NSW Ministry of Health and NADA COVID-19 Webinar for Alcohol and Other Drug NGOs

30th April 2020

On 30th April, NSW Health and NADA held a webinar which explored the current best practice approaches to infection control in response to COVID-19 and provided an opportunity to ask questions about adaptations you can make in your service. Dr Tony Gill, the Chief Addiction Medicine Specialist from the Ministry of Health, Centre for Alcohol and other Drugs was joined by Kathy Dempsey from the Clinical Excellence Commission (CEC) and a panel of members who have made shifts in their practice to maintain the health and safety of staff and clients in response to COVID-19. Below is a summary of the Q&A from the session.

Q. What steps should a service take in preparation for returning to residential service intake?

A. Services should consider:

- Their current infection prevention and control processes and whether staff are educated in relation to these
- Whether they have appropriate access to hand hygiene
- Whether they need to develop client education around changed processes and hygiene
- Whether there are appropriate waste management and cleaning processes in place.

Services should address any gaps in these areas prior to reopening. Additionally, services should implement verbal screening measures as part of the pre-admissions process, including asking clients about whether they have been well, had any temperatures, close contact with confirmed cases, or have undertaken any recent travel.

Useful resources:
Fact Sheet: Coronavirus (COVID-19) outbreak management in residential care facilities
Guideline: Coronavirus (COVID-19) infection prevention and control for residential care facilities
Coronavirus (COVID-19) resources for Aboriginal and Torres Strait Islander people and remote communities

Q. Is it unreasonable for us as a residential service to request a COVID-19 test for any prospective admission prior to accepting them into the service?

A. Current recommendations do not support screening of asymptomatic patients as part of the pre-admission process for residential rehabilitation services. A negative test doesn't rule out a person having the virus. The incubation period ranges from approximately 2-14 days (7-10 days on average), and people can have a negative test result while in the incubation window. A negative test result therefore does not completely rule out a patient having the virus, and screening of all prospective admissions does not provide an assurance that a service will remain COVID-free.

Services can verbally screen patients for a recent history of symptoms, close contact with confirmed cases and travel history. It is recommended that this type of screening be carried out as part of the pre-admission process.

NSW Health currently recommends that anyone with respiratory symptoms or unexplained fever should be tested for COVID-19. Hence, if a potential client reports a recent history of symptoms, they should be referred to a COVID testing clinic prior to entry into the service.

An up-to-date list of symptoms and current case definition is provided in the CDNA National Guidelines for Public Health Units.

Q. What is the role of temperature testing in screening new admissions?

A. Not every patient with COVID-19 will have a temperature. There will also be variation in results depending on the way you take temperatures and which device you use. Patients might not have a temperature at the time of testing but that doesn't necessarily mean they are disease-free. It would be preferable to focus on verbally screening clients for their recent symptom history, for example, asking “have you had any recent night sweats/chills?”

Q. If a prospective new resident was required to detox within a health facility ,could they then be screened before release to a community based residential rehabilitation service?

A. All detox units are sensitive to the presence of any symptoms and undertake regular COVID-19 screening. Anyone with symptoms is quickly isolated and tested.

Q. What are the risks of infection and transmission from clients exiting prison into residential treatment services? Is there scope for testing prior to release or on release?

A. Prisons and aged care facilities are more likely to support COVID-19 transmission, therefore testing and general infection control (cleaning, limited contact, etc.) are rigorous in these settings. Potential clients coming from a prison environment should be assessed on the basis of symptoms and epidemiological factors (i.e. any recent contact with a confirmed case), rather than relying solely on a positive or negative test. Our concern is the holding up of service waiting for a test.

Q. Our service is too small to isolate an infected person from anyone else in the service - an infection in our service will result in complete isolation of the whole service.

A. In this case it would probably be best to consider ongoing telehealth arrangements. Your service might want to consider having an onsite infection control practitioner provide advice specific to your site.

Q. Is a one-step daily clean of bathrooms/toilets sufficient, or is there a requirement for a two-step clean in a residential setting during lockdown when we reopen?

A. The CEC recommends enhancing cleaning measures (two-step or two-in-one step cleaning, at least daily or when visibly dirty). Consider giving people who are sharing facilities access to cleaning wipes and ensure cleaning is carried out at the end of each day (e.g. by maintaining a cleaning audit). It is important to isolate anyone who is symptomatic of COVID-19.

Useful resources:
Management of COVID-19 in Healthcare Settings, Clinical Excellence Commission.

Q. How many residents should be sharing a bathroom and presumably it would need to be cleaned in between?

A. Enhancing cleaning processes should be in place (see above). You do not necessarily need to clean bathrooms between every client, but services could consider giving residents access to cleaning wipes as well as ensuring bathrooms are thoroughly cleaned every day. Anyone who is symptomatic should be isolated so they are not sharing a bathroom with other clients.

Q. Are there any known cases of COVID-19 within the prison system?

A. There are currently no known cases within the prison system.

Q. If someone has tested positive for the virus and recovered can they catch it again?

A. The evidence around this is not yet clear.

Q. What if someone has tested negative but is still symptomatic?

A. If a symptomatic person has been tested and the test result is negative for COVID-19, they still shouldn’t attend a service until 48-72 hours after the cessation of any symptoms.

Q. When it comes to cleaning surfaces, which is better: a diluted bleach solution or the use of a hospital-grade disinfectant?

A. Detailed advice on environmental cleaning is available on the CEC website and the Australian Department of Health website – this advice covers which cleaning products to use and how. It's relatively easy to destroy the virus using a detergent solution and disinfectant. The recommendation for COVID-19 is cleaning with a detergent followed by disinfection. Disinfectants (e.g. bleach) are not to be used as general cleaning agents, unless combined with a detergent as a combination cleaning agent. Disinfection should always be undertaken following, and in addition to, detergent cleaning.

Useful resources:
Management of COVID-19 in Healthcare Settings, Clinical Excellence Commission.

Q. Are the "gold standard" / comprehensive pre-admission screening questions recommended?

A. As part of the pre-admission process, services should screen patients for a recent history of symptoms, close contacts with confirmed cases and travel history.

Q. A large percentage of AOD clients are homeless. Would clients be able to be moved into a hotel for 14 days to self-isolate?

A. LHDs can provide locations for homeless people to isolate if they don't require hospitalisation.

Q. It is critical that the Aboriginal and Torres Strait Islander community is protected from COVID-19, therefore it is not feasible to send an Indigenous client with suspected COVID-19 home. Will resources, especially PPE, be directed as a priority to an Indigenous service should a positive case emerge?

A. As for other situations where clients don't have a suitable place to self-isolate, your LHD can assist with locations for people to self-isolate if required. Discuss this with your LHD in advance.
Access to PPE has been improving. NADA has information about where to access PPE on their website. NSW Health has provided guidance for NSW Health funded NGOs to request PPE here.

Q. Can clients be isolated or quarantined within the community?

A. If clients are able to go home and isolate for 14 days then this would likely be preferable to remaining at a residential AOD service. However - in the event of a confirmed COVID-19 case within a residential rehabilitation service – the local Public Health Unit would become involved and would provide tailored advice depending on the specific circumstances (i.e. individual case or outbreak, what sort of support clients have at home etc). The Public Health Unit would also provide support with contact tracing.
In the event that a client tests negative but still has viral symptoms, they should stay isolated until 48 hours after symptoms have ended.

Useful resources:

Guideline: CDNA coronavirus (COVID-19) guidelines for outbreaks in residential care facilities

Q. What precautions are required for clients isolating within a service?

A. If a person is isolating within a service, contact and droplet precautions are required. Contact protection would include protective apron/gown and gloves. Droplet protection includes a protective mask and eyewear. A P2N95 respirator mask would be recommended if there were procedures being undertaken which might aerosolise the virus, which is unlikely in most residential settings.

Useful resources:
Recommended Guidance on Mask Use in New South Wales
Management of COVID-19 in Healthcare Settings, Clinical Excellence Commission.
Latest COVID-19 resources from the Clinical Excellence Commission

Q. What PPE is required to return to residential intake and service delivery?

A. Please refer to the PPE resources on the CEC website.
More information on appropriate levels of PPE for different circumstances is found in the CEC document Management of COVID-19 in Healthcare Settings (see pages 9-12).
Services that shared their approach to infection control and intake processes:

KEDESH REHABILITATION SERVICES

- *Eliminated face-to-face assessments*
- *Reduced beds from 2 to 1 clients per room*
- *Adapted screening processes - checking current symptoms and symptoms they may have had in the past few weeks, and contact with anyone, recent travel, current health issues which may make them more vulnerable.*
- *Disclaimer given to clients that rehab could be interrupted and that they may be asked to self-isolate as required*
- *Development of firm exit plans in case clients need to leave to isolate because we would find it hard to isolate people within the service*
- *Provision of education for clients around changed intake processes*
- *Reduced staff working on site where possible.*

TRIPLE CARE FARM, MISSION AUSTRALIA

- *Remained open*
- *Developed a pre-admission screening process which included symptom history, contact history, travel history, and consultation with the client's GP*
- *Able to isolate on site as needed*
- *Regular cleaning*
- *Education of staff not to come to work if unwell*
- *Moved aftercare service offsite to be delivered remotely*
- *Educating clients about the need for changes to service delivery*
- *Managing kitchen and catering staff by providing more catering and doing washing up with hot wash so people aren't preparing food in a communal kitchen setting.*