** of aerosol generating procedures *Examples of aerosol generating procedures include:* • *Cardiopulmonary resuscitation* • *Nebulisation of medication* • *Intubation* • *Suctioning airways*	• Respirator N95/P2 standard • Gown • Gloves • Protective eyewear	• Surgical mask not appropriate for clients undergoing these procedures

Isolation is used to separate ill persons who have an infectious disease from those who are healthy (e.g. tuberculosis and confirmed COVID-19 cases).

Quarantine is used to separate and restrict the movement of well persons who may have been exposed to an infectious disease to see if they become ill (e.g. returned travelers, cruise line crew and passengers).

Annexure 8

Recommendations

1) Separate toilets for medical team and secruity guards

2) Clinical waste bin at every level

3) PPE induction required - Instructing security guards not to assist with baggages if possible.

4) Enforce sanitisation of every member coming into the hotel before sign in.

5) Sign in / sign out. Recommend security guards to write the name / number of the person instead of letting the person stay at the counter and sign in

6) Protocol for recognition and proper testing of possibly infected security guards / staff.

7) Daily counts of PPE available to ensure no shortage of PPE.

8) Clinical protocol for review of COVID19 positives.

Issues:

- Same toilets outside the medical work room being used by medical team and security guards.

- Glass door source of contamination as required to push through

- No clinical waste bin at every level of guests room.

- Security guards offered to carry my doctor's bag up the stairs which I refused.

- Immediate isolation of possibly infected security guards were not done despite strong recommendations from the team that they need to be isolated in a hotel room (which needs to be disinfected afterwards) for testing. Instead the hotel manager told me that the possibly exposed security guards were in the same room together and requested for nursing staff to come into the room to test them which I have declined and said no.

- Nurses informed me in the morning that there was only 3x N 95 masks available on 16/6/2020. I informed the DHHS Team leader to please urgently order the N95 as there were 8 cases of COVID19 positives and the nursing staff were required to go up and review them on a daily basis before transfer. That day, I organised for the nursing staff to obtain N95 from other hotels after informing the medical team of our shortage.

- Nurses asked me if it was necessary to review COVID19 on a shift basis (2x/day) as they were doing this for all COVID19 positives. We created a protocol on that day 16/6/2020, of which once daily review with observations (blood pressure, temperature, heart rate, and oximetry on exercise) was sufficient, and to escalate complicated patients accordingly.

Gmail **Stuart Garrow** [redacted]

Stamford Outbreak Investigation Suggestions and a request

1 message

Stuart Garrow [redacted] 21 June 2020 at 16:38
To: "Sarah McGuinness (DHHS)" REDACTED

Dear Sarah
I expect you are pretty busy. I have a couple of suggestions from the quarantine hotel doctors and a request. Attached are some notes taken by one of the doctors ([redacted]) now in quarantine about events at Stamford which may be of assistance to you and the infection control consultants. I have also attached a proposal by another doctor ([redacted]) for environmental testing in the hotels. Perhaps you have already done some sampling around The Stamford before cleaning.

As you know we have about 30 doctors in the quarantine Hotel medical service from which we draw 8 doctors a day to run a 24 hour 7 day service. The duty doctors have a daily Zoom meeting at 8.30 to plan the day. We have had a number of guest speakers join us for about 30 minutes to discuss aspects of u work eh mental health, covid presentations etc. We record the meetings for everyone else to see . I was wondering if you or one of your colleagues could join us sometime soon to discuss your outbreak investigation at Stamford and other outbreaks to discuss methodology, findings , future plans etc.

Many thanks

Stuart Garrow
--

Dr Stuart Garrow MBBS MPH FRACGP
Clinical Lead Melbourne Quarantine Hotel Medical Service
AHPRA# [redacted]
Provider# [redacted]

[redacted]

2 attachments

Recommendations from doctors' team Stamford.doc
3K

Surface sampling of SARS-CoV2 (1).docx
153K