Covid-19 and long-term care in Aotearoa New Zealand

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1. Key points

- As at 22 July 2020, Aotearoa New Zealand (NZ) has experienced 1,555 cases of COVID-19. Of these, 1,506 have recovered and there have been 22 deaths.
- The Ministry of Health (MOH) identified five significant COVID-19 clusters in aged residential care (ARC) facilities, <1% of the 650 facilities throughout the country
- There were 153 COVID-19 cases linked to five ARC clusters accounting for 10.2% of all cases in the country. Cases of COVID-19 consisted of 39 residents and 78 health care workers, with a further 36 linked to the health-care workers.
- There were 16 COVID-19 related deaths in residents of ARC facilities, the majority occurring in hospital.
- The early stages of pandemic planning by the New Zealand Ministry of Health (MoH) and District Health Boards (DHB) focussed on hospital and secondary care.
- Planning for the impact on the ARC sector was limited in the early stages of the pandemic. When cases began to occur in ARC facilities, the MoH in partnership with the DHBs began to develop policies and procedures to support the ARC sector.
- While ARC facilities had existing infection control and pandemic policies, none were prepared for the scale of the outbreak or the resulting reduction in care home staff as a result of standing down staff who had contact with COVID19 cases.
- The psychosocial impact on staff, resident, and whānau (family) wellbeing is thought to have been significant.

2. Impact of COVID19 on the general population and long-term care users and staff so far

2.1. Population level measures to contain spread of COVID-19

NZ confirmed its first case of COVID-19 on 28 February 2020 and the fifth case a week later on 7 March 2020. On 16 March, all arrivals into the country were directed to self-isolate for 14 days and 3 days later the border was closed to all but NZ citizens or permanent residents. On 20 March 2020 Regional councils began closing public facilities and cancelling public events, and the government recommended people aged over 70 years old or with compromised immune systems to stay home.

On 21 March 2020 a 4-level alert system was introduced to manage and mitigate the risk of COVID-19 in NZ *(Table 1*). The alert system was designed to help people understand the level of risk and associated restrictions, with the current level informed by evolving knowledge of the virus and effectiveness of intervention measures to contain it. The government's official COVID-19 website www.covid19.govt.nz contained comprehensive guidance on what each level of the alert system meant for different sectors and services.

Table 1: Summary of the 4 level Alert system[3]

Alert Level		Risk Assessment
Level 4 – Lockdown	Likely the disease is not contained	- Community transmission is occuring. - Widespread outbreaks and new clusters
Level 3 – Restrict	High risk the disease is not contained	- Community transmission might be happening - New Clusters may emerge but can be controlled through testing and contact tracing
Level 2 – Reduce	The disease is contained, but the risk of community transmission remains	- Household transmission could be occuring - Single or isolated cluster outbreaks
Level 1 – Prepare	The disease is contained in New Zealand	- COVID-19 is uncontrolled overseas - Isolated household transmission could be occurring in New Zealand

Four days later on 25 March 2020 the government announced a state of emergency and the country moved to alert level 4 – a 4 week nationwide lockdown with people instructed to stay home, educational facilities closed, all businesses except essential services closed, and travels severely limited.

NZ came out of level 4 lockdown on 27 April 2020, and out of level 3 on 14 May 2020. Aged Care has continued to gradually ease restrictions since then. On 3 July 2020, at alert level 1, all aged facilities were open (except one remaining ARC cluster in Auckland) with standard hygiene precautions in place.[4]

2.2. Number of positive cases in population and deaths

As at 22 July 2020, NZ had carried out 446,367 tests, with 1,555 confirmed *(Table 2*). Of these, 1,506 have recovered and there were 22 deaths. There are 27 active cases in the country, all in managed isolation.

Table 2: Number of confirmed/probable cases and deaths attributable to COVID-19 in Aotearoa New Zealand by 10 year age bands[1]

Age Group	Active	Recovered	Deceased	Total
0 to 9	1	37	0	38
10 to 19	0	122	0	122
20 to 29	8	365	0	373
30 to 39	10	239	0	249
40 to 49	1	221	0	222
50 to 59	3	247	0	250

Age Group	Active	Recovered	Deceased	Total
60 to 69	2	177	3	182
70 to 79	2	71	7	80
80 to 89	0	23	7	30
90+	0	4	5	9
Total	**27**	**1506**	**22**	**1555**

2.3. Rates of infection and mortality among long-term care users and staff

The Ministry of Health (MoH) reports on significant case clusters, defined as 10 or more cases who are not part of the same household. Based on this definition, there were 153 cases and 16 deaths linked to five ARC clusters across 3 regions *(Table 3),* accounting for 10.2% of total cases and 72.7% of all deaths in the country.

Health care workers accounted for 78 (50.9%) of cases linked to the ARC clusters, with a further 36 others associated with the infected healthcare workers. The 39 infected ARC residents made up the remaining cases, 9% of the total beds across affected facilities. All COVID-19 ARC Cluster related deaths occurred in residents.

Table 3: COVID-19 cases and deaths linked to ARC facilities associated with significant clusters[2]

Region	No. of facilities	Number of beds	No. of cases	Cases in residents	No. of deaths
Auckland	2	186	63	12	4
Waikato	1	87	15	3	0
Christchurch	2	155	75	24	12
Total	5	428	153	39	16

3. Brief background to the long-term care system

Long term care (LTC) provision in Aotearoa New Zealand is publicly funded as part of a universal health care system and involves the provision of medical, nursing and social services for people with aged related healthcare needs. There are 20 District Health Boards (DHBs) in New Zealand who have responsibility for providing healthcare for geographically defined populations. LTC is overseen on a population level by DHBs who are contracted by MOH to purchase residential care and home-based support services for all who meet the eligibility criteria.

ARC facilities are owned by private companies or non-profit organisations and operate within a fixed-price environment, with different fees for different levels of care. There are four levels of LTC in NZ: rest home level of care for those requiring minimal support with activities of daily living, hospital level of care for those requiring increased nursing care, dementia level of care for those requiring a more secure environment, and psychogeriatric level of care for residents with more challenging behaviours requiring specialist nursing care. Access to the residential care government subsidy is asset tested where residents with assets below the threshold qualify for the subsidy. Residents with assets over a certain

threshold pay the cost of their care, up to a maximum amount, with their local DHB covering any additional cost associated with dementia, hospital or psycho-geriatric care.

Home-based support services for older people fall into two main categories: household management support and personal care. Personal care services are provided free regardless of a person's financial position, while household management support is means tested and generally limited to people on low-incomes. Respite care services are provided by aged care facilities, and are funded by a government Carer Support Subsidy, or day care, including dementia day care.

4. Long-term care policy and practice measures

4.1. Whole sector measures

MOH published COVID-19 specific guidelines to all services caring for older people including ARC, home based support services, day programs, and other community support. On 3 March 2020 DHBs were contacted by the MOH to ask how they were supporting ARC facilities with infection prevention and control (IPC) training and support. The MOH guidance included the use of personal protective equipment (PPE), management of residents or staff contracting COVID-19 infection, prevention and management of COVID-19 outbreaks, entry, exit and transfer from or between residential aged care facilities, visitation to facilities, and the management of at risk staff.

The NZ Aged Care Association (NZACA) supports over 90% of residential aged care facilities. They communicated with their members on 2 March 2020 that they were concerned about the potential for more cases of COVID-19 in ARC and the capacity required to respond. They also sought reassurance from the MOH and DHBs that ARC facilities would be supported through the pandemic. The update to members also provided guidance on actions the facilities should take in preparation for an outbreak such as reviewing how care was delivered, PPE and medication stocktakes, how an infected resident would be cared for, contingencies for staff shortages, and how they would commnicate with whānau remotely.

Table 4 outlines a summary of the guidance provided by MOH for both residential care and home/community support services at the different alert levels. While the guidance from MOH broadly aligned with NZACA advice, there was some disagreement about the precautionary measures required for new admissions to residential care during levels 2 and 3. NZACA advocated a more cautious approach at both alert levels, with almost all ARC facilities requiring a negative COVID-19 test result and 14 day isolation for all new admissions.

Table 4: Summary of the MOH alert level guidelines for ARC and LTC home & community services

	Alert Level 4	Alert Level 3	Alert Level 2	Alert Level 1
Residential care				
New admissions	Negative COVID-19 test prior to entry 14 day isolation	*COVID-19 suspected:* - Negative COVID-19 test prior to entry - 14 day isolation COVID not suspected:	*COVID-19 suspected:* - As for level 3 *COVID-19 not suspected*: - screening questionnaire	No routine testing required unless COVID-19 case definition is met

		- 14 day isolation	- Not routinely tested - Not required to self-isolate but checked daily for symptoms	No requirement for 14 day self-isolation
Current residents	All facilities on lockdown – no resident permitted to leave the premises All suspected or known cases to isolate on premises if hospital admission is not required	As for level 4	Resident outings can resume and they are not required to self-isolate on return	No restrictions
PPE	Full PPE for all confirmed or suspected cases Surgical mask at all other times with strict hand hygiene	As for level 4	Full PPE for all confirmed or suspected cases Surgical mask when caring for those in isolation but full PPE not required for asymptomatic residents	Full PPE for all confirmed or suspected cases, otherwise no PPE precautions required
Visitors	No non-urgent professional visits visitors only for palliative residents with PPE and physical distancing requirements	As for level 4	Visiting is allowed, including general family visits and non-essential service visits with basic precautions	Visiting should not be restricted and a contact register needs to be maintained
Home & community services				
Personal care	Essential personal care services to continue with strict infection control measures	As for level 4	Fully operational with appropriate infection control and distancing when able	As for level 2
Household management	Non-essential services to stop such as household management and social connection visits	Some home help "may be available on a case by case basis"	Fully operational with appropriate infection control and distancing	As for level 2
Respite	All facility based respite services closed Non-urgent respite care to be cancelled	As for level 4	Can open if they can adhere to general level 2 guidelines	Fully open

Day programs	All day programs suspended	As for level 4	Can reopen but following guidelines on group limits	Fully open
Guidelines for at risk staff	Encouraged to speak to their employers if they have underlying health conditions that make them at-risk	Where possible, 'at risk' workers should work virtually. A vulnerable workforce risk assessment framework was developed to enable assessment and mitigation of risk in the workforce		

An independent review[2] of COVID-19 clusters in ARC was undertaken, which has been recently released. The review notes that during the early stages of COVID-19 preparation was *"focussed mainly on hospital/secondary care management and the sector working on pandemic planning*" (p6) and that *"there was a perception that the Ministry, DHBs and PHUs [Public Health Units] were…all making high level decisions without considering the context of the ARC sector"*. (p10) which led to the release of, at times, contradictory policy responses. The review goes on to highlight some of the challenges aged care facilities faced in the lead up to, and throughout, the various alert levels including:

- Being underprepared for the impact of a positive case or large scale stand down of care home staff
- Maintaining adequate supplies of PPE
- A lack of clear guidance on when to lockdown with many, but not all, initiating lockdown before this was officially mandated by the Ministry of health

The review also noted "*ARC facilities which were part of larger organisations had detailed pandemic plans developed prior to the Aotearoa New Zealand outbreaks."* (p6)

4.2. Care coordination issues

4.2.1. Hospital discharges to residential and nursing homes

As outlined in *Table 4*, the requirements for entry into an ARC facility varied based on the national alert level. At all alert levels, where an individual met the case definition for COVID-19 or was symptomatic, admission was delayed until the person had a negative test returned. They could then be admitted to an ARC facility but were to remain in isolation for 14 days, be monitored daily, and appropriate PPE precautions taken. Anyone confirmed as COVID-19 positive was to remain in hospital until released from isolation.

The initial MOH case definition requirement of recent overseas travel or contact with a recently returned overseas traveller meant that ARC admissions were highly unlikely to meet the requirements for testing. Despite this, ARC facilities remained cautious and made a negative test a condition of admission.

At levels 4 and 3 the NZ Aged Care Association advised ARC providers to require all admissions to have a negative COVID-19 test prior to admission and mandatory 14 day isolation, whether they were symptomatic or not. MOH guidance at level 4 and 3 required all residents to isolate but only those who were symptomatic or suspected requiring a negative COVID-19 test.

At alert level 2, 14-day self-isolation was no longer mandatory. The NZACA advice to members was to continue to make isolation a condition of admission to their facilities. At level 1 the COVID-19 screening questionnaire utilised in level 2 for ARC was updated to align with the revised MOH criteria and thresholds for a suspected case.[7]

4.3. Care homes

4.3.1. Prevention of COVID19 infections

The Health Quality and Safety Commission (HQSC), responsible for advising the Ministry of Health on quality and safety improvements, released guidance for preventing and controlling outbreaks in NZ on 3 April 2020. This guidance included information on admissions to, and transfers between, facilities, as well as the prevention of spread within and between care facilities.[8,9]

The NZACA also released guidance on prevention and control measures, including staffing advice for homes [10] and how best to manage staffing in facilities providing multiple levels of care.[11] As with the Ministry of Health guidelines, NZACA guidance was tailored to the national COVID-19 alert level e.g level 3 advice[12] compared to level 2 advice for care[13], and visitors.[14]

The independent review of ARC clusters notes that early on in the pandemic, access to sufficient PPE supplies was challenging but that this improved following the development of a national supply chain. Most care homes had a minimum two week supply of PPE gear and but many would not have had sufficient quantities to manage an outbreak. Many facilities, even those without cases, allowed staff to wear PPE but the review comments that "*clarity around why this view was held or who was being protected was unclear*" (p7) and posited that this may have been influenced by their interpretation of infection prevention and control (IPC) policies. This is backed up by another review[15] undertaken by the NZ Auditor General into the MOH management of PPE in response to COVID-19 which comments that "*Guidelines about who should use what PPE and in what circumstances evolved during the response, and communications about those guidelines caused confusion. The changes in guidelines also challenged assumptions about the amounts of PPE that would be needed."*

Feedback from an ARC provider (*Todd, personal communication*) was that infection control and PPE training requirements were underestimated due to the turnover of staff and the difference between infection control policies and use of PPE in an outbreak compared with the usual use with isolated individuals. The ARC provider also commented on underestimating the amount of time required to keep abreast of, align with, and disseminate, the evolving policy changes during alert levels 4 and 3.

4.3.2. Controlling spread once infection is suspected or has entered a facility

As in section 4.3.1, the same HQSC document outlines a comprehensive COVID-19 outbreak management plan.[8,9]

Regional public health units worked in partnership with the local DHB and each aged care facility to provide support and guidance on controlling the spread of infection once a positive case or suspected case had been identified. Most residents found to be positive were transferred to hospital where infection control and escalation of treatment could be initiated if required. Some residents had to be moved to hospital settings when staffing of the facilities became unsustainable due to staff needing to be stood down from work while self-isolating.

Most COVID-19 related deaths of residents from ARC facilities occurred in hospital and there has been some criticism of decisions made by Public Health and DHBs to move residents from their usual place of care into hospital. Whilst concerns have been raised that this may not have been in the best interest of the resident, there was also a need to take into account the requirements of other residents and whether the facility was appropriately resourced to safely isolate and manage a case. Examples of resourcing issues included a facility where the numbers of staff stood down were so high there was no other option and another facility that was not able to adequately isolate without relocating some residents to free up space.

Examples of where moving residents to hospital were avoided were evident in some parts of the country. For example, one aged care facility who experienced a COVID19 outbreak chose to support their staff in nearby accommodation. This meant that staff could continue to work without needing to self-isolate for the required 2 weeks. There were no fatalities in the facility and no evidence was found of community transmission.

4.3.3. Managing staff availability and wellbeing

The DHBs released guidelines on how to manage staff who were considered to be vulnerable to the COVID19 virus finding a balance between the need for protection of staff, concerns about staff and their family welfare, and the need for health services to provide a safe and efficient service.[16] Vulnerable staff who still wanted to work were supported to do so by many ARC facilities who placed them in areas which were considered to be a low risk for infection.[2] However, DHB responses to protecting vulnerable staff varied around the country.

The MOH prepared for staffing shortfalls by creating mechanisms to fast-track registration and training of a COVID-19 surge workforce, including the training of kaiāwhina (carers) who could then be matched with potential employers who were looking to employ extra staff.[17]

Some aged care facilities have acknowledged the psychological burden on staff during the lockdown period, both from the stressors at work as well as their home situation, giving examples of staff being harassed on their way to work and being threatened with eviction by fearful landlords. Solutions were found for many of the issues, including provision of accommodation if needed, daily check-ins with staff, and regular health and welfare checks for

all staff were adopted by many facilities. Some facilities even implemented a temporary pay rise in acknowledgement of the increased stress.

The NZACA sought a legal opinion which reaffirmed the government's advice that *"Any person over 70 and any person with an underlying health condition who has a doctor's opinion saying they should not be at work during the COVID-19 situation has a reasonable claim to not be safe at work in the present circumstances. That is confirmed by the Government's general advice to all vulnerable persons to stay at home to avoid the risk of contracting the virus. An employer requiring any vulnerable person to come to work would be likely held to be in breach of their obligations under the law and could be the subject of significant penalties under the health and safety legislation."*[18]

4.3.4. Provision of health care and palliative care in care homes during COVID-19

At alert levels 3 and 4, ARC residents' access to routine health appointments were restricted and entry into the facility was limited to staff, essential and emergency services. Appropriate precautions were taken with residents leaving the facility including the use of PPE or 14-day isolation on return to the facility. Health services such as hospital outpatient clinics and general practice consultations were expected to provide telehealth consultations during level 3 and 4.[19] These restrictions were eased as the alert level reduced, with health care services back to normal at alert level 1, residents movements unrestricted, and visitation to facilities allowed with basic infection control and distancing precautions.

Guidelines were developed by Hospice NZ to assist with the provision of palliative care in ARC during the pandemic. The document provided recommendations on supporting the resident, their whānau, facility staff, and health professionals during the lockdown. However, face to face consultations were discontinued in most parts of the country preventing hospice staff to visit residents in ARC facilities.[20,21]

4.4. Community-based care

4.4.1. Measures to prevent spread of COVID19 infection

As outlined in section 4.1, the restrictions on home and community-based care relaxed as the national alert level reduced. At alert levels 3 and 4, only essential personal care services were provided using appropriate PPE and precautionary measures as advised by the MoH. At level 2 services were gradually re-introduced, albeit with safe COVID-19 measures in place including infection prevention control, physical distancing, contact tracing and conducting COVID-19 risk assessments.[22]

4.4.2. Managing staff availability and wellbeing

As per section 4.3.3

4.5. Impact on unpaid carers and measures to support them

The Ministry of Health recognised the additional strain on family and supports during the nationwide lockdown and relaxed the funding guidelines for carer support during alert levels 2-4.[23] This included flexibility to pay resident family members who were providing carer support and assistance with finding another support worker if required. Rules around what could be purchased with the funding were also relaxed.

4.6. Impact on people with intellectual disabilities and measures to support them

The Ministry of Health recognised that people with intellectual and other disabilities were vulnerable to the impact of COVID in a number of ways, including:

- Disabled people are more likely to be reliant on support workers for their essential supports so needed to take additional measures to 'maintain their bubble' during alert levels 2-4, and were also more likely to suffer negative health impacts if the disability support workforce was unable to work.
- Disabled people have poorer health outcomes generally and may have the co-morbidities that place them at higher risk of poorer outcomes if they had COVID-19.
- Disabled people may not be able to access the general information provided to the public and may need information about COVID-19 communicated in alternative formats, such as New Zealand Sign Language, Audio, Hard Copies, Braille, Video, Easy Read, Animation, Graphics and more.

The Ministry led a disability sector leadership group who together undertook a number of measures to ensure the continuity of essential disability supports while keeping disabled people, workers and carers safe. These measures included surety of funding for disability providers, guidance around essential disability services and PPE, outreach calling of disabled people most at-risk to ensure they had the supports they needed, tracking of risks to human rights, and setting up support for disability providers to access additional workforce if needed.

The Ministry also established the Disability Communications Advisory Group to inform disability communications. Membership includes people and organisations experienced in communications for disabled people. A large volume of accessible information was developed in multiple alternative formats about COVID-19, disability supports, health supports and general supports. Communications priorities include disability-specific messages and accessibility of broader health sector communications for disabled people. The information was published on the MOH and COVID-19 websites and shared through the disability networks.

This group transitioned to an all of government role in early April 2020, with a focus on helping to turn public information into formats accessible to disabled people. The translations and alternative formats can include material for Māori, Low Vision and Blind people, Low Hearing and Deaf people and people with learning/ intellectual disability. Communications go through a Comprehensive Co-Design and Quality Assurance processes with Disabled People's

Organisations (DPOs) to ensure content is translated and kept to the original intent of the messaging.

4.7. Impact on people living with dementia and measures to support them

The Ministry of Health released advice for ARC facilities providing care to residents with dementia during the pandemic.[24] This included strategies preparing and communicating with residents and whanau about the changes as well as practical tips on keeping them safe and how to manage identification and isolation of suspected cases. Due to the legalities and practical difficulties associated with isolation of residents with dementia, all secure units were managed as a single "bubble". There were also logistical issues associated with ARC facilities located in older buildings making zoning into "clean" and "infected" areas impossible to implement.

Guidance on supporting a person with dementia at home was also provided by the Ministry, with resources available for preparing an emergency support plan, explaining COVID-19 to a loved one with dementia, and practical tips on minimising distress and anxiety as well as how to support a person with dementia living alone.[25]

Other national organisations such as Alzheimer's NZ also released guidance for individuals affected by dementia and their carers.[26]

5. Lessons learnt so far

- NZ was fortunate to move decisively and early and has, to date, avoided the catastrophic COVID19 outbreak predicted by epidemiological modelling. ARC facilities were disproportionately affected with residents of ARC clusters accounting for 10% of cases in the country and 70% of deaths.
- Early pandemic planning at both MOH and DHB level did not adequately address the unique vulnerabilities of ARC residents, with initial MOH guidelines described by the ARC sector as lacking clarity or providing conflicting recommendations. Later guidelines developed as a partnership between MOH/DHBs resulting in improved working in the aged care sector.
- While ARC facilities had existing infection control plans in place, they were not prepared for the scale of the outbreak, in particular the loss of a significant proportion of their staff to illness or isolation.
- Access to PPE and guidelines on their appropriate use needed to be a lot clearer.
- The psychological impact on staff and residents cannot be underestimated.

5.1. Short-term calls for action

- A national ARC pandemic plan developed with a coordinated DHB and ARC response to future outbreaks
- Psychosocial support for staff
- Psychosocial support for residents and their whānau

- Streamline supply chain for essentials such as PPE
- Put in place 14-day isolation for all new admissions and re-admissions to ARC.
- Regularly test rest home staff and test everyone referred from a hospital setting prior to admission
- Identify strategies which would support residents in their facilities where possible including having a surge workforce in place in the event of an outbreak in a facility.

5.2. Longer term policy recommendations

- Acknowledgment of vulnerabilities of the ARC/LTC population and the need to explicitly factor their needs into any policy decisions
- The need to involve ARC and home/community care providers in policy development
- Clear and streamlined communication and support between DHBs and ARC
- Establish an ARC clinical nurse leader group to advise the government on policy responses.

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ANNEX 1. Questions to support international thematic reports:

a. Data on numbers of long-term care users and staff who have had COVID-19 and number of deaths

Are any of these data available in your country? *Please state the source and any calculations used to generate these data (ideally using footnotes) and mark as "not found" any data that is not publicly available in your country yet. In some countries it may make sense to do this separately for different States or Regions.*

		Residents	Staff
	How are care homes defined in the official mortality statistics in your country?		
	What is the total number of people who live in care homes (as per the definition of care homes used in the official mortality data in your country) And how many staff work there?	37,000 beds for 33,000 residents per year (TAS stats)	
	Numbers of tests carried out in care homes in your country	*?*	
	Number of care home residents and staff who tested positive for COVID-19	39	*78*
	Number of care homes that have experienced outbreaks (compared to total number of care home)	*5 ARC clusters out of ~650 ARC facilites in the country (<1%)*	
	Number of care home residents transferred to hospital due to suspected or confirmed COVID	Residents at dementia unit all moved into hospital.	*N.A.*
	Number of care home residents who died in hospital, deaths linked to COVID-19		*N.A.*
	Number of care home residents and staff who died and tested positive (before or after death) for COVID-19	16	*0*
	Number of people who died in the care home, and tested positive for COVID-19		*N.A.*
	Number of care home residents and staff who died from suspected/probable COVID-19	0	0
	Number of people who died in the care home from suspected/problable COVID-19	0	*N.A.*
	Number of excess deaths in care homes compared to same time period in previous years		*N.A.*
	Number of excess deaths of care home residents, compared to same period in previous years		

	Service users	**Staff**

Number of users of community-based care (home care, day care, etc) and staff who have been tested		
Number of users and staff who have tested positive		
Number of users and staff who have died with confirmed COVID infection		
Number of users and staff who have died from suspected/probable COVID infection		

Significant clusters in New Zealand
https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-current-situation/covid-19-current-cases/covid-19-significant-clusters

Cluster under investigation	Location	Total to date	New cases in last 24 hours	Current active cases	Origin	Status
Wedding	Bluff	98	0	0	Overseas exposure	Open
Marist College	Auckland	96	0	0	Unknown	Open
Hospitality Venue	Matamata	77	0	0	Overseas exposure	Open
ARC facility (1)	Christchurch	56	0	0	Unknown	Open
ARC facility (1)	Auckland	51	0	1	Unknown	Open
Private Function	Auckland	40	0	0	Unknown	Closed
World Hereford Conference	Queenstown	39	0	0	Overseas exposure	Closed
Community	Auckland	30	0	0	Unknown	Open
Ruby Princess Cruise Ship Cluster	Hawke's Bay	24	0	0	Overseas exposure	Open
ARC facility (2)	Christchurch	19	0	0	Unknown	Closed
Group travel to US	Wellington	16	0	0	Overseas exposure	Closed
Group travel to US	Auckland	16	0	0	Overseas exposure	Closed
ARC facility	Waikato	15	0	0	Overseas exposure	Open
Community	Christchurch	14	0	0	Overseas exposure	Closed
ARC facility (2)	Auckland	13	0	0	Overseas exposure	Closed
Wedding	Wellington	13	0	0	Overseas exposure	Close

Source: EpiSurv 09:00 7 June 2020

b. Measures adopted to prevent and manage COVID-19 infections in care homes

Measures to support care homes in preparing and dealing with outbreaks

National task force to coordinate COVID-19 response in care homes
There was no formal national taskforce for this despite the ARC sector lobbying government throughout level 3 and 4 to do so. Guidance documents were provided by the MOH but many ARC facilities found it difficult to keep abreast of the rapidly changing recommendations. Some DHBs released their own guidance, as did the NZACA, adding another layer of, at times, conflicting information for ARC facilities.

Notification of suspected cases to Public Health authorities
All cases were reported to local DHB Public Health Services who supported facilities in partnership with DHB Leaders and senior clinicians in their response.

Strike forces/ Rapid response teams
Rapid response teams to support staffing in aged care facilities (and other services) were set up in some regions however this varied across the country. A planned response with guidance at a government level when cases began to emerge was not always evident.

Reducing care home occupancy to facilitate management of potential outbreaks
Care homes not to take in new residents
Although there was no government directive to care homes, few facilities chose to not take new residents during the period of level 3 and 4 lock down. Once a case was confirmed, facilities were instructed by Public Health Services to not take new residents.
Short-term transfer of residents to alternative accommodation
Some residents had to be transferred to an acute hospital when there was a need to isolate all residents, largely due to staff shortages when many were directed to stand down and self-isolate.

Loosening regulation and inspections
After two facility outbreaks the government directed DHB's to complete a COVID-19 preparedness assessment of all facilities across the country. This work was expected to be completed within 2 weeks.

Funding to boost staff numbers: funding for additional workforce supply funding and to supplement viability of care homes
When a case was confirmed in a facility, Public health units could, but didn't always, direct staff to self-isolate at home. This created considerable staffing issues and in some areas staff

numbers were boosted from DHB resources. Many of these resources consisted of staff who had volunteered to make themselves available as part of an emergency COVID-19 response. Staff numbers needed to be boosted way above normal staffing levels when residents were being nursed in droplet precautions. In some instances, when staffing was unavailable or the physical environment was inadequate for quarantine, residents had to be transferred into acute hospitals.

Measures to prevent COVID-19 infections from entering a home

Isolation within facility for all residents

At the time of lockdown and before any cases were reported, residents were instructed to practice physical distancing, hand hygiene and good coughing, sneezing etiquette. A resident who was considered to be a close contact with a positive case was isolated within the facility. This meant they had to remain in their room, nursed in droplet precaution limiting interactions with clinical staff and no contact with other residents. These recommendations did not apply to residents in dementia or psychogeriatric hospitals.

Measures to restrict visitors to care homes

Rules to restrict visitors

Many care facilities went into complete lockdown the week prior to the national level 4 lockdown which meant no visitors including family, friends and others not on staff. Essential health workers and palliative visits were still allowed, with appropriate precautions.

Measures to reduce risk of staff passing on infections to residents

Travel restrictions for care staff

Care staff were instructed to self-isolate at home for 2 weeks after any international travel before returning to work.

Restrictions on staff entry into care homes

All care home staff were screened for symptoms at the start of each shift and were advised not to come to work if they were symptomatic and had travelled internationally or had been in contact with a COVID19 case. People not on staff were not allowed to enter the facility. Essential health workers and palliative visits were still allowed, with appropriate precautions.

Ensuring care staff only work in one care home

After one outbreak where a staff member had moved between two facilities (same organisation) a directive was given to all aged care providers to keep staff working in only one facility.

Staff remain in care homes, usually for at least 2 weeks

Once a confirmed case occurred in a care facility, all residential care staff who were considered to be a close contact had to self-isolate at home for 2 weeks. However, there are reports that this approach varied around the country and some facilities were able to maintain staff by supporting them with on site or nearby accommodation.

Use of Personal Protection Equipment (PPE)
PPE supply to care facilities was coordinated from the local DHB public hospital. Those who had a confirmed case were supported in obtaining more PPE as all residents went into isolation.

Measures to ensure that new or returning residents do not bring in the infection
Quarantine for people discharged from hospital
ARC facilities required a negative test prior to discharge and the completion of 14 days isolation – either during their hospital stay or on return to their facility.

Measures to monitor potential infections

Systematic symptom monitoring
Residents were screened daily for symptoms of COVID-19 as per the Ministry of Health screening guidelines.

Testing care home residents and staff
In some instances, once a case had been confirmed all residents and staff were tested based on whether they were considered a close contact or a casual contact. Guidelines on how this is defined was provided by the MoH and guided by the regional Public Health Services.

Training of care staff in recognizing atypical symptoms
This varied and was very dependent on DHB support. The situation was changing so fast and the MOH case definition for a suspected case also evolved with time, so it was not until some time that the need to be observant for atypical symptoms in this population became apparent.

Measures to control the infection once it has entered the facility

Contact tracing and isolation based on contact
Contact tracing and advice regarding case definitions (close contact or casual contract) and need for isolation was led by the DHB's public health teams working in partnership with the DHB lead clinicians brought in to support each aged care facility.

Isolation measures
Isolation of residents with possible, probable and confirmed COVID19 (risk zones)
Many, but not all, confirmed cases were transferred to hospital, as were possible and probable cases who were symptomatic. NZ was able to accommodate this because our hospitals had invested a lot in preparing for the impact of COVID19, cancelling elective

services and reducing occupancy. Hospital occupancy during level 3 and 4 was commonly around 50% in most parts of the country.
Isolation of residents with symptoms in single room/separate part of the facility
This varied. Some with multiple cases were able to group them together in a separate part of the facility while others were able to keep them to single rooms. However, some were unable to accommodate what was required and in these cases, residents were transferred to hospital. However, this varied around the country.
Removing residents who test positive to quarantine centres
Removing residents without symptoms of COVID19 to other accommodation

Ensuring access to health care for residents who have COVID-19

Telehealth visits from healthcare providers
General practitioners who had to self-isolate were providing telehealth support however in some instances Nurse Practitioners provided additional support when needed.

Access to palliative care
Palliative care continued to be provided in ARC by residential care staff. Specialist palliative care provided by hospices became extremely limited as visiting hospice staff were not able to enter the facilities however some telehealth was provided although this varied around the country.

Advanced directives
The need for advance care plans and clear documentation of the overall goals of care for residents has been identified as an important component of care. This becomes particularly important when residents are becoming ill and may choose to remain in the facility rather than be transferred to hospital.

Deploying additional healthcare staff to care homes
This was provided by the DHB however it was often challenging to get DHB staff to agree to work in residential care at short notice

Ensuring care homes have adequate supplies of medicines & equipment
Once a case had been confirmed this became part of the DHB daily planning and review with the facility and sometimes included things like cleaning and meal preparations as in some instances domestic staff also had to be sent home to self-isolate.

Managing staff availability and wellbeing

Government (local, national or regional) takes over funding/running of care home
No additional funding was made available for ARC. Some retrospective funding has been provided during level 1.

Funding to boost staff numbers: retention bonus paid to staff

Recruitment of additional staff
Recruitment of recent graduates and health students
Recruitment of staff that are new to the sector

Rapid response teams

Loosening staff regulations
Allowing staff with restricted work visas to work more hours

Supporting care home staff with accommodation and practical measures
There were reports of some small care facilities supporting staff with accommodation and meals in order for them to remain in the facility (effectively becoming part of the facility bubble) during level 4 lockdown. This meant that movement of staff in and out of the facility was minimal.

Psychological support to care home staff who may have experienced traumatic situations

Measures to compensate for impact of physical distancing in care homes

Methods to combat loneliness in residents

1. Use of technology to connect with family
   For example, instructions on how to install and use Zoom to keep family conversations going for people in long-term care.
   https://www.rymanhealthcare.co.nz/coronavirus-updates/zoom-how-to

2. Increased support from staff
   For example, staff in a care facility moved in with people with dementia.
   https://www.tvnz.co.nz/one-news/new-zealand/dunedin-rest-home-staff-move-in-residents-dementia-amid-coronavirus-lockdown