The Specialist Team

The Specialist Team are not placed to offer ongoing primary and allied health care but to provide support during the resident's stay only. They have the experience and knowledge to connect residents with ongoing services on their exit from the facility (if required), and to work closely with external health and wellbeing teams to identify appropriate directions for residents to facilitate external support if required.

Where possible the Specialist Team are included in the assessment of the resident in the pre-arrival process to review information that may initiate their team's response. For example, residents who have provided notification about a disability or mental health concern. They have representation at every resident arrival to further screen for indications of support being needed.

The Specialist Team goals are to:

- Provide support and assistance to all residents with additional needs that may include, though not limited to, mobility, mental health, emotional wellbeing, access to specialise services outside of the quarantine facility, functional living skills, social welfare, drug and alcohol or wellbeing.
- Work with Pod Team Leaders and staff to educate them on residents' needs to improve interactions with and support provided by the Pods.
- Work with Pod Team Leaders and staff to provide skills and ideas on how to work with residents with additional needs to improve outcomes.
- Provide Interpreting services for specific flights and provide information to Pods regarding accessing interpreters for other languages as required.
- Support whole of site operations to provide training to staff on identified areas of need within the skillset of the team.
- Create and roll out resident information or promotions to support fitness, health, and wellbeing. Refer to *Section 4: Resident care* for examples of resources prepared for resident health and wellbeing in quarantine.

The team structure

The Specialist Team works with residents and staff from both repatriation and domestic quarantine programs in both the pre-arrival process (if the information is known) and during the resident's 14-day quarantine stay.

The Tele Wellbeing Team has two Specialist Team members embedded in their structure, a Social/Welfare Worker and Mental Health Nurse who review resident information from the DFAT pre-arrival manifest, and responses by residents to the information gathering questioners. The remainder of the Specialist Team are based on site and comprises of; a social worker, physiotherapist, mental health worker, alcohol and other drugs worker, an occupational therapist, ands accredited interpreters (languages specific to anticipated resident needs). Note, the role of the interpreter has been fully outlined in an individual section of *Section 5: Health, wellbeing & clinical care.*

Section 5: Figure 1: The quarantine facility Specialist Team structure.

Roles and Responsibilities of the Specialist Team

All Specialist Team members are required to:

- Adhere to the infection control measures of the quarantine site outlined in the Infection Prevention Control and Management standard operations of practice.
- Comply with Chief Health Officer Directions as they relate to quarantine workers.
- Assess the needs of residents (with the resident) and develop resident support plans that name the role and responsibility of all involved quarantine services (not just Health led) so there is a clear shared understanding of the response to the resident.
- Work collaboratively with all on-site agencies and teams and off-site service providers, family, and any other support the resident identifies to provide the best response and support plan for residents.
- Update and ensure all communications relating to residents are appropriately documented on RMITs systems.
- Escalate to Medical Officers if the needs or risks of a resident may exceed the sites capability.

Tele Wellbeing Specialist Team members

The Tele Wellbeing Team conduct the pre-arrival checklists with residents and are therefore in a position to note and prepare for any resident concerns before arrival. A pre-escalation form is completed for each cohort of arrivals containing basic information to follow up.

This may include:

- Organizing access to emergency clothing for residents when they are unable to fund this themselves. For example, it was noted certain cohorts of repatriated residents did not have clothing suitable for the tropical climate of the Northern Territory and light material clothes were required. The Telewellbeing Team can obtain information including size, gender and room number, names, etc to refer to the welfare support onsite.
- Noting if residents are travelling with vulnerable people (such as the very young or very old) and passing this information to the Pod Team to flag these residents for assistance on arrival and further assess for additional support systems required.

Example pre-arrival email to ascertain resident support needs. It is noted the email is prepared with a personable style to present a supportive communication channel.

Hello,

I am a member of the Pre-Arrival Support Team at “quarantine facility name”. Our Team is dedicated to making sure that all (international) travellers entering quarantine will be safe, healthy and comfortable during their stay.

Could you please advise me if you have any health, medical or mobility issues that may impact on you while you are in quarantine?
What is the current status of your condition?
Do you take daily medications?
Will you bring enough medication for the duration of your quarantine period?

Is there anything we can prepare in advance to address any concerns you may have to ensure that you will have a smooth transition into the quarantine facility?

Could you please confirm if you will need an (Australian) SIM Card on arrival so that we can speak to you?
Do you have access to What's App on your mobile telephone? / or are prepared to download this as our team will be able to communicate with you via this application.

Looking forward to hearing from you soon, Regards

During the resident stay the Tele Wellbeing Team have regular contact with residents and may be the first to receive concerning information from residents. This may vary from basic medical queries to see if the quarantine facility is able to assist to emergency situations.

Tele Wellbeing completes a welcome call, a mid-stay check in, and a departure planning call at a minimum to all residents. Tele Wellbeing may increase the number of calls based on what the resident wishes to occur however three calls must occur for all residents at minimum. Residents identified, as needing more support by any of the onsite teams will receive further check in calls by Tele Wellbeing.

The Allied Health team members

The quarantine facility does not operate as a medical facility, therefore, the priority of Allied Health Professionals working in the facility is to ensure the safety of residents. This can be achieved by ensuring they are physically and cognitively appropriate to enter the facility, and are supported, where possible, to maintain the required level of functional independence to manage their (limited) daily tasks whilst in quarantine. The Allied Health/Specialist Team are registered health professionals and are deemed to have the level of skills and knowledge to independently manage residents in accordance to their professional role. Allied Health Professionals onsite are recommended to include: physiotherapists, occupational therapists, trauma nurse practitioners, mental health nurses and alcohol and other drugs nurses.

The quarantine facility requires a referral form to alert the Allied Health Team to a resident requiring review, it is recommended that assessment forms used in addition to the Specialist Team referral form (for specialised fields such as physiotherapy and occupational assessments) are sourced from the local primary or secondary health services.

Due to the expectation that residents will be able to independently care for themselves, there is no hands-on functional support available for residents. For example no assistance can be provided with general activities of daily living such as attending to hygiene.

To be safely managed in quarantine residents must be able to:

- Mobilise at least 25m, using a mobility aid if required (note that this is an approximate minimum distance; rooms in quarantine are generally small, however, a resident will likely need to mobilise independently from their drop-off point to their room).
- Mobilise up and down at least 5 steps using a single-hand rail.
- Transfer in and out of their bed and chairs.
- Complete all self-care tasks (showering, dressing and toileting) independently, using assistive devices if required.
- Collect and consume meals independently (includes cognitive and physical requirements to collect meals from the front of their room, open containers and feed themselves).
- Communicate in an emergency using one of the available technologies (i.e. phone, email, iPad, personal alarm).
- Have the cognitive ability to follow directions (using an interpreter if required) and adhere to guidelines around mask-wearing, moving around the facility and intermingling with other residents (maintaining social distancing and abiding by CHO Directions).

There is more flexibility about the above requirements if the person is travelling with a carer/personal support person, however, it is important that the carer is themselves physically and cognitively capable of managing all support requirements.

Generally, in any facility, there is a very limited number of disability access rooms available. These rooms need to be well set up for people with significant mobility impairments (including full-time wheelchair users), and include ramped access and large open-access bathrooms with flip-down shower benches and grab rails by the shower and toilet. There may be occasions where these rooms will be allocated to people with conditions that significantly affect their cognition or behaviour (i.e. dementia, traumatic brain injury, autism) in order to allow a greater degree of environmental flexibility and seclusion. It is important to note however that these cases can only be allocated to these rooms if they are travelling with a suitable carer.

Refer to Appendices A for the resource developed specifically aligned to CNR to help staff understand mobility requirements of residents to access the accommodation and laundry facilities.

Specialist referrals

The Pod Health Teams review residents face-to-face on a daily basis for health and well-being checks. During these rounds, the Pod staff will check for any other additional needs or supports a resident may require and refer to the relevant teams on site including the Specialist Team. Any agency, team, or contractor can make a referral to the Specialist Team. All referrals are sent to a dedicated Specialist Team referral email address with urgent referrals to be phoned through first with a written referral completed post-call.

The specialist referral form has been provided here, examples of how this is used for an occupational therapy referral can be found in Appendices B.

Section 5: Table 1 Specialist Team referral form	
Discuss all Specialist Service Referrals with Pod Team Leader first	
Name:	**HRN (if known):**
DOB:	**Date:**
Room #:	**Pod #:**
Referral for: ☐ **Mental health** ☐ **Physiotherapy** ☐ **Social Worker** ☐ **Occupational Therapist** ☐ **Alcohol and Other Drugs Services**	
Relevant Past Medical/Social/Mental Health History (if known):	
Nursing Assessment: Tell us what you are most concerned about for our resident.	
Tell us about how our resident presents in how they talk and/or present emotionally.	
Tell us how we could assist the resident.	
Have you discussed this referral with our resident?	
Is there something we can help you/or your team with to work with, or understand our resident?	

Specialist Pod Assessment Date:

Assessment: Risks presented: Plan:
Specialist Team please complete and file this referral. Email to Pod Team Leader when completed.

Management of referrals

Once a referral is received it is logged in the systems used by the team and allocated to the appropriate staff member. The information recorded in the system is recommended to include:

- Date the referral was received.
- Who the referral was for (Social Work, Physiotherapy etc).
- Resident information (name, date of birth, gender, room number, phone number/email).
- Whom the referral came from (name of nurse or Medical Officer).
- Reason for referral.
- If an interpreter is required.
- If a support plan has been initiated.
- Has contact with the resident been direct (face to face) or indirect (over the phone).
- Has follow up been organised (for example follow up meetings and phone calls).
- Were notes added to the residents RMITS or online medical record.
- When and why the referral was closed.

The Specialist Team will make contact with the resident via phone first if appropriate. If not, face-to-face contact will be made within a 24-hour timeframe of receiving the referral, unless the matter is more urgent. When the specific Specialist Team member is not available to respond to a referral within 24 hours, this will be escalated to the Specialist Co-ordinator and Pod Team Leader.

Specialist Team Support Plan

When appropriate, the Specialist Team will ensure a support plan is in place for the resident that includes all their needs and involves all teams and services involved in their support. This may involve the Medical Officers or liaison with NGO's to assist with welfare needs. This plan will be shared with all parties and added to the relevant case management systems. The plan will be reviewed and updated as required. All notes relating to any phone calls, emails, or face-to-face visits with the resident will be recorded in the resident online clinical records or the RMITS.

Section 5: Table 2: Specialist Support Plan

Specialist Team member overseeing support:		
Name:	**DOB:**	**Gender:**
Room number:		
My cultural background is:		
Language:		
Family/carer/partner/:		
Worries **Why are we involved? What are we worried about?** •	**Strengths** **What is working well?** •	**Goals** **What is our plan of Action? How, who and when will we action the identified goals?** •
Additional notes:		

Refer to Appendices C for an example of a completed Specialist Team Support Plan for a family with suspected domestic violence occurring and a template to use for children.

Closing a Referral

Support will be provided until the resident no longer requires the support onsite or when they exit the facility. If a resident identifies they no longer require the Specialist Team's support, a discussion will occur within the team to ensure all needs in quarantine are met and an email will be sent to all relevant parties of the case closing. The Specialist Team member will update their dedicated data base with the closing date and reason of case closure.

Project Acknowledgments

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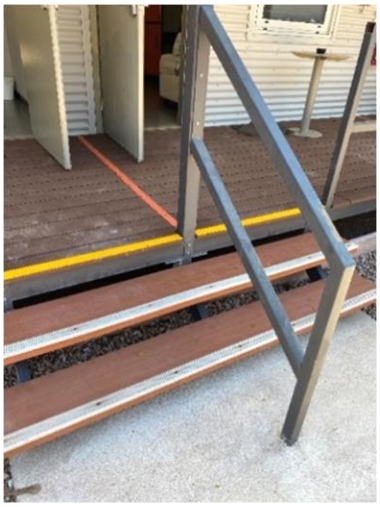
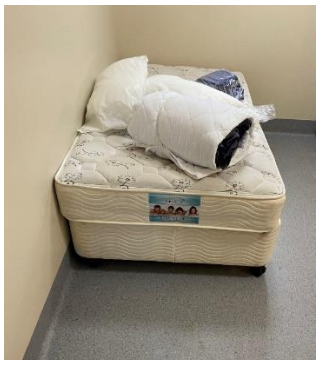
Appendices A

Allied Health Quarantine Assessment to Inform Mobility and Assisted Living Requirements.

The following resource presents an assessment of the quarantine site to provide measurements and information to align with mobility aids and assisted living. This is used by the Speciality Allied Health Team to ensure residents safety and aligns with work, health and safety requirements.

Standard Donga (4 rooms)

Access to Accommodation		
Steps	3-4 steps 140-190mm step height depending on end of donga and ground slope	
Rail	Shared single rail Standard height	
Front Entrance		
Door Width	840mm Opens outwards	
Mats/hazards	Door mats potential trip hazards	

Outside furniture		
Chair	450mm seat height 750mm armrests	
Table	830mm height Bolted to veranda	
Bedroom		
Single Bed	560mm height	

Bathroom		
Toilet	410mm seat height Nil rail Door swings out	
Shower	140mm hob height 80mm width Nil rail Lever tap Hand held shower head	

Disabled Access Donga (2 rooms)

Access to Accommodation		
Ramp	9m x 400mm elevation ~3degree	
Rail	Shared single rail Standard height	
Door Width	840mm Opens outwards	
Outside furniture		
Chair	450mm seat height 750mm armrests	
Table	830mm height Bolted to veranda	

Bedroom		
Single Bed x2	560mm height	

Disabled Bathroom		
Toilet	460mm seat height Wall Rail	
Shower	Hand held shower with rail Wall rail Lever tap Shower curtain	
Shower Bench	480mm height	

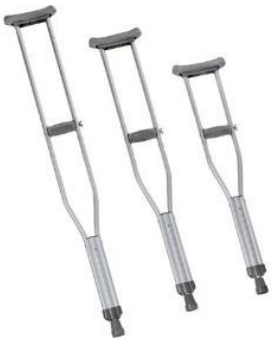
Family Donga

Disabled Bathroom		
Child proof railing installed		

Laundry Facilities

Access		
Ramp	10m x 460mm elevation ~3degree with rail	
Washer/Drier	Washer 600mm load height Drier 1550mm load height	

Available Equipment at CNR

Access equipment and Mobility Devices	
Over toilet chair	
Shower Chair	
Shower Stool	
4 Wheeled Walker (4WW)	
2 Wheeled Pick Up Frame (2WPUF)	
Walking Sticks	
Crutches	
Wheelchair	
Utility Chairs (TBC)	

OP Warehouse - Repatriation	Health Clinic Store room
	

Appendices B

Example Specialist referral form for occupational therapy.

Section 5: Table 3: Specialist Team referral form			
Discuss all Specialist Service Referrals with Pod Team Leader first			
Name:	Sophie McEwan	**HRN (if known):**	1234567
DOB:	17. 3.1952	**Date:**	25 March 2020
Room #:	C10 3A	**Pod #:**	Blue Team
Referral for : ☐ **Mental health** ☐ **Physiotherapy** ☐ **Social Worker** x **Occupational Therapist** ☐ **Alcohol and Other Drugs Services**			
Relevant Past Medical/Social/Mental Health History (if known): Left hip replacement and knee replacement Type 2 diabetes Parkinson's disease			
Nursing Assessment: Tell us what you are most concerned about for our resident. *Mrs McEwan has been observed to have very limited mobility. When the nurses spoke to her she advised she was having problems showering as she usually has a shower chair.* *The health team believe she may need assistance with doing laundry.* *Can you please assess if a shower chair may be suitable for this resident and any other additional aids to assist her whilst here.*			
Tell us about how our resident presents in how they talk and/or present emotionally. *Mrs McEwan is very pleasant and articulate and able to easily express her needs and concerns. She has stated she normally has family assist her with chores.* *She is not concerned with being in quarantine and has family to collect her and stay with when she exits the facility.*			
Tell us how we could assist the resident. *Please assess for a shower chair, review if additional assistance or aids may be required during her stay.*			

Have you discussed this referral with our resident? *Yes, she has been advised we will be contacting the specialist team onsite to meet with her and review her need for a shower chair or other aids.*
Is there something we can help you/or your team with to work with, or understand our resident? *No, the team will ensure they check on her in the morning and evening, and she has been located close to the security and health team within the zone.*

Appendices C

Completed Specialist Team Support Plan (for a family with suspected domestic violence).

Section 5: Table 4: Specialist Support Plan- example with suspected domestic violence		
Specialist Team member overseeing support: Social worker and welfare support		
Name: Priya Kaur	**DOB:** 11/10/2019 (3 year old)	**Gender:** Female
Room number: G2 7B		
My cultural background is: Indian		
Language: Main Punjabi and can Speak English		
Family/carer/partner/: Family members G2 7A Amandeep KAUR DOB: 7/5/1990 (30 years old) G2 7C Kari KAUR 12/09/2016 (6 years old) G2 7D Hameed RANI DOB 2/01/1987 (34 years old)		
Worries **Why are we involved? What are we worried about?** • Priya has been seen by the Medical Team and is being treated for impetigo. The Pod Health Team have reported this is not healing and is getting worse. • Priya has been observed to be wearing the same clothes for an estimated 3 days. The health staff have discussed the care and hygiene requirements for impetigo with Priya's father. • The health staff have noticed bruises around the wrists on Priya's and Kari. • The mother has new bruising on her forehead.	**Strengths** **What is working well?** • There is at least a twice daily check on the family: Health Team have been conducting their daily health checks with an additional check for Priya. • The family have a working phone and are contactable via this. • The children have been provided kids packs and have been observed to be playing happily. • The Medical Team will continue to review Priya and have provided antibiotic cream for her impetigo.	**Goals** **What is our plan of Action? How, who and when will we action the identified goals?** • Health leadership team meeting has been arranged (date and time)

• The Staff have never been able to engage with the mother on her own. • The father always talks on behalf of the family and has been observed to hold all the room keys. • Concerns are in regard to possible domestic violence.		

Additional notes:
Plans to take to the health leadership meeting

1. Clearly identify what the main concerns/worries are.
2. Identify the strengths and observable behaviours that indicate safety for the children and mother.
3. Verify if they need an interpreter and seek assistance to ensure the team speak with mom/dad in a culturally appropriate way.
4. Ensure communication is honest and discuss with the family the concerns.

Identify the best response plan

- What is the best way to speak to the mother on her own.
- Ensure there is use of non-blaming language “Can you tell me about the situation for you and the children? What do you think needs to happen for things to be better?”
- Observe non-verbal communication.
- Initiate a plan for the nurses to administer the anti-biotic cream.

Points to clarify

- How do we engage and speak with the children? Eg: three houses (house of worries, houses of good things and house of dreams), pictures and words, hand of safety etc.
- Who will go to see the family after the meeting?
- Pre-plan to clean the room, beddings if needed (who will clean)/ or move rooms

Meeting outcome aim:

- Identify what needs to happen that will make us confident the mother and children will be safe.
- Clear allocation of tasks to ensure this occurs.

Specialist Team Support Plan: guide for use with children

Worries **Why are we involved?**	Strengths **What is working well?**	Goals **What is our plan of Action? How will we do it?**
• What are we worried about? The child is here on their own and CNR staff are required to care for child until further notice (this could be the parent/caregiver returns from hospital, waiting for family member to arrive to care for child, allocations of abuse etc). • Who is worried? • What is the impact on the child/ren and if nothing changes what is the worse thing that could happen? • What makes this situation more complicated?	• Who is important to this child/ren and family that can continue to be involved to ensure the child continues to feel safe and stay connected while in quarantine? (exploring the families network) • Who is the person/people the child says makes them feel happy/safe even when things are hard? How can they be involved to support this child? • What are the best things about this family which will support/help the child in quarantine? • How does this child best communicate? • What are some things the child is good at, their interest, they can do on their own which will help them to self-care and keep them moving, active and connected while in quarantine?	• What needs to happen? Who will do it? Who can be part of the network? Time and frequency of these actions? • Does the child/ren know who to ask for help? Who has spoken to the children about the plan of action? • How will we know the emergency plan is working? • How long will this plan need to be in place for? • What contacts will the child have with their parent/caregiver if any? (phone call, visit to hospital etc)

On a scale of 0 -10 where ten means everyone knows the child/ren is safe enough to be on their own with the plan in place and zero means there is no plan in place child/ren are not safe and further assessment is needed, move visits to the family and child is required where would you rate this situation?