State Control Centre-Health

COVID-19 Positive Action Plan – Aboriginal Communities

Viral Respiratory Disease Pandemic Response Sub-Plan

Government of South Australia

SA Health

Document control information

Document Owner:	State Control Centre-Health
Title:	COVID-19 Positive Action Plan – Aboriginal Communities
Description:	Outlines the purpose, scope, and governance for managing a COVID-19 outbreak in regional and remote Aboriginal communities.
Subject:	COVID-19 management in Aboriginal Communities
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Next Review	
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Author	SCC-Health Planning
Comments	Version 2 of this plan includes much of the feedback received during the socialisation period. Later versions will look to assess and incorporate remaining feedback. Version 2.0 was approved by the SA Health Leadership Team on Thursday, 20 August 2020. Version 2.1 has been edited in preparation for release. There is no substantive change to content between versions 2.0 and 2.1.

Executive Summary

The occurrence of a positive COVID-19 test in a rural or remote Aboriginal community will result in a co-ordinated SA Health, SA Police and SA Ambulance Service response.

SA Health will deploy a Health Rapid Response Team consisting of Communicable Diseases Control Branch and State Control Centre – Health staff to coordinate management on the ground. SA Police will provide security to the team and community, and restrict the moment of people in and out of the affected area.

COVID-19 positive people will be moved to either the Royal Adelaide Hospital or Women's and Children's Hospital. Close contacts to positive people, identified by Communicable Disease Control Branch staff, will also be moved to Adelaide.

The Health Rapid Response Team will be reinforced by other SA Health and support personnel, which will enable the Team to provide ongoing surveillance and support to the community until at least 28 days after the last positive case. This will require significant logistic support and assistance from the Australian Defence Force may be required.

Recovered positive cases and close contacts will be returned to their community when it is safe for this to occur.

On current information, there is no intention for the Federal Biosecurity Act to be enacted in the event of an outbreak. This limits the State's ability to control movement of people back into the remote communities in the event of a COVID-19 case occurring in metropolitan Aboriginal people. In the event of a case occurring in Port Augusta, consideration of restricting movement back into remote communities needs to be strongly considered.

Community consultation of this plan is ongoing and the plan will be modified periodically in light of this consultation.

Introduction

1. This is the rural and remote Aboriginal communities plan to manage a COVID-19 positive case. It has been developed in partnership with Aboriginal Communities and SA Health. It has been developed because Aboriginal people and communities are particularly vulnerable to the adverse effects of COVID-19 due to remoteness, isolation, generally poorer housing infrastructure, overcrowding and high mobility, higher rates of chronic disease, and elevated rates of tobacco use, compared to other South Australians. In addition, some Aboriginal socio-cultural practices may place them at higher risk of transmission because these practices involve mobilisation and participation in communal cultural activities, such as traditional ceremonies and funerals. Finally, Aboriginal people living in South Australia generally have reduced access to both primary and tertiary health care services compared to the non-Aboriginal population.

Aim

2. The aim of this plan is to manage one or more COVID-19 positive cases occurring in a rural or remote Aboriginal community. The plan is based on four principles:

   a. transfer of COVID-19 positive cases to the Royal Adelaide Hospital (RAH) by the Royal Flying Doctor Service (RFDS)

   b. identification and movement of close contacts of positive cases for quarantining in Adelaide

   c. minimisation of movement into and out of the community with associated widespread community testing and ongoing daily assessment by the Health Rapid Response Team (HRRT) to identify new cases (this will require significant assistance from SA Police (SAPOL), who have actively been engaged in the development of this plan)

   d. safe return of recovered patients or quarantined contacts back to the community.

Scope

3. The plan is broken down into four stages:

   a. **Stage 1 Preliminary Actions.** This stage outlines all preparatory actions including preventative measures.

   b. **Stage 2 Initial Response Actions.** This stage outlines the State's response in first 72 hours after confirmed COVID-19 case.

   c. **Stage 3 Ongoing Response actions.** This stage describes the ongoing response and sustainment of prevention and treatment measures for the affected community, its members and across the State.

   d. **Stage 4 Cessation of response.** This stage describes the transition from COVID-19 response to routine preventative and treatment methods in affected communities.

Key considerations

COVID-19 Prevention

4. An important part of any response plan incorporates a prevention element. This element is discussed below as part of Stage 1 of the plan. Given the removal of biosecurity arrangements, there has been free movement of people between Adelaide and the remote communities. If there was community transmission of COVID-19 within Aboriginal communities in Adelaide, there would need to be

consideration as to whether travel into remote communities should be restricted. This would take a higher priority if community transmissions were to occur in Port Augusta.

Health Rapid Response Team

5. A successful response to an outbreak of COVID-19 in a remote Aboriginal community is dependent on the deployment of the HRRT. SAPOL have also developed rapid response capabilities to support SA Health in the minimisation of movement into and out of affected communities.

6. The role of the HRRT is to provide rapid on-ground assessment and management of the situation. The team is task-organised, but will generally consist of the following:

a. a Communicable Disease Control Branch (CDCB) doctor and contact tracer

b. a doctor, nurse and Aboriginal health worker, to provide clinical assessments and management of patients, contacts and community members

c. a Health Forward Commander to coordinate the functions and work of HRRT members

d. logistic and planning support personnel.

7. The HRRT will be deployed with two hours of notification of a positive case. Additional medical, nursing and laboratory support will also be deployed within the first 24 hours following a positive case, to supplement the HRRT and support the community. The HRRT will be in place for at least 28 days after the last positive case, necessitating ongoing logistical and planning support. Once on site and with support of the State Control Centre – Health (SCCH), the HRRT will implement community-specific management plans.

Four stages of the plan

8. The four stages of the plan, which are summarised above in paragraph 3, are described in detail in this section. Each stage of the plan should be read in conjunction with the relevant annexes, which contain more detail about specific elements of the planning, as well as specific support requirements.

Stage 1: Preliminary actions

9. **Preventative and preparatory measures**. Preliminary actions include preventative and preparatory measures. The former help to prevent the entry of COVID-19 into remote Aboriginal communities; and the latter ensure that SA Health and its partners are prepared to respond as quickly as possible in the event that prevention fails.

Preventative measures

10. Preventative measures include the following actions:

a. **Community involvement**. Community education has commenced and continues to occur regarding how to prevent the introduction of the virus, handwashing, physical distancing, and the requirement to present at a healthcare clinic immediately if they develop any symptoms of COVID-19. For further information about public information and community messaging during this stage, see *Annex I: Public Information and Community Messaging*.

b. **Ongoing access to healthcare**. Ongoing access to healthcare is vital for members of the community with existing medical conditions. Actions are being taken to ensure this

occurs, while minimising the potential for this to lead to the entry of COVID-19 into Aboriginal communities. Examples include the establishment of culturally appropriate entry restrictions and establishment of safe corridors.

c. **Restriction of entry into Aboriginal communities**. This is guided by the current risk of community transmission within South Australia, and involves the balancing of public health benefits against the potential for significant disruption to communities. It requires ongoing assessment to ensure this balance remains appropriate.

d. **Implementation of appropriate extraordinary entry conditions**. Extraordinary entry conditions such as 14-day quarantine requirements prior to entry can be problematic for members of the Aboriginal community. As a result, community-appropriate extraordinary entry conditions must be established, or additional support provided in circumstances where measures such as the 14-day quarantine period cannot be avoided.

e. **Establishment of safe corridors**. A safe corridor is a set of movement and entry conditions that reduce the risk of community members contracting COVID-19 when attending healthcare appointments. Safe corridor guidelines include guidance on travel, accommodation and healthcare appointments.

11. The last three preventative measures described in paragraph 10 are discussed in more detail in *Annex E: Return to Community*.

Preparatory measures

12. Preparatory measures include the following actions:

a. **Conduct of whole-of-Government response planning**. Agencies responsible for COVID-19 prevention and response are conducting ongoing interagency planning, to ensure that a coordinated response can be swiftly enacted in the event of a COVID-19 outbreak within an Aboriginal community. This planning includes delegation of responsibilities for components of the response and the conduct of desktop exercises to identify and rectify any coordination issues.

b. **Pre-positioning of durable COVID-19 response stores**. Any stores that could assist in a COVID-19 response, but which will not degrade due to local environmental conditions or other factors, are to be pre-positioned in an appropriate staging area. This will relieve some of the burden on logistics and air movements assets in the case of an outbreak.

c. **Preparation of supporting locations**. The Aboriginal Community Controlled Health Service (ACCHS) is to identify possible quarantine locations within Aboriginal communities. SCCH is to identify any other areas that may be required, for example cooking facilities and rear staging areas, and is to further identify the requirements enabling effective site use.

d. **Local Health Provider.** In the event a potential positive case has been identified, the local health care provider will contact CDCB notifying them of an index case. The process to effect evacuation of the patient will also be commenced, with the local health care provider contacting RFDS for the transfer of the positive case(s) to the RAH. If confirmation of a positive case can be achieved by the local health care provider, the on-call CDCB doctor must be contacted immediately on 1300 232 272.

e. **CDCB initial risk assessment.** After receiving notification of a potential case of COVID-19 within an Aboriginal community, CDCB staff gather further information from key local

health service staff and conduct a risk assessment. This assessment will lead to recommendations being made about the risk of further transmission and the scale of response required.

f. **SCCH Activity.** Notification of an index case must be communicated to the SCCH, which will in turn communicate with other relevant agencies. The Deputy State Controller Health is responsible for activation of the HRRT and notifying the Chief Public Health Officer (CPHO) and Chief Executive Officer (CEO). They are also responsible to request a reactivation of the State Emergency Committee (SEC).

g. **SAPOL Notification.** SAPOL Liaison in SCCH is responsible to notify the Police Operations Centre (POC). The POC is responsible for:

   i. notifying the Assistant Commissioner State Operations

   ii. notifying the Officer in Charge of the Local Service Area (LSA) where the infection has occurred

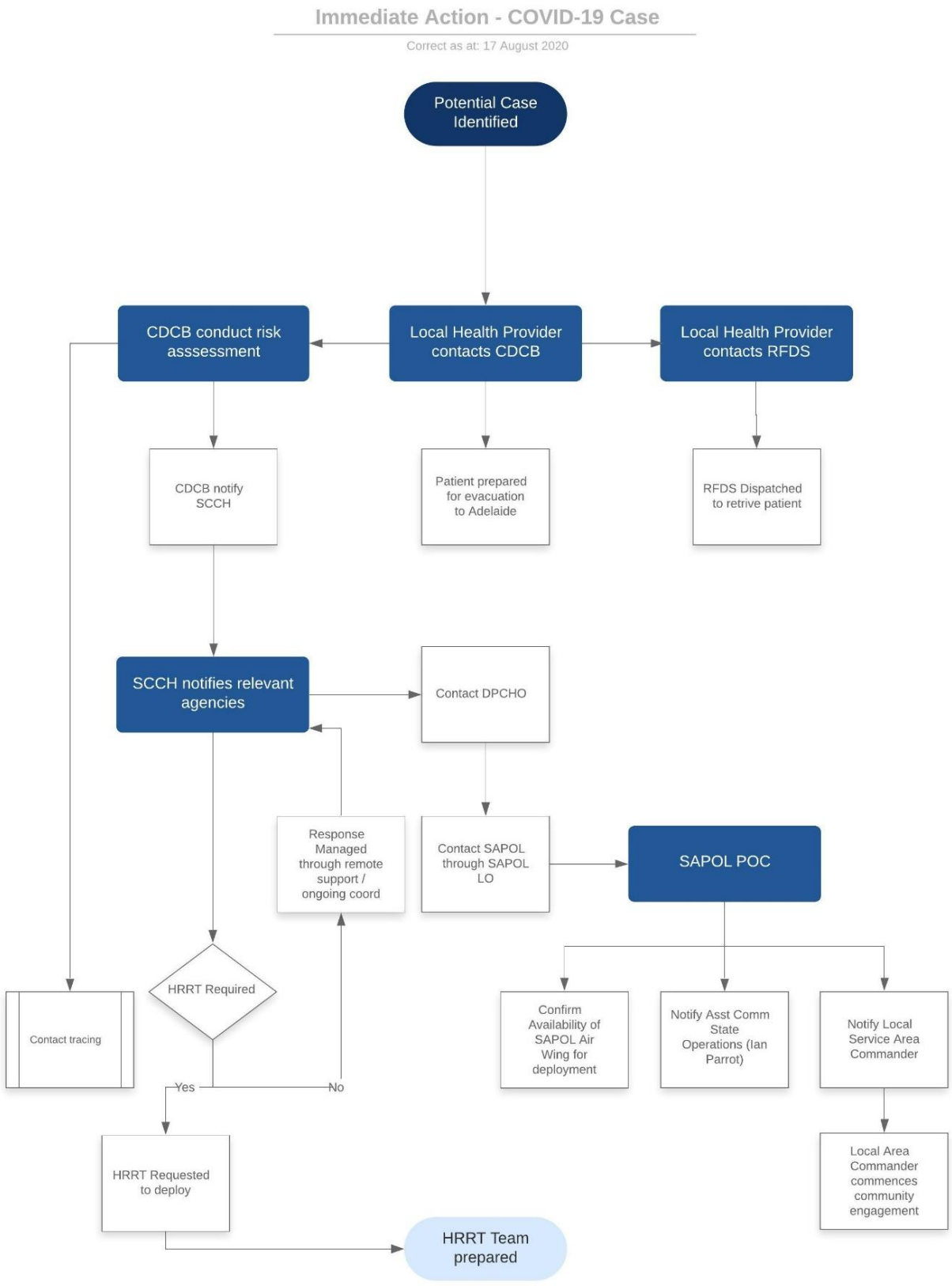
   iii. confirming the availability of the Police Air Wing to SCCH.

h. **Confirmation of air asset availability for short-notice insertion of support staff**. Air assets that can be activated on short notice, and their capacity, are to be identified. Support staff and any equipment they require that cannot be pre-positioned are also to be identified, and these staff placed on a short notice to move so that they can be inserted as quickly as possible in the case of an outbreak. Air movements are discussed in detail in *Annex B: Air Movements*.

i. **Engagement with community leaders**. The relevant SAPOL LSA Commander is responsible for informing community leaders within the affected community of the situation, and of what community actions are required to assist in an effective response. This is to be done as soon as practicable after SAPOL has been informed of the situation.

j. **Identification of HRRT members and their pre-briefing**. A HRRT consisting of seven personnel including a doctor, nurses, a team leader and supporting personnel, is to be deployed to the infected community as soon as possible in the event of an outbreak. These personnel, as well as any equipment they require that cannot be pre-positioned, are to be identified and prepared for short-notice activation and deployment.

13. The steps outlined in paragraphs 12d-12j are shown in the diagram below. These steps constitute the “immediate action” drill that is to occur in the event that a potential positive case is identified.


Immediate Action - COVID-19 Case
Correct as at: 17 August 2020
Potential Case Identified
CDCB conduct risk asssessment
Local Health Provider contacts CDCB
Local Health Provider contacts RFDS
CDCB notify SCCH
Patient prepared for evacuation to Adelaide
RFDS Dispatched to retrive patient
SCCH notifies relevant agencies
Contact DPCHO
Response Managed through remote support / ongoing coord
Contact SAPOL through SAPOL LO
SAPOL POC
HRRT Required
Contact tracing
Yes
No
Confirm Availability of SAPOL Air Wing for deployment
Notify Asst Comm State Operations (Ian Parrot)
Notify Local Service Area Commander
Local Area Commander commences community engagement
HRRT Requested to deploy
HRRT Team prepared

Stage 2: Initial response actions

14. This stage of the plan will commence if one or more positive cases of COVID-19 are diagnosed within the Aboriginal communities. It begins with the conduct of the immediate action drill (see paragraphs 12d-12j) and will last for the first 72 hours after this diagnosis has occurred. Actions during this period are especially important, as they will set the conditions for subsequent success in limiting the spread of the disease and providing effective treatment for infected persons.

Actions to occur during Stage 2

15. **Conduct of immediate action drill.** The immediate action drill, which was established during Stage 1 and which is summarised above in paragraphs 12d-12j, is to occur as soon as a potential case of COVID-19 is identified.

16. **Commencement of contact tracing and contact management by Communicable Disease Control Branch**. CDCB is to commence contact tracing as soon as possible after being informed of the existence of a proven case. This is to occur within the scope of the guidelines contained in *Annex A: Contact Tracing*, and the accompanying appendices.

17. **Deployment of Health Rapid Response Team by State Control Centre – Health**. The SCCH activates the HRRT as soon as the CDCB has informed them of the existence of the proven case of COVID-19. HRRT members are to confirm the manner by which they will move the affected community. They then commence this move as soon as possible. The first elements of the HRRT are to depart Adelaide no later than two hours after the SCCH has been informed of the situation. Due to airframe availability and capacity, the HRRT may need to be inserted in multiple lifts, and may therefore deploy progressively over the course of several hours. Once in location, the HRRT Health Forward Commander will coordinate the SA Health response in conjunction with community leaders and other Government agencies.

18. **Commencement of clinical management of affected persons by Aboriginal Community Controlled Health Service and SA Health**. Clinical management of affected persons is to commence immediately. This is to occur within the scope of the guidelines contained in *Annex B: Clinical Care of Affected Persons*, and the accompanying appendices.

19. **Closure of affected communities by South Australia Police**. SAPOL elements located in communities adjacent to the affected community are to move to the affected community as soon as possible. On arrival, they are to commence isolation of the community and to prevent community movement as much as possible. The exact manner in which these tasks are implemented will depend on the precise nature and location of the affected community, and will be determined at the time of the initial response.

20. **Implementation of quarantine and other measures by SAPOL and SA Health**. The ACCHS is to prepare quarantine facilities to accommodate confirmed cases and close contacts. These persons are to be moved to, and cared for within, these centres until they can be evacuated to Adelaide (see paragraph 21). Some communities may find communication of the need for quarantine challenging, and this may significantly influence the willingness of community members to participate. Significant support from community leaders is therefore required to implement this aspect of the plan.

21. **Transfer to Adelaide of infected personnel and their close contacts**. The RFDS will be notified of the outbreak by the SCCH. As soon as possible RFDS will commence movement of infected community members and their close contacts to Adelaide for treatment. SCCH has identified culturally appropriate locations for accommodation of close contacts while in Adelaide. More details on the transfer to Adelaide of infected personnel and their close contacts can be found in *Annex B: Clinical Care of Infected Persons* and *Annex C: Air Movements*.

22. **Identification of additional state support requirements**. Additional support requested will include many agencies and personnel, especially if entire communities require quarantine. Planners at the SCCH are to immediately establish a register of identified support requirements and are to update this register as additional requirements are identified then actioned. This is to be done in conjunction with other agencies when applicable. For example, services that may be identified as required include (but are not necessarily limited to):

a. supervision of quarantine

b. support for intercurrent health problems

c. support for other intercurrent problems (behaviour, infrastructure breakdown, etc.)

d. support for provision of food supplies

e. support for several activities of daily living

f. psychological and wellbeing support

g. support for environmental cleaning of households and clinics.

Outcome at the conclusion of this stage

23. At the conclusion of the initial response stage all relevant Government agencies and local community leaders have been informed of the situation. The HRRT has been stood up and deployed. SAPOL has moved resources into the area and commenced isolation of the affected community. Quarantine and clinical care of affected persons and their close contacts has commenced. Aeromedical evacuation of affected persons and their close contacts to Adelaide has commenced. Additional support requirements have been identified and support requested from the relevant agencies.

24. All of this has successfully occurred within the first 72 hours following the identification of one or more positive cases of COVID-19 within the Aboriginal communities. These initial actions have enabled SA Health to gain control the situation.

Stage 3: Ongoing response actions

25. Once the initial response actions have occurred and the response activities listed above have commenced, there will be a need to transition to steady-state activities that can occur over a prolonged period. This will be necessary to ensure the response can be sustained until after the COVID-19 outbreak has ended. Stage three will commence once the initial response actions conducted in stage two are completed (see above), and will end at the direction of the CPHO. This direction is likely to be given not prior to 28 days after the last diagnosis of a positive case of COVID-19 within the affected community.

Actions to occur during this stage

26. Several actions will need to occur during this stage; however, the exact nature and timing of these actions will vary depending on the circumstances of the outbreak. Factors such as the exact location of the affected community, the community's population, the extent and duration of the outbreak, and the balancing of personnel and resource requirements against the needs of other emergency response activities will need to be taken into account. The following actions will need to be applied flexibly in light of these and any other relevant factors.

a. **Ongoing COVID-19 case management**. Ongoing case management is to occur in accordance with the details provided in *Annex B: Clinical Care of Infected Persons*; and *Annex D: Access to Routine Medical Treatment and Re-entry to APY Lands*.

b. **Ongoing monitoring of the community through testing**. Monitoring of the community through testing is to occur in accordance with the details provided in *Annex B: Clinical Care of Infected Persons*.

c. **Facilitation of return to community**. Return of members to the community following successful treatment of COVID-19 in Adelaide is to occur in accordance with the details provided in *Annex E: Return to Community*.

d. **Repatriation of deceased**. Information on what is to occur in the unfortunate instance of the death of an Aboriginal community member while in the care of SA Health is in *Annex E: Return to Community*.

e. **Provision of translation and interpreter services**. Interpreters (either in person or preferably over the phone) are likely to be required by patients. Translators may be required at many stages, including: during obtaining of informed consent; during travel; at accommodation locations; during medical appointments; and during the response for matters including contract tracing, provision of clinical services or the issuing of directions. A translator should be available to a patient at any stage of their treatment and is to be organised through the relevant ACCHS. Local dialect must be considered for translation of any written material.

f. **Logistics considerations.** Several logistics considerations are required to enable the sustainment of long-term response operations. These include the resupply of pharmaceutical and medical consumables, catering, distribution of supplies and equipment, movement of people, vehicle recovery and waste management. These and other logistics considerations are detailed in *Annex F: Logistics*. Additional details on the movement of personnel by air transport are contained in *Annex C: Air Movements*.

g. **Personnel considerations**. Several personnel considerations are required to enable the continuation of response operations over a prolonged period. These include the possible need to expand the ACCHS workforce, the provision of health support to deployed staff, and the rotation of deployed personnel into and out of the affected community. These and other personnel considerations are detailed in *Annex G: Personnel*.

h. **Public information and community messaging**. Effective communication with Aboriginal communities and with leaders is critical to enabling an effective ongoing response to an outbreak of COVID-19. Considerations for public information and community messaging are detailed in *Annex I: Public Information and Community Messaging*.

i. **Capture of lessons learned**. Lessons learned are a review of actions taken to respond to a public health event or following a project or a public health intervention as a means of identifying and documenting best practices demonstrated and challenges encountered during the response to the event or the implementation of the project. An after-action review process that will enable the capture of lessons learned is contained in *Annex H: Capture of Lessons Learned*.

Outcome at the conclusion of this stage

27. All actions taken during this stage must bear in mind the ultimate goal of stopping the spread of the virus, while realising that this may take time and accordingly ensuring the long-term sustainability of operations. This stage of response plan will end on the direction of the CPHO and is likely to occur not before 28 days after the last positive diagnosis of COVID-19 occurs within the affected community.

Stage 4: Cessation of response actions

28. Cessation of response actions will commence when a determination is made by the CPHO that the Aboriginal community is no longer affected by COVID-19. This is likely to occur not before 28 days after the last diagnosis of a positive case within the community. Cessation of response actions may include:

a. the orderly conclusion of response activities

b. the refurbishment of locations that were used in support of response activities, and the hand back of these facilities to their usual occupants

c. the return of deployed personnel to their home locations

d. the return of unused medical and other stores to appropriate storage locations

e. the appropriate disposal of waste related to response activities

f. the resumption of 'business as usual' within the affected community. Note that if the COVID-19 state of emergency is still ongoing elsewhere, this may involve recommencing the actions described above in *Stage 1: Preliminary Actions*.

29. Because there will be a long lead-time before cessation of response actions, detailed planning of these actions will occur concurrently to the implementation of *Stage 3: Ongoing Response Actions*. SCCH is responsible for leading this planning activity. A whole-of-Government approach will be required to successfully cease response activities, so all other relevant Government agencies will be expected to contribute to the planning and implementation of this stage as appropriate.

Summary of supporting elements

30. This plan contains ten annexes, which provide further details about several of the actions and considerations summarised above. Most annexes are supported by one or more related appendices. All must be read in conjunction with each another, and are to be actioned as part of the implementation of each stage of the plan.

31. The ten annexes are:

a. Annex A: Contact Tracing

b. Annex B: Clinical Care of Infected Persons

c. Annex C: Air Movements

d. Annex D: Access to Routine Medical Treatment and Re-entry to APY Lands

e. Annex E: Return to Community

f. Annex F: Logistics

g. Annex G: Personnel

h. Annex H: Capture of Lessons Learned

i. Annex I: Public Information and Community Messaging.

Glossary and acronyms

Aboriginal	For the purpose of this document, the term Aboriginal is used to refer to Aboriginal and Torres Strait Islander people. This is not intended to exclude Torres Strait Islander people or people that identify as being of both Aboriginal and Torres Strait Islander descent.
Aboriginal communities	For the purpose of this document, Aboriginal communities refer to regional and remote Aboriginal communities
ACCHS	Aboriginal Community Controlled Health Service
ADF	Australian Defence Force
AHCSA	Aboriginal Health Council of South Australia
APY	Anangu Pitjantjatjara Yankunytjatjara
Biosecurity	Agreed upon state, federal, and community measures to prevent and control the entry, emergence, establishment or spread of COVID-19 in the APY lands and other remote Aboriginal communities. Measures include the restriction of travel into these communities.
CDCB	The Communicable Disease Control Branch (CDCB) is part of the Public Health and Clinical Systems Division in SA Health and aims to reduce the incidences of communicable and infectious diseases in South Australia.
Close contact	Face-to-face contact with a confirmed or probable case, greater than 15 minutes cumulative over the course of a week, from 48 hours before onset of symptoms in the confirmed or probable case, ***or*** sharing closed space with a confirmed or probable case for a prolonged period (e.g. more than 2 hours) from 48 hours before onset of symptoms in the confirmed or probable case. Refer to CDNA guidelines for further information.
Contact	Contacts who do not meet the close contact definition but may have had some exposure to the infectious case.
Control agency	As outlined in the South Australian *Emergency Management Act, 2004* SA Health is the hazard leader for human disease and control agency for human epidemics, food and waterborne diseases.
COVID-19	COVID-19 is a highly infectious respiratory disease caused by a new coronavirus. The disease was discovered in China in December 2019 and has since spread around the world.
DASSA	Drug and Alcohol Service of South Australia

DBA	Designated Biosecurity Area. Those regional and remote areas/ communities/ homelands in South Australia declared designated areas under the Commonwealth *Biosecurity Act, 2015*.
Duty nurse	The person responsible for basic healthcare oversight at accommodation e.g. Kanggawodli. May be required to assess for COVID-19 signs and symptoms upon check out of accommodation and return to community.
HBO	Human Biosecurity Officer. An HBO can exercise various powers under the Biosecurity Act, including the making of human biosecurity control orders.
HRRT	Health Rapid Response Team. In accordance with the SA Health Rapid Response Plan, the team is responsible for undertaking an initial assessment of a suspected or confirmed COVID-19 case with a view to inform the medical response should further resource support be required.
Isolation (also known as self-isolation)	When a person has been diagnosed with COVID-19 or is suspected of having it (and does not need to be in hospital), including while awaiting test results they must stay in self-isolation.
Infectious	Capable of spreading disease; or a disease that is capable of spreading (also known as communicable).
LHN	Local Health Network
Pandemic	Disease epidemic on a global scale.
PPE	Personal protective equipment that is worn by an individual to protect them or others from infection.
Quarantine (also known as self-quarantine)	When a person is not sick but is required to stay away from others due to a risk of exposure from COVID-19, such as interstate or overseas travel.
RAH	Royal Adelaide Hospital
RDM	Relevant Decision Maker for a Designated Biosecurity Area
Recovery	The coordinated process during and after a pandemic of assisting affected communities and businesses in the restoration of emotional, social, economic and physical well-being, achieved through the provision of information, specialist services and resources.
RFDS	Royal Flying Doctor Service

Physical distancing (also known as social distancing)	Measures used to reduce the physical and social interaction of people to slow the spread of the virus in the community (e.g. modification of workplace practices, closure of schools and childcare centres, cinemas and nightclubs, cancellation of sporting events, etc.).
SAAS	SA Ambulance Service
Safe Corridor	A set of conditions necessary to reduce the likelihood of infection, maintain biosecurity guidelines (if applicable), and circumvent the requirement for 14 days of quarantine, whilst community members access medical treatment outside their community.
Sentinel testing	Community testing to detect underlying disease in non-symptomatic patients.
SCC-Health	The SCC-Health (SA) has been established by SA Health to help in its coordination as control agency for COVID-19. The team is primarily SA Heath staff supported by staff from emergency services, health professionals, private sector, local and federal government. Formerly termed the Emergency Management Team (EMT).
Triaging	The sorting and allocation of treatment to patients (on arrival at a hospital emergency department, or GP surgery), according to a system of priorities to determine their urgency status for receiving clinical care.

Distribution list

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Annexes

Annex A: Contract Tracing

1. Once a community member tests positive for COVID-19 it is important that close contacts are traced because they are at risk of infection and become a potential source of transmission. Close contacts are those who have had shared close proximity and/or closed space with the positive case (see glossary and acronyms for a full definition). Once identified, close contacts will be required to quarantine within their community prior to being transferred to Adelaide (see *Transfers to Adelaide* below). Close contacts should be tested for COVID-19 as soon as practicable (see *Testing for COVID-19* below).

2. Contact tracing should commence immediately after a suspected first case by local staff who will be supported by SA Health upon arrival of the HRRT. The CDCB can also provide remote support via SCC-Health and additional staff, if required.

Contact tracing

Initial interview

3. Staff at ACCHS will be best placed to perform the initial patient interview since AHW:

4. have established relationships and rapport with the Aboriginal community and should be able to facilitate rapid and comprehensive information gathering

5. are best placed to identify and manage potential challenges to the interview process such as language barriers or cultural factors. Interpreters and support persons should be utilised as required to facilitate the interview

6. can conduct the interview promptly, and this will aid in the identification of contacts as the patient may not be available to interview when the HRRT arrives as it is likely they will be evacuation as a priority.

7. CDCB staff will be available to support AHW to perform the initial case interview by phone or video link. The interview process should align with standard CDCB procedures and a copy of the initial interview guide is available from CDCB. Training in the use of the guide is provided by CDCB upon request, prior to a community's first case.

8. The interview is intended to identify epidemiological and clinical risks, such as the following:

9. The infectious period (from the date and time of symptom onset)

10. The potential source of infection. The person may have been infected up to 14 days before onset of symptoms, so all contacts up to 14 days before onset should be identified. This will be most relevant if the person has had no recent travel history.

11. Close contacts of the person during their infectious period who may have been infected

12. The person's home situation, available supports, and capacity to isolate, should isolation within the community be required

13. Comorbidities that may place the person at higher risk of serious disease.

14. CDCB staff may also contact the patient for a follow-up interview for additional information, facilitated by AHW/community members. If the person is severely unwell, it may not be appropriate to conduct an interview with them; relatives and/or household members should be interviewed instead.

15. ACCHS staffing arrangements should consider the potential need for concurrent clinical and public health management (i.e. initial interview process) when a COVID-19 case is identified.

Close contacts

16. Close contacts are people who have been in contact with the patient during their infectious period, and who therefore may have been infected by the patient AND have the following:

17. Had face to face contact (in any setting) with the patient for a total of more than 15 minutes over the course of a week

18. Shared a closed space (e.g. office, classroom, clinic waiting room, communal room in a residential care facility) with the patient for a prolonged period (more than 2 hours)

19. Lived in the same household or household-like setting (e.g. hostel or boarding school) as the patient (termed 'household contact')

20. In addition, a close contact may also be someone that:

21. Had direct contact with body fluids or laboratory specimens of a patient (without recommended PPE or with failure of PPE)

22. Is defined by the Communicable Disease Network of Australia in other special scenarios (e.g. aircraft passengers or crew).

23. If this level of detail related to the contact history is unavailable, a risk-averse approach is to be taken. The social structure of Aboriginal communities includes extended family, kinship and other networks, often with high levels of social mixing. These dense contact networks pose an increased risk of transmission of COVID-19. Rapid decisions will need to be made as to who should be included in contact networks. Options are as follows:

24. Individuals who have made contact with the patient

25. Households who live with the patient

26. Extended contacts, defined as people living in other households that are often visited by the patient, and households where people often visit the patient's primary household

27. Entire communities, where there is a high level of social mixing and density of social networks

28. Networks of communities, where there is a high level of social mixing and density of social networks between communities.

Source contacts

29. Source contacts are those from whom the patient may have acquired infection. They are people who have been in contact with a patient in the 14 days before onset of symptoms, AND have had the following:

30. Face to face contact (in any setting) with the case for a total of more than 15 minutes over the course of a week

31. Sharing a closed space (e.g. office, classroom, clinic waiting room, communal room in a residential care facility) with the case for a prolonged period (more than 2 hours).

32. Prompt identification of potential source contacts is essential as they may be unaware of their COVID-19 infection and have the potential to transmit the virus further. If the patient has not travelled outside the community, it is likely that the source of infection is another person within the community, and therefore multiple other patients may already exist.

Additional considerations

33. Persons who live in the household or have regular contact with the case may be defined as *both* close contacts and potential source contacts.

34. All contacts should be clearly documented (including their contact details) to facilitate communication and management, and a template to record contacts is found at Appendix A1. Existing community records or other databases may be useful in constructing lists of people to be contacted.

35. Health workers and other people in contact with persons with COVID-19, who have taken recommended infection control precautions, including appropriate use of PPE, are not considered close contacts. Key health service staff and community members who are critical to supporting the outbreak response, and who are identified as an extended or community contact, should have an individual risk assessment undertaken. The risk of exposure will need to be balanced with the risk of not having critical community supports available to assist the response.

Interview findings and final risk assessment

36. The findings of the interviews (including identified close contacts and source contacts) will be discussed with CDCB. The discussion should include a risk assessment that considers the following:

37. Possible or likely source of infection, and how any continuing risk of transmission might be controlled

38. The management of close and extended contacts

39. Additional actions required such as:

a. Restrict all movement in and out of community (except outbreak response team and clinical surge workforce)

b. Confining people to their designated household

c. Mobile delivery of health services to care for people during the 14-day period

d. Reducing the number of susceptible people by offering relocation to safe quarantine accommodation for those who are more likely to contract the virus (epidemiological risk) or those who are more likely to have an adverse outcome (clinical risk), such as vulnerable, elderly, or sick people, to either a location within or outside the community. The duration of removal will be determined by the risk assessment.

Contact management

40. Management of contacts should be as per the above risk assessment. Contacts will be defined as priority if they are determined to be at greater clinical risk, or pose greater epidemiological risk, and should be identified.

41. Support from ACCHS and other community members will be essential to identify and communicate with source and close contacts. Consideration should be given to requesting assistance to facilitate contact management, such as from police or community staff.

Close contacts

42. Identified close contacts will be contacted, quarantined for 14 days from last contact with infectious person, screened daily for signs and symptoms of COVID-19, and tested at day zero and day 12. This should be done as soon as possible.

Source contacts

43. Identified source contacts will be assessed for signs and symptoms of COVID-19, tested if indicated via the risk assessment, and evaluated for any continuing risk of infection to other people.

Record keeping and data management

44. The interview findings should be clearly documented and stored securely. A copy of the interview record should be forwarded to CDCB. A database should be maintained with the details of the interview to assist in contact management.

Appendices

45. This annex is accompanied by the following appendices:

a. Appendix A1: Record of Contact Tracing.

Appendix A1: Record of Contact Tracing

Name	DOB	Sex	Phone	Address	Contact type (household or community)	Date/time of last exposure	Able to isolate?	Any known risk factors e.g. chronic disease, highly mobile	Occupation (especially if working in high risk setting e.g. aged care)

Annex B: Clinical Care of Infected Persons

COVID-19 case management

1. COVID-19 is transmitted person to person through close contact with an infectious person (including in the 24 hours before they had symptoms), contact with droplets from an infected person's sneeze or cough, or by touching objects or surfaces (like doorknobs or tables) that have droplets from an infected person, and then touching your mouth or face. At present, everyone is susceptible. Control of transmission is by interrupting and tracing these contacts until the infectious period has expired.

2. When the first case is diagnosed in a community, it is likely there will be multiple undiagnosed cases, which presents significant risk to the Aboriginal community. The occurrence of COVID-19 in a community is likely to cause significant distress; however, it is important that a calm, firm, and measured approach to containing and controlling it is adopted, with the aim of eliminating the virus. Cases may also present in neighbouring communities. This section outlines four key principles that will guide what should be done when learning of a positive case, as follows:

a. Provision of clinical response and state support (such as quarantine and deployment of the Health Rapid Response Team (HRRT))

b. Transfers to Adelaide for positive cases and their close contacts

c. Community action

d. Monitoring the community through testing.

3. An overarching principle is that enacting the above demands extensive communication with communities to promote understanding, cooperation, and their safety.

Clinical response and state support

4. To best support communities, Aboriginal community leaders and clinicians must work closely with SA Health and other stakeholders to ensure effective management of COVID-19.

Clinical response

5. Reducing early onward transmission of the virus and ensuring those impacted are provided with appropriate and culturally sensitive care should be the focus of care. First case presentation will likely present with a respiratory illness, and COVID-19 will be included in the differential diagnosis. Classification of cases is as follows:

6. Suspect: clinically compatible illness AND epidemiological links, or

7. Confirmed: positive SARS-Co-V-2 test, by rapid or conventional testing.

8. A suspected or confirmed case is the trigger to activate Local Health Service plans for quarantining of patients prior to evacuation to Adelaide.

Communication with CDCB

9. Upon a proven case of COVID-19 the on-call Communicable Disease Control Branch (CDCB) doctor must be contacted immediately on 1300 232 272 by the Aboriginal Health Worker (AHW). If the case is proven after-hours, the caller may be presented with a CDCB answering service. If this occurs, the caller must convey the urgent need to talk to the CDCB doctor. Early contact with the CDCB is also desirable to communicate details of patients highly suspected of having the virus.

Initial Risk Assessment

10. After receiving notification of a potential case of COVID-19 within an Aboriginal community, CDCB staff will gather further information from key local health service staff to conduct a risk assessment. The assessment should consider the potential for spread, and determine the type and scale of the response required. The specific information sought should include the likely source of infection, travel history, symptom onset and severity of illness, an initial estimate of contacts, size of susceptible population, and the density of social networks to enable decisions to be made.

Obtaining this information will give an indication of the likelihood of undetected community transmission. The *Close contacts* section below gives guidance on this process.

11. The CDCB lead will immediately notify the State Control Centre-Health, and an urgent Response Coordination Team meeting will be convened. This team will make decisions and recommendations on the risk of further transmission and scale of the response required, including the need for the deployment of the HRRT.

Clinical management

12. AHW should implement infection control when providing healthcare to patients, in accordance with existing SA Health guidelines, including quarantine of the patient and appropriate use of PPE.

13. Clinical care guidelines for use by the ACCHS whilst the patient outcome is determined are outlined in the following appendices:

a. *Guide to management of those tested for COVID-19* is at Appendix B1

b. *Clinical guidelines to suspected cases and follow-up requirements* at Appendix B2. The location of the patient's management should be based on clinical need and their ability to maintain effective isolation for the entire infectious period

c. *Clinical groups, processes, and procedures for the management and care in communities with a known COVID-19 case* is at Appendix B3.

14. There will be a low threshold for evacuation to protect the community from any further transmission. While awaiting transport positive cases and ideally close contacts should be quarantined. Communities must identify areas where cases can be managed prior to evacuation.

15. In addition to the guidance provided in the above appendices, AHW or Aboriginal Health Practitioners (AHP) should in association with the HRRT

a. Closely monitor remaining community. This should continue for up to 28 days after the last known positive case is transferred to Adelaide

b. Mobilise 'healthcare in the home' initiatives where available, with special considerations afforded to the most vulnerable members, such as the elderly and those with chronic health conditions

c. Deep clean all surfaces of homes, clinics, community buildings, and vehicles that have contained positive cases or their contacts. Guidelines to *Cleaning homes and health facilities* are at Appendix F3.

Quarantine

16. ACCHS will need to prepare quarantine facilities to accommodate confirmed cases, suspected cases, and close contacts. Until test results confirm otherwise, suspected cases will be managed as if they have tested positive.

17. Facilities for groups of confirmed cases, suspected cases, and close contacts should be completely separate from each other. The facilities must have the capacity to care for patients for several hours to several days, depending on the swab logistic and transfer requirements. Preparations should allow for accommodation, food, hygiene and healthcare needs.

18. Some communities may find communication of the need to quarantine to community members challenging, and this may significantly influence their willingness to participate. Therefore, significant assistance from community leaders to support quarantine will be necessary. SAPOL may be required to enforce quarantine if the safety of the community is compromised.

Deployment of the HRRT

19. The SA Health HRRT augments local healthcare provided by ACCHS upon a confirmed case of COVID-19. It will provide leadership (by a Health Forward Commander), security, health (including a CDCB Public Health lead), logistic, contact tracing and pathology support. This team will be adjusted in size according to community need and is likely to remain in place for at least four weeks. The HRRT will rely heavily on key community and local health service

staff to coordinate the public health response. Logistics and personnel support from the Australian Defence Force (ADF) may be requested by SA Health, if required.

20. Once the HRRT is in location, the Health Forward Commander will coordinate the local response in conjunction with Community Leader, ACCHS and SCC-Health. Details regarding the roles and responsibilities of the HRRT are outlined in the *SA Health COVID-19 Rapid Response Plan* (including the HRRT capability).

Community action

21. The underlying principle is to prevent COVID-19 entering and becoming established in Aboriginal communities. Significant community education has occurred and continues to occur in communities on how to prevent the introduction of the disease; eg "staying still" and handwashing (see the communication section further on in this plan). Like the general population, the only way to control this disease is for the whole community to follow public health advice. They need to be aware that considerable assistance from outside of the community will arrive to help them.

22. Members of the community have an important role in limiting the spread of COVID-19, therefore it is important they are empowered to take the necessary actions to help keep their community safe (see Annex I: Public information and community messaging). To empower communities, it is important that actions are negotiated and agreed upon through strong communication and education rather than simply 'applied' through the authorities. This is because an authoritarian approach may be experienced as disempowering and thereby deter people from engaging in the life saving actions. If a COVID-19 case is identified, the lifesaving actions community members can take are as follows:

a. Stay in their homes until tracing and testing can be conducted (this may take a number of days)

b. To facilitate contact tracing, community members should not leave the community

c. Not enter the community (unless approved as an essential worker)

d. Notify health care providers of any symptoms of COVID-19

e. Where culturally appropriate, Continue physical distancing, handwashing and other hygiene practices.

f. If communities are unable to enact these measures, request additional support and resources from SCC-Health.

Monitoring the community through testing

23. Monitoring the community through testing is a critical step toward effectively managing COVID-19. Since intense transmission could be expected, screening the whole community is likely to be appropriate, as directed by CDCB. Screening could include clinical assessment, rapid testing or conventional testing with the objective to quickly and sensitively locate all undiscovered cases. Assessments will need to be repeated as new cases are found. The testing regime for each community will be determined by their level of risk and clinical needs.

24. Whole of community tests will demand additional logistic support such as increased transport frequency. This support will demand careful coordination between SA Pathology, SA Health, and communities, details of which are in the section *logistics, personnel support and lessons learned.*

Tests

25. There are two types of tests available, as detailed following.

a. **Swab tests**. Swabs are taken and transferred to Adelaide pathology labs for PCR testing. Results are usually available 16-24 hours after arrival in the laboratory. Swabs should be prioritised as *urgent* when COVID-19 is suspected.

b. **Point of Care (POC) tests**. POC testing is more rapid than swab testing with results available within 60 minutes. However, only four samples can be analysed at any time, which makes it unsuitable for routine testing. POC machines have been installed in rural SA pathology labs and a number of Aboriginal health facilities.

When to perform a test

26. Tests may be performed individually on a case-to-case basis, or as a part of a broader community initiative. A decision to test someone for COVID-19 will be based on several factors: clinical presentation, potential community contact, resource levels, and evolving Community Health and SA Health guidelines.

Record keeping and data management

27. Those conducting the tests, regardless of their type, will be required to maintain a database of invitees, screened people, and results.

Further testing advice

28. If communities have any questions, please call SA Pathology enquiries on (08) 8222 3000 or CDCB on 1300 232 272.

Appendices

29. This annex is accompanied by the following appendices:

a. Appendix B1: Guide to management of those tested for COVID-19

b. Appendix B2: Clinical groups, processes, and procedures for the management and care in communities with a known COVID-19 case.

c. Appendix B3: Clinical Guidelines to suspected cases and follow-up requirements.

Appendix B1: Guide to management of those tested for COVID-19

Low risk

Where there is low or no evidence of COVID-19 in a community or region, the risk of an individual presenting with a respiratory illness having COVID-19 is low. While testing in this situation will result in a low case yield the aim is to detect community transmission as early as possible (sentinel or enhanced testing).

In general, those tested with a **low pre-test probability** of COVID-19 are also considered to be a lower risk to others and can be managed in the community by physical distancing at home while awaiting their test results. The exception to this is if a person presents with severe lower respiratory tract infection in whom evacuation would be required on clinical grounds.

High risk

People who present with epidemiological criteria (I.e close contact) and/or as clinical criteria should be considered higher risk for COVID-19. Assessing the strength of the epidemiological criteria should be made in conjunction with a Medical Consultant from SA Health Communicable Disease Control Branch (via SCC-Health Operations).

If the epidemiological risk is high and point of care (POC) testing is not available, the suspected case should be securely isolated and contact tracing undertaken prior to receiving the test result (see initial decision-making process under public health response section).

Whether to isolate the case and contacts in the community or evacuate outside of the community via an appropriate transport service will depend on a range of factors including availability of an appropriate facility locally and supports and the time taken to receive a test result (further detail provided under case management).

Appendix B2: Clinical groups, processes, and procedures for the management and care in communities with a known COVID-19 case

Clinical considerations

Clinics should have as part of their local clinic COVID-19 pandemic preparedness plans:

Clear triage protocols to identify patients who present with respiratory symptoms including clear process for identifying epidemiological links

Dedicated clinic and waiting areas for potentially infectious clients

Adequate supplies (4 weeks) of the full suite of PPE and pathology specimen collection supplies (swabs) and staff trained in the correct use of this equipment (if respiratory swabs are not taken onsite an accessible local testing clinic must be available with clear protocols for following up clients while awaiting results)

Clear infection control guidelines and training in their use to minimise risk of exposure to health service staff.

A team of health workers and community carers dedicated to treating COVID-19 patients only (as to avoid potential contamination/cross infection with non-COVID-19 patients).

Table. Summary requirements clinical management

Item	Detail	Responsibility
Suspected case testing	Triage, respiratory area, clear testing guidelines, staff trained	Local health service, ACCHS, SA Health
Supplies	Swabs, RAPID PCR (SUCH AS GENE XPERT) cartridges, oxygen	SA Health, Kirby Institute
PPE	Direct ordering SA Health stockpile	SCC-Health
Swab transport to lab	Air services to supplement existing	SCC-Health
Local Isolation facility	For suspected cases pending results or confirmed cases unable to be evacuated	SCC-Health
Patient transport	Air retrieval for suspected cases	RFDS, MedSTAR
Workforce support	Additional staff to undertake testing	SCC-Health

Response procedure

Consideration of a response should be based on notification of a suspect case. Information on suspect cases should be phoned immediately to CDCB. An immediate consultation by teleconference to consider the potential for spread and the type and scale of the response should be held between the CDCB lead, and support staff, SCC-Health, and the Health service.

The consultation should consider the potential for spread and the type and scale of the response.

Confirmation of the diagnosis

The diagnosis should be confirmed by the most rapid available means. Specimens should be taken and sent for immediate testing. If local testing is available, this should be used to confirm the diagnosis. This is the responsibility of the health service. If a suspect case has epidemiological links or other reasons to increase the pre-test probability of being a case, he or she should be managed as a confirmed case until confirmation is available.

SCC-Health Operations can arrange clinical support to all health workers (via phone or telehealth).

Appendix B3: Clinical Guidelines to suspected cases and follow-up requirements

Suspected case criteria	Pre-test probability of COVID-19	Action while awaiting test result – if no POC testing
Clinical criteria **Fever (≥38°C) or history of fever (e.g. night sweats, chills) OR acute respiratory infection (e.g. cough, shortness of breath, sore throat)** **AND** **Epidemiological criteria (see SONG)** **In the 14 days prior to illness onset:** **• Close contact with a confirmed or probable case of COVID 19** **• International or interstate travel or travel outside designated area for remote** **• People who live in or have travelled through a geographically localised area with elevated risk of community transmission** **• In remote, close contact with an individual exempted from the 14-day quarantine requirement under the *Biosecurity Act*** **• Health worker** **OR** **Severe Lower respiratory tract infection**	High	**Discuss with CDCB via SCC-Health Operations** to assist decision making regarding most suitable location for patient isolation: • In community • Evacuate to alternate location if no local facility available Health workers may be more able to self-isolate in the community. Testing should also be prioritised to reduce the need for quarantine **Discuss with usual clinical support arrangements** Decision to evacuate to hospital based on clinical grounds
Clinical criteria alone **Fever (≥38°C) or history of fever (e.g. night sweats, chills) OR acute respiratory infection (e.g. cough, shortness of breath, sore throat)**	Low	Should stay at home until their symptoms have resolved

Annex C: Air Movements

Transfers to Adelaide

1. After initial quarantine within the community, the ACCHS will transfer positive cases to Adelaide. Adults that have tested positive for COVID-19 will be transferred to the Royal Adelaide Hospital, and those under 18 years will be transferred to the Women's and Children's Hospital. Close contacts will be transferred to a facility(ies) arranged by SCC-Health, which will also include comprehensive health monitoring and care. The movement of close contacts will be co-ordinated by the SCC-H.

Appendices

3. This annex is accompanied by the following appendices:

a. Appendix C1: Aeromedical evacuations for COVID-19 positive community members

b. Appendix C2: Utilised airfields

c. Appendix C3: Manifest template for routine travel

d. Appendix C4: Welcome to Kanggawodli brief.

Appendix C1: Aeromedical evacuations for COVID-19 positive community members

Depending on the clinical situation of the patient, they may be transferred by RFDS alone or with a MedStar retrieval team. The SCC-Heath will assist in the co-ordination of this evacuation.

Mild illness:

Transportation to airstrip

Options (Ambulance or Local vehicle equipped with plastic shielding between driver/back passenger area to prevent cross infection)

Both parties wearing appropriate PPE (Transport staff wearing mask/gloves/gown and patient wearing surgical mask/N95 mask)

Receiving team at airstrip prepared (All wearing appropriate PPE including face shield/mask/gloves/gown)

Minimise time waiting at airstrip.

Transportation to metropolitan tertiary health centre

RFDS or MedStar retrieval team

Clear communication link between departure and receiving teams to allow coordination of patient transfer

Medical equipment: Bag and mask available for manual ventilation if required

Adequate O2 supply

Severe illness:

Transportation to airstrip

Ambulance

Both parties wearing appropriate PPE (Transport staff wearing mask/gloves/gown and patient wearing surgical mask/N95 mask)

Receiving team at airstrip prepared

All wearing appropriate PPE including mask/gloves/gown

Minimise time waiting at airstrip

Transportation to metropolitan tertiary health centre

RFDS or MedStar retrieval team

Communication

Clear communication link between departure and receiving teams to allow coordination of patient transfer

PPE – hazmat, P2/N95 mask, gloves, gown, face shield

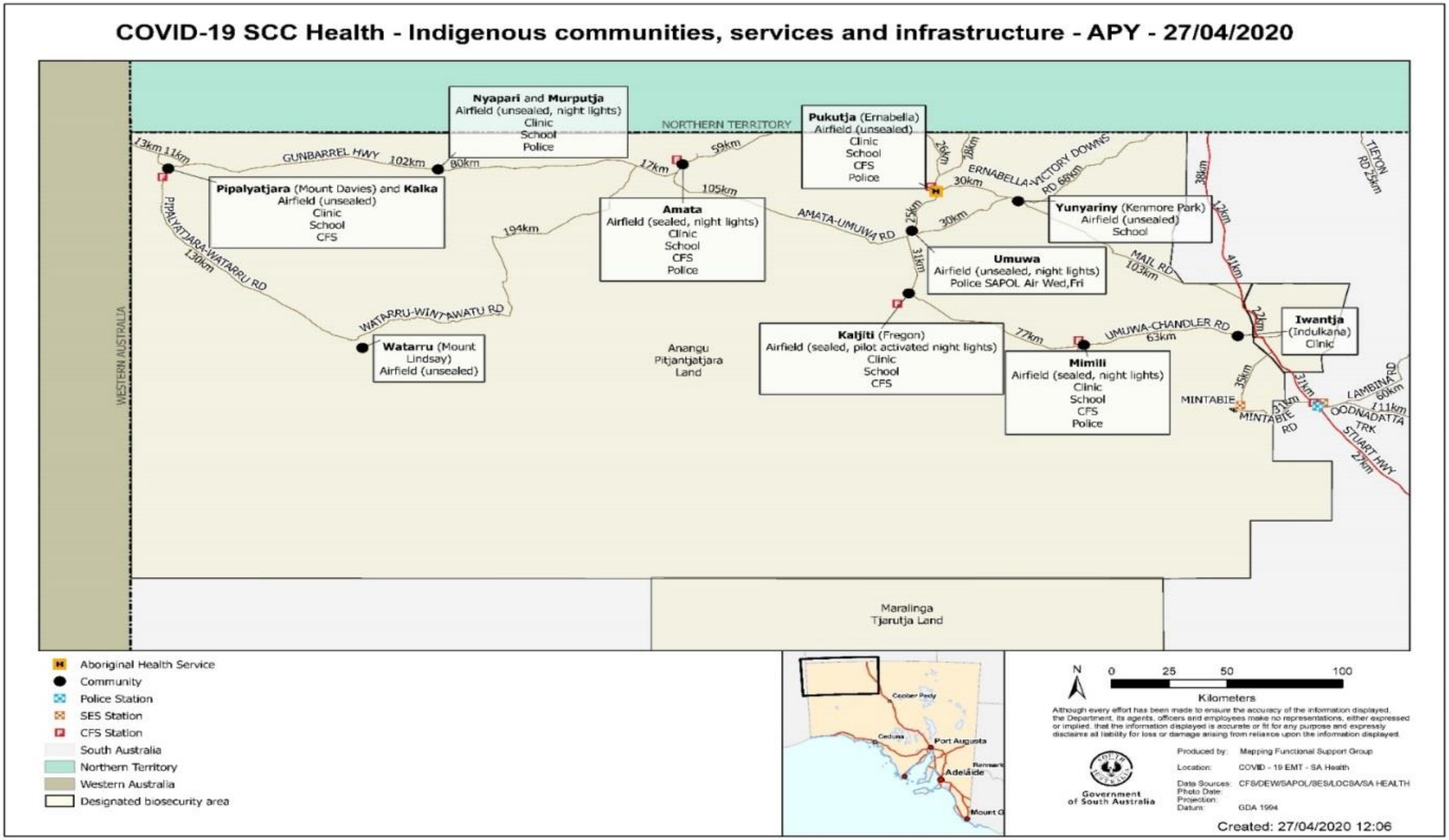
Medical equipment (Bag and mask for manual ventilation if required)

Adequate O2 supply

Emergency airway equipment e.g. emergency intubation kit

Staff

Trained staff with advanced airway management skills if available e.g. intubation.


COVID-19 SCC Health - Indigenous communities, services and infrastructure - APY - 27/04/2020
NORTHERN TERRITORY
WESTERN AUSTRALIA
Nyapari and Murputja
Airfield (unsealed, night lights)
Clinic
School
Police
Pukutja (Ernabella)
Airfield (unsealed)
Clinic
School
CFS
Police
Pipalyatjara (Mount Davies) and Kalka
Airfield (unsealed)
Clinic
School
CFS
Amata
Airfield (sealed, night lights)
Clinic
School
CFS
Police
Umuwa
Airfield (unsealed, night lights)
Police SAPOL Air Wed,Fri
Yunyariny (Kenmore Park)
Airfield (unsealed)
School
Watarru (Mount Lindsay)
Airfield (unsealed)
Kaljiti (Fregon)
Airfield (sealed, pilot activated night lights)
Clinic
School
CFS
Mimili
Airfield (sealed, night lights)
Clinic
School
CFS
Police
Iwantja
(Indulkana)
Clinic
Anangu Pitjantjatjara Land
Maralinga Tjarutja Land
GUNBARREL HWY
PIPALYATJARA-WATARRU RD
WATARRU-WINTAWATU RD
AMATA-UMUWA RD
ERNABELLA-VICTORY DOWNS RD
MAIL RD
UMUWA-CHANDLER RD
MINTABIE
MINTABIE RD
LAMBINA RD
OODNADATTA TRK
STUART HWY
TIEYON RD
Aboriginal Health Service
Community
Police Station
SES Station
CFS Station
South Australia
Northern Territory
Western Australia
Designated biosecurity area
Coober Pedy
Ceduna
Port Augusta
Adelaide
N
0
25
50
100
Kilometers
Although every effort has been made to ensure the accuracy of the information displayed, the Department, its agents, officers and employees make no representations, either expressed or implied, that the information displayed is accurate or fit for any purpose and expressly disclaims all liability for loss or damage arising from reliance upon the information displayed.
Government of South Australia
Produced by: Mapping Functional Support Group
Location: COVID - 19 EMT - SA Health
Data Sources: CFS/DEW/SAPOL/SES/LOCSA/SA HEALTH
Photo Date:
Projection:
Datum: GDA 1994
Created: 27/04/2020 12:06

Appendix C3: Manifest template for routine travel

TRAVEL AND APPOINTMENT MANIFEST 10/06/2020

KEY: RED items to be confirmed

The information contained in this document is confidential. If you are not the intended recipient, any use, disclosure or copying of this document is unauthorised. Please advise sender by email and then delete it from your system.

TRAVEL PLANNING						BIOGRAPHICS								APPOINTMENTS							AIR TRANSPORT				ACCOMMODATION					
From the APY Lands	**Seat No.**	**To the APY Lands**	**Seat No.**	**Family Group**	**Pod Group (if accommodated at Kanggawodli)**	**First Name**	**Last Name**	**Patient or Escort**	**Contact Number**	**DOB**	**Age**	**Sex**	**Home Location**	**Direct Admit / OPD**	**Appt Location**	**No. of appts**	**First Appt Date**	**Appt Time**	**Appt Type**	**Notes**	**Pick up / Drop Off Location**	**Passenger weight (kg)**	**Luggage weight (kg) (max 10 kg if flying)**	**Transport requirements (e.g. disability assistance)**	**SA Health Quarantine Accomm Required**	**Accommodation requirements (e.g. disabled access)**	**Dietary requirements**	**Neonatal requirements (e.g. cot, formula)**	**Medical requirements (e.g. aids, medications)**	**A in**
	1		1	A	1.1			P	TBC		8 months		Fregon	OPD		1		930	Ortho	Paeds OPD		10	10	NA	Yes	No Special Requirements	Full Diet	NA	NA	
	2		2	A	1.1			E	TBC		32 years		Fregon							(Escort for…)		65	10	NA	Yes	No Special Requirements	Full Diet	Formula and cot	NA	
	3		3	B	1.2			P	No phone		68 years		Amata	OPD		1		1200	Eye			57	10	NA	Yes	No Special Requirements	Full Diet	NA	NA	
	4		4	B																Escort										
	5		5	C																										
	6		6	D																										
	7		7	E																										

Appendix C4: Welcome to Kanggawodli brief

Note: this welcome can be adapted to other quarantine accommodation

Welcome script to be read by interpreter services as applicable, for example:

Pitjantjatjara
Yankunytjatjara
Arrernte
English

Start with introduction of staff names/roles.

This journey home has been arranged for you to help get you the medical care you need, and keep your communities healthy and safe - free of the coronavirus, and to safely return home as quickly as possible. If you haven't travelled here from your home community by a Safe Corridor you will be staying with us for 14 days.

We all want to make sure you are comfortable, safe and healthy while you are here with us.

From our team we welcome you to Kanggawodli.

Kanggawodli is on Kaurna country.

There is lots to see and do at Kanggawodli and you will be safe and be together if you follow some simple actions.

Good hygiene practices:
Wash your hands regularly
Cover your coughs and sneezes with a tissue or your elbow (demonstrate this practice)
Maintain physical distance from others
Report any cold and flu symptoms
If not sure, just ask us.

Do you know some of the signs that you have coronavirus?

fever – feeling hot then cold / sweating / shaking
cough – dry cough
sore throat
more tired than usual
short of breath
sore muscles

If you start to get any of these symptoms, please let a health worker know straight away. You can have a health check to make sure you are okay. This is important to make sure that no one else in your group gets sick.

You can have coronavirus and have no symptoms at first.

This is why you must stay at least 1.5 metres away from each other as much as you can to stop the spread (demonstrate distance).

Wash your hands for 20 seconds with soap as much as you can.

If you use a tissue to sneeze or blow your nose please put straight in a bin and wash your hands for twenty seconds with soap.

Keep surfaces clean.

It is very hard to isolate but it is very important to remote communities to keep home safe from coronavirus.

Do not mix with community members from other pods if they have not travelled here with you. If you do, it may take longer to get home. We want to get you home as quickly as we can.

We have arranged things to keep you occupied while you are here including internet, Wi-Fi, movies, arts, crafts, fire and kangaroo tail.

We will provide you with plenty of food and snacks too.

Your medications will be provided for you.

It is really important that you do not leave Kanggawodli, unless it is for a medical appointment, if you do, you will not be allowed to come back as you may pick up the virus and bring it back.

This means everyone may become sick and also stops them from returning home to the lands.

No visitors can come into the facility, only staff to help you who will wear protective equipment to keep you safe.

Luggage will be weighed before you leave. If you have any excess luggage, it will be paid for by yourself or will have to be left behind.

You will eat meals only with those people staying in your pod.

Rooms, bathrooms and toilets will be cleaned every day.

There will be separate laundry days per pod.

At the end of your stay you will travel to the Adelaide airport.

You will be transport back to your home - safe and free of the virus.

We understand that this may be difficult, and you want to get home. We want to help you to get home under the new rules that have been put in place on declared biosecurity areas, such as your community.

We are here to help, keep you safe and comfortable and if you need anything at all or you have any questions please ask.

Annex D: Access to Routine Medical Treatment and Re-entry to APY Lands

Accessing healthcare during the preliminary stage

1. This section outlines prevention strategies and the importance of community involvement when implementing them, which can include border control measures. It also documents the ways community members can access non-COVID-19 related medical care they may need outside their communities, in ways that keep them and their communities safe from the virus.

Entry into Aboriginal communities

2. One prevention strategy to reduce the risk of COVID-19 entering regional and remote Aboriginal communities is to restrict entry. The level of restriction should be guided by the current risk of community transmission within South Australia to create a balance between the public health benefits and the significant disruption to communities.

3. Entry to land that is owned by an Aboriginal authority may be subject to agreements with the South Australian and federal governments, and outlines how Aboriginal owned land is accessed and used. Landholding authorities managing Aboriginal owned land have the power to manage how non-residents can enter or move across these areas. Permits are required to enter some Aboriginal communities and applications to enter must be made in writing to the appropriate authority. Those who must apply for a permit varies between communities, and individual permits contain specific conditions. Travel restrictions are being enforced in many Aboriginal communities to protect the health of their people during the current COVID-19 pandemic.

4. Health checks are also currently required prior to entry to some Aboriginal communities via a COVID-19 Record of Health Status - Individual form at Appendix E1.

Community involvement

5. Significant community education has occurred and continues to occur in communities regarding how to prevent the introduction of the virus, for example handwashing and physical distancing (further information can be found in the section Public information and community messaging). As in the general population, the only way to control the virus in Aboriginal communities is for the whole community to participate and support each other in following public health advice.

6. A critical piece of advice is that if any member of the community develops symptoms of COVID-19, they should present to their health clinic straight away for assessment and testing to facilitate early identification. This understanding should extend beyond Aboriginal Community Controlled Health Services (ACCHS) into everyday practices of communities.

Health service preparedness

7. COVID-19 response plans should be prepared for healthcare clinics that consider the following:

a. Clear triage protocols to identify patients who present with respiratory symptoms, including clear process for identifying epidemiological links

b. Dedicated clinic and waiting areas for potentially infectious clients

c. Adequate supplies (4 weeks) of the full suite of PPE and pathology specimen collection supplies (swabs), and staff trained in the correct use of this equipment. If respiratory swabs are not taken onsite, an accessible local testing clinic must be available with clear protocols for following up clients while awaiting results

d. Clear infection control guidelines and training in their use to minimise risk of exposure to health service staff

e. Promotion of influenza vaccination to the whole population, including non-community member essential workers, and pneumococcal vaccination as per current guidelines

Business as usual

8. Accessing healthcare will be business as usual for those communities not affected by extra-ordinary entry restrictions. These healthcare appointments will operate as per usual without the requirement for additional support from

SCC-Health, the community may decide that these BAU appointments should adhere to a set of Safe Corridor Guidelines to reduce the likelihood of COVID-19 being introduced from higher risk areas.

Appendices

13. This annex is accompanied by the following appendices:

a. Appendix D1: Kanggawodli brief.

b.

Appendix D1: Kanggawodli brief

Kanggawodli Site Layout and Description

Kanggawodli has four (4) pods

Each pod has four rooms with two beds each. Total 32 beds.

Each pod has two bathrooms and toilets, with wheelchair accessibility.

Each pod has a small communal kitchenette.

Each pod has a separate fenced outdoor area.

One communal dining area and one communal laundry for all pods.

Modifications to the current site plan have been undertaken to ensure the facility can host four (4) different intakes of residents. Residents will have access to internal amenities in the pods and separate external areas with access to fire pits and approved designated smoking areas.

Signage is to be prominently displayed to ensure residents are aware of expectations around the sections listed below.

Visitors are not permitted to enter Kanggawodli Quarantine Centre.

(Medical services are permitted and required to adhere to wearing appropriate PPE when entering the isolation pods).

Referrals to Kanggawodli

Patients will be discharging from a SA Health hospital direct to Kanggawodli in the first instance. This may be extended to Aboriginal people stranded who cannot return home.

Quarantine time starts from admission to hospital to the remainder of the 14 days at Kanggawodli.

Influenza vaccination and a Health Screen assessment will be undertaken on arrival to Kanggawodli.

Admissions and Resident Site Orientation

Residents will be read a welcome script in English and via an interpreter if required. The script can be found (here) need hyperlink

Residents who leave Kanggawodli, and do not adhere to Safe Corridor guidelines will not be permitted to return to Kanggawodli and will be transferred to a hostel or SA Housing accommodation, the site supervisor will advise SA Health immediately if this occurs.

Residents will be provided an Orientation at Kanggawodli, which includes:

Amenities

Access to health care and medications

Internet safety

Provisions of personal requests (access to personal hygiene products, tobacco, etc.)

Isolation requirements (see below)

Emergency evacuation procedure

Information is provided to residents verbally and in writing (information pack) upon admission during induction to the site.

Entry and Exit Requirements

Residents will be arriving in the same pod on the same day; otherwise quarantine may be extended out further than the 14 days, if residents are entering the pod on different days. The aim is to accommodate patients together from the same geographical community group if possible, however cultural sensitivities will be acknowledged.

Residents will most likely exit on different days according to the time spent in quarantine in hospital – to a total of 14 days. For example, if a resident has spent six days in hospital, then discharged to Kanggawodli, they will only require another eight days in quarantine.

No new residents will be admitted to a pod, until an accommodation pod is completely empty and DISCHARGE CLEAN performed, to ensure the start of NEW arrival groups on the same day for the next intake.

In order to comply with Physical distancing requirements, occupancy will be limited to one person per room. However, both beds in any one room of the pod can be used if both occupants are from the same family/household.

Occupants of each pod are required to remain in their pod, their front courtyard areas and their fenced off 'back yard' areas.

Should residents need to contact staff members, they can do so by phones that are located in their rooms. There are also duress alarms in case of emergency.

Should residents choose to self-discharge from Kanggawodli before the 14 day quarantine period is finalised, they are allowed to do so, noting that they will not be able to re-enter the premises once off site.

Workforce Requirements, resident safety and wellbeing

All staff are to wear (droplet precaution PPE) within the isolation pods or in close contact with a resident.

Registered Nurses will undertake routine wellbeing and health observations twice a day and be available 24 hours a day, 7 days a week.

Should a resident become unwell, the nurse or hostel worker will contact an Extended Care Paramedic (as per our SAAS Agreement) or an ambulance as required.

A resident that develops respiratory symptoms will be isolated in a separate pod, if available or another site, if unable to accommodate in another pod – and a Viral PCR swab undertaken at this time.

Residents will have access to staff 24 hours a day, 7 days a week, including clinical observations from Registered Nurses (RN), cultural supports from Hostel Workers and 'in-reach' access to Social Worker and Social & Emotional Wellbeing Team members. All staff will wear appropriate droplet precaution PPE when in direct contact with a resident or in the isolation pod.

Residents will also have access to Primary Health Care (PHC) via remote access, such as Video Conferencing (VC) or direct access to an RN.

Escalation of Care: Should residents require further case or emergency care, Kanggawodli staff will ensure access to:

000/SAAS

GP Locum

RN to work with home treating team (i.e. Cancer or Dialysis treating teams, etc.)

Process to transport resident to an appointment external to Kanggawodli whilst maintain quarantine.

Common Area usage and processes to maintain 'Quarantine'

Meals

BREAKFAST: Hostel Workers will ensure breakfast trolleys are provided in each pod, so residents can help themselves and eat in their rooms or outside in their courtyard areas. Hostel Workers will pick up breakfast trolleys and wash dishes.

LUNCH and DINNER: will be served in the main dining area. Hostel Workers will ensure each pod has a separate time to access the main dining room. Hostel Workers will also ensure that the dining area is cleaned in between sittings.

To comply with Physical distancing, only two persons per table will be allowed.

Access to other dining room amenities will be closed and residents will need to access their bathrooms in their pod if required.

Laundry

Each pod will have a designated laundry day for residents to do their own laundry and to not co-mingle with other pods of residents. Communal laundry will be cleaned as per Infection Control advice at the end of each day of all machines, benches and surfaces.

Each resident has been provided with their own laundry basket to be used only for them. All resident linen will be sent off site to Spotless for laundering.

Hand Hygiene

The 5 moments of hand hygiene are to be complied with by all staff at all times as per Policy Directive, Hand Hygiene, Infection Prevention and Control, SA Health.

Patient ID

Staff must identify the patient at the beginning of a care episode and at each patient intervention using the 3 mandatory identifiers; 1. Medical Record Number, 2. Name and 3. Date of birth.

Because of the non-transferability of the Medical Record Number across health care services, an additional patient identifier should be used such as address or Medicare number during inter-hospital patient transfers.

See the SA Health Policy Directive, Patient Identification, Patient Identification Guideline and NALHN OWI01168 Patient Identification Procedure for further information.

Consent

All guidelines involving the provision of medical treatment to a patient must be undertaken in accordance with the Consent to Medical Treatment and Palliative Care Act 1995.

Work Health Safety

Staff following this guideline have a duty of care for taking reasonable steps to protect their own health and safety and not adversely affecting another person while at work. Further information is available from the NALHN Work Health and Safety Services intranet.

Guest brief

Each person entering accommodation must be briefed with the following details:

Safety information – verbal, translated or by handout in an appropriate language if the patient is not fluent in English

Catering arrangements

Room cleaning/linen replacement schedules

Other arrangements

Information relating to the need to quarantine (briefing notes), including actions that should be taken if the Safe Corridor is not maintained

Opportunities and benefits of restrictions

Daily clinical observations, including a COVID-19 screen upon arrival and the offer of an influenza vaccination

Welfare packages including basic health hygiene products. Consideration given to inclusion of specific requirements such as medical supplies (cost of packages the responsibility of SCC-Health)

Personal requests (personal hygiene and any other requests for consideration).

Appendix C4 is an example of a useful welcome brief and may be adapted as necessary.

Hygiene and Infection Control

Signage prominently displayed relating to expectations of cough etiquette/hand hygiene process, appropriate physical distancing, times of meal sittings and laundry day allocation.

Daily cleaning of pods will be undertaken by the Hostel Workers, using droplet precautions PPE. This includes using hospital grade disinfectant 'Clinell' wipes to decontaminate surfaces.

All benches in kitchen will be cleared and items will be stored in cupboards to assist with easier cleaning.

Library and tactile activities such as painting will be closed for use during this period.

Multiple hand-sanitiser stations are set up around the site and gel available in all pods and dining area.

Medical support services

Health and medical support to guests is the responsibility of the accommodation facility if at Kanggawodli or a suitable alternate location. When planning accommodation, the following should be considered:

DASSA services may need to be engaged. Coordinate with SCC-Health Operations

Pre-identified medications and other medical supplies will be arranged by LHN

COVID-19 screening and regular wellbeing checks at the accommodation will be provided by the onsite clinical staff throughout a patient's stay, and upon departure

Tests for COVID-19 must take place if patient becomes symptomatic of COVID-19

Non-COVID-19 related medical issues will be referred to the relevant local health provider, which may include supply of Closing the Gap (CtG) eligible pharmacy medicines via video conferencing

COVID-19 related medical issues will be referred to the relevant local health provider. Escalation will be to the RAH (site pre-flagged with SAAS).

Mental health and wellbeing

Successful accommodation will be reliant on the ability to support the practice of culture within the physical and psychological confines of quarantine. Patients who experience exacerbation of existing mental health conditions including any Community Treatment Orders, or the development of new symptoms are to be referred to the relevant services via SCC-Health Operations. Mental health treatments/supports will be provided for all community members if needed.

The accommodation provider will undertake a daily check for general health, hygiene, and wellbeing, whilst also ensuring all persons are accounted for.

Medical event

A medical event may be a non-life-threatening incident that requires urgent (but not emergency) care. This might include broken finger, acute gastroenteritis, or deep laceration requiring sutures. Each SAAS response is to ensure contact with people on site where possible is limited and minimises any other unnecessary contact. Should an Ambulance be required, the call will be triaged via the Medical Priority Dispatch System and the most appropriate resource will be dispatched. If transport is required, then the patient will be transported by SAAS to the appropriate LHN. On discharge, the LHN will organise transport with SAAS via the normal booking procedure.

Medical emergencies

If emergency treatment is administered, life saving measures are to be prioritised over Safe Corridor guidelines. If CPR is required, the attending first aider may choose 'hands only CPR' until help arrives. Emergencies (mental and physical) should be managed by the accommodation facility or attending health professional through normal Triple Zero '000' procedures. They should advise SCC-Health Operations of any emergency care provided as soon as possible.

Presentation of COVID-19 symptoms

If a patient presents with any symptoms of COVID-19, they should be isolated and immediately transported to the Royal Adelaide Hospital (or Women's and Children's Hospital if under 18 years). All travel companions and close contacts of the case must be quarantined at a site that will be determined by SCC-Health Operations.

Hospital admissions and medical appointments

Prior to the patient's departure from their community, ACCHS are responsible for making inpatient and outpatient appointments. After patients arrive at the accommodation site, duty nurses are responsible for coordinating inpatient and outpatient appointments and care. This includes confirming appointments at least 24 hours prior to each. Duty nurses must re-issue Safe Corridor guidelines to the treating facility at this time. Any queries from the treating facility relating to meeting these guidelines should be directed to SCC-Health Operations.

Security at accommodation

It may be necessary for security officers to act as patient safety officers at their accommodation site. These officers may also provide support to the patient in maintaining Safe Corridor guidelines, if the patient finds this helpful.

The requirement for patient safety officers will be assessed, based on risk, for each group undertaking quarantine. Risk considerations will include:

The community member's medical and behavioural history (e.g. mental health/substance use/history of violence)

Wellbeing of patients (some groups may be more distressed than others), including cultural avoidance relationships, community inter-relationships, family and intimate partner violence.

Site layout

Staff rest/welfare requirements

Fire response resources within the accommodation precinct (i.e. fire response capacity)

Number of persons to be located at the site

Maintain Safe Corridor boundaries (i.e. keeping patients safe from intrusion).

Should a patient or carer choose to leave the site for any purpose other than to attend a medical appointment under Safe Corridor guidelines, Safety Officers are not permitted to allow that person back on-site until they have been risk assessed and cleared by a Human Biosecurity Officer. SCC-Health Operations may need to contact SA Housing for Emergency accommodation for the individual, if this occurs. 14-day quarantine may be required at the quarantine site. If this is required, arrangements to collect the guest's belongings are to be made by accommodation management; family members residing in the same pod can gather belongings on behalf of management if appropriate.

For non-emergency police attendance, call 131 444. For life threatening emergency call Triple Zero '000'.

Transport to and from medical treatment

Transport to/from outpatient appointments will be arranged through the SCC-Health SAAS Liaison Officer in conjunction with accommodation management and site nurses, with all steps taken to minimise the risk of coronavirus (COVID-19).

Annex E: Return to community

1. Community members may travel to Adelaide with the support of SA Health for COVID-19 related or unrelated medical care. Some may travel alone, while others may be accompanied by support persons or children. Likewise, some may spend time in hospital while others receive outpatient care. Finally, some community members may travel to Adelaide simply because they have been in close contact with a person who tested positive for COVID-19. Regardless of why community members travel to Adelaide with the support of SA Health, the ways they return home are similar.

Safe Corridors

2. In the event of more stringent movement controls under the State's Emergency Management Act, access and egress from Aboriginal communities may be further restricted. In this instance movement to Aboriginal Lands may necessitate the use of 'Safe Corridors'. The term 'Safe Corridor' was previously used to describe the conditions necessary to reduce the likelihood of infection whilst community members access medical treatment outside their community, and here it is used to describe the continuation of this corridor to ensure community members can get home safely. Community members will also join a Safe Corridor, if required by their home community's response plan.

Return to community case definition

3. There are four criteria that must be met if SA Health is to support member's *return to community*. They are follows:

a. Recognised community member as confirmed by that community's Aboriginal leader/s or AHW AND

b. The community is their primary place of residence AND

c. The community has extra-ordinary entry restriction similar to that of a DBA AND

d. Member's treatment in Adelaide (either COVID-19 or non-COVID-19 related) was approved and arranged by the ACCHS and/or other health provider. Evidenced by medical referral or emergency care documentation/confirmation as per ACCHS OR member is an approved travel companion for the person who received treatment (i.e. support person or dependent) AND

e. Their treatment is complete (if treated or quarantined for COVID-19 related illness, medical clearance stating the member is no longer infectious is required); AND

4. to *return to community* through private arrangement.

Transport arrangements

5. For those that meet the conditions for SCC-Health support to *return to community* as listed in the *return to community* case definition above, transport home will be by road or air depending on the distance from Adelaide, number of passengers requiring transport, cost and efficiency.

6. The following actions should be taken to facilitate *return to community*.

Actions in Adelaide

7. Once all medical treatment is complete, the following actions should be taken:

a. The duty nurse notifies SCC-Health Operations that treatment has ceased (with as much notice as possible)

b. SCC-Health Operations identifies a departure date

c. SCC-Health Logistics make relevant transport bookings

d. SCC-Health Operations advises ACCHS, Community Leaders, and if applicable, Relevant Decision Makers and HBO of anticipated return date and details.

e. Service providers are responsible for obtaining relevant standard entry permits associated with entry to Aboriginal communities for their staff (e.g. pilots, drivers, health workers) – NOTE: these are in addition to Emergency Management Act permits, if applicable

f. Duty nurse or medical facility is to re-screen travellers no later than 72 hours prior to being transported back to their community.

g. Prior to day of departure, the home community for each patient should be contacted (ideally with 48-hours' notice) to reconfirm travel arrangements - including information of arrival date and time, pickup location, health condition, and luggage or travel requirements.

8. Please note this advice is subject to change depending on the epidemiology of coronavirus (COVID-19) in South Australia and associated risk – to be determined by Human Biosecurity Officers.

Actions at Aboriginal community

9. Should there be extra-ordinary entry requirements, Community Leaders to consider the community member's individual circumstances when determining entry and conditions for returning residents that have received healthcare in Adelaide.

Repatriation of the deceased

10. In the unfortunate instance where the death of an Aboriginal community member occurs when in the care of SA Health, standard LHN *Care of the Patient Following Death Procedure* will apply.

11. If the death is COVID-19 related, refer to the *SA Health Management of Deceased during a Pandemic Sub-Plan*. This document has been prepared to provide information and guidelines for the management of mass fatalities in the event of a pandemic viral respiratory disease outbreak. This document includes general information about funeral assistance that may include support for repatriation.

12. Aboriginal Liaison Officers are available to assist the immediate family during this difficult time, and further support can be accessed via Funeral Assistance SA on 1300 762 577.

Annex F: Logistics

1. ACCHS will continue to use their existing logistic arrangements for supply, distribution and maintenance of health support. Where applicable, SA Health will augment and complement existing process through a combination of supplying resources to Aboriginal communities and evacuating COVID-19 cases, along with their close contacts and clinical escorts for treatment and/or quarantine in Adelaide.

2. Individual communities have different logistic needs. This section provides a generalised appreciation of logistic needs for the COVID-19 plan. Additional considerations relating to each individual community are to be developed in COVID-19 response plans.

3. If a gap is identified in the provision of logistics to any of these Aboriginal communities, SA Health will work collaboratively with the local ACCHS, other government agencies, and Lands Management to identify sustainable and cost-effective solutions. The SCC-Health will provide coordination and control of SA Health assets deployed forward, including the provision of services.

4. To ensure a prudent approach to goods management supporting the COVID-19 response, there is a requirement for:

a. Close engagement between SA Health, ACCHS, other support Agencies and contracted providers to ensure requirements, priorities and issues are promptly addressed. The SA Health lead for this is SCC-Health

b. Close engagement with enabling organisations including contractors, SAPOL, SA Housing and local Lands Community Councils, principally through established mechanisms to enable improved support agreements.

Pharmaceutical and medical consumable re-supplies

5. Local ACCHS remain responsible for the ongoing provision of pharmaceutical and medical consumables to enable primary health care, including PPE. SA Health will provide additional resources such as consumables for testing of COVID-19, as they are made available. Any additional costs, such as provision of primary health care to essential staff within the Aboriginal communities are to be submitted to SA Health for cost capture and processed within existing procurement management processes, through SCC-Health Logistics Officer: logistics.healthEMT@sa.gov.au. A guide to *COVID-19 swab logistics* is at Appendix F1, and a list of *SA Pathology service providers* is at Appendix F2. Please note this guide was correct at the time this document was drafted, however it is subject to change.

Catering

6. Catering support to SA Health teams required in addition to BAU is a responsibility of SA Health and may be achieved through a combination of ration packs, fresh supplies and/or contracted catering support. With the support of SCC-Health, the Logistics Officer will identify the best solution for catering for the duration of the time that additional SA Health support is required. Reconciliation of costs will be processed through SA Health with procurement, through SCC-Health Logistics Officer, responsible for processing payments.

Catering for patients, close contacts and clinical escorts

7. Patients (positive and suspected), along with close contacts and clinical escorts from the ACCHS, will require catering support. SA Health will fund catering support in the following circumstances:

a. Prior to evacuation once patient has been identified and isolated

b. During evacuation

c. While in quarantine in Adelaide prior to entering Aboriginal communities (including transit).

8. Where feasible, the ACCHS is to facilitate provision of catering of patients, contacts and clinical escorts, with cost capture and reconciliation through SA Health. Processing of catering costs is as per above, through the SCC-Health Logistics Officer, giving consideration to resources outlined within the logistic planning support tool.

Distribution

9. Distribution of supplies and equipment will be conducted in a priority method utilising ground, air and sea methods as applicable, depending on the outbreak location. Where possible, existing distribution pathways will be utilised for routine resupplies before creating bespoke logistic solutions. The SCC-Health Logistics Officer is responsible for preparing the distribution plan in conjunction with supporting departments (Transport, SES, SAPOL, ADF, etc.), in accordance with the *SA Health Medical Transport Plan*.

Movement of people

Ground Transport

10. Ground movement of patients, contacts and clinical escorts will be achieved through a combination of ACCHS and SA Government transport assets within the Aboriginal community. If additional transportation is required, the SA Health Forward Commander, in conjunction with SCC-Health Operations, is to identify the best means to achieve the transport solution. Requests for transport are to be sent to SCC-Health Logistics for actioning.

Air Transport

11. All air transportation relevant to patients, contacts and clinical escorts for COVID-19 will be coordinated through SCC-Health Operations. Further detail on patient, close contact and clinical escort movement is outlined in the *SA Health Medical Transport Plan*.

Vehicle Recovery

12. In the event of a breakdown of a SA Government vehicle, recovery is through existing SA government Financing Authority (SAFA) arrangements. SAFA vehicle management protocols can be found at https://www.safa.sa.gov.au/fleetsa. Contact SAFA Crash Management on (08) 8226 7356, or (08) 8226 7349.

13. Further details on vehicle breakdown management can be found at: https://www.safa.sa.gov.au/fleetsa/crash-or-incident.

Waste management

Medical waste

14. Where applicable, disposal of medical waste is to be achieved through existing ACCHS arrangements. Additional costs associated with an increased demand of medical waste disposal are to be cost captured by the relevant heath service and submitted to procurement through the SCC-Health Logistics Officer for reconciliation.

General waste

15. General waste is to be disposed under local arrangements. Where additional costs are incurred, the Forward Commander is to liaise with SCC-Health for cost capture and reconciliation. Fuel waste is not to be disposed of within Aboriginal communities without the permission of the Land Council or other community governing body, and only when appropriate disposal facilities are available. SA Health is responsible for the cost of transportation and disposal of any fuel waste generated by forward teams.

Ablutions

16. SA Health Logistics to identify a suitable ablution solution for all SA Health teams deployed to assist with heightened requirements due to COVID-19 for the duration of the task, if located without adequate facilities for the additional capacity. Where no suitable ablutions can be identified, the Forward Commander, in conjunction with SCC-Health, is to identify a contracted solution (including wastewater disposal). Field latrines and grey waste are not to be disposed of in Aboriginal communities without the express permission of the relevant Land Council or other community governing body.

Security and compliance

17. The underlying principle is that public safety and security is in line with the rest of South Australia and that SAPOL will manage all security matters in accordance with current arrangements. This is inclusive of Aboriginal communities, with SAPOL utilising existing management plans and community COVID-19 response plans within these communities.

18. SAPOL will continue to work closely with community leaders to restrict movements of community members and essential workers into communities.

19. For personnel deployed to Aboriginal communities they are to be given induction training into the nuances of the community in which they are being deployed. This is to ensure cultural awareness and to risk mitigate against any security issues that may arise for personnel and assets deployed.

20. Compliance with any Directions issued under the following acts of parliament will be managed by SAPOL.

21. South Australian *Emergency Management Act 2004*

22. South Australian *Public Health Act 2011*

23. These powers are to be explicitly presented as they apply in particular circumstances. If required, SAPOL will support Authorised Officers and Emergency Officers from other agencies who are also designated under the above Acts.

Appendices

24. This annex is accompanied by the following appendices:

a. Appendix F1: COVID-19 swab logistics

b. Appendix F2: Cleaning homes and health facilities

Appendix F1: COVID-19 swab logistics

Please note this guide was correct at the time this document was drafted, however it is subject to change.

HRRT logistics function will arrange specialised transport option. SCC-Health logistics email (logistics.healthEMT@sa.gov.au) will be able to help coordinate pickup and delivery of urgent swabs to the nearest pathology lab with the capability to perform COVID-19 testing.

Standard swab packing requirements

All swab packs must be stored between 4 and 25°C at all times: this includes during transport to locations prior to and after swabbing. To maintain this temperature range, swabs ideally will be transported in a cooled esky, transport bag or cool box.

Specimens for COVID-19 virus detection should reach the laboratory as soon as possible after collection. Correct handling of specimens during transportation is essential.

All specimens must be transported and packaged to:

protect the safety of everyone who is required to handle the specimen and package

ensure that the material is transported under conditions that will maintain sample integrity

ensure the sample arrives at its intended destination.

Storage and packaging of specimens

Managing the specimen

Collected specimens should be placed directly into the transport medium after collection. Recommended transport media are viral transport medium (VTM) or Liquid Amies. Note: dry swabs are NOT recommended unless (the specimens are to be processed immediately at the point sample collection e.g. if collected at a facility equipped with a rapid molecular testing equipment).

Storage and shipping conditions

Specimens should reach the laboratory as soon as possible, if kept at room temperature.

Store specimens at 2-8°C for up to 72 hours after collection. If a delay in testing or shipping is expected, store specimens at -70°C or below and shipped on dry ice.

Packing for transport

All specimens transported outside your facility must be triple packaged.

The specimen container (tube, pot, etc.) acts as the first layer of packaging which must be contained within a second layer such as a specimen bag for transport.

The pathology request form/s must travel with the specimen/s.

All second layer containers must be placed within a third layer container such as an esky, transport bag or cool box.

Address label

Having clarified the destination details with SA Pathology first, then the outer packaging must be clearly labelled with the following details in the following order:

Identify the contents as Diagnostic Specimens

Specify the name, address and contact details of the receiving laboratory

Specify the name, address and contact details of the sender.

Air transport

The SCC-Health will have visibility of business as usual (BAU) flights that can be used to deliver the swabs to a central point for transfer to Adelaide. Swabs are not to be sent to the Northern Territory for testing.

Air transport may be required and will be co-ordinated by the SCC-Health. Air transport options include (but are not limited to) Chartair BAU, SAPOL airwing, RFDS, Rex and charter airlines such as Wrightsair will also be considered. BAU flights may have to be supplemented to ensure timely delivery of specimens if the background incidence of COVID-19 in the wider community (rural and metro SA) increases. Note: it has been suggested that one extra stop (at Pukatja) on the Tuesday Chartair BAU flight to Amata/Mimili would make a lot of difference to pathology specimen pickup – however this is to be negotiated through SCC-Health.

In addition, SAPOL currently run flights weekly to APY lands, Thursday but have capacity to increase flights upon request through SCC-Health SAPOL Liaison Officer (sapol.healthEMT@sa.gov.au) for attention SAPOL Liaison. This is to be utilised as a primary option for movements of swabs, with contingency as Wrightsair (based at William Creek). Wrightsair given it is based in William Creek could be utilised for transport of urgent swabs from remote APY lands communities to Adelaide or Port Augusta. Both SAPOL and Wrightsair can cover the APY lands to the far North of the State as well as in the West. Utilising small aircraft provided reduces flight transport times down to three hours direct from APY lands to Adelaide Airport. Patients will be informed of test results via health service providers. Positive results will be relayed by CDCB.

Further information

If you have any questions, please call SA Pathology enquiries on (08) 8222 3000 and ask for Specimen Reception. For SA Pathology service providers, refer to Appendix F2.

Information about routine environmental cleaning and disinfection in the community (homes)

This is a summary guide. The full guide is at Coronavirus (COVID-19) Information about routine environmental cleaning and disinfection in the community

Cleaning is an essential part of disinfection because dirt and grime can inactivate many disinfectants. Cleaning reduces the amount of dirt and so allows the disinfectant to work. Removal of germs such as the virus that causes COVID-19 requires thorough cleaning followed by disinfection.

The length of time the virus that causes COVID-19 can survive on inanimate surfaces varies depending on factors such as the amount of contaminated body fluid (e.g. respiratory droplets) or soiling present, and environmental temperature and humidity.

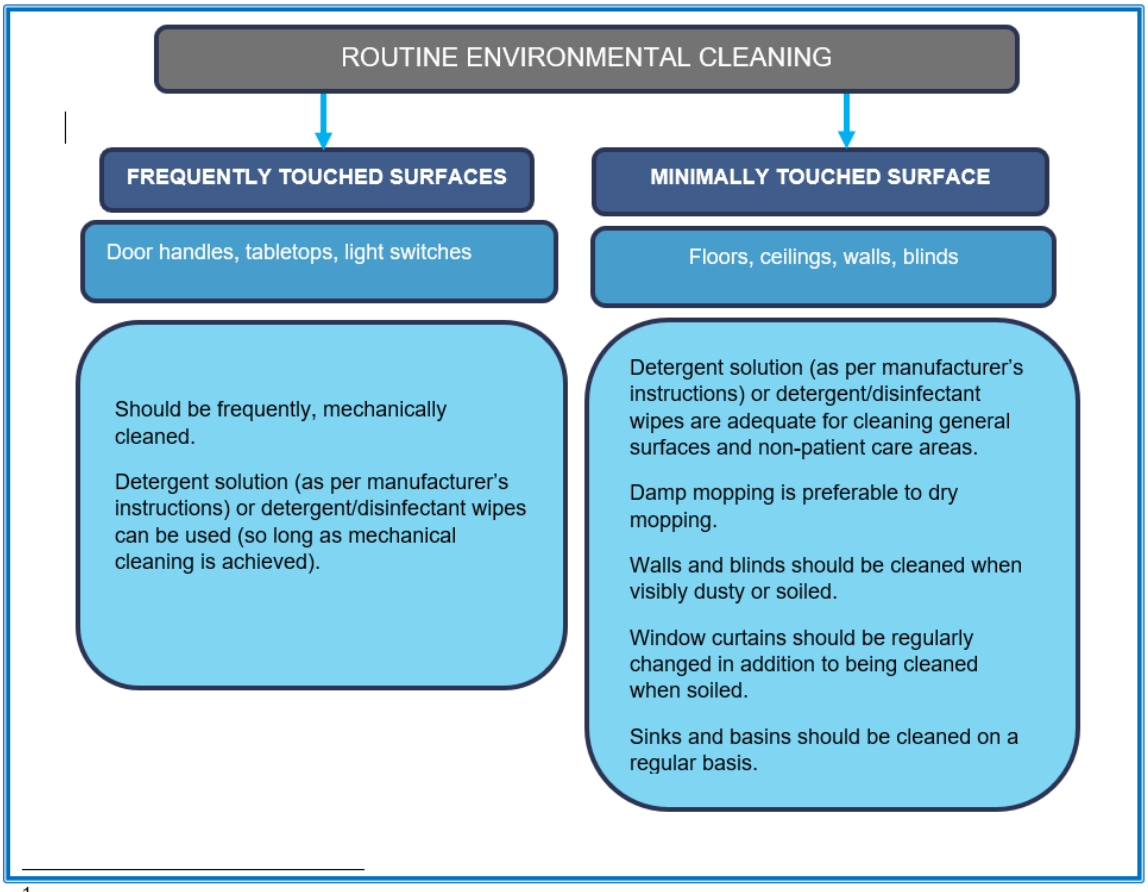
Coronaviruses can survive on surfaces for many hours or more but are readily inactivated by cleaning and disinfection.

It is good practice to routinely clean surfaces as follows:

Clean frequently touched surfaces with detergent solution (see diagram below).

Clean general surfaces and fittings when visibly soiled and immediately after any spillage.

Routine environmental cleaning requirements can be divided into two groups[1]:



[1] Adapted from Australian Guidelines for the Prevention and Control of Infection in Healthcare, Canberra: National Health and Medical Research Council (2019).

Information about routine environmental cleaning and disinfection in health and residential care facilities.

This is a summary guide. Full guide is at Coronavirus (COVID-19) Environmental cleaning and disinfection principles for health and residential care facilities

General principles

Cleaning and disinfection is recommended. This can be accomplished using a two-step process, or a combined detergent/disinfectant product. Disinfectants that are used within a healthcare setting must be either a:

TGA approved (registered or listed) hospital-grade disinfectant, preferably with label claims against coronavirus, or

chlorine-base product such as sodium hypochlorite at 1,000 ppm available chlorine.

Detergent and/or disinfectant-impregnated wipes with appropriate claims for activity against coronavirus can be used for small items of patient care equipment (see below).

Use disposable cleaning equipment and cloths where possible or launder as per the SA Health Cleaning Standard for healthcare facilities (section 4.2 Cleaning equipment).

Environmental surfaces should be cleaned on a regular basis: at least once daily; following aerosol-generating procedures or other activities that might contaminate the environment; and on patient discharge. Frequently touched surfaces such as handles and door knobs should be cleaned more often.

Cleaning and disinfection of patient rooms should only be performed by staff trained in the use of the appropriate personal protective equipment including disposable face mask, long-sleeved gown, gloves, and eye protection.

Patient Care Equipment

Use disposable or dedicated patient care equipment wherever possible and clean and disinfect between each use. Disinfectant wipes can be used on small items of equipment, but care must be taken with the use of chemicals on electrical equipment, where an alcohol wipe may be more appropriate. Always refer to equipment manufacturer's instructions for suitable cleaning and disinfection products.

No special treatment of patient cutlery and crockery is required.

Linen

Used linen should be bagged inside the room and managed as for patients on transmissionbased precautions. A linen chute should not be used as this may create aerosols.

Waste

Dispose of waste as per transmission-based precautions in the medical waste stream.

The following table lists the "active at in-use" concentrations of commonly used disinfectants against coronavirus. These results do not include the 2019-nCoV, but it is likely the new strain has similar physical properties to the tested strains. Note: this is a general guide only and some products may have combinations of ingredients that may have proven activity against coronavirus or similar non-enveloped viruses.

Compound	Active at in-use concentrations?	Minimum effective concentration
Sodium hypochlorite	Yes	0.1% (1,000ppm available chlorine)
Alcohol (ethanol)	Yes	70%
Quarternary ammonium compounds + 70% ethanol	Yes	0.04% + 70% ethanol
Quarternary ammonium compounds + HCl (acidified Quat)	Yes	0.04% + 1% HCl
Quarternary ammonium compounds (Quat)	**No**	

Adapted from Reference 2.

References

1. Casanova LM, Jeon S, Rutala WA, Weber DJ, Sobsey MD. Effects of air temperature and relative humidity on coronavirus survival on surfaces. Appl. Environ. Microbiol. 2010, 76(9): 2712-2717.
2. Geller C, Varbanov M, Duval RE. Human Coronaviruses: Insights into Environmental Resistance and its Influence on the Development of New Antiseptic Strategies. Viruses 2012, 4(11): 3044-3068.

Annex G: Personnel support

Expanding the ACCHS workforce

1. SA Health has established a pool of health workers who have experience working in Aboriginal communities, who may augment ACCHS staff if required. When considering deployment of this workforce, the following checks should be made:

a. AHPRA Registration

b. SA Working with Children

c. Police

d. Other considerations include deployment and shift durations, which will be negotiated by SCC-Health in relation to each community's needs.

Workplace health and safety

2. Activities conducted within SA Health facilities, and in Aboriginal communities delivering health capability, are challenging and involve a degree of risk. The requirement to achieve tasks must not compromise the safety of patients, staff, equipment or capability and does not justify taking undue or uncontrolled risks.

3. Safety is everyone's responsibility and managers at all levels have a duty of care to ensure the workplace is as safe as reasonably practicable for all personnel in that workplace. The South Australian *Workplace Health and Safety Act 2012* directly contributes to the preservation of SA Health capability by establishing a framework that reduces unnecessary injury to personnel, loss of equipment, and reduces financial and administrative burdens arising from any loss of capability.

Health support to deployed staff

Organic health support

4. In the case of widespread community transmission, SA Health may deploy organic health support to its staff.

Accessing care outside an Aboriginal community

5. In normal circumstances, ACCHS provide care to Aboriginal people. They also provide urgent care to non-Aboriginal staff employed within Aboriginal communities (i.e. to preserve life, limb or eyesight). This means non-Aboriginal staff are required to access most of their healthcare outside the community. In some circumstances, such as for DBAs or communities with extra-ordinary entry restrictions, travel out of the community for primary health care may result in some staff having to quarantine for 14 days before returning, jeopardising the continuity of essential services to Aboriginal communities.

6. To ensure continuity of services, ACCHS are requested to extend the provision of care to non-Aboriginal staff employed within Aboriginal communities to include primary health care support. Additional costs borne by the ACCHS are to be paid for via cost capture through SA Health.

Continuing support from contractors and other agencies

7. To ensure a reliable approach to the provision of materials and equipment supporting the COVID-19 response, there is a requirement to maintain relationships with the following:

8. ACCHS, other support Agencies and contracted providers to ensure requirements, priorities and issues and promptly addressed

9. Contractors, SAPOL, SA Housing and local lands councils principally through established mechanisms to enable improved support agreements.

Appendices

10. This annex is accompanied by the following appendices:

a. Appendix G1: Service provider details.

Appendix G1: Service provider details

Contacts involved in the operation pre-identified

Individuals may require referral to services relating to their health and wellbeing. Contacts are identified in the information pack travellers will receive.

Service provider	Refer to	Details
Management Team		
Forward Commanders:		
SA Health Emergency Management	SCC-H to advise	
CDCB Biosecurity enquires only	On Call CDCB Doctor	1300 232 272
Other:		
Kanggawodli	Onsite Contact Kanggawodli Operations Manager – Wade Allen	Phone: 08 8342 2250 Address: 16-22 Clements St, Dudley Park SA 5008
Northern Adelaide Local Health Network (NALHN)	Maree Geraghty Chief Executive Officer	0413 302 549 08 8182 9122
SAPOL Zone Emergency Management Committee Coordinator	Varies by zone	
Health and Wellbeing		
Clinical Assessment Service	On Call CDCB Doctor	1300 232 272
APY contacts	Richard King, General Manager APY Mark Jackman RASAC	0401 124 876 08 8950 5400 (business hours)
SA COVID-19 Aboriginal Mental Health Support and Advice Line (Thirrili)	Available 9.00am to 5.00pm, Monday to Friday	1800 841 313
Drug and Alcohol Services South Australia (DASSA)	*Call centre to triage patient requirements*	1300 13 1340
Security		
SA Police	Police Operations	Phone: 08 8207 4497 (08:00-22:00) 131 444 (non-emergency) Triple 000 (emergency)

Private Security MSS Security	SA Operations 24/7 Paul Stahl – Service Support Manager Geoff Merchant – General Manager	Phone: 08 8400 6888 Email: sa.opscentre@msssecurity.com.au Mobile: 0407 982 729 Mobile: 0434 183 888 Email: Geoff.merchant@msssecurity.com.au
Accommodation		
Safe Corridor: Kanggawodli	Onsite Contact Kanggawodli Operations Manager – Wade Allen	Phone: 08 8342 2250 Address: 16-22 Clements St, Dudley Park SA 5008
SA Housing Relief (after hours)	Duty Officer	Mobile: 0427 975 927
Aircraft		
Cobham Aviation Services	Roy Frost - Operations Manager Gavin Mailes	Mobile: 0431 729 886 Phone: 08 9479 9707 Email: roy.frost@cobham.com Mobile: 0457 826 357
Wrightsair	Office Number	Phone: 08 8670 7962 Email: info@wrightsair.com.au
Royal Flying Doctor Service	Office Number	Phone: 08 8238 3333
Commercial Coaches		
Bushbee Bus Service NT	Grant	0407 907 464
Explorer Coachlines Pty Ltd	*Office Number* *Duty Number*	Phone: 08 8293 2966 Fax: 08 8293 6664 Mobile: 0418 836 926 Email: enquiries@explorercoachlines.com.au Address: 60 Everard Avenue, Keswick SA 5035

Annex H: Capture of lessons learned

Background

Process improvement provides a methodology from which organisations can continually improve the quality of their services and safeguarding high standards of care. This practice evaluates and analyses operational processes and procedures for the purpose of driving continuous improvement to enhance output, increase efficiency, or increase the effectiveness of the process or procedure.

After Action Review

To enhance the provision of services to Aboriginal Lands during the COVID-19 pandemic, the After Action Review (AAR) process is the preferred method to enable critical lessons and knowledge from stakeholders are transferred quickly, thereby ensuring more favourable care and support outcomes.

An AAR is a qualitative review of actions taken to respond to a public health event or following a project or a public health intervention as a means of identifying and documenting best practices demonstrated and challenges encountered during the response to the event or the implementation of the project.

The process enables all stakeholders an opportunity to talk about what happened for a particular event or process, and other teams can then use this experience right away. In this way, the performance of all the government departments and supporting entities improves in a timely manner.

AAR Benefits

AARs provide an opportunity to assess what happened and why. They are learning-focused discussions that are designed to help the team and the organisation's leaders discover what to do differently.

It is important to note that AARs are not limited to major events, incidents or large formal projects. An AAR can be utilised after routine briefings or regular operational functions. They are particularly useful when a near miss or serious safety incident occurs, revealing important lessons.

AAR Conduct and Methodology

An AAR is a structured meeting that does the following:

Focuses on why things happened.

Compares intended results with what was accomplished.

Encourages stakeholder participation.

Emphasises trust and the value of feedback.

For the AAR process to be successful, participants need to discover for themselves the lessons provided by the experience. The more open and honest the discussion, the better. Key elements of an effective AAR are as follows:

Discuss the purpose and rules: The AAR does not seek to criticise negatively or find fault. The emphasis should be on learning and quality improvement, thereby enabling maximum participation, openness, and honesty.

Encourage active participation: When setting the rules for an AAR, the most fundamental aspect is trust. Disagreement between participants can and will occur however blame is not part of the discussion.

Successful AAR requires use of a facilitator to act as neutral party helping focus the discussion. This person asks questions and can often lead the discussion in such a way that it remains non-judgmental.

AAR is designed to elicit improvement in organisational performance and is not about individual performance.

AAR should be conducted as soon as possible after a major event. By conducting an AAR quickly, stakeholders will get a more accurate appreciation of what occurred.

Facilitators must focus the discussion with skilful, direct, open questioning. Participants should be directed to think about specific issues or areas.

Discussion questions typically centre around three themes:

What was supposed to happen? What did happen? Why was there a difference?

What worked? What did not work? Why?

What would you do differently next time?

Whole of Government Implementation

As controlling agency for COVID-19 in South Australia, SA Health will work with the following key agencies across government in order to implement an active learning process:

Local Government (through the Local Government Association)

Department of Education

SA Prison Health Services

Primary Industry and Regions SA (PIRSA)

Department of Planning, Transport and Infrastructure

Department of Human Services

Emergency Services (including SES, CFS, SAAS and MFS)

SA Police

Department of Premier and Cabinet

Australian Defence Force

Aboriginal and Torres Strait Islander Organisations

Industry

Royal Flying Doctor Service (RFDS) and MedSTAR

Behalf of the State Control Centre-Health will lead a Whole of Government (WoG) AAR on COVID-19 response within Aboriginal Lands after the following:

A critical incident or event as defined by the State Controller (Commissioner SA Police)

A critical incident or event as defined by the State Controller Health

On confirmation of a breach of the Biosecurity protocols for designated Biosecurity areas as defined by the Commonwealth of Australia Biosecurity Act (2015)

Implementation below Whole of Government level

Health Services and Local Health Networks (LHNs) are encouraged to conduct tactical and operational level AARs as part of their routine activities, along with preparedness and response to the SA Health viral Respiratory Disease Pandemic Response Plan

Frequency

Can be done multiple ways, suggest cells conduct either daily, weekly or ongoing notes and one final AAR just prior to collapse of SCC-Health.

Publication of Lessons Learnt

TBA

Information Record Management

TBA

AAR Tool kit

The World Health Organization (WHO) has developed specific tool kits for AAR designed to address learning for public health events or emergencies to enable collective learning and better preparation for future events or emergencies. Tool kits can be found at https://www.who.int/ihr/procedures/AAR-Toolkit/en/

Annex I: Public information and community messaging

Effective communication within Aboriginal communities and with leaders is critical to preventing COVID-19 from entering communities, and if it does enter, the provision of clear and consistent communication will ensure the right messages reach the right people at the right time to help contain the virus. In addition, information of interest to the general public must be made available and communicated where appropriate.

Because of the complexity and criticality of communication in this context, SA Health (through SCC-Health Public Information Officer) is working with several partners to create a comprehensive plan. These partners are the Aboriginal Health Council of SA, ACCHS, Aboriginal Affairs and Reconciliation in the Department of the Premier and Cabinet (DPC-AAR), and SAPOL. The plan builds on the significant engagement and communication activities these partners have already undertaken which includes public health messaging that can be found at: https://www.covid-19.sa.gov.au/school-and-community/Aboriginal-communities.

The communication plan consists of three distinct phases, as follows:

Pre-outbreak

COVID-19 information: what it is, what it does, and how to prevent it (including hygiene strategies)

Preparing community by letting them know what would happen if someone in a community needs treatment and support.

Outbreak

Triggers and early activation – who will the 'trusted source' of information come from, what will happen, what are the early Public Information essential actions for the HRRT

Activation and action – messaging and information, direct contact with on-the-ground com-munity leaders on their plans and communications

Ongoing support and input for families and close contacts who will need to be in isolation in Adelaide with COVID-positive community members

Continued Public Information activity into directly affected and other communities.

Recovery

Supporting health and welfare response

Supporting return to community planning and messaging

Assessment and action for ongoing communication and issues management.

As a representative of the Control Agency (SA Health), SCC-Health Public Information Officer will work closely with partners to coordinate a public information response to any COVID-19 outbreak in Aboriginal communities.

Government of South Australia

SA Health