Lessons learnt from COVID-19

A thematic analysis of the experiences of CHA member organisation senior executives in managing the COVID-19 pandemic in Victoria.

Prepared by: A/Professor Elisabeth Jacob, Dr Rosemary Ford and Ms Kristy Griffiths

March 2021

In collaboration with

Catholic Health Australia

ACU
AUSTRALIAN CATHOLIC UNIVERSITY

Executive summary

Throughout the COVID-19 pandemic in 2020, Catholic Health Australia (CHA) played a vital role in the provision of healthcare services to the Australian community, and support for government. During the year, Australia reported 28,486 cases and 908 deaths1. The State of Victoria moved through the largest phase of the pandemic, accounting for 75 per cent of Australia's cases and 90 per cent of deaths1, a large majority of which occurred in residential aged care facilities[2]. In this report, senior executives from four Victoria-based CHA member organisations provide their experiences and learnings.

A number of inherent organisational governance strengths at both the group executive/board of directors' level and the facility-wide operational level sustained balance and certitude in preliminary COVID-19 preparations and responses. During the second phase of the pandemic (June to November 2020), under stringent time pressures, organisations faced many challenges in protecting the safety and wellbeing of patients, residents, and staff. Many new/updated policies and procedures were enacted, for example, entry point assessment, staff PPE upskilling/supervision, restriction of staff movement, closure of shared spaces and contact tracing processes. Initial expectations of patients with COVID-19 requiring intensive care did not eventuate, and the surge of COVID-19 positive cases in aged care (inclusive of carers) was not foreseen, prepared for, nor resourced. Interactions with state/federal government were burdensome, related mostly to the lack of expertise and certainty from the DHHS and the Public Health Unit. The context of these challenges, and the learnings regarding future management of crisis, infectious or otherwise, are documented.

At the conclusion of their interviews, participants reported a job well-done by their organisations, expressed by one as, "I think we did a pretty cracking job in difficult circumstances", while another welcomed the opportunity to thrive in a new healthcare environment, stating that, "2020 has changed the healthcare environment pretty irreversibly. We need now to adopt a new set of regulations and restrictions, and we want to get our staff thriving in the new environment".

KEY LEARNINGS FROM THE PANDEMIC

Organisational level

1. A strong leadership team is important to set the tone for the organisation and ensure that authority and responsibility are clear.
2. In the face of certain pre-determined infectious triggers, central control needs to be maintained and a rigid, step-by-step response should be enacted.
3. Regular communication between the executive, CEO and board positions is vital to enable trouble shooting and a sounding board for decision making.
4. Key governance issues for pandemic management include the maintenance of a single voice, full preparation for different pandemic scenarios, the maintenance of organisational agility, and a strategic approach to organisational/government interactions.
5. The establishment of a 'critical incident team' for each health service was essential to enable the daily managing of emerging issues. These teams involved all personnel required for decision making, including infectious control, logistics, operations, procurement, communications and liaison personnel. Activation of a critical incident team resulted in a flatter hierarchical structure, and a single voice of communication to staff.
6. Communication with all stakeholders – staff, residents, families and government – was essential to ensuring control of the narrative by the health service, managing expectations, and keeping people informed of changes and management plans.
7. Organisations were required to provide extra resourcing and enact infection control protocols related to staff and patient safety, on many fronts and under strong time pressure, namely, infection risk, single site protocols, infection control and PPE upskilling and contact tracing.
8. Visitor restrictions led to tension between managing infection risk and meeting the human needs of aged residents and patients. Increased use of IT resources created the means for resident communication to and from the outside community.
9. Workforce management was a significant issue. This included managing staff fears, staff wellbeing, furlough and the surge workforce.
10. Executive strength and certainty in decision making was very important, as was their focus on backing other voices of authority in the organisation.

1. Coronavirus (COVID-19) current situation and case numbers. www.health.gov.au Australian Department of Health, 26/12/2020

2. Cousins, S. (2020). Experts criticize Australia's aged care failing over COVID-19. www.thelancet.com, Vol 396, 24/10/20

11. Procurement of PPE and other supplies was an important part of early planning by each facility. Supplying adequate high-level PPE for staff ensured they felt supported and valued by the health service.
12. Cohorting of patients into different groups based on their stage of illness was an important infection control management strategy. This was difficult in health services not designed with cohorting in mind.

Recommendations for health services

1. Establish a formal leadership (critical incident) team to manage the crisis which includes all key governance areas (infection control, logistics, operations, procurement, communications and liaison personnel).
2. Create a register to document all State and Commonwealth legislation, directive, and policy so that actions can be lodged for later review (date of first implementation, person responsible for implementation and the evidence).
3. Key staff should be removed from normal governance roles to enable focus on the crisis and development of organisational policies and guidelines.
4. Establish a communication process for government, boards, CEO, staff, clients and families to ensure control of the narrative and ensure a single voice with stakeholders.
5. Design IT systems to enable communication with key stakeholders inside and outside of the facility.
6. Procurement of essential PPE and other supplies should be seen as a priority in early planning.
7. When designing new facilities ensure cohorting of patients is included as essential to enable infection control management, particularly in aged care.
8. Prioritise the human factor when managing the crisis and its impact on staff, patients and families. Burnout is a significant issue for staff managing the pandemic over a long period.
9. Planning needs to be broad and not only focus on international experiences to decrease unexpected outcomes from the pandemic.

Recommendations for government

1. Allocate one line of communication to prevent confusion of messages from multiple departments.
2. Federal and state/territory governments must develop a single voice for communication with health services.
3. Federal and state/territory governments must maintain public health capacity and expertise to take a lead in providing best practice and standard protocols for pandemic management.
4. Additional resources need to be made available to health services to manage the increased need for furloughing of staff, infection control procedures, upskilling of staff and contact tracing.
5. The different needs of health services need to be individually negotiated regarding issues such as staff furlough and the surge workforce.

Contents

1. Introduction

A cluster of people presenting with atypical pneumonia was reported out of Wuhan, China, in December 2019[1]. Australia encountered its first positive COVID-19 case on 25 January 2020, in a returning international traveller[2]. The World Health Organisation declared the COVID-19 outbreak a global pandemic on 11 March 2020[3]. As Australia observed the impact of the virus on other countries, a federal and state response was implemented to manage the potential pressure on Australia's health care system seen in countries such as Italy, China and Iran. Australia's international borders were closed on 20 March 2020, to limit the spread of the virus. During 2020, Australia reported 28,486 cases and 908 deaths[4]. The State of Victoria moved through the largest phase of the pandemic, accounting for 75 per cent of Australia's cases and 90 per cent of deaths[4], a large majority of which occurred in residential aged care facilities[5].

The second wave of the COVID-19 pandemic commenced in Victoria on 11 June 2020. At its peak, there were 725 new cases in a 24-hour period, and 6,768 active cases[1]. The second wave ended on 24 November 2020, with the discharge from hospital of the last COVID-19 patient[1]. Aged care and older people were particularly vulnerable to the virus and experienced the highest mortality rate.

Throughout the COVID-19 pandemic in 2020, member organisations of Catholic Health Australia (CHA) played a vital role in provision of healthcare services to the Australian community, and support for government. CHA is the peak national body for Australia's largest non-government not-for-profit providers of health and aged care services, consisting of 75 hospitals and 550 residential and community aged care services[6].

METHOD

The purpose of this project was to evaluate the experiences of senior executives of CHA member organisations in managing the COVID-19 pandemic in their Victoria-based health services and identify the key learnings to take forward to future pandemic, or other public health planning. This work was funded by a collaboration of Catholic Health Australia and Strategic Partnerships Directorate, Australian Catholic University (ACU).

Project team members from ACU who undertook the thematic analysis and report were Associate Professor Elisabeth Jacob, Dr Rosemary Ford and Ms Kristy Griffiths. By undertaking a thematic analysis of interview data, the project team aimed to:

- analyse methods used to manage the recent pandemic in Victoria; and
- identify areas of strength and improvement to assist with managing future pandemics.

DATA COLLECTION

Participants were recruited for the project through email or personal request by the interview team, consisting of Tom Ristoski (ACU), Dr Ricky Chan (ACU) and James Kemp (CHA). Participation was voluntary. Narrative data for this project were collected from seven executive-level managers from four CHA member organisations in Victoria, namely, Mercy Health, St John of God Healthcare, St Vincent's Health Australia and Villa Maria Catholic Homes. Data were collected through face-to-face and Zoom interview (mean time – 50 minutes) and written report during November/ December 2020. Interview data was transcribed verbatim to enable thematic analysis. Transcripts were deidentified and quotations reported as attributed to Org1 – 4. Overall, the narratives paint a picture of rapid change and catastrophic developments. According to one participant: "As you can see, we lived through a massive crisis… we were at the epicentre of it". Participants kept their core responsibilities to patient and staff safety in the forefront of all decisions, but often these decisions were enacted under duress and "… without common agreement. COVID-19 is an unknown and it moves so quickly".

1. Pedersen, S. F., & Ho, Y. C. (2020). SARS-CoV-2: a storm is raging. J Clin Invest, 130(5), 2202-2205. https://doi.org/10.1172/JCI137647

2. Department of Health. (2020). First confirmed case of novel coronavirus in Australia. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia

3. World Health Organisation. (2020). Coronavirus disease (COVID-19) pandemic.https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19

4. Coronavirus (COVID-19) current situation and case numbers. www.health.gov.au Australian Department of Health, 26/12/2020

5. Cousins, S. (2020). Experts criticize Australia's aged care failing over COVID-19. www.thelancet.com, Vol 396, 24/10/20

6. https://www.cha.org.au/about

2. Outcomes

The analysis of narrative data is presented below under three key themes: first, 'strength in governance'; second, 'facility-wide challenges (infection risk, governance, workforce)' and third, 'new learnings'.

2.1 STRENGTH IN GOVERNANCE

An important aspect of each organisation's inherent strength was reported to lay in its governance structure. In this section, project participants report the manner in which their organisation's executive team responded to early warnings of COVID-19, in particular the importance of strong governance at both the Group Executive/Board of Directors level and the facility-wide operational level.

2.1.1 GROUP EXECUTIVE LEVEL GOVERNANCE

Late in 2019 and into early 2020, central or group senior executives of CHA member organisations began their preliminary discussion regarding COVID-19. As noted by one participant below, "we had robust discussion about where authority and responsibility lay in terms of corporate governance, from the board level to executive level and facility level".

> "We conducted weekly reporting to the board via Teams/Zoom. Our central executive team developed a clear picture of accountability, first, to keep the board informed, and, second to understand triggers for seeking board approval. We had robust discussion about where authority and responsibility lay in terms of corporate governance, from the board level to executive level and facility level. We had a board that had confidence and trust in the executive. On the board we had the benefit of two medical experts (clinical medicine and infectious diseases) – we used them as sounding boards, running ideas past them, saying, "This is what we're about to do, do you have any questions or concerns?" (Org1)

> "We had a very good governance process through our clinical governance framework. As CEO, I provided daily information to the Board Chair, more than would normally be required. I kept the Board of Directors up-to-date, the owners and the archdiocese were kept informed through the Board Chair." (Org2)

> "In Victoria, we felt completely supported by the board and the CEO (based in Perth). The CEO would ring me a couple of times a week – 'How are you? I hear this is a problem, what do you need?' If I rang the CEO for guidance on weekends or out of hours, he always gave priority to Victoria, he was always available. The Board Chair and board were a fantastic support, they bridged the distance between Perth and Victoria by writing to every caregiver to acknowledge their work and thank them. The letter gave significant detail to make it meaningful and real." (Org3)

In summary, it can be seen that CHA member organisations had the benefit of strong governance processes which sustained their balance and certitude in initial COVID-19 preparations and responses. Executive level governance provided a framework from which to manage the challenges associated with COVID-19.

2.1.2 FACILITY-WIDE GOVERNANCE

Early in 2020, the Australian press reported COVID-19-related health facility disruption in Northern Italy, prompting pre-emptive planning and preparation in CHA member organisations. A key facility-wide organisational strength was the adoption of a critical incident team early in 2020. These crisis teams, explained by participants below, had common characteristics of strength in operational structure, diversity of expertise, and the capacity to adapt to changes in risk level. These teams had various names – Incident Command and Control, Critical Incident team, Coronavirus Emergency Response Group and Group Executive Leadership team.

> "We set up a Critical Incident Team and followed a disaster recovery and business continuity plan that had been developed 18 months previously. We had training so that key staff in leadership roles across the organisation knew exactly what they had to do." (Org4)

> "We moved into a command and control incident response immediately in February this year. The Incident Controller took full command and control of the situation, with the assistance of six deputies covering infectious control, logistics, operations, procurement, communications and liaison. We stipulated one way of doing things, one set of policies and procedures with only minor variation according to site requirements. At every meeting, communication would be agreed, the stock level and procurement would be reviewed and then each member would mobilise their teams to action." (Org2)

> "Early on, we moved our decentralised way of working to central monitoring and control. We needed to avoid inconsistent policies and protocols. We stepped in at group executive level, not taking over but controlling the narrative and agenda. We did this in a collaborative way with the facilities, we were able to manipulate our three services (public hospital, private hospital, aged care) to play particular roles in managing the pandemic." (Org1)

> "The most important strengths were good leadership and culture. We developed a central Coronavirus Emergency Response Group giving us a coordinated approach across our organisation. The Group CEO and all facility CEOs attended weekly leadership meetings – all decisions were group policy/group directive. This approach flattened the pyramid. We had all necessary

expertise around that table whether it was HR or IT or procurement or infection control. Meetings were held twice weekly, daily and twice daily when needed… CEOs had the authority to act very quickly. We had flexibility in our response, both in upscaling and downscaling." (Org3)

Other facility-wide strengths are reported below, namely, communication and procurement processes. An important organisational strength reported by all participants was early facility-wide communication, with frequent and consistent updates, and the drive to "[control] the narrative and agenda" regarding infectious control.

"Our strength was in our communication processes. We utilised our standard communications and logistics platform. We sent pre-emptive letters to every single aged resident and every family to say, 'If COVID hits your site, this is likely what is going to happen, this is how it will happen, and this is how we will communicate.'" (Org2)

"We communicated with everyone – staff, residents in lockdown, families. Even if we didn't have the answers or anything new to report. We surveyed staff, clients and residents to get their feedback, criticisms and support. We held a weekly live-cast via MS Teams for all staff, with guests from across the organisation." (Org4)

"One member of our Coronavirus Emergency Response Group Team was a communications person. They communicated set information to key people throughout the organisation via intranet, emails, SMS and whatever was effective. We had good connection from top to bottom, from the board to the patient-facing areas they felt supported and connected. You never go through a period like this without – not quite mistakes, but learnings. Our ability and our preparedness to connect as a single organisation was really helpful." (Org3)

"Information gathering was of central importance, in addition to normal data gathering we developed a dashboard that also sought key pandemic indicators. The dashboard was great for informing the executive but also for reassuring the board that we were monitoring appropriately. Our structure, with public hospitals within a privately owned organisation… gave us the ability to tap very quickly into government (through the public door) for early information that we could roll out across our entire group." (Org1)

It can be seen that frequent and open communication with staff was a key issue for all organisations. The excerpt below shows how staff worked to keep their organisation safe, in this case through alerting their organisation to a potential risk.

"In Colac, and later in Shepperton, a staff member informed us about a COVID positive test in a local school child. Many staff had children at the school. We were able to go into full protection, face masks, gowns and goggles, sign-in and sign-out register, and visitor hand hygiene under observation. Our infectious control practices were in place four days ahead of government information. Clearly our staff felt comfortable to say, 'Hang on… we should go into this, let's jump up a level.'" (Org2)

Procurement of PPE and other supplies was an important part of early planning by each facility. Early modelling of PPE usage was undertaken by all organisations, inclusive of masks, gowns, head coverings, goggles and overshoes. The PPE orders were modelled for worst case scenarios: "110 cases per day, 200 cases per day. Adequate supplies during the first wave of the pandemic were not adequate for the second wave". One participant noted that '3,000 masks were available at one stage, but Werribee alone was using 55,000 a week and we were one hospital out of 60 in the state, the state stockpile of 3,000,000 masks was not going to last very long at all." (Org2)

"We started in January before the pandemic – we mapped out our worst-case scenario, if we get 20 cases what are we going to do, if we get 100 cases what are we going to do? During the first wave of the pandemic we monitored PPE usage at our sites, getting baseline daily usage. We used our previous modelling to assess need in each of our regional hospitals. We then brought information to the leadership meetings and got authority – "Ok, we will buy it". Our infection control, IT and supplies people were often several days ahead of the state health departments in terms of making procurement orders, making sure that we had the PPE in the right areas." (Org3)

"Procurement was also a strength, and I think the other big strength for us was staying ahead of the curve – we had mask and goggles in place before they were required – our infectious diseases physician was working from best practice and alerting us to our exposure in aged care. We had an emergency PPE supply at every residential aged care home, we did this in March when the first wave hit Werribee and we put three days' supply in every single home. We needed a buffer of three days for normal restocking [from the state stockpile]. The minute we had a positive test for a staff member, we had everyone in full PPE." (Org2)

"We purchased top shelf N95 masks for our caregivers. They never felt that they were going to run out or get second best. You have 'churn' through your PPE supplies – it's not just a case of COVID positive patients, there are many suspected COVIDs, and you don't know the status of elective surgery patients. Staff had no concerns regarding the level of PPE." (Org3)

In summary, facility-wide governance processes adapted to the threat, posed by COVID-19, to hospital/facility functioning. Participants reported that they quickly moved to a command and control or central emergency response team arrangement and brought all necessary expertise to the team – infection control, HR, IT and procurement. The infectious diseases/public health specialists were considered vitally important, reliably able to interpret and advise teams. Strength lay in each teams' diversity of expertise and the willingness of team individuals to resolve problems and take immediate action. Communication processes and proactive procurement of PPE equipment ensured that staff felt heard and supported in providing the required care.

2.2 FACILITY-WIDE CHALLENGES

It is seen in Section 2.1 that CHA member organisations relied initially on their strong executive level and facility-wide governance strengths to prepare and plan for COVID-19. As time passed, the first wave and the long second wave of the pandemic tested organisations, each of which experienced challenges related to infection risk, governance and workforce management.

2.2.1 INFECTION RISK

Facilities faced many infection risks. Participants reported that managing cross-infection within, and between, staff groups, patient groups, and visitors was the most important and challenging feature of pandemic management. A number of aged care residences were swept into the crisis, described by one participant as a tragedy.

> "Parkville [aged care residence] was our tragedy, it went every way we didn't want it to go. We had 22 deaths and 55 people affected by COVID as well as close to 30 or 40 staff. We had three index cases [different infection sources], possibly one from a hospital transfer." (Org2)

Organisations needed to enact infection control protocols related to staff and patient safety, on many fronts and under strong time pressure, namely, infection risk, single site protocols, infection control and PPE upskilling and contact tracing.

CROSS INFECTION

One participant noted that "Any cross-infection means that we are failing, once we get cross-infection then we know that things aren't right". An early, pre-emptive response was important, explained by one participant as "hit it hard, fast, get ahead of it, because once it takes over you can't control it."(Org2)

> "The biggest issue we faced was staff safety. Early on, momentarily, we dropped the ball on staff safety. There was a sort of understanding that they're nurses, they're doctors, they're putting on their brave face and they're doing the right thing. The defining moment came at our first staff infection. We actually thought, 'no, we're not happy with this, we should aim for zero staff infection'. So we had to recalibrate, we did root cause analysis type work with all staff who contracted COVID-19 and worked out how it happened and how we needed to support staff." (Org1)

Additional measures were adopted to keep clinical staff safe. In the excerpt below, one participant explains the steps they took to quell the rising staff infection rate.

> "We made a decision to up the PPE from level three to level four because our staff were still getting infected. Once we upped it to level four we thought, okay, we'll probably be criticised by government, but we can't be criticised for protecting staff. The rate of staff infections dropped dramatically, also due to our other precautions. So, the big focus became staff protection, not at the expense of patient protection. In future, COVID-19 or some other form of crisis – staff and patient safety are of equal importance." (Org1)

As noted above, staff safety was a dominant priority in facility-wide management. However, participants below report a number of unexpected challenges, some resulting from naïve and/or careless staff behaviour (tearoom crowding), while others resulted from a failure to decipher the unique nuances of COVID contagion (working over multiple sites).

The common staff tearoom was recognised as a potential area for cross-contamination. One participant explains that staff behaved naïvely in these cramped, overcrowded spaces – prompting an immediate close down of tea rooms. Another participant explains how their original focus on staff – patient infection risk, needed to broaden to include risks associated with meal break and living arrangements.

> "We saw people remove their mask in tearoom – incorrectly, and potentially spread the virus to surfaces and implements in the room. Then the next person

comes in expecting that every surface is clean. We decided to just close them down and say no to tea rooms. Even if they were being methodically cleaned, staff behaviour was too dangerous. We then moved to large outside marquees." (Org2)

"We realised we had focused on staff processes whilst they were with patients and had forgotten to focus on processes in tearooms, on meal breaks and at home. We did the math, there was room for no more than two people in a tearoom, so we closed them down. We set up open air gazebos with meal equipment so that staff were outside in fresh air. We spoke to staff about their responsibility to protect themselves and this also extended into their home life. The risk timeframe extended from patient care through to home activities. Consistent behaviours and actions were required." (Org1)

SINGLE SITE POLICY

Care staff are known to work across health facilities, or at least one other health facility. The participant below explains how the facility attempted to limit the risk of cross-infection from one facility to another. A 'single site plan' was established, this meant that "If they'd worked in a COVID-19 positive site, they weren't allowed to work with us." (Org2)

The first excerpt below explains a clear and consistent approach to limiting staff movement.

"We asked all staff to be vigilant about illness, potential exposure to COVID, their other work sites and their general suburban movements. We wanted to identify staff who worked elsewhere, for example (in) healthcare, disability, community, aged care. We asked them to choose us as a single workplace, for which we paid them a full wage [to compensate loss of wages]. We also reduced staff movement across, and within, our organisation." (Org4)

The 'single site' plan proved to be difficult to implement, as noted by one participant: "We couldn't action a simple solution, the single site plan, to resolve a very complex issue". In addition, there was a realisation that care staff weren't only exposed to infection through their work, but also through their domestic arrangements. In the first excerpt below, a participant explains this risk. In the second excerpt, a participant explains another anomaly of the single site plan, namely, that the 'surge workforce' was potentially drawn from COVID positive sites.

"Staff had to sign in every other day and tick where they'd worked in the last few days. What we didn't ask them, however, was do you live with someone who works in an aged care facility? A number of our staff became infected due to residing in a five-occupant co-share environment, with occupants working in different aged care facilities. So, we encouraged the single site, single life, single residence – it's a solution that sounds easy but it's far from easy. Most of our aged carers got infected through living with people who worked in other facilities, not from working at multiple sites." (Org2)

"It defies logic that we would take agency staff and the surge workforce, who came to us from unknown worksites, yet we would ask our own staff to adhere to the single site plan. We had to actually furlough [send home on full pay] some members of the surge workforce because they failed our own screening process [exposure at a COVID positive worksite]. It became clear very early, that we couldn't action a simple solution, the single site plan, to resolve a very complex issue." (Org2)

INFECTION CONTROL AND PPE UPSKILLING

Management challenges occurred in all facilities in relation to staff knowledge and skills regarding infection control practices, including the use of PPE. One study participant was "Somewhat surprised by how much clinical staff didn't seem to know about safe PPE use – donning and doffing". Organisations moved quickly to upskill staff.

"Donning and doffing of PPE – clinical staff have these skills but a lot of nurses and doctors have not necessarily practiced or worked with them. Our staff are provided with the training and the education. We have a 15-minute PPE workshop at the beginning of every single shift, these are crucial skills." (Org1)

"We started with the basics, simple things like handwashing, hand sanitiser. We did PPE training on how to don and doff the required gear, it is more difficult than appears. We did this in various ways and formats, including in person, online, via text message, Facebook, signage on sites, and even Instagram. We deployed infection specialty RNs and our internal Learning and Organisational Development team for on-site training and practical support for staff." (Org4)

Organisations also undertook training and upskilling of staff in preparation for aged residents and patients with severe COVID-19 respiratory symptoms. Registered and enrolled nurses and nursing assistants' capability with respiratory assessment and management were targeted.

"We realised that we will potentially have a lot of patients who have respiratory compromise. Do we have the skills to manage and monitor these people… particularly in our aged care? We didn't. So, we ran through our public hospitals respiratory support workshops, basic and refresher courses for RNs, ENs, and AINs, ENs – making sure that they were able to maintain patients' respiratory function within the confines of the equipment available to them." (Org1)

It was noted by one participant that despite training support and clear messaging about the need and urgency for change, at the ward/unit level change did not always take place. The participant below notes that "You've got to go and reassess everything yourself and make sure, for example, a new directive was communicated to all areas to restrict staff movement between floors – but unless you see it, don't believe it!" (Org2). Direct observation of all staff, inclusive of outside contract staff, was necessary. In the second transcript, a participant explains the performance of poorly trained terminal cleaning contract staff.

"You can do the training, but we found that you have to go and look, so you need people to observe because even our educators contaminated themselves when they did the first training video. We put PPE spotters in all of our [facilities] to monitor and take corrective action whenever necessary. They walked around clinical areas and would say 'Not using it properly, not using it properly' – just keep telling them. A good strategy originated from our operating theatres where they would have a spotter for their shift, a pink sticker designated the role. That whole group of staff observed/corrected each other, thereby also learning it themselves. That was a model we used elsewhere."

(Org2)

"We had been assured that we were getting COVID-trained terminal cleaning contract staff. Our infection control observer saw them wearing three masks, three sets of gloves and PPE and their terminal cleaning performance was too basic, with use of inappropriate material, solutions and processes, for example, failure to wipe down light switches. The observer realised that these staff have no understanding of infectious control – we're in trouble." (Org2)

CONTACT TRACING

The Victoria Public Health Unit requested that health organisations undertake their own contact tracing. It is seen that facilities and organisations responded immediately to ensure that each positive COVID-19 test result for care staff was immedicably traced: "Staff were sent off shift if they had been the first contact, you had to move quickly, within the first hour." As noted by one participant, "We've never seen anything like it, we've dealt with flu outbreaks and gastro outbreaks and contained those, but it was the speed with which this worked and people without symptoms were infectious." (Org2)

"We set up the infectious control role for making first contact because it takes a high level of assessment and decision-making expertise. In aged care, the information was then passed to a group of staff, predominantly registered nurses, to follow through with contact tracing, these staff were well placed as they knew the families. In the hospitals we had an on-call roster for extra help with tracing if we had an outbreak. We developed a training package. We were quite good in the end, we were contact tracing within three to six hours and had everyone traced and furloughed offsite." (Org2)

"We set up contact tracing resources, it was operated out of head office in WA. This particularly helped us during an outbreak in our accommodation centre for our intellectual disabled clients. Our disability team gained so much support from the Perth central office, particularly technical support in relation to contact tracing. We could have had a much bigger outbreak, but we nipped it in the bud." (Org3)

In summary, CHA member organisations faced challenges and disruptions in clinical functioning. The long-term second wave of the pandemic (June to November 2020) tested organisations' ability to manage infection risk and maintain staff and patient safety. In response to challenges, facilities acted quickly and competently. Many new/updated policies and procedures for COVID-19 risk management were enacted, for example, assessment of staff at facility entry points, upskilling/supervision of staffs' PPE use, restriction of staff movement, closure of shared spaces and contact tracing processes.

2.2.2 AGED RESIDENT/PATIENT SAFETY AND WELL-BEING

There was tension between managing risk on one hand, and meeting the human needs of aged residents and patients on the other. A participant reports their own distress over denying visitor access: "The most challenging time was our lockdown of [health service] residents for 80 days straight – 22 people losing their lives – did the resident die of COVID? We can't say. Did they die because they gave up? Quite possibly." (Org2). In the first excerpt below, the participant notes that visitor restriction was necessary to maintain infection control, while the second participant notes their realisation that decisions about visitor restriction were likely to be long-term.

"We closed our sites to all visitors completely except for palliative and distress visits. This was one of the hardest aspects of managing the outbreaks across aged care residences, and while it was an emotional and distressing time for our residents, staff and families, it was a necessary step to maintaining infection control." (Org4)

"Our infectious diseases physician said, 'We're not here just to eliminate risk for someone, we're here to look at their whole life. This pandemic isn't going to go away quickly, so what we put in place today – be prepared to have it in for three or four months.' Initially, with visitor restriction, we had restricted hours, restricted places, and all visitors completed a hand hygiene course online and their practice was observed." (Org2)

The rationale for visitor restriction was questioned by some participants, who believed that staff were the highest point of exposure for aged residents, and visitor risk could be managed.

"Then visitors to aged care were banned state-wide, but we believed that a visitor was never going to be a high

point of exposure. A person would never visit if they posed a risk to their parent, and they would follow the rules, wash hands/time limits. They wanted to be there to care." (Org2)

Participants were also aware of their responsibility to manage the distress experienced by family members who could not continue their normal support role. One participant noted the powerlessness of the individual who "couldn't visit the loved one for three or four months, knowing they are likely to die, and you won't be here."

"We decided from the very beginning, that we didn't want our family members sitting outside the residence – waiting for information. We phoned every resident's family individually within the first 24 hours of an outbreak or a notification of COVID-19 onsite. If their loved one had become infected, they needed to know immediately. If their relative was severely ill and expected to die, they needed to know immediately. We undertook to have daily communication at every site once COVID-19 was present, to every resident, every family member and every staff member. We then followed up with phone calls daily to anyone who was COVID positive, be that staff or be that residents or relatives." (Org2)

"Residents with COVID were given a mobile phone to keep in their room, families were encouraged to call as often as possible, to maintain the connection. Staff made daily outbound calls to family members to keep them informed about their loved one's condition and relay messages. Inbound calls from family were diverted to the call centre, chiefly to ensure all calls from family were always answered and second, to enable care staff to maintain their focus on caring." (Org4)

Visitor restriction created hardship for patients, aged residents, visitors and staff. Facilities worked hard to keep communication channels open with patients/residents, with families, between patients/residents and family, and within resident groups.

2.2.3 GOVERNANCE

As noted in Section 2.1, CHA member organisations had strength in governance which sustained balance and certitude in their COVID-19 preparation and response. Participants reported that they had all necessary expertise around the table – infection control, HR, IT, and procurement, and moved to a command and control arrangement very quickly. These governance strengths were put to the test during the pandemic in three key areas: first, maintenance of a single voice; second, scenario planning and organisational agility; and third, interactions with state/federal government.

THE SINGLE VOICE

Participants reported their determination for consistency of message: "To control the narrative and agenda" to have "One source of truth" in terms of policies and procedures. The maintenance of a single voice within facilities was difficult. Participants recount their experiences below.

"We made a decision early on to centralise communication to ensure that the messaging was consistent and correct, and to maintain our philosophy of being open and honest throughout." (Org4)

"We were very clear about who held the key health knowledge to manage this crisis, we identified leads in clinical governance, PPE, legal and risk and we were very clear about who had the authority to make decisions, who didn't have the authority and who had to defer up. We continued to have individuals speak out who were not the delegated authority, but these people held authority due to their knowledge and position and people [would] listen to them. We sought to limit the number of decision-makers and keep information entirely consistent." (Org1)

"We understood that weakness in infectious control, came from variation in practice. Incident Command convened each day, sometimes twice per day and having an infectious diseases physician as our one source of truth to interpret and advise on everything was one of our greatest strengths. Every decision was documented, and situation updates were sent out every single day, for all staff. The updates were written in a way that everything you'd read was an update from the day before, so you had a consistent understanding of changes to previous instruction." (Org2)

Controlling the many voices of authority or 'the white noise' inside the organisation was made more difficult by clinical staffs' work roles in outside organisations. The participant below notes the movement of medical staff back and forward between hospitals.

"Our organisation shares a lot of doctors with other organisations – Epworth Private and Cabrini as examples. This became a problem, medical staff were adopting processes and policies that we weren't landing on. We had a particular way we wanted to do things, and it was a problem that we had to manage quickly and early. We wanted it tight, top notch, consistent, however, we continued to have white noise." (Org1)

The difficulties in relation to maintaining a single set of policies and procedures was not relentless however, and many participants gave praise for the manner in which staff responded to instructions. For instance, below a participant recounts the efforts taken by staff "to protect themselves, their colleagues, their patients and community". It was found that some COVID-19 positive staff who had inadvertently attended work, had caused no spread because they adhered to the organisation's "sensible, repeated, safe instructions".

"We had examples of staff who caught the virus in their community/their homes and worked in our hospitals but didn't spread it to anybody. They complied with instructions from our infection control people – sensible, repeated, safe instructions – essentially asking them to protect themselves, their colleagues, their patients and community. That was something that staff wanted to do." (Org3)

SCENARIO PLANNING AND ORGANISATIONAL AGILITY

Based on overseas evidence of high utilisation of intensive care units, CHA member organisations engaged in pre-emptive preparation of clinical spaces and new purchasing. However, as noted below, the utilisation patterns in Victoria related to a "tsunami of elderly residents" and other patients not requiring ventilator support. The need for ICU beds did not eventuate. As noted by the participant below, "Our plan probably wasn't agile enough to quickly pivot."

"We planned our pandemic response in accord with overseas news and common belief. We got our ICU beds

freed up, we bought extra ventilators. However [the need] never eventuated. [Instead] we had a tsunami of elderly residents coming at us and a tsunami of other patient." (Org1)

"Early predictions were that we'd need double or triple capacity in intensive care. If you looked at the Italian experience, it was that ICUs were being inundated, people were being ventilated in corridors. We prepared well. In my hospital we trained up around 100 nurses ready to work in an intensive care unit, we did a great job as an organisation, getting that up really quickly. But our crisis was different." (Org3)

INTERACTION WITH STATE/FEDERAL GOVERNMENT

The Victorian State Government and Department of Health and Human Services (DHHS) had a governance and leadership role with public and private health facilities. Challenges occurred for Victorian-based CHA member organisations in their interactions with the state government, the Ministry and the DHHS.

These challenges are reported by participants below. The first challenge relates to the government's lack of a pandemic plan and public health expertise, and the problems contact tracing and quarantine.

"Victoria's problem was that the department did not have strength in their public health expertise, it had no governance structure to support rapid distribution of resources – no expertise at the ground level in each local health district. They were caught on the hop. Their most senior public health person was several rungs down the ladder, making it difficult for that person to respond quickly to the pandemic. Health departments in any jurisdiction need to start with the assumption that [a pandemic] will happen. Departments need to be prepared; not the case in Victoria. There are more than 80 local district health boards in the state of Victoria, you cannot properly handle an emergency with that governance arrangement." (Org3)

"[The Victorian State Government] didn't appear to have a strong public health unit… the right people on the ground with local knowledge and good strategies. Public health expertise has been diminishing in Victoria over the last 20 years. So, they were scrambling to put together a coherent public health team, for instance, contact tracing in Victoria was problematic. We did our own contact tracing using an electronic system and we actually assisted the DHHS to set up the contact tracing system." (Org1)

"Quarantine problems… that was the start of it for our outbreaks in aged care. Why didn't the DHHS not think to involve the experts in quarantine management? At the beginning of the year, hospitals were not involved in hotel quarantine. Now in Victoria, Alfred Health actually oversees hotel quarantine, they provide good infection prevention governance in that space now." (Org3)

State government policy announcements occurred frequently, each of which required rapid uptake of the information and rapid implementation of new procedures or changes to the old. According to the participant below, the department 'did the best it could, given the complexity and urgency'.

"The department consulted very well. At our weekly CEO/DHHS meeting [I was the state representative for our organisation], we had 'a heads up' regarding their focus. We usually knew something was coming, but not yet ready for release. Obviously, they were concerned about things hitting the media before they were ready to talk about it. The department provided a daily CEO update briefing, between 4 and 6pm which I read each evening and made a plan for the next day. The DHHS was clear about a minimum requirement but left implementation to us, so we enacted policy that we thought was reasonable for our situation. I think the DHHS did the best it could, given the complexity and urgency." (Org3)

Alongside this positive acclamation regarding the Victorian DHHS, there were many reports about "message overload" and "multiple requests for information and raw data". In the excerpt below, the participant explains the heavy messaging load they faced each day, and the lack of coordination between the state government, the DHHS and other departments.

> "We faced unprecedented multiple requests for information and raw data from the state, government, the ministry and the DHHS. There was often a similar request from three different officials – we scrambled to communicate with public officials, for example, 'We've already supplied it. Who did you supply it to? Well, we supplied it to this person. Why did they want it? I don't know.'" (Org1)

Also of concern for clear messaging was the Commonwealth/state government overlay in aged care services. The participant describes their organisation's response to an aged care provider who was overwhelmed with state and federal government directives.

> "BlueCross (residential aged care facility) turned to us for assistance. It was eye-opening for us – they had five different plans to implement, three from Commonwealth agents and two from state agents, most of which didn't articulate. BlueCross didn't have the personnel to deal with it. We responded by giving them extra services to assist them. Even though it's a Commonwealth responsibility, there needed to be a centralised crisis leadership team [Commonwealth/state] one point of reference, remove the multiple channels. It got there eventually but it was just very, very slow." (Org1)

Three key governance challenges occurred in facilities. Early in the second wave, facilities faced a surge of COVID-19 positive cases in residential aged care. Original planning, based on overseas events, focused on ICU capability, purchasing and workforce preparation. The need to pivot from ICU care to aged care proved difficult. Also difficult was the maintenance of the single voice for the organisation, and this remained an ongoing issue. Finally, interacting with state/federal government proved to be burdensome and frustrating, predominantly due to the lack of expertise and certainty from the DHHS and the Public Health Unit.

2.2.4 WORKFORCE

Each facility experienced challenges in workforce management. All hospital staff were under work pressure due to new learnings, procedures and responsibilities. In addition, as community members, they were also subject to the fears and miscomprehensions in common circulation. Participants report their management challenges related to staff fear, staff wellbeing, furlough and the surge workforce.

STAFF FEAR

As a consequence of overseas reporting of COVID-19 case numbers and deaths, clinical-based care staff, inclusive of medical and nursing staff, were understandably worried for their safety and that of their family. In the excerpts below, a participant recounts the difficulties in managing fear behaviours and maintaining a single information stream.

> "It was in that early stage of fear related to news from Europe that doctors and nurses were dying. We had some medical staff wanting to do the full PPE from the beginning and we actually didn't have any cases. We were consistent from the beginning about only one information stream, but that didn't prevent some staff from taking their own decisions and being over-reactive. Medicine and nursing are evidence-based, science-based professions, but we were presenting them with best-guess decisions, because there is no science here and there is no evidence, and we've got no time to gather it. This sort of thinking requires a leap of faith and that was really hard." (Org2)

> "A hospital COVID-19 action group and an aged care COVID-19 action group were established as forums for staff, in addition we had crisis meetings with staff in the event of a positive case or outbreak. The clinical directors and medical director were there, and sometimes it was a matter of calming staff. A number of medical specialists said they would walk off the job if we couldn't protect them, their fear was related to contagion, personal illness and family safety." (Org2)

Fear of contagion caused a high level of staff absenteeism. As noted by one participant "we would have about 30 per cent of the roster who wouldn't want to come into work, particularly in aged care, and in hospitals too, they didn't want to be here" (Org2). The participant below notes the priority given to protection of staff.

> "The price of top shelf masks has gone from $2 to $7 or $15 – can we buy 10,000 at that price? Answer, yes, our whole process was driven by a desire to support the caregivers. Our primary motivation was to make sure that we never left anybody without masks or gowns, without gloves, without instructions, without advice, without guidance, without appropriate support in their workplace." (Org3)

Communication with staff was also a priority for organisations. In the two excerpts below, participants recount the level of involvement with staff to assuage their fear and reluctance to return to work.

> "We found that, within the first 24 hours of a lockdown, care staff often don't come in even if they say they will. This was a challenge for us, and understandable, as there was a lot of fear and apprehension about working within a residence with an active outbreak. We found that staff responded to our information about numbers of infections, steps taken to keep them safe. Staff returned, usually the next day or two after the initial lockdown commenced." (Org4)

> "Our HR staff would ring every single staff member and go through the script of what is COVID and how you will be protected at work. About 95 per cent came back to work overtime. The important thing too in our aged care sites is that the service manager kept in touch with staff who were fearful about being at work, supporting them and helping them to adjust." (Org2)

STAFF WELLBEING

Early in the pandemic crisis, there was a sense of business as usual, as one participant noted, "Our first impressions were always that this was going to go away in a few weeks, possibly a few months, and we would be over it. We didn't think we'd be dealing with this for one or two years" (Org3). However, it quickly became apparent that "Hospital executives were burning out, they were still trying to do their day job as well as trying to manage crisis" (Org1). The participants below report swift action to utilise staff time efficiently.

"We had to quickly intervene and initiate different rostering structures, such as Team As and Team Bs. We pulled our clinical and facility managers out of their day job with the instruction that 'Your entire role is leading the pandemic crisis response, you don't need to make any other decisions outside of that'. There was resistance, but it freshened the team once we got into the swing of things. We learned that we must move to a command and control crisis response the minute we had triggers. The business as usual model – it's not going to work in a pandemic." (Org1)

"We put our infection control team on a 24-hour, seven-day roster. We had infection control expertise available all day, all night. We had a roster for every command position over the seven-day cycle with three or four people for every key role." (Org2)

"We started getting cracks in staff endurance – fatigue, and burnout in members of our Coronavirus Emergency Response Group, our hospital CEOs, particularly those directly involved with state government. We put 'buddies' in place on a roster to give them a break, we pulled in the mental health people and they said, 'Look, you can't go on doing this forever, you're going to have to change your behaviour, you've got to have a second in charge here.'" (Org3)

In addition to burnout through overwork, many staff experienced adverse mental health and wellbeing consequences. As noted by one participant, "A key part of our incident command centre is management of human resources, we are concerned with the mental health and wellbeing of staff who have COVID-19 and the mental health issues of people who are scared of COVID-19." (Org2)

"We hold group discussions, we've got an intranet site for COVID-19 and for mental health where people can go through the links of all the things available that they can use. We have had so much trouble with unhelpful communication, different things being said, so we manage this very carefully." (Org2)

"We had support from our New South Wales Mental Health Trauma Services. Our CEOs identified those people who were struggling. We did all we could to make sure that people got rest and that they're supported." (Org3)

FURLOUGH

The level of spread of COVID-19 infection in staff and patients, and the speed of transmission, proved very difficult for organisations to manage. A single new staff infection was often contact traced to large numbers of staff within a single or multiple facility/ies. These staff were furloughed, that is, sent home on full pay. One participant notes that "It took us by surprise in a way that we weren't prepared for – it was the level and the speed with which it took hold – home after home after home" (Org2).

"We were really well prepared for one or two odd cases or odd situations. However, we quickly had COVID-19 positive cases at the XX Hospital and the XX Hospital. We then had large numbers of furloughed staff, and finally we had to furlough the entire anaesthetic staff because of an exposure. This meant that all women who were about to give birth had to be moved, all babies had to be moved. The Department of Public Health insisted on all staff being furloughed, I had to ring the minister and say, I'm going to have to close your major maternity hospital because I've got no staff.'" (Org2)

"Our hospital was the first hospital in Victoria to be hit with COVID-19 and we lost 55 per cent of our medical staff overnight in the emergency department. That was mainly through furloughing, we had four doctors who lived together – one of them tested COVID positive. These doctors worked different shifts and crossed over with just about every doctor and nurse that we employed. Having an early hit like this was a strength in hindsight, it got us prepared for what it really could do." (Org2)

SURGE WORKFORCE

At the peak of the pandemic, a high number of essential clinical staff in Victorian facilities were furloughed. The state government established a 'surge workforce', comprised of clinical staff from Victoria and interstate. Organisations experienced a number of difficulties with the surge workforce, for example, individuals were inadequately trained and prepared, and some failed to meet the facility's strict screening protocols.

"The government provided a surge workforce. We found these care staff were often poorly trained and not expecting to work with COVID-19 positive patients/residents. Many came to us from multiple worksites, which contravened our internal single site policy. There were problems with accommodation and wages. To expedite matters we negotiated accommodation closer to our services, paying for it ourselves. Negotiating those things in the midst of a crisis was very difficult." (Org4)

"We actually ran into trouble in aged care due to DHHS's instigation of a surge workforce to replace our own furloughed staff. Then we found that some of these staff failed our own screening process as they had worked at a COVID-19 positive home. This happened more than once, it was a constant insecurity, you had to keep an eye on everything." (Org2)

Clinical, non-clinical and administrative staff experienced work stress due to COVID-19. Staff experienced fear of COVID-19 contagion for themselves and/or family, and some were reluctant to continue working in their facility. Some staff were at risk of burn-out, particularly those with responsibility for COVID-19 planning and implementation in addition to their normal work responsibilities. Facilities acted quickly and competently to support staff. Facilities also acted quickly to manage the problems related to staff furlough and the surge workforce.

3. New learnings

Inherent governance strengths of a number of Victoria-based CHA member organisations have been documented in this report. It is seen that these strengths sustained balance and certitude in the early months of the COVID-19 pandemic and during the second wave from June to November 2020 (Section 1). It is also seen (Section 2) that facility-wide decision-making occurred under stringent time pressure, and there were multiple disruptions in clinical practice. Important learnings, as reported by participants, are presented below.

3.1 STRENGTH IN GOVERNANCE

Project participants identified their organisations' inherent governance strengths, namely, their governance structures and communication and procurement strategies. Participants report below on their 2020 pandemic learnings, particularly in relation to early responses but also longer-term governance issues.

In the early planning/preparation stage, many organisations relied on their existing 'critical response plan' or 'pandemic plan'. The participant below learned that the following steps need to be actioned in the early stage.

> "Move into an organisation-wide incident command and control system immediately. Make sure you have high level infectious diseases consultants and public health expertise. Put in check lists and screening tools on every point of entry/entry in the facility. Monitor outbreaks across the state, for example, Victoria had an outbreak in the meat works industry, we should immediately have put 'meat workers' on our screening tool. Close every tearoom down immediately, do not allow staff to gather." (Org2)

The participant below recounts that the business as usual model does not suffice during pandemic management, and reconfiguration of organisational governance structures are needed. In excerpts one and two below, participants note that the crisis team needs persons with skills and expertise, particularly in infectious diseases and/or public health, but also human resources management, information technology and procurement. In excerpt three, the participant reports the vital support provided by the team's infectious diseases physician, in this case, explaining one of the many nuances of a highly contagious airborne virus (the 12-day cycle).

> "One of the biggest lessons was that our business as usual model was not sustainable during the pandemic. First, move to a centralised command and control crisis response. Second, put the right team together with the needed skills and expertise and the right team leaders. Third, support the authority of team leaders, clearly communicate their authority to make and implement decisions. We have already developed a new policy that steps out triggers and responses." (Org1)

> "The public health expertise is incredibly important at a group level. In addition, we learned the importance of rapid action in changes to policy and protocols, and our human resources managers (HR), information technologists (IT) and procurement managers were vital. You need no weak links in that group of experts, bring them together and give them authority to get on with it." (Org3)

> "My biggest learning is that whatever prevention measure or intervention you put in place today, you won't see an effect [positive/negative] for 12 days. For example, N49 masks and face shields on every nurse – you will continue to see positive COVID-19 in staff, you will think it's getting worse. You need to wait, you have

a 12-day infection cycle. It was our infectious diseases physician who explained these issues, told us to stay the course." (Org2)

Many organisations learned that their existing crisis management plans lacked policy and procedures regarding management of a highly contagious airborne virus. Participants report below that they have already undertaken review and development of new standards.

"We've reviewed all our actions. Is everything documented? What did we do at specific time points? How and when did we communicate, and what was said? What have we learnt? We have documented our standards for the [Org2] Incident Command System – activation, deactivation, roles/responsibilities, task lists of who does what. This resides in our practice manual. We've got standard operating procedures for the first 24 hours of a COVID-19 [or other] crisis." (Org2)

The early stage of preparation and planning was seen by many participants as a time of urgent, best-guess decision-making, in some cases without evidence or science, nor the time to gather it. In this difficult time, a participant learnt the need to "Bring yourself forward¬ ¬– I know how to deal with this and I'm going to get on with it". Three excerpts below describe participants stepping up to difficult decisions, described as 'backing yourself' and being brave and making decisions.

"Be brave and make decisions, take control, centralise, and push back against government bureaucracy. You know your organisation, your people, and your service. Make the choices that you think are needed – and back them. You can move quickly when you need. It's hard and there are always blockers with different expectations, time pressures, and resource capacity. But it can be done." (Org4)

"We had 38 aged care residents rushed into our acute hospital. We pre-emptively implemented all precautions assuming residents to be COVID-19 positive¬ ¬– in fact, 24 were positive. I provided the N95 mask and face shield to all nursing staff, but I had pushback regarding my stewardship of resources. Our hospital executive team had a daily huddle during which we asked ourselves¬ ¬– what has the last 24 hours taught us, what's expected over the next 24 hours, how do we need to respond and support? We backed ourselves and ran with the masks and face shields for one week. We didn't have cross infection in our hospital, a sign that we got it right. Three days after we admitted the aged residents, N49 masks were recommended, and quite soon N49 masks and face shields became the gold standard." (Org3)

"[I was concerned that] I was overreacting. But I learned that having the worst case scenario at the back of your mind meant that you knew what you might have to do, anything less was perfectly permissible." (Org3)

Although communication was a strength within organisational governance, over the longer term, and in response to changes in facility-wide policies and interventions, new communication processes became necessary. The participant below learned that getting the information to those who needed it, was a vital step in staying ahead of rapid change. The second participant notes that having all key executive and management staff in the leadership team meeting kept the message clear and saved time.

"We'd often call for a dial-in meeting for 3pm with our leadership team to get an update on what's happening. We are across a region, so keeping people in the loop around current situations was vital¬ ¬– what decisions have been made, what extra restrictions are in place, what the Premier will announce in the next couple of days. Everyone felt really well informed, so when they were talking to nurses, doctors, patients, they knew what was happening and why." (Org3)

"Our central Coronavirus Emergency Response Group made all key decisions and all key people were involved. We avoided the need to report to others, they were all in the room, all agreed at the same time. It meant that there was an ability to enact things more quickly, with more authority. It was incredibly fast moving, two meetings per day if needed. Currently we are back to fortnightly leadership meetings. There's a need for flexibility in the response. I think one of the points I've learned is that the ability to downscale responses as much as to upscale them is important." (Org3)

In relation to strength in governance, participants reported new learnings regarding early and long-term pandemic management. In future, in the face of certain pre-determined infectious triggers, participants report that they will follow a rigid step-by-step response. This includes moving to an emergency management arrangement, the cessation of a business as usual model of governance, and removal of key staff from their normal role to a COVID-19 focused role. Participants learned that their policies and procedures on infectious management, clinical, non-clinical and administrative, must be up-to-date and evidence-based. Also important was the lesson regarding stepping up to leadership and being brave¬ ¬– in the face of conflicting points of view, the executive learned that they needed to back themselves and back other voices of authority in the organisation.

3.2 FACILITY-WIDE CHALLENGES

Participants reported various learnings from the many challenges and disruptions in clinical practice. It is useful here to specify the lessons learnt so that CHA can prepare for future crisis, either infectious disease or other. The key learnings are described below under infection risk and governance.

INFECTION RISK

In Section 2, participants recounted many difficulties in the management of infection risk, particularly and most urgently in the residential aged care sector, as noted by one participant below.

"In Victoria, most of our infections were either aged care residents or their carers. The scenario of COVID-19 in aged care was not in anybody's pandemic plan – we were underprepared and under-resourced. Aged care has got to be our focus going forward." (Org3)

The international press carried graphic reports of highly burdened ICUs, it is therefore not surprising that early scenarios were modelled on the assumption of high use of ICUs. According to one participant, "We planned for the pandemic by freeing up ICU beds, training staff, and buying extra ventilators – we were wedded to the ICU scenario. We learned that our plan wasn't agile enough to quickly pivot to another focus" (Org1). Another participant also reported the need to model various scenarios. "We did so much planning, modelling, and yet we didn't get it right. Moving forward,

we will expand our education to enable us to visualise other scenarios than just ICU" (Org3).

The participant recounts below her acute care hospital's response to an unexpected demand from government, certainly not a scenario that could have been foreseen: "We had to take 38 care residents [into our acute facility] with 45 minutes notice, we had never considered that scenario in any of our modelling and we had 10 minutes to plan". The learnings that occurred during and after the event are described, the situation was complex, but the acute facility had the organisational agility to swing into immediate action.

> "The first resident arrived from the aged care facility around midday and the last around midnight. From the DHHS's point of view, evacuation of residents from the facility was urgent. It was a matter of quickly getting the aged residents to us, with some paperwork if possible, if not it would follow at some point. Our executive team remained onsite – key steps, processes and systems were set up on the hop and staff resources were moved from areas of the hospital. The Director of Nursing Services greeted every resident, triaged their care needs, and allocated rooms. We got pastoral care involved, they made contact with the resident and called their family member. It was just complex on every level. Residents had no personal effects. We were in full PPE and the paramedics were in full HAZMAT suits. Residents were scared, some were very sick with COVID-19, all were dehydrated. The provision of fluid and nutrition was a priority. Also, normal patient services could not be compromised. It was the most challenging day but it was also probably the most rewarding day." (Org3)

Other learnings occurred in relation to COVID-19's impact on aged persons in private residential aged care facilities. In the first excerpt, a participant notes that her acute-care facility was ill-prepared to respond to the needs of aged care facilities struggling to manage the pandemic. She describes their new response and the push for the maintenance of on-site residential care. In the second and third excerpts, participants describe their current response to new notifications in aged care.

> "At first, we didn't have the processes in place to do assessment of their [aged care facilities] infection prevention, their clinical governance, and their corporate governance. But we can now go in and assess the situation and decide what support we can offer. We have since developed tools for conducting an aged care assessment, and kits that contain full PPE, inclusive of HAZMAT suits. Following assessment, we consult our group executive, clarify the risks, and seek approval to send in support, for example, the provision of two weeks of nursing care for 10 to 15 residents onsite in the aged care facility. We would need to be able to deliver PPE supplies to the aged care facility, ready to go the next day. Education of existing aged care staff would be a priority, as is negotiation over PPE supplies and infectious control procedures." (Org3)

> "Immediately following our first case of staff infection in aged care we established a Residential Aged Care Response team. This team met within an hour, or less, at any notification of infection. We visited the site and organised additional skill resources because site clinical expertise wasn't necessarily there. Our infectious diseases physician spent 4.5 hours within an aged care facility to understand the work paradigms. We did a lot of education, a lot of development, a lot of training on infection control, particularly between the first and second wave. We also did live staff video updates twice a week and daily at certain times [during which] the task force leader and infectious diseases physician advised and answered questions." (Org2)

> "We developed quick response teams into aged care, led by expertise in the public hospitals. Key issues were tackled by the response team, such as, management of resident flow, and staff training in PPE and clinical assessments skills. We provided extra infrastructure and knowledge that facilities suddenly found they needed in the pandemic. As time passed and in response to the high threat in aged care we delegated our private hospitals to receive aged care residents and step down COVID-19 positive residents no longer requiring intensive COVID-19 management in the public hospital." (Org1)

A new state-wide response to COVID-19 in aged care has been developed [cluster plan published 6 November 2020*]. One participant explains that "the minute there is a positive case in an aged care facility now, it's activation to the Victorian Aged Care Response Centre (VACRC). Every health region/cluster in Victoria has a lead hospital" (Org3).

> "In our region, Monash Health is the lead hospital regarding response to aged care outbreaks. They are notified of a COVID-19 positive case, they undertake the contact tracing, and they support staff, provide additional staff and provide education. They act quickly, one case is considered an outbreak in an aged care residence. Monash Health is very good at assessing whether the resident can be cared for on-site and safely isolated away from the rest of the cohort, or whether transfer is needed. Monash Health does the primary assessment in the residence, and then the secondary sweep involves other services (such as ours) within that cluster network to provide staffing and support." (Org3)

Also, in relation to aged care, one participant evaluated problem points in the built environment. A number of key points are presented below, chief among them is the ability to "break up large wings and create smaller room cohorts" (Org4).

**In response to coronavirus (COVID-19), all private and public health services across Victoria are assigned to regionally based clusters to plan, prepare and respond to outbreaks in their cluster. Each cluster has a lead health service responsible for coordination and oversight. All Victorian RACFs have been mapped to one of these clusters. In the event of an outbreak, RACFs are contacted by a team from their designated cluster.*

COVID-19 Plan for the Victorian Aged-Care Sector. https://www.dhhs.vic.gov.au/covid-19-victorian-residential-and-aged-care-facility-plan, 06/11/20.

> "The built environment in aged care must take into account that the highest risk of infection is from staff and visitors. Visiting spaces should be available at the front of the building so that visitor traffic through the building is avoided. Buildings need multiple entry points that can be managed easily to control or stop the flow of visitors and staff. There should be more hand wash sinks and sanitiser points – inside bedroom doors, outside bedroom doors and in bathrooms. Shared bedrooms and bathrooms are no longer suitable, except for couples. Buildings also need storage for large amounts of PPE on site, good-sized internal and external waste disposal points and regular clinical waste removal." (Org4)

Many new learnings occurred in relation to aged care. One participant explains how these learnings will be carried forward to better manage common infectious outbreaks in her aged care facility. The second participant explains the new normal in her facilities.

> "A learning for us to take forward is to have health care infections on our risk matrix along with mitigating strategies. One that we will be utilising is mask wearing during winter months to manage influenza – stringent infection controls not only make sense in protecting lives but also financially. Every outbreak affects occupancy, staff sick leave, use of agency staff, casual coverage and increased cleaning costs." (Org4)

> "Standard procedure now is mask and eye goggles at all acute care and aged care. Standard procedure is screening of all visitors on entry, and all staff at the beginning of their shifts. One challenge now is that we are getting complacent because the crisis is over. That is a huge challenge." (Org2)

A large COVID-19 outbreak in residential aged care, involving both residents and carers, was not part of any organisation's scenario planning – an aged care response was not initially prepared nor resourced. Key learnings were made in relation to broadening the base of possible scenarios and building organisational agility so that skills and experience can be transferred quickly to new challenges. Other learnings in aged care related to organisations' skill and capacity to respond to the needs of residential aged care facilities. Key in this response is aged care assessment and clinical/administrative support to maintain on-site care of aged residents.

FACILITY-WIDE GOVERNANCE

Lessons were learned regarding two key facility-wide governance issues: first, the single voice and second, interaction with government. In Section 2, participants recounted their struggles to maintain a "single voice" in their facilities; the "one source of truth to interpret and advise on everything". Two participants below recount their learnings on supporting the 'single voice'.

> "I learnt to back our critical incident team's infectious diseases expert regarding complicated decisions. Other team members would insist on an approach at odds with our own expert, even other infectious diseases experts. It's complicated, there are points of difference that a non-expert can't decipher. There is often no precedent, no evidence. I quickly learned that I must back our team's expert, his sense of scope and national and state involvement really added value." (Org2)

> "The infection control consultants – I learnt to adhere to their discernment of issues, trust their learning and training, rather than undertake verbatim government regulations, which may not be suitable." (Org4)

Facilities found interaction with government to be difficult to manage, due to both the speed and unpredictability of government directives and government message overload. Once a government directive was received, it was often time-sensitive, examples include the furloughing of the entire anaesthetic staff in an acute facility, the requirement to COVID-19 swab all elective surgery cases, and the management of contact tracing in-house. A number of learnings were reported by participants in reference to managing these large disruptions in clinical practice. In the excerpt below, a participant reports that the big issues must be negotiated between a senior hospital executive and a senior DHHS staff member.

> "My learning was that it requires someone senior to navigate the public sector. We found that our calls were going to a junior person in the Public Health Unit. A junior person can only follow the script – and the script said that in the event of contact with a positive case, then everyone is furloughed. This meant that our entire anaesthetic workforce was to furlough. As a senior executive of the hospital, I phoned straight through to the Health Secretary to say, 'I need you to escalate this for me'. I then called the head of the Public Health

> Unit and said, 'I want you dealing with this one, let's get some logic on this'. We came up with a good process and a plan for staggered return of key staff. We worked from 10pm until 3am to negotiate a way forward." (Org2)

The second learning related to interaction with government was the need to get control over message overload, for example, "Different instructions/information from the Federal Health Department and the State Health Department. It would change, sometimes twice a day; mind-boggling" (Org2). A participant explains in the excerpt below that they needed to direct government "to set up a coherent crisis team" with controlled communication channels.

> "Changes to protocol were coming so thick and fast that you could never keep up. We created a register to document all state and Commonwealth legislation, directive and policy so that we could actually sign off on it (date of first implementation, person responsible for implementation and the evidence). This data is important for us to reflect on and potentially provide for future inquiries or even a Royal Commission." (Org1)

A key intervention in the management of aged persons with COVID-19 was separate them into cohorts. Patients in the same stage of illness (length of time since positive test) were cohorted together. Separation of cohorts was strictly controlled, and the DHHS required frequent updates. The participant below describes her learnings on how to manage a reporting responsibility in a rapidly changing situation.

> "Cohorting, moving patients, keeping cohort sections secure, managing access points – the DHHS kept asking us for live updates on cohorting, so we kept sending off the maps of our structure with color-coded rooms. But by the time data were sent, we'd have changed it. We learned how to manage better, we regrouped and developed a paper, an instruction list." (Org2)

The participant below explains her organisation's difficulty in managing government communications and directives from "three states all with different jurisdictional approaches and COVID-19 scenarios" and the learnings they took forward.

> "Our group executive needed to understand state-based issues and provide support, guidance and policy activation. We addressed the jurisdictional complexity by appointing a hospital CEO in each state as our representative in state government meetings. At our weekly CEO/DHHS meeting [in each state] we had 'a heads up' regarding their focus and we usually knew something was coming. Each state representative filtered the information and presented it to our Coronavirus Emergency Response Group and to all state-based CEOs." (Org3)

Learnings occurred throughout 2020 regarding how to manage and sustain the single voice of authority within organisations. Also, in relation to communication flow with government, any large disruption to clinical functioning, for example, furlough of key staff, needed senior executive/senior government officer dialogue and management.

4. Report conclusion

Australia encountered its first positive COVID-19 case on 25 January 2020 (international traveller). On 11 June, the state of Victoria moved into a second phase of the pandemic. At its conclusion on 24 November, Victoria's second phase accounted for 75 per cent of Australia's cases and 90 per cent of deaths. Aged persons in residential care, and their carers, were particularly vulnerable to the virus and experienced the highest mortality rate.

CHA member organisations had the benefit of strong executive level governance processes which sustained them during initial COVID-19 preparations and responses. In addition, facility-wide governance processes quickly adapted to the threat – they moved away from a business as usual governance structure to a central emergency response team arrangement. They brought all necessary expertise to the team, inclusive of infection control, HR, IT and procurement. Strength lay in each team's diversity of expertise and the willingness of team individuals to take immediate action and resolve problems.

The long-term second wave of the pandemic (June to November 2020) tested organisations' ability to manage infection risk and maintain staff and patient safety. In response to challenges, facilities acted quickly and competently. Many new/updated policies and procedures for COVID-19 risk management were enacted, for example, entry point staff/visitor assessment, upskilling of staffs' PPE use, restriction of staff movement, closure of shared spaces and processes for contact tracing.

Participants reported new learnings regarding early and long-term pandemic management. In future, in the face of certain pre-determined infectious triggers, participants report that they will follow a rigid, step-by-step response, inclusive of moving to an emergency management arrangement, ceasing a business as usual model of governance, and removal of key staff from their normal role to a COVID-19 focused role. Participants learned that their policies and procedures on infectious management, clinical, non-clinical and administrative, must be up to date and evidence based. Also important was the lesson regarding stepping up to leadership and being brave – in the face of conflicting points of view, the executive learned that they needed to back themselves and back other designated voices of authority in the organisation.

Early in the second wave, facilities faced a surge of COVID-19 positive cases in residential aged care. Original planning, based on overseas events, focused on ICU capability, purchasing and workforce preparation. The need to pivot from ICU care to aged care proved difficult. Key learnings were made in relation to broadening the base of possible scenarios and building organisational agility so that skills and experience can be transferred quickly to new challenges. Organisations reported many new learnings in relation to aged care, mostly related to their own skill and capacity to respond to the needs of residential aged care facilities. Key in this response is aged care assessment and clinical/administrative support to maintain on-site care of aged residents.

FOR MORE INFORMATION ABOUT THIS REPORT
PLEASE CONTACT:

James Kemp
Health Policy Director
Catholic Health Australia

+61 414 973 573
jamesk@cha.org.au
cha.org.au
+61 2 6203 2777

Tom Ristoski
Director Strategic Partnerships and Executive Education
Australian Catholic University

+61 2 9465 9196
Tom.Ristoski@acu.edu.au
acu.edu.au/executiveeducation

About Catholic Health Australia

Catholic Health Australia is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities and related organisations and services.

80 hospitals and more than 25,000 aged care beds are operated by different bodies of the Catholic Church within Australia. Approximately 40,000 home care and support consumers are also supported. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australis can be obtained at www.cha.org.au.

About Australian Catholic University

At ACU we pride ourselves on offering a welcoming environment for everyone. At the same time, we're a university committed to standing for something clear. We stand up for people in need and causes that matter. We're guided by clear values, the pursuit of knowledge, human dignity and the common good.

We're young, but we are making our mark. ACU is ranked in the top 40 of Generation Y universities worldwide* and top two per cent of all universities worldwide**. We've grown rapidly over the past few years, and now have eight campuses around Australia, and a campus in Rome, Italy. We put our students and staff at the centre of a vibrant global network of scholars, partnerships and opportunities.

We're closely integrated into our communities and industries, working with them to answer the big questions, and to create tangible results. Our research programs tackle enduring and pressing issues in society, in Australia and around the world.

ACU
AUSTRALIAN CATHOLIC UNIVERSITY

CRICOS registered provider: 00004G