Question on notice no. 127

Portfolio question number: AE22-127

2021-22 Additional estimates

Legal and Constitutional Affairs Committee, Home Affairs Portfolio

Senator Nick McKim: asked the Australian Border Force on 14 February 2022—

Did the Department develop or know of a response plan in the case of a COVID-19 outbreak in immigration detention?
a. if so:
i. What date was it finalised?
ii. Who had access to it?
iii. Was there a different plan concerning APODs?
iv. Please provide a copy to the Committee.
b. How many detainees have been released from held detention (including APODs) into community detention or onto bridging visas due to COVID-19 risks?
Answer —
Please see the attached answer.

SENATE STANDING COMMITTEE ON LEGAL AND CONSTITUTIONAL AFFAIRS
ADDITIONAL BUDGET ESTIMATES
14 FEBRUARY 2022

Home Affairs Portfolio
Australian Border Force

Program 2.4: IMA Offshore Management

AE22-127 - Immigration detention facilities - COVID-19 response plan

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Did the Department develop or know of a response plan in the case of a COVID-19 outbreak in immigration detention?
a. if so:

i. What date was it finalised?
ii. Who had access to it?
iii. Was there a different plan concerning APODs?
iv. Please provide a copy to the Committee.

b. How many detainees have been released from held detention (including APODs) into community detention or onto bridging visas due to COVID-19 risks?

Answer:
Since the start of the COVID-19 pandemic in March 2020, the Department and its service providers implemented infection control measures and Outbreak Management Plans at all Immigration Detention Facilities (IDFs), including alternative places of detention (APODs). These are working documents and are reviewed and updated on a regular basis.

The first overarching Outbreak Management Plan was issued on 6 March 2020. The most recent version (version 12.02) was issued on 23 December 2021. There is no finalisation date due to the evolving nature of COVID-19, including regular updates where required as a result of updated COVID-19 advice and measures published by the Australian Health Protection Principal Committee (AHPPC) statements and public health units.

These are accessible by the Department of Home Affairs (including the Australian Border Force), detention service providers, state based health authorities, and other stakeholders such as oversight bodies.

There was no different plan concerning APODs.

The most recent version of the overarching Outbreak Management Plan is attached.

No detainees have been released from the IDN into community detention or onto bridging visas due to COVID-19 risks.

International Health and Medical Services

COVID-19 Outbreak Management Plan

Linked to:

Standards for Medical Facilities

RACGP managing influenza in general practice

Coronavirus Disease 2019 (COVID-19) Outbreaks in Correctional and Detention Facilities

Version 12.02

Document Owner: International Health and Medical Services

Document Manager: General Manager, IHMS

Effective Date: 23 December 2021

ihms International Health and Medical Services

Document Control Record

Revision History

Version	Effective Date	Description	Prepared by
1.00	06/03/2020	New Document	Regional Operations Director, MS
2.00	09/03/2020	Major updates to section 6, 7, 8 & 9. Minor update to position tables and contingency staffing.	Regional Operations Director, MS
3.00	12/03/2020	Major updates to trigger points and descriptors. Updated case definition. Update to resources.	Regional Operations Director, MS
4.00	30/03/2020	Major updates to align with CDNA guidelines, including: Site based outbreak management team and responsibilities, COVID-19 Management flow charts, update of PPE requirements, case definitions, declaring an outbreak.	Regional Operations Director, MS
5.00	03/04/2020	Updated trigger point definitions, Department and Serco OMT members & meeting agenda added, Site/clinic entry screening updated, access to health care added, site activity planning added, outbreak management section updated with staffing, monitoring and review sections, admission and discharge from hospital updated. Reporting section updated. Forms added: Transfer advice & initial public health unit initial report.	Regional Operations Director, MS
5.01	06/04/2020	Contractual requirement for outbreak management plan added in introduction, PPE stock levels description amended, health workforce planning section updated, human resources section description updated, level of health care provided by IHMS described and updated in section 12, updated staff education reference material links.	Regional Operations Director, MS
5.02	12/4/2020	Updated section 4.3 interaction with stakeholders, minor updates to section 9	Director of Nursing, IHMS
5.03	15/4/2020	Minor changes to section 9, corrections made to 4.3	Director of Nursing, IHMS
6.0	17/7/2020	Changes to reflect trigger point plan +	Director of Nursing, IHMS

7.0	31/7/2020	Update to reflect changes in CDNA guidelines: Prevention of introduction into the facility PPE stock levels Vulnerable Persons Detainee Contact Register Contact Management Updated/added: OMT Leaders CMT Members	Regional Operations Director, MS
7.01	7/8/2020	Added: Agency staff and visiting health professionals	Director of Nursing, IHMS
8.00	14/8/2020	Updated: Prevention of Introduction into the Facility Prevention of spread within and between facilities Isolation and cohorting Close contact definition Close contact testing Quarantine & Isolation OMT Function Declaring an Outbreak OMT leaders Infection Control	Regional Operations Director, MS
9.0	18/8/2020	Updated: Vulnerable persons Isolation and Cohorting Monitoring an Outbreak Declaring the Outbreak Over Added: Reviewing outbreak management Contact assessment Contact education	Regional Operations Director, MS
10.0	21/2/2021	Added: Quarantine Facilities Model of care – detainees in 14 day quarantine Routine testing of quarantine staff Updated key personnel contacts throughout document	Director of Nursing, IHMS

11.00	12/04/2021	Updated: Key personnel contacts throughout document. Vulnerable persons. PPE E-Learning for staff included. Isolation and Cohorting- Adaption to wording. Monitoring an outbreak - Removal of circumstances. Detainee Contact Register - Inclusion of RIC. reporting. Removal total number of detainees with fever and/or ARI. Staff contacts reporting Changed from daily reporting to business days. Planning and risk assessment flow chart; Removal influenza section. Removal of prescribing Antiviral medication. Manage suspected outbreak flowchart; Revision of wording.	Director of Nursing, IHMS, Regional QHS Compliance Manager, Area Medical Directors Medical Director, Government Services
12.00	03/08/2021	Update: Purpose CMT Members Information Sources OMT Leaders IHMS Site Leadership Regional Roles Staff Vaccination External Appointments Telehealth Medication Management Mitigation of Transmission Infection Control Occupational Exposure External Appointments / Hospital Transfers Case and outbreak management Notification of Outbreak Public health units Consultations Supporting Continuous Improvement	
12.01	19/08/2021	Update: Staffing update Trigger points Social distancing / physical distancing	
12.02	23/12/2021	Updates: Staffing update throughout doc 7.4 – Health workforce planning; 7.10 Staff education; 7.11 Staff vaccination; 9.2 Vulnerable persons; 9’5 Clinic entry screening; 9.5.1 Equipment; 10.1 Infection control; 10.9 & 10.10 Zoning & Air Scrubbers; 11.1 Admissions & transfers; 11.3 Restricting spread within & between facilities	Director of Nursing, IHMS, Area Medical Directors Senior Medical Director, Government Services
Version 12.02 approved by Director of Nursing, IHMS			**Approved Date**: 23/12/2021

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1 Introduction

A pandemic will spread globally and present a widespread threat to employee health and thus business continuity. The company as a whole could be impacted, and it is unlikely the problem will be confined to one group or site.

Outbreak planning is a complex dynamic issue requiring implementation of plans in response to certain “triggers“. Assessment as to whether a trigger point is reached should include consideration of World Health Organization (WHO) pandemic phases as well as any local national or sub-national alert or pandemic phases, and any local or broader impacts.

In the case of a pandemic being declared, IHMS will need to maintain capacity to respond to the health needs of Detainees while ensuring both the protection of staff and business continuity.

IHMS note this plan is contractually required under Schedule 2, clause 6.6 - Disease Prevention and infection control & 6.7 – Serious communicable disease.

1.1 Purpose

This plan intends to:

- Identify trigger points and key activities to be implemented based on these triggers;
- Clearly identify the governance structure and Crisis Management Team (CMT), and the Site based Outbreak Management Team (OMT), and outline the responsibilities of key roles;
- Describe and implement the hierarchy of controls as described by the APHCC
- Identify contingency arrangements for business continuity, including planning for succession and use of alternative work processes;
- Identify staff training requirements;
- Identify contingency arrangements for Detainees with particular needs (e.g. vulnerable groups, and particularly patients with comorbidities);
- Document infection control policies and identify triage algorithms for the management of suspected and known cases;
- Outline the support IHMS will provide for Detainees in isolation and/or quarantine; and
- List essential resources including key stakeholders, such as public health units.

2 Trigger point definitions – Community

Trigger points will be used to guide activities of the CMT. Activation of community trigger points will be used as early warning indicators for activities within the held detention environment. The trigger points will be fluid as a way of scaling up and down activities as the pandemic reaches its peak and declines.

No cases reported in community		**Cases reported in community**					
Level 1		**Level 2**		**Level 3**		**Level 4**	
A **Mild**	**B** **Moderate**	**A** **Mild / Moderate**	**B** **Severe**	**A** **Mild / Moderate**	**B** **Severe**	**A** **Mild / Moderate**	**B** **Severe**
No cases in country		Cases in country		Limited transmission in community May or may not be employee cases	Increasing transmission in community May or may not be employee cases	Widespread transmission in community May or may not be employee cases	
Impact: Low community awareness No effect on services	**Impact:** Community awareness is rising No effect on services	**Impact:** Community awareness continues to rise Low community anxiety No effect on services No restrictions on public gatherings / schools	**Impact:** Community awareness/anxiety increasing No effect on services Public health communications No restrictions on public gatherings / schools	**Impact:** Some community anxiety / fear Medical services adequate Essential services becoming effected Some employees may be ill - probably mild cases Some public health announcements and interventions Some restrictions on public gatherings / schools No / minimal business disruption	**Impact:** Increasing community anxiety / fear Medical services strained Essential services strained Some employees may be ill - may be severe cases Significant public health comms Increasing restrictions on public gatherings / schools Some business disruption	**Impact:** Peak community anxiety / fear Medical services strained / overwhelmed Essential services strained / overwhelmed Significant public health communications Severe restrictions on public gatherings / schools Significant absenteeism - some employees critically ill, staff are becoming fatigued	

3 Trigger point definitions – Immigration Detention Network

Prevention			Targeted or response action	
Response Level 1	**Response level 2**	**Response level 3**	**Response level 4a**	**Response level 4b**
Identification of disease outbreak internationally which may impact Australia No known cases in Australia	Case/s Detected in Australia Person to person transmission detected Australia Cases under investigation	A potential COVID-19 outbreak: Two or more cases of ARI in detainees or staff of a detention facility within 3 days (72 hrs). OR Enough is known about disease to tailor measures to specific needs Numerous person to person transmission detected Australia Number of cases under investigation escalates quickly Pandemic notified Cases identified proximate to Detention network (ie – staff/detainee identified as having been in close contact with confirmed case)	1 or more confirmed case(s) identified in the staffing population.	1 or more confirmed case(s) identified in the detainee population
Impact: Low awareness in facility No affect on services	**Impact:** Some anxiety / fear in facility Medical services adequate FDSP services adequate Health announcements across facilities and some interventions Some social distancing implemented No / minimal business disruption	**Impact:** Some anxiety / fear in facility Medical services adequate FDSP services adequate Health announcements across facilities and some interventions Some social/physical distancing implemented No / minimal business disruption Additional Screening Scrutiny introduced Additional cleaning services introduced Non-contact visits (social distancing)	**Impact:** Increasing anxiety / fear in facility Medical services becoming affected FDSP services becoming affected Health announcements across facilities and interventions Engagement with PHU Social/Physical distancing implemented Some employees may be ill Minimal business disruption Quarantine Units online Quarantine Units additional cleaning services introduced Controlled movement commenced	**Impact:** Increasing anxiety / fear in facility Medical services strained FDSP services strained Health announcements across facilities and interventions Engagement with PHU Social/Physical distancing implemented Some employees may be ill - Some business disruption Additional Quarantine Units online Suspension of non-critical services Additional quarantine measures introduced

4 Governance

4.1 Crisis Management Team (CMT)

The IHMS Crisis Management Team (CMT) is in charge of managing the crisis once it has occurred and instigating the short term impact minimisation actions in the action table. The CMT will be activated at Level 3 or earlier if directed by the General Manager, IHMS. The leadership team of the CMT will remain in place for the duration of the pandemic and become dormant at its conclusion for remobilization as indicated for the purposes of post pandemic learnings.

Alternates are identified below for the leadership roles of this team. A pandemic will be managed using existing systems and resources as far as possible.

Core team roles include:

- ***Crisis Management Team Leader:*** Overarching responsibility for pandemic preparation, response and recovery. Head of the team and the final arbiter of all decisions during a crisis.
- ***Crisis Management Team Coordinator:*** Responsible for detailed tracking and coordination of crisis management team activities.
- ***Team Members:*** Are responsible for attending all meetings and ensuring their teams are kept informed as required.

4.2 CMT members

Role	Name	Contact Details	Alternate 1	Alternate 2
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		
	[redacted]	[redacted]		
	[redacted]	[redacted]		
	[redacted]	[redacted]		
	[redacted]	[redacted]		

Role	Name	Contact Details	Alternate 1	Alternate 2
	[redacted]			
	[redacted]			
	[redacted]			
	[redacted]			
	[redacted]			
	[redacted]	[redacted]		

4.3 Interaction with stakeholders

Proactive routine and ad hoc interaction and communication with the Department of Home Affairs (Department), the FDSP and other stakeholders is essential during the activation period of the CMT. In the lead-up to activation of the CMT, IHMS will participate in scenario planning exercises with the Department and the FDSP to test and improve operational plans for the pandemic response.

Following each meeting of the CMT, minutes noting key events confirmed cases, deaths, key media headlines and any other critical information generated. Minutes will include the version number and release date and in addition to key events will include clear instructions of what is expected from the action holders.

It is envisaged that the Department will coordinate and manage a regular meeting schedule for additional information sharing between the Department, IHMS, and the FDSP. IHMS will ensure senior level representation at those meetings. IHMS will also ensure key members are available for ad hoc meetings as the situation dictates.

The IHMS CMT will ensure all stakeholders are kept informed as required of key events and other critical information. This includes our sub-contractors, network providers, the Commonwealth Ombudsman, the Office of the Australian Information Commissioner, relevant state government departments and agencies. Other professional agencies such as the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP), Australian Health Professional Regulation Authority (AHPRA), and other relevant bodies may at times provide correspondence specific to their members. IHMS will ensure they are aware of any relevant information communicated by these stakeholders is disseminated.

4.4 Briefings and situation reports

The CMT will establish a schedule of internal briefings as early as possible to encourage effective information sharing. The purpose of these briefings is to update other managers on the unfolding situation.

The frequency of communications will be driven by the severity of the event. As a general rule the CMT will run a minimum of one conference call per week in the initial phase of management of the situation. Frequency of calls is reviewed regularly.

Weekly business updates/situation reports will be circulated to all IHMS staff and sites during the crisis by the Director of Corporate Affairs, or the identified alternate person. Daily media summaries will be circulated to CMT members by the Director of Corporate Affairs.

4.5 Monitoring

It is essential that the CMT have access to information that will allows it to:

- Identify that a crisis may occur / will occur / has occurred.
- Monitor the situation as it unfolds.

Therefore, it is important to identify information sources that can be trusted for their timely and accurate information.

As a minimum, three people on the CMT must be setup to receive regular email updates and/or special notifications from the trusted sources listed above (where email updates are available).

It is the responsibility of these team members to inform the CMT immediately if an event occurs that could require escalation.

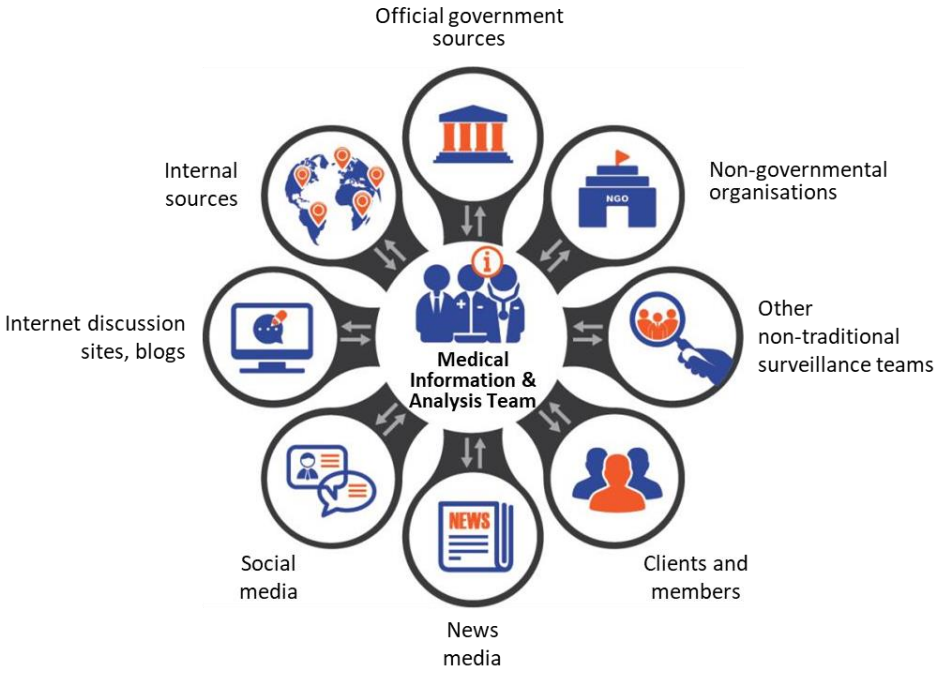


Figure 1: Non-linear purposeful bi-directional engagement with communities of stakeholders

4.6 Information sources

The below links are to the current Australian Health Protection Principle Committee statements. IHMS have included principles from these documents in the formation of the IHMS Outbreak management Plan.

- https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-national-principles-for-infection-prevention-and-control-in-quarantine - 7 July 2021
- https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-vaccinating-and-testing-quarantine-workers - 29 June 2021
- https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-minimising-the-risk-of-transmission-from-high-risk-international-travellers-in-managed-quarantine-facilities - 29 June 2021
- https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-continuous-learning-in-managed-quarantine-for-international-arrivals - 14 April 2021

Other significant information sources include:

- CDNA National Guidelines for public health units – https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm- 24 June 2021
- CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Correctional and Detention Facilities – https://www.health.gov.au/resources/publications/cdna-guidelines-for-the-prevention-control-and-public-health-management-of-covid-19-outbreaks-in-correctional-and-detention-facilities-in-australia-12 August 2020
- Infection Control Expert Group Guidance on the Use of Personal Protective Equipment (PPE) for Health Care Workers in the Context of COVID-19 https://www.health.gov.au/resources/publications/guidance-on-the-use-of-personal-protective-equipment-ppe-for-health-care-workers-in-the-context-of-covid-19- June 2021

Information Source	Monitored By	Method Of Monitoring (email alerts etc).
Department of Health	[redacted]	Media alerts Active checking of website https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm
Department of Home Affairs	[redacted]	Active contact through the Detention Onshore Health Contracts Section, the Detention Health Operations Section, the Offshore Health Services Contracts Section and the Offshore Health Operations Section
NSW Health	[redacted]	Website updates https://www.health.nsw.gov.au/Infectious/diseases/Pages/coronavirus.aspx
QLD Health	[redacted]	Website updates https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/diseases/coronavirus
VIC Health	[redacted]	Website updates https://www.dhhs.vic.gov.au/coronavirus
WA Health	[redacted]	Website updates https://ww2.health.wa.gov.au/Articles/A_E/Coronavirus
NT Health	[redacted]	Website updates https://health.nt.gov.au/health-alerts/novel-coronavirus-covid-19
SA Health	[redacted]	Website updates https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+topics+a+-+z/novel+coronavirus
ACT Health	[redacted]	Website updates https://health.act.gov.au/public-health-alert/updated-information-about-covid-19
RACGP	[redacted]	Website updates https://www.racgp.org.au/
Travel Updates	[redacted]	Website updates https://www.smartraveller.gov.au/news-and-updates/coronavirus-covid-19
WHO	[redacted]	Active checking of website updates and daily sitreps https://www.who.int/emergencies/diseases/novel-coronavirus-2019
Media and Social Media	[redacted]	Email alerts, summary of information in daily news summary to leadership team

4.7 Local regulations and legal compliance

It is an IHMS policy that the company will be compliant with local regulations at all times. These regulations may change during a crisis, and so all departments must monitor government communications to ensure all regulatory changes are acted upon as soon as possible.

If there is ANY doubt about what is or is not legally compliant, the department MUST seek legal advice before acting. Advice should first be sought from the internal IHMS legal department, and then, if necessary, from an external legal specialist with experience in the area of concern.

The Corporate Crisis Management Team must be notified of any significant legal or regulatory issues immediately.

4.8 Review of CMT Performance

After the immediate crisis is over the CMT should also review their performance during the crisis. Discussion should be focused on:

What went right: What practices and procedures proved themselves to be valid and should be maintained.

What went wrong: What practices and procedures were inappropriate in this situation and should either be modified or discarded completely.

4.9 Impact assessment

In process with the CMT, a risk assessment shall be complete and evaluate the impact of the crisis on its operations. In general this will be done through discussions between the regional and corporate crisis management teams.
The impact assessment should include:

- Assessment of any change in risk as a result of the incident.
- Assessment of the capacity to continue business in the affected location, particularly in relation to property damage and local community support.
- Assessment of financial losses, incurred during the incident and in the immediate aftermath.
- Assessment of structural damage to facilities, including an estimated timeline for repairs / rebuilding.
- Assessment of the impact on IHMS reputation, both within the immediate community and nationally.

5 Site Outbreak Management Team (OMT)

5.1 Function

Several functions are critical within the outbreak management team (OMT), and some roles may be performed by the same person.

In the case a facility enters level 4 or if clinically warranted, the OMT should meet daily to:

- direct and oversee the management of the outbreak
- monitor the outbreak progress and initiate changes in response, as required
- liaise with GPs and the state/territory Department of Health, as arranged.

Role	Function
[redacted])	The chairperson is responsible for co-ordinating outbreak control meetings, setting meeting times, agenda and delegating tasks.
[redacted]	Team member and key representative for ABF in site meetings
[redacted]	Team member and key representative for Serco in site meetings
[redacted]	The secretary organises OMT meetings, notifies team members of any changes, and records and distributes minutes of meetings.
[redacted]	The coordinator ensures that all infection control decisions of the OMT are carried out, and coordinates activities required to contain and investigate the outbreak.
[redacted]	Some GPs may be available to participate in the OMT. It is valuable to identify a clinical lead amongst those GPs who attend a facility. In the management of an outbreak, the role of this person is important in facilitating assessment and management of ill detainees, and in working with the detention facility and the department to implement control strategies.
[redacted]	An understanding of what assistance can be provided by PHUs and role/responsibility clarification should be confirmed at the initial OMT meeting, although it is usually not necessary for PHUs to be part of the OMT.

5.2 Meeting Agenda

The following meeting agenda will be observed by all OMTs:

1. Action item review - All
2. Outbreak Monitoring – update on current cases and emerging clinical issues - IHMS
3. Temperature check – Serco / ABF
4. Infection control update - IHMS
5. Site accommodations and movements – Serco/IHMS
6. Detainee welfare and communications - All
7. Vulnerable Detainees – IHMS
8. Policy or practice changes - All
9. Reporting - All
10. Other or new business - All

5.3 OMT Leaders

Facility	Name of Leader	Contact Details	Alternate 1	Contact Details
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

6 Communications

6.1 Principles

Some communications and audiences take precedence over others. This should be determined in advance by giving each item a priority ranking. If a situation occurs where there are not enough staff to run all the communications, then all efforts should be put into maintaining those that are critical.

Audiences for communication are:

- CMT/OMT members
- Department of Home Affairs
- Other IHMS staff
- FDSP
- Patients
- Federal, State and Territory Health Departments
- Hospitals
- Local services (including pharmacies)
- Suppliers
- Other Community Services

6.2 Setup

Some of these communication channels, such as websites, mass emails and hotlines, must be set up before they can be used. In addition, people must be trained in how to use them. There may not be time to do this during a crisis, and so the Human Resources department must ensure these channels have been setup and are ready to go in advance.

6.3 Identify backup

For all critical communications at least two backup communication channels must be identified and setup. These backup channels can be used if the original communication channel is not available in a crisis. Contact lists should be held in hard copy in case of an IT outage.

6.4 What to say

Information communicated to employees should include:

- The basics of what is known about the event, to include that it is an evolving situation, in lay terms;
- A most recent facts/changes section, for those who are up to date;
- Action plans that everyone can take to minimise their becoming a case, especially important since being able to DO something about a threat is a key element for most in reducing event associated stress;
- Rumour control contact information and why rumour control is important in an organisation;
- Who to contact if you need to talk (e.g. EAP service, medical office/personnel, etc.).

Information communicated to Department of Home Affairs should include:

- Regular situation reporting of IHMS pandemic planning and implementation;
- Statistics of any suspected or confirmed cases;
- Site updates;
- Communications cycle and key contacts;

Information communicated to patients should include:

- Key public health messages, including prevention techniques, how to identify Covid-19 symptoms and what to do in the event of developing symptoms
- IHMS actions in response to the pandemic,
- Where to go for more information (IHMS staff, information posters)
- Expectations with regards to follow-up communications and how information will be updated (eg through site notice boards)

Information communicated to other stakeholders (including Health Departments, hospitals, local suppliers and community services) will be on an as-required basis, for example if a detainee needs to be relocated to hospital for treatment. Information to stakeholders will include appropriate clinical information and update on IHMS planning and actions and involve open two-way communication.

6.5 Communications checklist

Audience (Who?)	Frequency / Timing (When?)	Communication Channel(S) (How?)	Channel Setup?	Template Wording Has Been Prepared And Inserted Below?	Comm Prepared By	Comm Approved By
IHMS CMT	As per CMT meeting schedule, and as required	Group email	Yes	Yes	CMT Coordinator	CMT Leader
Department of Home Affairs	Daily	Phone call from CMT Leader or delegate, email updates as required	Yes	N/A	CMT Leader	CMT Leader
FDSP	Weekly or as required by changing events	Regular site meetings, phone call from designated CMT member, joint departmental engagements	Yes	N/A	CMT Coordinator	CMT Leader

Audience (Who?)	Frequency / Timing (When?)	Communication Channel(S) (How?)	Channel Setup?	Template Wording Has Been Prepared And Inserted Below?	Comm Prepared By	Comm Approved By
Patients	Weekly or as required by changing events	Site posters, handouts and meetings with patients	Yes	Yes	CMT Coordinator	CMT Leader
Federal, State and Territory Health Departments	As required, in coordination with Home Affairs	Phone, email and fax from designated CMT member	Yes	N/A	CMT Coordinator	CMT Leader
Hospitals, local suppliers and community services	As required	Phone calls, email and fax from local site staff, GAN or CD as required	Yes	N/A	CMT Coordinator	CMT Leader
Media	If contacted by media	Email	Yes	All media enquiries to be referred to the Department of Home Affairs	CMT Coordinator	CMT Leader

6.6 Public health units

Public health units and communicable disease control services in state and territory health departments manage outbreak response. In the event of a pandemic affecting detainees within immigration detention facilities, IHMS, the FDSP and the Department will collaborate with the state based authorities to implement a range of strategies to support the health of detainees, such as case and contact follow-up, management and treatment.

COVID-19 is a notifiable condition under the Australian National Notifiable Diseases Surveillance System (NNDSS). This means that in all Australian states and territories, either the medical officer requesting the test and/or the laboratory performing the test, are responsible for notifying the relevant jurisdictional public health authority of the case of COVID-19, as per local legislative requirements.

Australian Capital Territory	Business Hours: [redacted] After Hours: [redacted]
Queensland	[redacted]
New South Wales	[redacted]

South Australia	[redacted]
Northern Territory	[redacted]
Western Australia	[redacted]
Victoria	[redacted]

7 Human Resources

During a crisis it is possible that some senior managers will be unavailable (either temporarily or permanently) due to illness, death, the need to care for a family member, etc. If this occurs, the manager's vital responsibilities will need to be temporarily / permanently assumed by others. If there is a need for long term replacement of a role, temporary or permanent recruitment processes will be commenced. When an alternate assumes the responsibility of a senior manager, this needs to be communicated to all employees.

The following table outlines the successors of all members of management.

7.1 IHMS site leadership

Site Leader	Position	Alternate Leader
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

7.2 IHMS national roles

Name	Position	Alternate 1	Alternate 2
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	

7.3 Regional roles

Name	Position	Alternate 1	Alternate 2
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		

Name	Position	Alternate 1	Alternate 2
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	

7.4 Health workforce planning

Outbreak management present significant workforce challenges for IHMS. Different services may experience increased demand for staff at the same time (e.g. clinical, public health, administrative, support and human resources staff). Staff absenteeism and furlough requirements during an outbreak has the potential to place significant further strain on the health workforce and business continuity. IHMS will maintain a workforce planning document highlighting risks, site activities required per staffing group by rated by priority and detail of staff on sites able to complete site activities, and risk.

IHMS intend to submit a number of ASRs for the Department's consideration to consider surge staffing and increased outbreak management staffing.. The ASRs will be seeking the approval for IHMS to seek reimbursement for surge and increased outbreak staffing to meet the CDNA guidelines under Schedule 6 – Health Services Fee and Other Payments, Clause 13 Additional Services, Table A – Complexity Factors and Triggers: Any extreme, unforeseen, unforeseeable, catastrophic event that cannot be reasonably prepared for and not currently captured in the current scope and pricing. As per discussion between the Department and IHMS, there may also be a need for 24/7 onsite coverage for certain periods during an outbreak.

7.5 Agency staff and visiting health professionals

Agency nursing staff and visiting health professionals are used on some sites to meet the care needs of detainees on referral to the clinic environment. All agency staff and visiting health professionals will adhere to practices on site that are in place to mitigate risks and maintain high levels of infection control. IHMS staff receives regular communications by way of email and staff meetings which ensures currency of knowledge and ensures satisfactory adherence with changes in protocols, screening, reporting and risk mitigation strategies. Agency staff are not included in these communications and

therefore, different strategies are adopted to ensure systemic application of current practices and policies, to ensure this, the current practices will occur:

The agency (the subcontractor), will confirm in writing:

- That they are aware of any alternate place of employment held by the clinicians that they have allocated to the detention network, this includes any alternate/additional placements allocated to the nurse by the agency
- The agency shall confirm in writing that their staff do not work in state quarantine hotels
- The agency will provide documented evidence that they ensure that all of their staff have not come in casual or close contact with COVID 19
- The agency will provide documented evidence on how they communicate the occurrence of a close contact or positive case with their clinicians as well as with stakeholders such as IHMS.
- The agency should confirm in writing that they are aware that if the clinician allocated to work within the detention network has been in close contact with a positive case of COVID 19 that they will
    - Advise the clinician not to attend work
    - Seek advice from the public health unit
    - In writing, advise IHMS of the full name of the nurse, the last time they were on site and what advice was given by the public health unit in relation to the particular case.

The clinician, each time he/she comes to the detention network to provide care will:

- Consent to complete temperature and COVID 19 symptom screening each time they enter site.
- Will work only in the area allocated and with the specific detainee requiring care
- Will adhere to standard precautions and the wearing of PPE in line with the outbreak management plan trigger points
- Acknowledge awareness of their responsibility to report and to not work within our environment if they are experiencing any symptoms of COVID 19 or have been in any social or work environment which has had a positive case of COVID 19 that may warrant them a close or casual contact
- IHMS, each time any clinician arrives for a shift, will ensure:
- Screening for COVID 19 is completed
- That the clinician is aware of the above listed points and knows how to escalate concerns
- Is oriented to the site including where to access PPE, handwashing and how to dispose of waste appropriately.

7.6 Site staffing contingencies

All IHMS sites will complete the following activities:

- Advise staff that they may be called upon at short notice to temporarily work different hours, in a different location or in a different way;
- Ensure staff are aware that requests for flexibility on their part will be made with regard to appropriate use of their skills and their award conditions;
- Determine minimum staffing levels sufficient to safely maintain services;
- Identify part-time staff who can work additional hours;
- Identify staff who are prepared to defer annual or long service leave;
- Identify casual staff who can work additional hours (while at the same time appropriately managing worker fatigue);

- Identify staff who have recently left the organisation and who can be temporarily engaged;
- Identify staff who can provide non-clinical support;
- Identify staff who may be considered ‘vulnerable’ due to health issues in the case of an outbreak;
- Identify agency and partner resources which can be called upon; and
- Identify resources from the IHMS national team that can provide targeted site support service

7.7 Staff contact details

During a crisis the site will need to have immediate access to all staff names, locations and contact details. As a minimum all sites must have accurate records containing:

- Staff names;
- Office / Site locations;
- Work contact details;
- Home contact details; and
- Name and contact for ‘next of kin’

7.8 Relocation procedures

During a crisis it may be necessary to relocate critical staff in order to maintain operations. If relocation is required, the Working from Home (WFH) policy will be implemented for critical staff. Staff will only be directed to observe these arrangements on instruction by their administrative manager (via the CMT Team Leader).

Testing of WFH capabilities of the Medical Services Management teams should be progressed as follows:

- Each department head to confirm any individuals within their teams who are NOT currently enabled to work from home.
- Rolling testing of full work from home capability over a two week period whereby the entire department works from home. This should include anyone who is not currently enabled to work from home to test the actual ‘critical functioning’.
    - Full testing of at home functionality (important for employees who are enabled but rarely work from home).
    - Full testing of impact of entire team working from home on the rest of the organisation and their own working rhythms.
    - Full testing of current ‘critical staff’ listings.

7.9 Travel restrictions

IHMS travel restrictions will need to be decided at the time of the crisis, depending on the situation.

Different levels of travel restrictions may be imposed:

1) **Travel Advisory** – issued to all travellers to a certain location/s to advise them of risk in the location that they are traveling to, and activities to avoid. Travel is permitted.
2) **Business Critical Travel Only** – All personal and leisure travel to affected areas is discouraged. Non-essential business travel should be postponed or cancelled, and alternative arrangements made. Deployments should be postponed / reconsidered.
3) **Travel Ban** – total restriction on all staff movement to and from a country or region. All travellers currently in such countries should return home immediately.

7.10 Staff education

Education and training underpin efforts to integrate infection prevention and control practices into practice at all levels of every healthcare facility.

Essential education for all healthcare workers should cover infection prevention and control work practices and their role in preventing the spread of infection.

All staff working in IHMS facilities will have completed the following training as a minimum prior to attending site:

1) The Hand Hygiene Australia learning modules
2) Infection Control Series e-Learning
3) PPE E-Learning
4) Clinical Skills Assessments
    a. Hand Hygiene
    b. Temperature Assessment
    c. PPE Donning and Doffing

Staff will not be able to access an IHMS site without completing items 1 & 2. Item will be completed during first shift.

Staff will be required to complete training on a yearly basis.

Staff will also be required to complete annual fit testing and fit checking training if they are involved in duties requiring the use of N95/P2 masks.

Useful resources:

- Medical Respirators N95 Fitting Instructions
- PPE for combined contact and droplet precautions

7.11 Staff vaccination

Staff vaccination is mandated as per state regulations for transmission prevention within facilities. All staff working with detainees who are in RIC facilities or medical isolation will need to have been fully vaccinated in line with respective state guidelines.

8 Supply Chain Management

The IHMS management of PPE and supplies will be coordinated through national and international supply chain management mechanisms that include but are not restricted to:

- using forecasts that are based on rational quantification models to ensure the rationalisation of requested supplies;
- monitoring and controlling PPE/stock requests from sites;
- promoting the use of a centralised request management approach to avoid duplication of stock and ensuring strict adherence to essential stock management rules to limit wastage, overstock and stock ruptures;
- monitoring and controlling the end-to-end distribution of stock;

8.1 PPE stock levels

Minimum levels of PPE have been identified for IHMS sites. IHMS will predict a base line stock requirement based on detainee numbers in the detention network and/or other locations as directed by the department. Stock levels are intended to cover a 30 day period where cases have been identified or there is a risk of outbreak.

8.2 Access to Commonwealth stock PPE

IHMS will escalate all requirements for access to stock of commonwealth PPE through the Department.

9 Site Response Planning

9.1 Health promotion

Health promotion is the process of encouraging and enabling Detainees to increase control over, and to improve their health. Health promotion activities that are to be implemented in IHMS medical facilities shall only be activities that have been proven as effective by a sound research evidence base.

Key elements of the program will include:

- Active involvement of the patients in the consultative process, through the encouragement of patient autonomy and participation in health-related decision-making; and
- Support for patient self-management, adopting a more holistic approach to clinical care that includes and values prevention.

The health promotion and prevention programs which will be run in each IHMS facility will vary depending on the patient population, their collective needs as well as their specific individual needs.

9.2 Vulnerable persons

IHMS will complete a report detailing vulnerable patients accommodated in detention facilities. Vulnerable patients will be scheduled for clinical review once prior to the pandemic reaching level 3. The list of vulnerable persons will be sent to all stakeholders as updates occur from IHMS national office.

The CDNA deem that a detention centre is a high risk setting for a COVID-19 outbreak. As a result, all detainees meet the epidemiological criteria for being ‘at risk’. The presence of certain health conditions also increases the likelihood of severe COVID-19.

IHMS utilises the criteria as stipulated by the Department of Health (People at higher risk of coronavirus health.gov.au)

Note: risk factors for inclusion will be subject to review and the local IHMS teams may also identify individuals on a case-by-case basis to be added.

9.3 Identification of COVID-19

Suspected cases are likely to be identified by:

- Detention staff (including security and department officers)
- other detainees
- self referral by detainees
- at reception screening or through other means

All sites should monitor staff and detainees for signs and symptoms of COVID-19 with a high level of vigilance and a low threshold for investigation. Staff and detainees should be closely monitored for fever or acute respiratory infection2 (ARI, with or without fever). This monitoring will occur daily by way of site and clinic entry screening.

If a person with ARI is identified, they should be promptly investigated for a causative agent. While awaiting results the patient should be treated as a suspect case and appropriate infection control measures including quarantine and the use of PPE should be used, to prevent further spread of the disease.

9.4 Access to health care

Detainees who wish to access health care services whilst in held immigration detention do so via the Medical Request Form system. Detainees are requested to complete FM_015_Medical Request Form (MRF). All requests will be triaged and appointments will be made in line with IHMS Triage guidelines utilising the appointment prioritisation tool. This will ensure that all detainees receive an appointment in a clinically appropriate time frame. If appropriate, healthcare provision can occur by way of telehealth or on site at an IHMS clinic.

Urgent or emergency medical care shall be provided according to Site Triage guidelines which ensure urgent medical cases are given priority. Upon induction to site, detainees are informed of clinic opening hours and the arrangements for emergency and afterhours care.

If a detainee becomes unwell, they can approach the Facilities & Detainees Service Provider (FDSP), who will contact IHMS. IHMS will facilitate the triage of the individual.

Care delivered in the living quarters which of the patients shall only be provided by IHMS when determined clinically necessary by IHMS staff or, in the event of an emergency, when called by the FDSP.

9.5 Clinic entry screening

- All persons entering a clinic will be screened for symptoms
- All person should enter through one entrance only to the site or clinic;
- Explain to all patients and accompanying persons the purpose of the screening;
- If an infectious case is suspected, consider people accompanying the patient to be potentially infected with the virus, they also need to be screened;
- Ensure the right to privacy and confidentiality of anyone identified as a suspected case are maintained;
- Should a person be identified by the screening assessment to be a suspected case, they should be given a surgical mask, discreetly and immediately moved to the identified single room / isolation area;
- Each facility should have an identified area where a suspected patient may be placed;
- Staff will contact the relevant managers in cases where persons are dissatisfied or refuse to comply with prevailing infection prevention and control procedures.

9.5.1 Equipment

Equipment required for the screening are will include:

- Disinfectant wipes
- Hand Sanitiser
- COVID-19 patient information hand-outs

- Surgical masks
- P2/N95 masks
- Supply of gloves, gowns, goggles.
- Closed contaminated waste disposal container.

9.5.2 Immediate actions to be taken for a positive screening

Person must be immediately provided with a surgical respiratory mask and moved to an approved quarantine area.

The suspected case should be advised to stay in the quarantine area until further instruction on management and / or appropriate transfer is organised.

Place a surgical mask on the patient, use of the mask can be discontinued once inside the quarantine room.

PPE must be worn by anyone in contact with the patient:

- N95 mask
- Eye protection
- Gown
- Gloves

9.6 Refusal of screening procedures

Any person who refuses to undergo the screening process should not be allowed enter the clinic and the incident should be reported to the appropriate person as listed below

- [redacted] Report to the Medical Director / Operations Lead and ABF
- [redacted]: Report to ABF and relevant stakeholder
- [redacted]: Reporting to ABF/Serco
- [redacted]: Reporting to ABF/Serco

9.7 Social/Physical distancing

Social distancing is a public health measure that is used to reduce spread of a contagious virus. Its aim is to separate infected people and their close contacts from non-infected people, to reduce the risk of spreading the virus.

Social distancing is more useful early in the outbreak to try to reduce the intensity of transmission. At the peak, the virus will be ubiquitous in the community and social distancing is unlikely to slow the spread.

Types of social distancing measures that could be implemented include:

- Minimising gatherings of detainees;
- Quarantine of contacts;
- Confinement of cases;
- Limit or restrict hand-shaking;
- Restrict visitors to the facility; and
- Change shift patterns to reduce worker numbers per shift but extend clinic hours

IHMS will be guided by government public health initiatives to reduce community transmission

9.8 Health service provision

IHMS will review service provision levels in order to prioritise and divert resources to managing acute medical cases. Strategies could include:

- Temporary cessation of non-urgent allied health services;
- Temporary cessation of non-essential clinic activities including group health promotion and routine mental health screening consults;
- Triaging of GP, nurse and mental health appointments as clinically appropriate in order to free up resources and appointments for priority cases;
- Reviewing and limiting non urgent offsite specialist medical appointments;
- Reducing and/or temporary cessation of the offshore mental health community outreach service and consider alternatives such as telehealth;
- Reduction in staff numbers per shift/split shifts to limit employee exposure;
- Increase levels of critical medication stock in clinic;
- Increase communication level with external service providers; and
- Potential extension of clinic hours to manage cases

  IHMS will make recommendations as per clinical indications to ensure protection of the detention environment however will not implement suggested changes until recommendations are supported by the department.

9.9 Site activity planning

Activity	Priority	Staff group that can complete task	Can task be done remotely	Potential risk mitigations / actions
Checking and re-stocking of compound panadol	1	RN	No	Nurse roster to adjusted based on available resources

Activity	Priority	Staff group that can complete task	Can task be done remotely	Potential risk mitigations / actions
Cold Chain management	1	RN	No	Nurse roster to adjusted based on available resources
Collection of MRFs in compounds	1	RN	No	Nurse roster to adjusted based on available resources
Contacting external providers for updates (ie: patient admitted in hospital)	1	All clinical Staff	Yes	Potential to be done by staff remotely
Ordering of medical supplies (PPE, equipment, dressing etc)	1	All clinical Staff	No	Nurse roster to adjusted based on available resources
Pathology Requests	1	GP	Yes	Potential for Telehealth
Radiology Requests	1	GP	Yes	Potential for Telehealth
Review of pathology results	1	GP	Yes	Potential for Telehealth
Review of radiology results	1	GP	Yes	Potential for Telehealth
Site Checklists	1	RN	No	Nurse roster to adjusted based on available resources
Triage of Appointments	1	RN	No	Nurse roster to adjusted based on available resources
Appointment scheduling / management of calendars	2	All staff	Yes	Admin staff to support completing remotely
Request for Transport	2	All staff	Yes	Admin staff to complete remotely
Fitness to Travel Assessments (physical check / collection of vital observations)	1	RN	No	Nurse roster to adjusted based on available resources
GP appointments	1	GP	Yes	Reduced clinic hours, Tele-health
Health Discharge Assessments (physical check / collection of vital observations)	1	RN	No	Nurse roster to adjusted based on available resources
Health Induction Assessments	1	GP	Yes	Potential for Telehealth
Health Induction Assessments: RN component (physical Obs, immunisation screen, MH screen, D&A screen)	1	RN	No	Nurse roster to adjusted based on available resources
Immunisations administration	1	RN	No	Nurse roster to adjusted based on available resources
Management of medical vulnerable patients (such as insulin dependent diabetics, hypertension, significant co-morbidities etc)	1	All clinical Staff	No	Nurse roster to adjusted based on available resources
Pathology Collection	1	Clinical staff	No	Nurse roster to adjusted based on available resources
Psychiatrist appointments	1	Psychiatrist	Yes	Reduced clinic hours, Tele-health
Public Health Screening	1	All clinical Staff	Yes	HAS to complete where site staff are not available

Activity	Priority	Staff group that can complete task	Can task be done remotely	Potential risk mitigations / actions
RN appointments	1	RN	No	Nurse roster to adjust based on available resources
Outreach to patients in the compounds	2	All staff	No	Will need to assess case by case, Nurse roster to adjusted based on available resources
Radiology Collection	2	External Provider	No	Reduced clinic hours / service, provide for critical cases
Group Health Promotion	3	All staff	No	All group health promotion to cease
Dental appointments (onsite)	1	External Provider	No	Reduced clinic hours / service, provide for critical cases
D&A Medical specialist (onsite for some)	2	External Provider	Yes	Potential for Telehealth
Optometrist appointments (onsite)	2	External Provider	No	Reduced clinic hours / service, provide for critical cases
Physiotherapy appointments (onsite)	2	External Provider	No	Reduced clinic hours / service, provide for critical cases
Podiatry appointments (onsite)	2	External Provider	No	Reduced clinic hours / service, provide for critical cases
Torture and Trauma counselling services (onsite)	2	External Provider	Yes	Potential for Telehealth
Management of patients not compliant on critical medications list	1	All clinical Staff	No	Nurse roster to adjusted based on available resources
Medication Dispensing	1	RN, MHN	No	Nurse roster to adjusted based on available resources
Medication Ordering	1	All clinical Staff	No	Nurse roster to adjusted based on available resources
Medication Prescribing	1	GP	Yes	Potential for Telehealth
OSTP	1	RN, MHN	No	Nurse roster to adjusted based on available resources
S4D / S8 register checks	1	All clinical Staff	No	Nurse roster to adjusted based on available resources
SAMRA	1	GP	Yes	Potential for Telehealth
D&A CNS appointments (sites with this resource)	1	D&A CNS / RN	Yes	Nurse roster to adjusted, Tele-health
MHN appointments	1	MHN	Yes	Nurse roster to adjusted, Tele-health
Supportive Monitoring & Engagement / KeepSafe reviews (MH clinicians)	1	MHN, Psychologist	No	Roster to adjusted, Tele-health
Counsellor appointments (sites with this resource)	2	Counsellor	Yes	Nurse roster to adjusted, Tele-health
Psychologist appointments (sites with this resource)	2	Psychologist	Yes	Nurse roster to adjusted, Tele-health
Scheduled Mental Health Assessments	2	MH clinicians	Yes	Nurse roster to adjusted, Tele-health

9.9.1 External appointments

IHMS will be guided by external service providers as to the availability of appointments and potential delays in service provision. Over the course of the pandemic many external providers have transitioned to telehealth appointments and these increase during times of increased community transmission. During an outbreak all efforts should be made to facilitate telehealth appointments where appropriate.

9.9.2 Telehealth

Telehealth refers to consultation with detainees via telephone. This is for specialist external appointments or used internally by IHMS. During an outbreak it is essential to have telehealth ability including remote visualisation.

9.9.3 Medication management

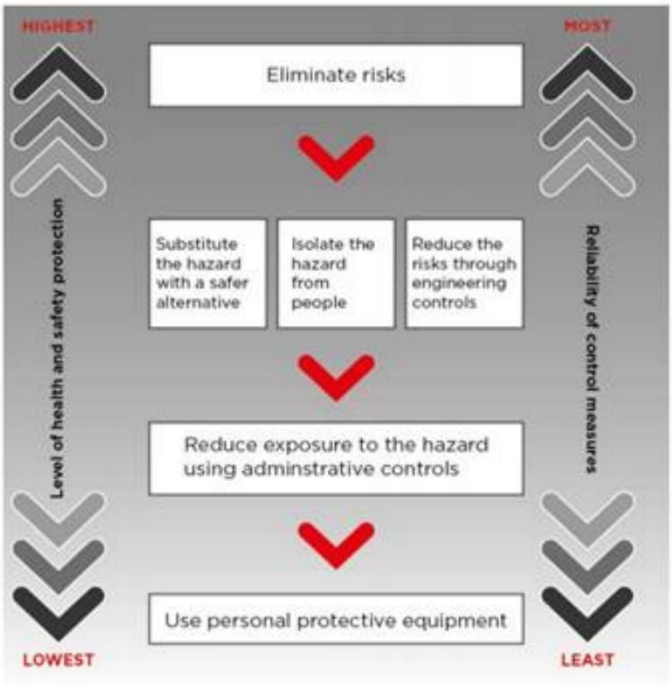
SAMRAS will be reviewed in the case of an outbreak. Medication requirements will need to be assessed on a case by case basis. Sites will also need to make plans for OSTP administration.

10 Mitigation of Transmission

The Hierarchy of controls “consists of hazard control measures broadly grouped as the following:

- Eliminate risks
- Substitute the hazard with a safer alternative
- Isolate the hazard from the people
  Reduce the risk through engineering controls
- Administrative controls to reduce exposure
- PPE

The most effective measures are listed in effectiveness from most to least effective. Please see diagram below.



The diagram shows the most effective measures higher in the list

Based on the available evidence, the COVID-19 virus is transmitted between people through close contact and droplets, and increasingly believed to be by airborne transmission. The people most at risk of infection are those who are in close contact with a COVID-19 patient or who care for COVID-19 patients.

There are emerging strains, like the Delta variant which appears significantly more transmissible than previous identified variants.

Preventive and mitigation measures are key in both healthcare and the detention setting. The most effective preventive measures in the community include:

- Vaccination
- performing hand hygiene frequently with an alcohol-based hand rub if your hands are not visibly dirty or with soap and water if hands are dirty;
- avoiding touching your eyes, nose and mouth;
- practicing respiratory hygiene by coughing or sneezing into a bent elbow or tissue and then immediately disposing of the tissue;
- wearing a surgical mask if you have respiratory symptoms and performing hand hygiene after disposing of the mask;
- maintaining social distance (a minimum of 1.5 m) from individuals with respiratory symptoms.

10.1 Infection control

The overall aim of infection control measures is to reduce exposure to and transmission of a pathogen. The risk of transmission can be greatly decreased by:

- Individual measures (e.g. hand hygiene and respiratory etiquette)
- Appropriate use of standard, contact and droplet infection control precautions
- Appropriate use of PPE (e.g. gloves, gowns, eye protection and respiratory protection, as appropriate)
- Organisational environmental measures, including: signage; triaging and patient management; quarantine and isolation and/or cohorting of patients; increased environmental cleaning; and staff vaccination when available as per state regulations.

During the pandemic, SARS-CoV-2 variants have emerged overseas. Some of these are denoted 'variants of concern'(VOC) as there is evidence of for epidemiological, biological or immunological features of concern. Some SARS-CoV-2 VOC may be associated with increased transmissibility or higher mortality compared to other lineages. More information is also coming out in regards to the most recent variant - Omicron

IHMS will review, reinforce and continue to monitor the full range of existing infection prevention and control measures in response to SARS-CoV-2 variants and operate in accordance with reference- "Infection Control Expert Group (ICEG) endorsed infection control guidance".

10.2 Standard precautions

Standard precautions are a group of infection prevention practices always used in healthcare settings, and must be used in detention facilities with a suspected or confirmed COVID-19 outbreak. Both healthcare staff and detention staff must abide by precautions to protect themselves and others if a detainee is unwell.

Standard precautions include performing hand hygiene before and after every episode of detainee contact (5 moments), the use of PPE (including gloves, gown, appropriate mask and eye protection) depending on the anticipated exposure, good respiratory hygiene/cough etiquette and regular cleaning of the environment and equipment.

10.3 Transmission-based precautions

Transmission based precautions are infection control precautions used in addition to standard precautions to prevent the spread of COVID-19. COVID-19 is most commonly spread by contact and droplets. Less commonly airborne spread may occur..

Contact and Airborne precautions are the additional infection control precautions required when caring for detainees with suspected or confirmed COVID-19.

For further information about transmission-based precautions when caring for detainees with suspected or confirmed COVID-19, refer to health.gov.au "Guidance on the use of personal protective equipment (PPE) for healthcare workers in the context of COVID-19.

Opinions on the level of PPE use for different situations can also be gained from the PHU and other relevant state authorities (eg CQV is available to provide PPE advice in Victoria)

10.4 Occupational Exposure to Covid-19

Protection of HW includes having appropriate risk assessment and risk mitigation strategies in place. However, there may be occupational exposures which need to be reported and investigated as soon as possible. The risk varies based on the type of work being performed, the potential for interaction with infected people, the type of PPE worn or not worn and contamination of the work environment and precautions in place. Caring for a patient in the correct PPE is not considered occupational exposure in this context.

An occupational exposure is defined as an incident which occurs during a person's employment and involves contact with blood or other body substances. Greatest occupational exposure risk for COVID-19 is splash to eyes, nose/nares or mouth of respiratory particles.

Where such an exposure occurs, the following principles apply:

Carry out first aid immediately:

- Skin: wash the exposed site with soap and water
- Eyes: rinse thoroughly while eyes are open with water/normal saline
- Mouth: spit out and rinse with water several times
- Clothing: Remove, shower if necessary
- The HSM should be notified.

10.5 Disposal of PPE and other waste

- Waste should be disposed in the normal way for clinical waste
- All non-clinical waste is disposed of into general waste

10.6 Handling of linen

- Routine procedures for handling of infectious linen should be followed
- Visibly soiled linen should be placed in a (soluble) plastic bag inside a linen skip

10.7 Environmental cleaning of patient care areas

- Cleaners should observe contact and droplet precautions.
- Cleaning with water and household detergents and use of common disinfectant products should be sufficient for general precautionary cleaning. In most circumstances usual cleaning protocols are sufficient.
- With higher level human-to-human transmission, at Stage 3b, increased frequency of cleaning are implemented for surfaces which are touched frequently and by multiple people (e.g. elevator buttons, door handles, light switches, etc.).

10.8 Routine surveillance testing of quarantine staff

As the pandemic has become more entrenched in everyday life, state Health Departments are introducing routine testing of staff that are at increased risk of exposure to COVID-19 regardless of symptom status. Testing regimes are varied however can be as regular as every second day from day 0 to day 16. IHMS will complete routine staff surveillance screening as directed by the relevant state health department.

10.9 Zoning

- During an outbreak, IHMS, FDSP and ABF should seek advice from the local PHU in regards to their recommendations for the implementation of a facility zoning system, a system which stipulates the required PPE level for each zone/area. Zoning systems have been commonly used in the management of COVID outbreaks in residential aged care facilities

10.10 Air scrubbers

Air scrubbers remove virus particles from the air. They are recommended in quarantine areas to reduce the risk of transmission. ABF and the FDSP must provide a supply of units at each quarantine site. Ideally an air scrubber is located within the room of an isolated person and also in any dead spaces in the corridors ie at each end of the corridor. Air scrubbers are also recommended in the clinic space.

11 Admissions and transfers

11.1 Prevention of Introduction into the Facility

IHMS will be guided by the most recent ABF Operational Notification- COVID-19 quarantine placement arrangements for detainees.

IHMS will screen incoming detainees for COVID-19 symptoms in the designated area (each site to define), prior to transfer to accommodation. New detainees to the facility, who have been in geographic areas with elevated risk of community transmission within the past 14 days, should be quarantined until 14 days from when they were last in the area with community transmission, prior to being allowed to mix with other detainees.

Quarantine should be undertaken either in a single room with access to private toileting facilities, or if unavailable, quarantined detainees may be cohorted in a separate area of the facility.

Some detainees, although located in areas with known community transmission, may be considered lower risk. These include those who have been transferred directly from another facility and:

• Where that facility has no suspect, probable or confirmed cases of COVID-19,

• Where the detainee has only been in that facility within the preceding 14 days,

• Where the detainees have been screened for COVID-19 and are asymptomatic on entry.

Consideration should be given to cohorting these individuals separately to other detainees in quarantine. Where this is not feasible, an exception can be considered (on a case by case basis) if the new detainee has been in a facility with no known suspect, probable or confirmed cases of COVID-19 in the facility and with strict infection prevention and control procedures in place (e.g. an inmate/detainee transferred to a detention facility with appropriate PPE used during the transfer).

Incoming detainees who are unwell should be tested and isolated until a negative test is obtained.

11.2 Model of care – detainees in 14 day quarantine

IHMS has developed a model of care for detainees entering the IDF from external locations requiring a 14 day period of quarantine. The period of quarantine may be determined by:

- Recent exposure to an area of high community transmission
- Recent international travel
- Transfer from another IDF
- At the direction of ABF under Operational Notifications
- At the direction of the state health department

The quarantine will be delivered in line with the CDNA guidelines and state regulations however may or may not include:

- Quarantining a number of individual detainees as a cohort who have the same epidemiological criteria

- Quarantining as an individual requiring isolation to a single room and given access to common and outdoor areas based on a schedule
- Use of specific staffing restricted to working only in the quarantine facility

Individual quarantine plans are developed for each facility that has been nominated as a quarantine facility, unit or room. Prior examples are:

- The Blaxland Infection Prevention and Control Plan
- The Meriton Infection Prevention and Control Plan

11.3 Prevention of spread within and between facilities

Detainees who are being transferred from another facility should be screened for COVID-19 symptoms prior to transfer to and upon arrival at the new facility. Detainees, who have been in areas with community transmission in the past 14 days, should be quarantined until 14 days from when they were last in the area with community transmission, prior to being allowed to mix with other detainees. Quarantine should be undertaken either in a single room with access to private toileting facilities, or if unavailable, quarantined detainees may be cohorted in a separate area of the facility. Refer to isolation and cohorting., or model of care 'detainees in 14 day quarantine'.

The following is the agreed process for quarantine following a transfer:

Community arrivals – 14 days.

Corrections arrivals – Either 14 days or nil. Depends on the information you receive

Charter transfers – If from no transmission state – Nil quarantine

Commercial transfers – 5 days. No swabbing unless symptomatic/been at hotspots/flight identified as hot spot. If flight or airport identified as hotspot then increase to 14 days.

Refused Immigration Clearance (RIC) RED ZONE – 14 days and swabbing as per State Hotel Quarantine Guidelines. Full separate staff with full PPE. Post exit swabbing to be completed as per State Hotel Quarantine Guidelines.

Refused Immigration Clearance (RIC) Green Zone – 14 days.

External appointments / hospital transfers: 14 days in line with the CDNA guidelines if they have been in an area of community transmission or according to state health/public health unit advice. Following swabbing, local state advice should be followed. Consideration may be given for decreased quarantine or an exemption from quarantine on a case by case basis.

Special purpose visits: 14 days quarantine if there is any community transmission. Consideration may be given for decreased quarantine or an exemption from quarantine on a case by case basis.

11.4 Health induction

It is preferable that admission of new detainees to an affected centre during an outbreak does not take place. Where new admissions are unavoidable, new detainees must be informed about the current outbreak and adequate outbreak control measures must be in place for these new detainees. Health induction assessments will continue to be completed onsite.

11.5 Transfers to hospital for emergency care

If transfer to hospital is required, the ambulance service and receiving hospital must be notified of the outbreak/suspected outbreak verbally and through using a transfer advice form (see Appendix). Detainees may be transferred with usual escorts and accompanying health care staff. All escorts should adhere to appropriate PPE requirements during transfer.

11.6 Returns to the facility following hospital admission

Return of detainees who have been hospitalised is permitted, provided appropriate accommodation and infection prevention and control requirements can be met. All returns must be discussed with the treating teams prior to discharge and any concerns escalated to the IHMS MD and PHU if required.

Before transport of a detainee from a hospital to an IDN, IHMS must receive a verbal or written handover from the discharge facility. Serco transport staff must seek approval of movement from the HSM (during business hours) or the IHMS Health Advice Service (outside business hours).

12 Case and Outbreak Management

In accordance with the CDNA guidelines, a COVID-19 outbreak is defined as a single confirmed case of COVID-19 of a detainee, staff member or attendee of a detention facility.

Detainees with suspected or confirmed COVID-19 require appropriate healthcare support.

Special considerations in the management of detainees with suspected or confirmed COVID19 in a detention facility include:

- Immediately medically isolate ill detainees (or cohort) and minimise interaction with others.
- If COVID-19 is suspected, have a low threshold for requesting medical review and testing. All suspect cases should be immediately quarantined.
- Transfer detainees to hospital if clinically indicated or as instructed by the PHU or the local referral hospital. If transfer is required, advise the hospital in advance that the detainee is being transferred from a detention facility where there is potential or confirmed COVID-19.
- Usual escorts and healthcare staff may accompany unwell inmates provided appropriate PPE is used. Notification of a case must be completed using the Public Health Unit Initial Report (see Appendix).

IHMS is contracted to provide a primary level of care to detainees. Secondary and tertiary level care is provided by specialists and local hospitals. As such IHMS is not set up with the requisite facilities, equipment and staffing to provide clinically appropriate care to those detainees requiring acute care or hospitalisation.

IHMS staff will prioritise assessment to patients in relation to potential to hospitalisation for COVID-19 or other infections.

In the instance of confirmed COVID-19, detention management in liaison with facility healthcare staff should consider this an opportunity to:

- Identify and implement enhanced infection control measures
- Review monitoring and screening processes, with a view to increasing or enhancing
- Review outbreak plans and requirements for implementation.

12.1 Response to a suspected case in a staff member

Health care workers and other members of staff who develop symptoms of respiratory illness should immediately be excluded from the facility and remain away whilst a diagnosis is sought. If COVID-19 is excluded, the staff member may return to work once symptoms are absent. If a diagnosis of COVID-19 is confirmed, the staff member must be excluded from work (refer to guidance here) until they meet the criteria for release from isolation outlined in the CDNA COVID-19 Interim National Guideline. The detention facility must make appropriate notification to the relevant authorities. Notification of a case must be completed using the Public Health Unit Initial Report (see Appendix).

12.2 Case Definition

The CDNA COVID-19 Interim National Guideline provides a case definition for COVID-19 suspect and confirmed cases. Case definitions provide the criteria that allow unambiguous classification of an ill person as a confirmed case, or a suspect case.

COVID-19 should be suspected in any Detainee with fever or acute respiratory infection (with or without fever) in a setting where there is confirmed local transmission of COVID-19.

12.3 Case investigation

IHMS response to a case will be carried out in collaboration with the national and local teams managing the case, and be guided by the state or country public health unit.

The following steps will be taken in all cases:

1. Confirm the onset date and symptoms of the illness.
2. Notification of the local/state public health unit
3. Incident reporting and notification of relevant stakeholders.
4. Review case and contact history in collaboration with stakeholders i.e. staff and detainee contacts
5. Confirm results of relevant pathology tests, or recommend that tests be done.
6. Ensure appropriate infection control guidelines are followed in caring for the case.

The PHU will advise and assist with the following:

- confirming the presence of an outbreak
- identifying the control measures that need to be in place
- testing of the initial respiratory specimens.
- Provide advice regarding contact tracing and outbreak management

12.4 Testing for COVID-19

The recommended test and methods of sampling for COVID-19 is outlined in the CDNA COVID-19 Interim National Guideline. Once requested by a medical officer, collection by an appropriately trained health provider is the preferred option for obtaining appropriate respiratory samples. Staff who have received the applicable training in respiratory sample collection and the proper use of PPE may also collect the appropriate samples. Detainees do not need to be transferred to hospital for the purpose of testing for COVID-19. Guided by the clinical picture, the responsible medical officer may request testing for additional respiratory pathogens.

12.5 Declaring an Outbreak

A ***potential*** COVID-19 outbreak is defined as:

- Two or more cases of Acute Respiratory Infection in detainees or staff of a detention facility within 3 days (72 hrs).

A ***confirmed*** COVID-19 outbreak is defined as:

- A single confirmed case of COVID-19 in a resident, staff member or attendee of a high risk setting. This definition includes any confirmed case who attends a high-risk setting during their infectious period.

While the definitions provided above offer guidance, the state/territory PHU will assist the detention facility in deciding whether to declare an outbreak.

12.6 Notification of an outbreak

An outbreak management team meeting should be stood up with all stakeholders invited. IHMS, Serco, ABF and the public health unit should be invited. Notification should be completed both during business hours and after business hours, as below:

12.6.1 Within business hours

During business hours the HSM will escalate the confirmed case to the public health unit, the area medical director, operations manager and director of nursing. The HSM will need to notify the superintendent and an Apollo incident report should be completed.

12.6.2 After Hours

After hours, between 06:00 and 21:30 AEDT (7 days/week) the duty phone will need to be phoned on ([redacted]

After hours, between 21:30 and 06:00 AEDT (7 days/week) the duty phone will need to be phoned on [redacted].

The Area Medical Director and Senior Medical Director should be contacted.

12.7 Public health units

Public health units and communicable disease control services in state and territory health departments manage outbreak response. In the event of a pandemic affecting detainees within immigration detention facilities, IHMS will collaborate with the state based authorities to implement a range of strategies to support the health of detainees, such as case and contact follow-up, management and treatment.

COVID-19 is a notifiable condition under the Australian National Notifiable Diseases Surveillance System (NNDSS). This means that in all Australian states and territories, either the medical officer requesting the test and/or the laboratory performing the test, are responsible for notifying the relevant jurisdictional public health authority of the case of COVID-19, as per local legislative requirements.

State	Contact Details
Queensland	[redacted] (13 HEALTH)
New South Wales	PHU South West Sydney: [redacted] After hours: Notify stakeholders: Contact the ABF via [redacted] and [redacted] Call Liverpool Hospital switchboard Ask for the PHU or the Public health physician on call [redacted]
Australian Capital Territory	Business Hours: [redacted] After Hours:[redacted]

Victoria	[redacted]
Tasmania	[redacted]
South Australia	[redacted]
Western Australia	[redacted] WA Health
Northern Territory	[redacted]

12.8 Contact management

This will be managed in accordance with the most current CDNA guidelines.

12.8.1 Close contact definition

A primary close contact is defined as a person who has:

- had face-to-face contact of any duration or shared a closed space (for at least 1 hour) with a confirmed case during their infectious period (from 48 hours before onset of symptoms until the case is no longer infectious (refer to Release from isolation).
- the exposure may be any duration depending on risk setting such as: transmission has already been proven to have readily occurred, there are concerns about adequate air exchange in an indoor environment or concerns about the nature of contact in the place of exposure (e.g. the contact has been exposed to shouting or singing)
- been exposed to a setting or exposure site where there is a high prevalence of infection e.g. a country where there is community transmission of COVID-19, or unprotected exposure in a quarantine hotel for returned travellers
- been in a venue where transmission has been demonstrated to have occurred during the time frame in which the transmission would be expected to have occurred.

If the case is asymptomatic, see PCR positive tests in asymptomatic or pre-symptomatic persons for information on determining the asymptomatic (or pre-symptomatic) case's infectious period and to inform identification of contacts.

Contact needs to have occurred within the infectious period of the case: a period extending from 48 hours before onset of symptoms in the case until the case is classified as no longer infectious (refer to Release from isolation). More conservative periods (e.g. 72 hours prior to illness onset) may be considered in high risk settings, at the discretion of the PHU.

If the case is asymptomatic, see PCR positive tests in asymptomatic or pre-symptomatic persons for information on determining the asymptomatic (or pre-symptomatic) case's infectious period and to inform identification of contacts.

Note that:

- Healthcare workers and other contacts who have taken recommended infection control precautions, including the use of appropriate PPE, while caring for an infectious confirmed COVID-19 case are not generally considered to be primary close contacts, provided that appropriate PPE has been worn and there has not been any breaches.
- For aircraft passengers, passengers who were seated in the same row or two rows in front or behind a confirmed case are considered primary close contacts in most instances. Other factors PHUs may consider when determining close contacts among passengers include possible interactions within airport terminals, such as sitting in gate lounges and moving between gates, and transport to, from and within the airport. If the confirmed case was infected with a SARS-CoV-2 variant of concern, PHUs may consider classifying all passengers on board the flight as primary close contacts. Similar criteria can be used for people who have had close contact on bus or train trips.
- For aircraft crew exposed to a confirmed case, the relevant PHU should conduct a case-by-case risk assessment, in collaboration with airlines, to identify which crew members should be considered primary close contacts.

12.9 Consultations

When a detainee on site requires medical assistance, consultations preferentially occur by telehealth. If a visit to the detainee's room/area is required, infection control measures include:

- Discussion by telehealth regarding impending visit to request detainee to perform hand hygiene and wear a mask
- FDSP do not enter the room unless required to manage a security risk
- All staff entering the room (IHMS and FDSP) must be wearing full PPE including face shield
- Accommodation room door is to be opened for the least amount of time practicable
- Consults should be considered to be organised in a well-ventilated area if possible
- Other than in an emergency, face to face consultations are to be kept to 15 minutes or less
- Follow up consultations will preferentially occur by telehealth
- Clinical equipment is to be kept to the minimum required for the consultation
- Surfaces, including door handles and table tops are wiped with alcohol impregnated wipes on exit and any clinical equipment is either left in the room, disposed of or cleaned as required.

Code blues will require the appropriate level of precautions dependant on the situation.

12.9.1 Quarantine & Isolation – when an outbreak is declared

The **quarantine** of Detainees is important when managing an outbreak. Quarantine is the physical separation of suspected or potential cases. If quarantine is not possible, cohorting of patients should occur as advised by an infection control professional.

Isolation is the physical separation of infected individuals and will be implemented in an outbreak.

12.9.2 Isolation and Cohorting

A detainee with an acute respiratory infection should be placed in a single room with their own ensuite/bathroom facilities, if possible, while a diagnosis is sought. Detainees requiring droplet precautions should be restricted to their room. If possible, it is preferable for unwell Detainees to be located in single rooms in a single wing or unit, so that staff can provide care without moving throughout facility. Detainees may attend urgent medical or procedural appointments but should wear a mask when moving to the clinic. Escort staff accompanying Detainees to another room for appointments need to wear PPE and must wash their hands after leaving the Detainee. Clinical observations should be minimised to clinical requirements only.

If the Detainee requires transfer to another facility, including hospital, advise the hospital and transport provider in advance that the Detainee is being transferred from a facility where there is potential or confirmed COVID-19. Detainees may be transferred with usual escorts and healthcare staff provided appropriate PPE is used (follow the advice of healthcare staff).

Should the numbers of cases in a facility increase in an outbreak situation, isolation resources may become under pressure. If a single room is not available, the following principles should be used to guide placement:

- Give highest priority to single room placement to Detainees with excessive cough and sputum production.
- Place Detainees together in the same room (cohort) with similar signs and symptoms or infected with the same pathogen (if known) and assessed as being suitable roommates.
- Staff must ensure they change their PPE and perform hand hygiene when moving between detainees cohorted in the same room
- If the aforementioned options are not available and a detainee needs to be isolated, staff should contact the local public health unit to seek advice on the best alternative.

12.9.3 Contact tracing

Contact tracing is managed by the relevant state/territory or country public health authority with the assistance of IHMS. Notification of a case must be completed using the Public Health Unit Initial Report (see Appendix).

In the immigration detention environments, contact tracing involves:

- IHMS, ABF and the FDSP carrying out the instructions of the relevant state/territory public health authority regarding the compilation of the contacts list and the subsequent management of the contacts.
- IHMS, ABF and the FDSP to liaise with other detention service providers as needed in identification and compilation of the contacts list.
- The identification of individuals, including other Detainees, Departmental and service provider staff and community members, who have had close and/or prolonged contact with the infected party.
- In identifying contacts, consideration will be given to how the Detainees travelled to Australia, who they shared a room with and interacted with in the relevant IDFs; contact with the public on excursions, appointments or after discharge from a facility.
- Testing of identified contacts.
- Where appropriate, the quarantine or isolation and treatment of identified contacts.

12.10 Monitoring an outbreak

Updates to information in the line list should occur through daily meetings of the OMT, or more frequently if major changes occur. The Detainee contact report should be provided to the PHU each day (or as arranged) until the outbreak is declared over.

Updated information may be reviewed by the PHU for evidence of ongoing transmission and effectiveness of control measures and prophylaxis. The PHU may discuss this with the detention facility OMT and advise of any required changes to current outbreak control measures.

The OMT will review all control measures and shall work closely with the PHU during the outbreak.

Specialised advice is available from the following sources:

- A local state, territory or regional PHU.
- Infection control practitioners may be available for advice in local hospitals, state and territory health departments, or as private consultants.
- Infectious Disease physicians may be approached for specialist management of complex infections.

12.11 Staffing during outbreak

IHMS will routinely communicate with stakeholders through the OMT regarding the level of staffing required to effectively manage an outbreak.

These reviews will need to be completed on a site-by-site basis and identify resources required to ensure staff allocated to the care of detainees are able to be managed by a dedicated team, and hours on site are adequate to manage the health care needs of all detainees.

All staff will continue to be required to self-monitor for signs and symptoms of acute respiratory illness and self-exclude from work if unwell.

12.12 Declaring the outbreak over

The time from the onset of symptoms of the last case until the outbreak is declared over can vary. Generally, A COVID-19 outbreak can be declared over if no new cases occur within 14 days (maximum incubation period) following the date of isolation of the case. A decision to declare the outbreak over should be made by the OMT, in consultation with the PHU.

The OMT may make decisions about ongoing facility surveillance after declaring the outbreak over, considering the following needs:

- To maintain general infection control measures.
- To monitor the status of ill Detainees, communicating with the public health authority if their status changes.
- To notify any late, COVID-19 related deaths to the PHU.
- To alert the PHU to any new cases, signalling either re-introduction of infection or previously undetected ongoing transmission.
- To advise relevant state/territory/national agencies of the outbreak in a detention facility, if applicable.

13 Reporting

The timeframe for delivery, content and format of this reporting will be agreed with the Department prior to commencement. IHMS will also report incidents, results and events that are vital to the management of the health of the centre and detainees on occurrence of events.

13.1 Detainee Contact Register

The IHMS Contact Register will be maintained and sent daily and contains the following information:

- total number of detainees tested
- total number of detainees in operational quarantine
- total number of detainees in medical quarantine
- total number of detainees in refused immigration clearance quarantine
- total number of detainees in isolation
- date of onset of illness of each person

- symptoms of each person
- number of people admitted to hospital with fever and/or ARI (if applicable)
- whether appropriate respiratory specimens have been collected
- results of any respiratory specimens already tested

13.2 HAS Overnight quarantine spreadsheet

After hours quarantine spreadsheet that's updated overnight by the Health Advice Service documenting people going into quarantine after hours and sent every morning at the completion the night shift.

13.3 Staff contacts reporting

The IHMS staff contacts reporting will be maintained on business days and contains the following information:

- Staff not able to attend work due to illness or other issue related to COVID-19 i.e. carer responsibilities,
- Staff being tested for COVID-19
- Results of staff testing

13.4 Staff vaccination record report

A de-identified report is sent weekly to the Department detailing vaccination rates amongst IHMS Staff.

13.5 PPE training report

Once weekly report that documents theoretical and practical components of PPE training provided weekly to the Department.

13.6 Influenza vaccination report

Weekly update on detainee uptake of the influenza vaccination

13.7 Vulnerable detainee report

Monthly report submitted to the department, with increased submissions during outbreaks.

13.8 Public health alerts

Daily reports detailing exposure venues in relevant states, produced daily during outbreaks.

13.9 Vaccination consenting dashboard

Daily submission to the Department during the consenting phase of vaccination roll out.

13.10 Incident reporting

Incident report will be submitted for a person diagnosed with COVID-19.

COVID_19 register dashboard will be used to communicate details of the case.

14 Recovery

The recovery phase will be focussed on returning services to business as usual, and so requirements will depend on the extent of the impact of the outbreak at each site. IHMS will work with all stakeholders to support health services and facility recovery.

The OMT in collaboration with the local PHU should consider a debrief for any outbreak, a prolonged outbreak, or one with unusual features in relation to outbreak management. A debrief provides the opportunity to identify strengths and weaknesses in outbreak response and investigation processes, and provide information to help improve the management of similar outbreaks in the future. It should involve all members of the OMT and any others who participated in the response to the outbreak.

This is an important stage to conduct evaluations and lessons learnt exercises and incorporate these lessons into future plans and strategic policies. Auditing and replenishing stockpiles of essential medical supplies and equipment is also a key activity during the recovery stage, as well as implementing measures to provided support staff and patients.

15 Supporting Continuous Improvement

IHMS should encourage an environment of constant vigilance, reinforcement of best practice, and high levels of support for staff to raise concerns and issues within their employment setting through a culture of speaking up for safety.

Checks, audits and reviews are to focus on assuring compliance and on identifying aspects of the system that could be managed by the modification of existing controls or by the application of additional controls.

16 Appendices

Flowcharts for COVID-19 Management in Detention Facilities

See next page

PLANNING AND RISK ASSESSMENT COVID-19

TASK	ACTION / INFORMATION
Plan for cases	• Develop a facility management plan • Ensure all staff are aware of this plan
Vaccinate all Detainees and staff against influenza	• Ensure all staff and detainees are aware of the importance of annual influenza vaccination. • Provide free influenza vaccination for all staff on site. • Encourage healthcare staff to vaccinate detainees against influenza.
Infection control preparedness	• Provide annual infection control training to all healthcare staff that includes information about COVID-19 • Ensure personal protective equipment (PPE), hand washing facilities and alcohol based hand rubs are available near point of care. • Encourage frequent and appropriate hand hygiene at all times (5 Moments). • Ensure infection control signage is available for use. • Consider how case isolation will be managed. • Develop contingency staffing plans in event of staff illness and isolation. • Ensure stocked hygiene stations are at each entrance
Assess for signs of infection	**Risk Assessment for COVID-19:** • Healthcare staff and facility management should keep up to date with the latest guidelines on who should be tested for COVID-19: https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna- song-novel-coronavirus.htm Any staff members exhibiting fever or acute respiratory infection (with or without fever) should arrange for testing for COVID-19 as soon as possible and not present to work until a negative result has been returned. • Healthcare staff should be vigilant in monitoring for COVID-19 and should strictly adhere to social distancing, respiratory and hand hygiene.
	Identify signs/symptoms of COVID-19 • Fever *OR* acute respiratory infection (e.g. shortness of breath or cough) with or without fever.

MANAGE A SUSPECTED OR CONFIRMED CASE OF COVID-19

TASK	ACTION / INFORMATION
Collect specimens	• Each detainee with suspected COVID-19 should be reviewed by the GP or nurse (HAS afterhours) • Obtain laboratory request forms for respiratory viral testing INCLUDING CORONAVIRUS. • Collect the appropriate respiratory sample. Use a single viral transport collection swab for each person. • Observe droplet precautions when collecting specimens i.e. gown, gloves, type of mask as per state requirement and eye protection (goggles/faceshield). Wash hands before and after collection.
Implement additional infection control measures immediately	• Commence droplet precautions including gown, gloves, eye protection (goggles/faceshield) and a fluid resistant surgical mask when caring for detainees with a COVID-like illness. Maintain a 1.5 metre distance between an infected person and others. • Quarantine detainees with COVID-like illness, if feasible. (Single room with Bathroom facilities) • Staff and visitors with a COVID-like illness must stay away from the facility until well and see medical advice. • Screening nurse to instruct visitors to clean hands. • Recommend Immunising detainees and staff who have not been immunised with the current influenza vaccine as soon as possible.
Implement additional infection control measures immediately	• Symptomatic and supportive treatment under the guidance of the GP • Transfer to hospital as indicated.

IMPORTANT

All pathology requests sent should have the <u>urgent</u> box ticked on the form

Please also write on the form "detention centre – high risk".

MANAGE A SUSPECTED OUTBREAK OF COVID-19

TASK	ACTION / INFORMATION
Confirm Outbreak	• A single confirmed case of COVID 19 in a detainee, staff member or attendee of high risk setting. This definition includes any confirmed case who attends a high risk setting during their infectious state period.
Document and monitor outbreak daily	• Nominate an outbreak coordinator and management team at the facility. • Continual update of the COVID vulnerable list. • Create a detailed list of detainees and staff with COVID-like illness including location, influenza vaccination status, onset date, symptoms, specimens taken and results, treatment and outcome. Update the list daily.
Inform and Manage	• Inform the relevant state or territory Public Health Unit as soon as one case identified. Continual communication with PHU and other stakeholders as relevant to manage the outbreak. • Inform GPs, facility staff, Detainees and other stakeholders.
End Outbreak	• No new cases for **14 days** from onset of symptoms in last case. • Send final detailed list to the relevant state or territory Public Health Unit Review and evaluate outbreak management.

Personal Protective Equipment Requirement by Precaution				
Personal Protective Equipment	**Precaution**			
	Standard	**Contact**	**Droplet**	**Airborne**
Gloves	Yes	Yes	Yes	Yes
Gown/Apron (impermeable)	Yes	Yes	Yes	Yes
Surgical Mask	Yes	Yes	Yes	No
P2/N95 Respirator	Not required	Not required	Not required	Yes
Goggles/face shield	Not required	Yes	Yes	Yes

Transmission-Based Precautions

Infection Control Measure	Route of transmission		
	Contact	**Droplet**	**Airborne**
Single room with own bathroom facilities	Yes *OR* Cohort patients with door closed	Yes *OR* Cohort patients with door closed	Yes, preferred
Negative pressure ventilation room	Not required	Not required	Yes, transfer
Special handling of equipment	Single use or if reusable, reprocess according to manufacturer's instructions before reuse.	Standard Precautions. Avoid contaminating environmental surfaces and equipment with used gloves.	Standard Precautions. Avoid contaminating environmental surfaces and equipment with used gloves.
Transport of patients	Surgical mask if coughing /sneezing and other signs and symptoms COVID-19. Notify the facility receiving patient. Advise transport staff of level of precautions to be maintained.	Don surgical mask prior to entering patient room and for the duration of transport. Notify the facility receiving patient. Advise transport staff of level of precautions to be maintained. Patient should wear a mask during transport. Patients on oxygen therapy must be changed to nasal prongs and have a surgical mask over the top of the nasal prongs for transport (if medical condition allows).	Don surgical mask prior to entering patient room and for the duration of transport. Notify the facility receiving patient. Advise transport staff of level of precautions to be maintained. Patient should wear a mask during transport. Patients on oxygen therapy must be changed to nasal prongs and have a surgical mask over the top of the nasal prongs for transport (if medical condition allows).
Patient specific precautions	Remove gloves and gown/apron and perform hand hygiene on leaving the room. Patient Medical Records must not be taken into the room. Signage at the entrance of room.	Visitors to patient room must also wear surgical mask and perform hand hygiene. Patient Medical Records must not be taken into the room. Signage at the entrance of room.	All clinicians to use a fit-tested P2/N95 mask. Visitors to patient room must also wear P2/N95 mask and perform hand hygiene. Patient Medical Records must not be taken into the room. Signage at the entrance of room.
Clinic room cleaning	Standard cleaning protocol between patients.	Cleaning and Disinfection - Consult with infection prevention and control professional.	Cleaning and Disinfection - Consult with infection prevention and control professional.

Family Name:	Identification number:	**Transfer Advice Form during suspected/outbreak requiring transfer to hospital**
Given Name:	☐ Male ☐ Female	
Age:	Date of Birth: _____ / _____ /_____	
Language:	Interpreter required: ☐ Yes ☐ No	
Current Location:		

Please be advised that this patient is being transferred from a facility where there is a cluster/ outbreak of **COVID-19**. At this stage the outbreak is:

Suspected ☐	Confirmed ☐

Please ensure that appropriate infection control precautions are taken upon receipt of this patient.

At the time of transfer:

☐	Patient **does not have** an acute respiratory illness
☐	Patient is a **suspected case of COVID-19**
☐	Patient is a **confirmed case of COVID-19**
☐	Patient is believed to have had **close contact with a confirmed case of COVID-19**

Referring Health Care Worker Name:	
Signature:	**Date**

Facility Address:	
Contact Number:	

Date/time:	Public Health Officer:	

Person notifying outbreak:	Position:	**Public Health Unit Initial Report**
Contact Number:	Email:	

Facility Details			
Name of Facility:			
Address:			
Health Service Manager:			
Email:		Phone:	
Description of facility:			
Total No. of Detainees		Total No. of Staff:	
Total number of Detainees who identify as Aboriginal or Torres Strait Islander:			
Age range of Detainees:		Number of compounds:	
Floor plan provided:	Yes / No		

Detainees		
Compound	**Detainee Name**	**Additional Details**

Staff		
Staff group	**No. of staff**	**No. casual staff**
Management		
Admin		
Healthcare		
Security		
Other (specify)		

IHMS Reference Documents

Focus Area	Reference Documents
Governance	IHMS Procedure 1.1.1 Clinical Governance IHMS Procedure 1.1.2 Corporate Governance
Infection Control	IHMS Policy 4.1 Infection Control IHMS Procedure 4.1.1 Precautions for Infection Control IHMS Clinical Practice Guideline 4.1.1.1 Infection Control Practices IHMS Clinical Practice Guideline 4.1.1.2 Infection Precaution Practices
Access to Care	IHMS Policy 3.1 Access to Care Policy IHMS Procedure 3.1.10 Access to Care Procedure IHMS Procedure 3.1.3 Access to Urgent Medical Care IHMS Procedure 3.1.2 Management of Appointments
Communicable Diseases	IHMS Policy 4.2 Communicable Diseases IHMS Procedure 4.2.1 Communicable Disease Outbreak Management
Health Promotion	IHMS Procedure 3.8.1 Health Promotion
Risk Management	IHMS Procedure 2.2.1 Risk Management Procedure
Communication	IHMS Policy 2.3 Communication Policy
Performance Management	IHMS Procedure 1.1.5 Performance Management
Human Resource Management	IHMS Policy 7.1 Human Resource Management IHMS Procedure 7.1.8 Code of Conduct IHMS Procedure 7.1.11 Business Travel IHMS Practice Guideline 7.1.1.2 Recruitment Process
Local and Regional Regulatory Requirements	IHMS Local and Regional Regulatory Requirements
Staff Induction	IHMS Procedure 7.1.10 Site Orientation and Staff Induction
Safe or Single Room Accommodation	IHMS Procedure 2.3.8 Determining safe accommodation
Other	Novel Coronavirus Key Poster Novel Coronavirus Participant Hand-out Screening Alter Poster Point of Entry Screening Poster

External References

Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19), Department of Health, Canberra, Retrieved from: https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19_2.pdf

Coronavirus Disease 2019 (COVID-19): CDNA National Guidelines for Public Health Units. Retrieved from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/$File/interim-COVID-19-SoNG-v1.16.pdf

2019 Novel Coronavirus (2019-nCoV) Strategic Preparedness and Response Plan, World Health Organisation. Retrieved from: https://www.who.int/docs/default-source/coronaviruse/srp-04022020.pdf

Rational Use of Personal Protective Equipment for Coronavirus Disease 2019 (COVID-19), World Health Organisation. Retrieved from: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control

The WHO Pandemic Phases, World Health Organisation. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK143061/

Interim Infection Prevention and Control Recommendations, Centres for Disease Control and Prevention. Retrieve from: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html

The Royal Australian College of General Practitioners. Infection Prevention and Control Standards for General Practices and Other Office-Based and Community-Based Practices. 5th edn. East Melbourne, Vic: RACGP, 2014. Retrieved from: https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20standards/Infection-prevention-and-control.pdf

Australian Guidelines for the Prevention and Control of Infection in Healthcare, National Health and Medical Research Council, 2010. Retrieved from: www.nhmrc.gov.au

Communicable Diseases Network Australia. Retrieved from: www.health.gov.au

Australian Health Management Plan for Pandemic Influenza, Australian Government Department of Health 2009. Retrieved from: www.health.gov.au

Pandemic Risk Management Guideline for Businesses, Queensland Government. Retrieved from: https://www.business.qld.gov.au/_designs/content/guide-printing2?parent=61119&SQ_DESIGN_NAME=print_layout

CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Correctional and Detention Facilities V1.00 – initial release 31/03/2020