



**CRE-DH**

Centre of  
Research Excellence in  
Disability and Health



# MANAGING COVID-19 OUTBREAKS IN DISABILITY RESIDENTIAL SETTINGS: LESSONS FROM VICTORIA'S SECOND WAVE

in partnership with



# MANAGING COVID-19 OUTBREAKS IN DISABILITY RESIDENTIAL SETTINGS: LESSONS FROM VICTORIA'S SECOND WAVE

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## About the report

Researchers from the University of Melbourne and UNSW Canberra interviewed senior managers, team leaders and disability support workers from disability residential homes across Victoria.

## Acknowledgements

We thank all the staff who participated in the interviews for generously giving their time and sharing their insights.

## Suggested citation

Huska M, Dickinson H, Devine A, Dimov S & Kavanagh A (2021). *Managing outbreaks of COVID-19 in residential disability settings: Lessons from Victoria's second wave - Research Report*. Melbourne: The University of Melbourne. <https://doi.org/10.26188/14669568>

Published June 2021

ISBN 978 0 7340 5649 8

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# EXECUTIVE SUMMARY

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## Background

Disability residential settings pose unique risks for the acquisition and transmission of SARS-CoV-2 because people with disability living in those settings are in contact with multiple workers and implementing optimal infection control may be difficult. Some residents may also have underlying health conditions, which place them at greater risk of serious disease or death if they are infected with SARS-CoV-2, the virus that causes the COVID-19 disease. Despite the recognised risks of outbreaks in disability residential settings early in the pandemic, we observed outbreaks in over 50 disability group homes in Victoria's second wave between late June and October 2020.

## This study

We conducted qualitative interviews with six senior managers, six team leaders/house managers (referred to as TLs hereafter), and eight disability support workers (DSWs). Interviewees were asked about access to information, communication, training, access to Personal Protective Equipment (PPE), and testing and contact tracing. Interviews also covered responses to suspected or confirmed cases and the impacts of the pandemic on residents and staff.

## Main findings

### Government and organisational responses

- Governments lacked understanding of the unique needs of people with disability living in and staff working in residential settings
- Governments often responded late, and their responses reflected their lack of understanding of these settings
- There was a lack of coordination between Commonwealth and State and Territory governments and agencies creating challenges for services in how to respond to the rapidly evolving pandemic

### Access to information, training, PPE, testing and tracing

- In the absence of leadership from government, services developed their own pandemic response plans
- Access to information and training was challenging, placed pressure on staff and took considerable time and resources, with some providers paying for specialist infection control advice and support
- While online training was available, interviewees emphasised the importance of practical hands-on training to consolidate learning
- Senior managers and TLs reported that in some cases, workers lacked confidence or were not prepared to work in COVID positive settings, sometimes because they thought other workers were not complying with COVID-safe practices
- Access to PPE was difficult even when it was possible to claim through participants' plans, with services and staff purchasing their own
- Some services reported doing their own contact tracing when COVID-19 cases occurred because there were considerable delays by the Victorian Department of Health and Human Services (DHHS) contacting them
- Communications within organisations was challenging, with TLs feeling the responsibility for communications fell to them; particular difficulties were encountered with casual and agency staff
- TLs and DSWs were responsible for communicating with residents, sometimes developing their own resources with the support of therapists
- COVID-19 resulted in additional expenditure by services and extra hours by staff in order to provide information, training and PPE

# EXECUTIVE SUMMARY

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## Impact of COVID-19 on the health and wellbeing of residents, staff and families

- Interviewees reported that some residents found being at home preferable to going to their day programs and were likely to seek new options when public health restrictions were reduced
- TLs and DSWs reported that residents' lack of contact with other people through employment, family visits, and in the community impacted on the mental health and wellbeing of residents and sometimes saw escalation of behaviours of concern or new behaviours emerge
- Interviewees noted the additional pressures on families unable to visit family members living in disability residential settings and the challenges for families who were unable to use respite services they had access to prior to the pandemic
- TLs and DSWs also reported mental health problems, which they felt went unrecognised although some found innovative ways to support each other
- Financial pressures were also noted by staff who could not access JobKeeper and who had reduced hours during the pandemic with flow on effects for their mental health

## Recommendations

We make a number of recommendations to better protect people with disability living in residential settings and the workers that support them.

1. **Develop and refine pandemic preparedness and response plans tailored to the unique circumstances of disability residential settings**, taking into account this study's findings. We encourage these plans to be developed and refined in collaboration with managers, workers and residents who live and work in these settings, and resident's families.
2. **Greater coordination between Commonwealth and State and Territory governments and agencies with clear delineation of responsibilities and roles in terms of pandemic preparedness and response.** This should include oversight and monitoring of the implementation of guidelines and plans. There should be capacity to be able to mobilise disability COVID-19 and emergency response teams should outbreaks occur.
3. **Greater support for services and staff** through easy access to training (including hands-on training noting challenges in COVID positive settings), PPE, testing and contact tracing and specialist infection control, communication and behavioural supports. This should be rapidly responsive and not dependent on being able to access supports through NDIS participant plans. Additional resources should be provided to services so that managers and TLs have the time to attend to the additional challenges of supporting residents and staff in disability residential settings during COVID-19 and any future emergencies. Supporting services to implement procedures to reduce worker mobility and recompense workers who have reduced hours because of these changes or because they need to take sick leave is also required. Peer networks of support for workers should also be explored.
4. **Proactive outreach to residents, workers and families** to provide support to promote their mental health and wellbeing during the pandemic. This requires working closely with staff and residents to identify tailored approaches to support their mental health.
5. **Financial support for services and staff** to respond to the pandemic, purchase equipment, and compensate DSWs for reduced hours and/or sick leave.

# BACKGROUND

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In March 2020 the NHMRC Centre of Research Excellence in Disability and Health issued two statements of concern about risks for people with disability in the COVID-19 pandemic. The statements identified the heightened risk of infection for people with disability who have multiple workers providing support, difficulties with physical distancing, with those living and working in congregate environments particularly at risk. We made a series of recommendations for the disability and health sectors. In relation to the disability service sector these related to upscaling capacity in infection control, developing a standby workforce capacity, facilitating priority access to PPE, and provision of paid pandemic leave for DSWs<sup>(1,2)</sup>. We also called for particular attention to the transmission risks associated with casualised work<sup>(3)</sup>, where disability support workers (DSWs) without sick leave might be incentivised to go to work unwell within congregate living and working environments. We argued for much stronger oversight of these environments to ensure the health and wellbeing of DSWs and the people with disability they support, was protected<sup>(4)</sup>.

In Victoria's second wave we released a third statement (July 2020) following outbreaks in the public housing towers where many people with disability are known to live. Among other recommendations, we reiterated the need for proactive outreach and auditing of services by the relevant government agencies including the Victorian government, the National Disability Insurance Agency, and NDIS Quality and Safeguards Commission<sup>(5)</sup>.

## Outbreaks in disability residential settings in Victoria

Unfortunately, the concerns we and others had raised about the risks in congregate settings played out during Victoria's second wave when we saw outbreaks in disability residential settings such as group homes and Supported Residential Services<sup>(6-8)</sup>. By 21 August 2020, it was reported there were active cases across

50 disability residential settings<sup>(9)</sup> and anecdotally we heard of challenges faced by services and DSWs in responding to the outbreaks.

Outbreaks in disability residential settings revealed the complexities in coordination between State and Commonwealth government agencies across the disability and public health portfolios. For example, while the NDIS Quality and Safeguarding Commission was the regulator for NDIS registered providers who ran group homes (Supported Independent Living), 40 percent of group homes in Victoria were still regulated by the Victorian government as they were still transitioning from state government to not-for-profit providers. Furthermore, public health restrictions and directives were the responsibility of the DHHS.

In response to the growing number of cases and unique challenges in preventing and responding to outbreaks in disability residential settings, the Victorian and Commonwealth governments announced the establishment of a joint Disability Response Centre on 21 August 2020, which included the Victorian Department of Health and Human Services, the National Disability Insurance Agency (NDIA), the NDIS Quality and Safeguarding Commission (NQSC) and the Commonwealth Department of Social Services<sup>(9)</sup>. As part of that announcement there was \$15 million committed to a scheme aiming to reduce the mobility of workers across different sites to reduce transmission. However, even at this time, the national guidelines for the management of outbreaks in disability residential settings to which service providers were referred, were guidelines developed for residential aged care. It was not until March 2021 that the Communicable Disease Network of Australia released a Disability supplement to their guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities specific for disability residential settings<sup>(10)</sup>.



## Our research

Throughout the pandemic the CRE-DH has conducted research to inform government, services and community responses. This research has included three national surveys of DSWs the first in May to June 2020 and the second between September and October 2020. These surveys revealed issues around infection control training, access to PPE, worker mobility, and financial and psychological stressors for DSWs. The third survey concentrated on vaccination and was conducted between March and April 2021. The third survey demonstrated relatively high levels of vaccine hesitancy relating to concerns regarding vaccine safety as well as lack of confidence in the efficacy of the COVID-19 vaccines<sup>(11)</sup>.

## This qualitative study

Following outbreaks of COVID-19 in disability residential settings in Victoria, we conducted qualitative interviews with disability support workers and team leaders working in disability residential settings as well as senior managers of those services. The aim of these interviews was to better understand their experiences during this time period in terms of preparedness for outbreaks, information and communications, experiences working in COVID-19 positive settings or concerns about working in those settings, as well as the consequences of the second wave on the wellbeing of DSWs and people with disability in those settings.

## This report

We summarise the methods and findings of the qualitative study followed by a discussion on how the experiences can inform future planning of disability sector support needs during a pandemic or other emergency response. Our report concentrates on the findings that are particularly relevant to policy and future preparedness for infectious disease

outbreaks. We conclude with recommendations for consideration by state and federal governments, relevant government agencies including the National Disability Insurance Agency (NDIA), NDIS Quality and Safeguards Commission (NQSC), and providers of disability residential supports.

# METHODS

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## Recruitment

Participants from the online surveys who had indicated they worked in residential support settings, as either TLs or DSWs, were invited via email to participate in the qualitative study. We approached CEOs of residential service providers in Victoria, interviewing either the CEO or senior managers responsible for managing the organisational COVID response. All CEOs and TLs were asked a series of preliminary questions via a secure online survey platform and their consent to participate was collected at this point also.

## Data collection

We undertook semi-structured interviews with six senior managers, six team leaders/house managers, and eight disability support workers. The senior managers were from six different providers of residential supports. The TLs and DSWs worked for seven disability services across metropolitan Melbourne and regional Victoria.

### Interviews with senior managers covered:

- the type and quality of information and communication with governments
- actions taken by organisations to suspected or confirmed cases among residents and/or staff
- support for staff and/or residents during the second wave
- challenges faced by service providers.

### Interviews with TLs and DSWs covered:

- workplace pandemic preparedness including provision of information, communication, training, infection control and access to PPE for staff and residents
- responses (or anticipated responses) to suspected or confirmed cases among staff and/or residents

- impact of the COVID-19 pandemic and lockdowns on staff and residents.

Ethics approval for the study was obtained from the University of Melbourne's Human Research Ethics Committee (HREC number: 2056824.1).

## Analysis

Three project team members completed independent initial thematic coding analysis of a sample of TL and DSW transcripts. Emerging themes were identified, with subsequent further interpretation discussed by the three project team members producing a thematic framework. This framework was used for subsequent analysis of all TL, DSW and senior management transcripts. Further refinement of central themes was completed by the project team, with analysis of senior management interview transcripts following a similar thematic analysis.



# MAIN FINDINGS

None of the TLs or DSWs interviewed had been involved in managing a COVID-positive resident, however, almost all reported having experienced being made aware of a potential contact risk with a suspected case in a resident, but more often in a staff member, with some reporting having been a close contact of a confirmed case in a staff member. Three senior managers reported having COVID-positive cases in staff or residents and at least one suspected case.

## Government and organisational responses

Interviewees described feeling ‘left behind’ and ‘forgotten’ in government responses to COVID-19, that there was a lack of understanding of the risks specific to disability residential settings, and that responses were poorly coordinated across government departments. The lack of relevant information and direction led to services needing to develop their own responses.

### Government responses

Interviewees reported widespread concern that governments had not considered the unique needs of people with disability and the disability workforce until some significant time after the pandemic had started when infection levels were rising. They thought governments’ responses were uncoordinated and came too late.

There was very little information for a very long time to disability providers; almost, um, unrecognised as a sector that needed support... And then when the support did come it was almost too little too late and uncoordinated. (Team Leader)

When this all started up to July/August, you did not hear disability support workers listed in any media information. It was always health care workers ... Disability workers are on the frontline as much as health care workers. (Disability Support Worker)

Interviewees reported that State and Territory and Commonwealth governments were slow in responding to the specific needs of people with disability living, and DSWs working, in disability residential settings. This resulted in difficulties accessing clear relevant information and guidance on how to manage outbreaks in these settings. TLs and DSWs thought government responses failed to recognise the implications and provide guidance on the COVID-19 response and associated restrictions on disability residential settings, and, on the capacity of staff to continue to provide support to residents across all aspects of their lives including personal care and health supports, activities of daily living, recreation and work. As senior managers explained, providers were often left with protocols from aged care to fill the gap in specific guidance to disability residential settings:

... people were trying to apply aged care solutions to supported accommodation for disability and it's a very different model...there wasn't a deep understanding in government of what the model of supported independent living looks like. (Senior Manager)

and Human Services come into the house and do an assessment and within five minutes, they're like "oh, this is quite different to a nursing home." And I'm just sitting there going, ....it is very different. They were from the COVID response team of DHHS. (Team Leader)

## Cross-government responses to COVID-19

All senior managers identified the lack of coordination between government departments, relevant portfolios and agencies, as being a significant issue and one that had hindered an effective response in the early days of the pandemic. As one explained:

The issue was a lack of coordination because there are so many multiple players playing in the space of disability. So you've got the DSS, the central government, you've got NDIS, then you've got a state government who by and large have devolved their residential services. And then you've got, of course, the state government responsibility for managing the pandemic. Then as time went on that layering was further, complicated by having a disaster response group within the Victorian government, a public health division and of course, the people in the DHHS who continue to work in disability. So my guess would be that the majority of people then were faced with confusion, with multiple people saying multiple things, and although most of the responses then became reactive. What disability could learn from all of this for the future is the need to be more proactive and coordinated because of the multiple players in this space. (Senior Manager)

Some providers reported having a less complicated organisational context because their services still fell under the purview of the Victorian government and not the NDIA. These organisations believed they had a far easier time managing in the pandemic context as their perception was that the NDIA and the NDIS Quality and Safeguards Commission had been far less effective in their communication and support than the state government.

DSWs expressed concern when a resident's newly experienced pandemic induced distress and challenging behaviours developed, no funding was available in the resident's NDIS plan to access appropriate supports. Further, DSWs felt the general lack of contact from the NDIS during the pandemic reflected minimal understanding by the NDIA, of individual disability response needs within the context of a community wide public health pandemic response.

**I think just more of an understanding as to what goes on on the ground.  
(Disability Support Worker)**

TLs reported minimal to no awareness of either the NDIA or the NDIS Quality and Safeguards Commission being in direct communication with their organisation or providing services with direct guidance on how resident's NDIS plans could be more flexibly utilised in response to the changing needs arising as a result of the pandemic.

TLs reported organisations persisted in their view that a resident's current NDIS plan could adequately provide support to do this without any form of review or discussion:

Through this COVID, they should have reviewed all of the clients' NDIS packages. They should have had a look what they could do a little bit more towards activities and things inside the home. I mean, I'm sure they're bored brainless in their own home, working from home. So how do these people feel when they can't responsively tell you what's wrong? What's wrong, mate? What can I do to help you? What do you feel like eating? Well, you can do it on a daily basis, you do it automatically. Go to the fridge, make yourself something. These people can't. They can't even toilet without our assistance. So there's got to be a lot more quality to these people. You know, they are the forgotten community. (Team Leader)

## Organisational responses

In the absence of leadership from government, organisations developed and implemented their own pandemic response plans, with some organisations engaging infection control consultants to support them. The costs of these consultants had to be borne by the providers. Some providers came together to share intelligence and to support one another.

Senior managers reported taking action before it was identified by government as being important. For example, offering to pay casual staff for a shift if they were not able to work due to having symptoms consistent with COVID-19 well ahead of the pandemic pay that was made available in some jurisdictions (e.g., Victoria). They also made rostering changes to reduce the number of homes that individuals worked in.

Senior managers reported they invested considerable time in developing lines of communication that enabled regular and consistent messaging across their organisations. Some adopted a cascade approach with messages being sent out electronically then staff at each level of the organisation checking that the messages had been received and understood by those they supervised. This was largely seen to have been effective, although there were challenges with some groups such as agency workers.

The senior manager responses contrasted with TLs' accounts where they identified the lack of a coordinated and consistent communication strategy. Although understanding the evolving nature of the pandemic required regular updates, the volume of information received presented challenges. TLs reported the time pressures associated with absorbing all new information and ensuring all staff had access and understood expectations. Some team leaders felt their organisation could have done more to support the increased expectations and responsibilities they took on during the pandemic, such as by providing additional administrative hours.

From the perspective of TLs, organisations relied on them to ensure that DSWs accessed and implemented guidelines. Permanently employed DSWs generally reported receiving information directly from the organisation or via their team leader. Casually employed DSWs reported receiving information via the supervisor of the organisation they had been employed through who was responsible for casual employees, TLs or other DSWs when they arrived for their shift.

DSWs reported inconsistencies in how information was interpreted and shared, with conflicting information provided by line management and between colleagues. Team leaders and DSWs alike, described a need for more timely access to current reliable information that was specific to the needs of staff and residents of disability group homes.

**There was very little information, and a lot of it seemed contradictory. And it felt like my organisation wasn't keeping up with guidelines set by the government, so it was very confusing and very stressful, especially at the beginning. It still feels like they're a week behind on guidelines and restrictions. It takes them a long time to come to a decision, and then to filter it out to frontline staff.**  
(Disability Support Worker)

Interviewees generally reported that communication, trust, and collaboration between team leaders, DSWs and site supervisors worked well. In some, the lack of consistent information and communication strategies, impacted staff trust in organisational leadership. For example, communications were not always perceived as transparent, or supportive of the impact of the pandemic on TLs and DSWs. This was highlighted in relation to communications about potential loss of income, as well as the impact of delivering COVID safe support behaviours, whether to prevent infection or respond to suspected or confirmed cases.

For some this amplified concern frontline workers were not being listened to:

**I hear of other organisations that are being very innovative in the way they're providing support. In our organisation, when a number of us have given some ideas, "We've brainstormed. Here's a whole lot of ideas that we chatted about," they say, "Thank you, and here's all the reasons we can't do that." (Disability Support Worker)**

Communication between staff working in disability residential settings was critical to facilitate the day-to-day functioning of teams and homes, providing a sense of safety and support for each other, as well as the residents.

The manager and staff were in frequent contact, people that were on shift were actually responsible for ringing ahead to the next people that were on shift to ask them the seven questions or the four questions, whatever level it was at the time, so that you could actually ascertain before people came on site, rather than just arrive now and “you’ve got a temperature, you’re not allowed in.” They were asked that a couple of hours in advance so that the person on site could then actually contact the office and say, “This person can’t come in. I need a replacement.” (Disability Support Worker)

Both TLs and DSWs reported organisations predominantly relied upon staff to determine how information would be shared with residents. TLs and DSWs reported that access to a speech therapist had been important in developing Easy English resources and social stories and that Behavioural Intervention Support (BIS) was important.

We’ve been open and honest with them. We sit with them with the news. We had a resident who became obsessed with the figures and the negativity of COVID. So the Behaviour Support Specialist designed a social story around that. (Team Leader)

TLs and DSWs described practical challenges in promoting ‘COVID safe practice’ because some people with disability found it difficult to understand and comply with COVID safe practices. This was further compounded by the design of residential settings (particularly older facilities), where shared bathrooms and living spaces are the norm, which made it even more difficult for staff to support safe practice, such as social distancing and hygiene practices.

## **Access to information, training, personal protective equipment (PPE), testing and tracing**

Senior managers, TLs and DSWs reported challenges in accessing information and training and PPE. They also reported DSWs being refused tests even though they were in the priority group for testing. Managers and staff reported the lack of understanding of disability residential settings and weaknesses in the contact tracing systems leaving services themselves to perform this role.

### **Information and training**

Senior managers reported investing significant time and resource into the provision of relevant training for staff members. This was reflected in interviews with TLs and DSWs, where all those we spoke to reported training on infection control, including on the appropriate use of PPE, was made available through their organisations on their intranet. Whilst TLs expressed confidence in their individual knowledge and capacity to correctly implement COVID-19 practices, some expressed concern that their organisation’s reliance on online resources failed to support all team members to develop confidence and competence in the delivery of COVID-19 infection control practice.

A lot of information was provided on the intranet which has proved beneficial to the computer savvy staff but not so for the staff who aren’t confident in accessing the intranet. I print a lot of the information out and place it into the folders so that they have access to the information as well. Even the COVID Safe Plan that was emailed, I printed out. It makes reference to all these policies and procedures but if you went to 100% of my staffing team, they wouldn’t be able to come back to you and say, I know where to locate this, this, this and this. (Team Leader)

Senior leaders, TLs and DSWs thought that while online training was crucial, it was most effective when it was complemented by practice hands-on experience.

Services found it challenging to keep training up-to-date and disseminate it to all staff amidst the rapidly evolving pandemic and changes in government responses.

It is important to note, confidence in their knowledge and ability to implement COVID-19 safe practice expressed by team leaders, translated into a willingness to support a COVID-19 positive resident if this situation was to arise. Although a number of senior managers did note that despite several DSWs volunteering to work in the case of COVID-positive residents being identified when such a situation arose, they often found individuals not willing to work in such a context. While DSWs also reported confidence in their own practices, there was less willingness and more anxiety about the prospect of supporting a COVID-19 positive resident:

**When staff were unclear last time about some of the procedures in place, and were perhaps a little bit flippant and – and when I go back into the house and goggles aren't being worn, and sometimes masks are hanging around people's ears and – and not feeling supported by management. I don't want to be in that environment if someone shows symptoms or if someone is positive, because I don't feel safe. (Disability Support Worker)**

## Personal Protective Equipment

Senior managers reported that not being identified as priorities to access the government central stockpile of PPE meant that organisations spent a significant amount of time sourcing this early on within the pandemic, whereas aged care providers did not have this challenge. Providers went to extraordinary lengths to identify and secure PPE so that their staff would have access to this. One even reported sourcing a pattern for gowns and working with volunteers to produce these in a range of different colours. Many organisations reported that they incurred significant costs purchasing PPE and that these costs were not able to be recovered.

**It's more than \$700,000 to date. With the support that the NDIS has now come up with that you can claim PPE through peoples' packages from the end of July to the end of September, we'll probably get \$100,000 back. (Senior Manager)**

Several senior managers identified that the process of claiming back costs for PPE through individual packages is an extremely time intensive exercise itself and felt a bulk payment from the NDIS would have been far more effective.

TLs and DSWs expressed dismay at the continued delays in access to adequate supplies of PPE.

Some TLs independently sourced resources such as hand sanitiser. TLs and DSWs also raised concern about the lack of government and organisational monitoring and support to ensure DSWs had access to, and were appropriately utilising PPE.

By contrast, one TL reported their organisation as having an established relationship with a health service provider. The team leader identified this as enabling access to up-to-date and relevant information and guidance; practical training in the use of PPE; and, importantly, reliable access to PPE and effective infection control practices in place. A number of senior managers reported utilising networks to assist addressing the same issues.

## COVID-19 testing

Early in the pandemic, residents and staff in disability residential settings were not identified as having priority access to COVID testing. Subsequent to being given priority access, some reported not all testing sites were aware of this revised 'status' and were turned away because they were asymptomatic.

Conversely, TLs and DSWs reported there were instances of residents being required to be tested multiple times. This was despite DSW/TL's efforts to communicate to authorities that the resident's cough in question was related to long standing dysphagia associated with their disability. TLs and DSWs also identified the reality that some residents would not be able to cooperate with testing; even if this was under legitimate circumstances. Again, the lack of disability responsive guidelines on what protocols should be



considered in such circumstances, amplified their concern for resident health and wellbeing during the pandemic and response.

### Contact tracing

TLs and DSWs reported that services took responsibility of contact tracing and alerting staff when they may have been exposed to COVID-19 and that they did not have the expertise or authority to undertake this task. This was of particular concern when staff became aware of having been a workplace contact of a confirmed case, where significant delay in follow up with workplace contacts occurred:

**I don't understand how it wasn't communicated to DHHS. Once you get a positive result, doesn't that automatically go to the contact tracing team? So when I'm getting a phone call from my manager, instead of from contact tracing, it feels like DHHS has just palmed it off. (Disability Support Worker)**

Similarly, senior managers reported that because the test and trace system was not operating effectively they had to do the contact tracing.

**The testing was a debacle, the tracking, you know, they didn't have phones. I had the same person ring me so we had the three ladies who were positive. I had the same person ring me about two, one person twice but nobody was ringing me about the other two. (Senior Manager)**

### Impact of COVID-19 on the health and wellbeing of residents, staff and families

The impacts of COVID-19 on the health and wellbeing of residents, staff and families were manifold. While some residents had seen new opportunities when their traditional programs closed down, our

interviewees reported a deterioration in mental health and wellbeing for residents, staff and families.

### Impact on residents

There were positive and negative impacts on residents. Senior managers reported being surprised that early on within the pandemic there had been:

**a decline in incidents, both from a staff and resident perspective. (Senior Manager)**

This was contrary to their expectations that there might be incidents as a result of the significant changes that residents and staff alike encountered. Others suggested that they expected the changes associated with lockdown might have long-term impact in the types of services that individuals might choose to access. For some residents being at home and not going to day programs had been a positive experience and a number of individuals had indicated that they did not want to return to the services they accessed prior to the pandemic.

Although TLs and DSWs shared senior managers' opinion that many residents preferred being at home to attending their usual day program activities, they also identified examples of how they felt residents were made more 'vulnerable' within the public health response. For example, the lock down and subsequent loss of access to family, employment and the wider community, was reported to have a significant toll on the mental health and well-being of residents. Compounding this was the fact that many TLs and DSWs did not feel they were given sufficient authority, resources or support to adequately address these concerns.

DSWs frequently commented on the challenge of supporting people with disability who had difficulties comprehending these public health restrictions and the many changes happening in their day-to-day life. For some residents, declining mental health escalated known challenging behaviours or caused these to



be observed for the first time. On these occasions, TLs reported the positive benefit for resident's when their current NDIS plan included capacity building supports. This enabled online access to behavioural specialists when a resident experienced pandemic induced distress, or support from a speech pathologist with communication strategies and resources to enhance resident understanding and mitigate distress. Yet as described above, the use of NDIS plans to provide this type of support was applied inconsistently across residential settings:

So, for example, our lady that lives within the group home that has behaviours of concern has a practitioner, and a behaviour specialist. I had been in consultation with her using Zoom, and had regular updates about what needed to be implemented during that time, and she was very helpful. The speech pathologist for the majority of the ladies, again through NDIS, we amalgamated it all together and we've managed to – she's built social stories as well as accessing NDIS to get iPads and then she's set up cheat sheets for Zoom. (Team Leader)

TLs and DSWs also identified the limited training for staff and varying levels of resident access to mental health supports, amplified an already stressful environment. Both perceived this placed residents and staff at increased mental health and physical risk:

I think that from the point of view of the organisation, they really have had the clients in mind in all their planning, and that is excellent. They have tried to keep staff safe. I will agree with that. But I also believe that they have not perhaps kept the mental health and wellbeing of staff and clients as close to the forefront as the health of the clients and staff. (Disability Support Worker)

### **Impact of the COVID-19 on families of residents**

Concern was also expressed for the potential unintended consequences the absence of a specific

plan for disability residential settings on the ability of families to be in contact with current residents and access to respite services because some providers needed to cancel or cease respite bookings. Without access to funding for alternative options, organisations were unable to offer supports which sustain informal carers, increasing the potential for unintended consequences such as relinquishment of family members with disability into the care of the

Because of the children and persons they support and just trying to live a normal family life with the rest of their family and have that happy balance and then to pull respite where they were able to have time to recuperate and recover and – and spend time with their other family members, without the demands of the person that they're supporting at home, is a godsend to them. And then, we just ripped it out from them. So yeah, my fear was relinquishment. (Team Leader)

In response to these concerns some senior managers explained they had invested time and energy into supporting families and residents to meet via online mechanisms (e.g., zoom):

... but that became complicated and the reality is there are a number of elderly families that just don't know how to use Zoom. (Senior Manager)

### **Impact of the COVID-19 on TLs and DSWs**

Senior managers reported giving careful thought to how to support DSWs who they recognised were being asked to take on significant and difficult roles. As one explained:

**it was actually about looking after them and recognising, you know, they're disability support workers, this is working for, eight, nine, 10 hours in full PPE with people that are COVID positive, that is full-on. One provider had set up an equipped house in the case that they had a worker who had been exposed to COVID in the workplace and was unable to isolate at home. Others sent care packages to workers who were being asked to self-isolate. (Senior Manager)**

Senior managers were concerned that COVID-19 might have resulted in burnout of staff with some potentially leaving the workforce.

Nonetheless, many TLs and DSWs felt there was not sufficient support, but instead there was an expectation they would simply cope with the considerable addition to workload. Some TLs, in response to this concern, used their discretion and initiative to produce a roster affording staff more consecutive days off and a greater opportunity to rest and recover.

Many TLs and DSWs also identified the importance of 'worker networks' for peer support, discussion and assistance with understanding their individual site situations, as individual organisation pandemic responses unfolded. Some commented, when staff were redeployed and movement across sites became restricted, worker networks became less accessible.

More broadly, TLs and DSWs felt organisations could have done more to provide greater support for the mental health and well-being of staff:

**They point us to free counselling; everyone puts on their worry hat and says, "Well, if I go and talk to them are they really independent, or does that get fed back to work?" So, they much prefer to go through their GP if they needed counselling or something like that. (Disability Support Worker)**

Adding to the emotional stress experienced by TLs and DSWs, was the additional financial challenges experienced during the pandemic and response. For example, as service providers moved to minimise movement of staff across residential services, many DSWs had their hours significantly reduced with no or limited access to paid leave (with one reporting their hours were reduced to zero). Compounding this financial and mental stress, was the challenges service providers and individuals experienced in trying to navigate and access welfare initiatives such as JobKeeper:

**Staff who have not worked since March or worked full time, they're redeployed and they've got three hours of work. The organisation applied for JobKeeper on a number of occasions, and we actually got it for three days, and then the government changed the rules again and we became ineligible again. (Disability Support Worker)**

# DISCUSSION

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**This small study provides important insights into the challenges experienced by managers and workers in Victorian disability residential settings in the second wave of Victoria's COVID-19 pandemic.**

Governments lacked understanding of the unique challenges of living and working in disability residential settings, as reflected in their reliance on guidelines for aged care. Government responses were reported as coming too late and there was a lack of coordination between different government agencies such as the NDIA, NDIS Quality and Safeguarding Commission, and the Commonwealth and Victorian Departments of Health. Services were left to develop and implement their own pandemic response plans, sometimes paying for expert advice from infection control specialists.

There were challenges accessing appropriate information and training and a preference for practical hands-on training in addition to online resources. Services needed to find ways to communicate information to staff with TLs reporting considerable responsibilities being placed on them. TLs and DSWs reported a lack of monitoring of COVID-19 safe practices and that some DSWs were not complying with guidelines. This undermined their confidence in working in COVID-19 positive settings. Access to PPE was lacking with providers and staff often accessing their own equipment. Access to testing was difficult early in the pandemic despite DSWs being prioritised for testing. Where outbreaks did occur communication with the DHHS Victoria was often late with services having to conduct their own contact tracing.

The COVID-19 pandemic public health response also had considerable ramifications for residents, staff and families. While TLs and DSWs reported that some residents found that they were happier at home than in the day programs they accessed before the Victorian lockdown, others reported that the lack of social contact undermined residents' mental health and sometimes escalated behaviours of concern. Staff

themselves also experienced mental distress which they felt was recognised by their managers although some reported peer networks of support were helpful. DSWs also reported financial pressures due to loss of income from reduced hours. Interviewees also reported stresses on families unable to visit family members as well as on families who were no longer able to access respite.

# RECOMMENDATIONS

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- 1. Develop and refine pandemic preparedness and response plans tailored to the unique circumstances of disability residential settings,** taking into account this study's findings. We encourage these plans to be developed and refined in collaboration with managers, workers and residents who live and work in these settings, and resident's families.
- 2. Greater coordination between Commonwealth and State and Territory governments and agencies with clear delineation of responsibilities and roles in terms of pandemic preparedness and response.** This should include oversight and monitoring of the implementation of guidelines and plans. There should be capacity to be able to mobilise disability COVID-19 and emergency response teams should outbreaks occur.
- 3. Greater support for services and staff** through easy access to training (including hands-on training noting challenges in COVID positive settings), PPE, testing and contact tracing and specialist infection control, communication and behavioural supports. This should be rapidly responsive and not dependent on being able to access supports through NDIS participant plans. Additional resources should be provided to services so that managers and TLs have the time to attend to the additional challenges of supporting residents and staff in disability residential settings during COVID-19 and any future emergencies. Supporting services to implement procedures to reduce worker mobility and recompense workers who have reduced hours because of these changes or because they need to take sick leave is also required. Peer networks of support for workers should also be explored.
- 4. Proactive outreach to residents, workers and families** to provide support to promote their mental health and wellbeing during the pandemic. This requires working closely with staff and residents to identify tailored approaches to support their mental health.
- 5. Financial support for services and staff** to respond to the pandemic, purchase equipment, and compensate DSWs for reduced hours and/or sick leave.

# REFERENCES

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1. Kavanagh A, Carey G, Dickinson H, Llewellyn G, Bonhady B & Trollor J. Targeted COVID-19 responses needed for people with disability - Statement of Concern #1, 15 March 2020. Melbourne: Centre of Research Excellence in Disability and Health. <https://credh.org.au/covid-19/>
2. Kavanagh A, Carey G, Dickinson H, Llewellyn G. Policy action to protect people with disability and COVID-19 Statement of Concern #2, 23 March 2020. Melbourne: Centre of Research Excellence in Disability and Health. <https://credh.org.au/covid-19/>
3. Dickinson H, Carey G & Kavanagh A. Personalisation and pandemic: an unforeseen collision course? *Disability & Society*, 2020;35(6):1012–7. <https://doi.org/10.1080/09687599.2020.1772201>
4. Kavanagh A. Protecting people with disability during the pandemic. *Pursuit*, 22 April 2020. Available at: <https://pursuit.unimelb.edu.au/articles/protecting-people-with-disability-during-the-pandemic>
5. Kavanagh A, Carey G, Dickinson H & Llewellyn G. *Recommendations for a tailored COVID-19 response for people with disability during COVID-19*, 14 July 2020. Melbourne: Centre of Research Excellence in Disability and Health. <https://credh.org.au/covid-19/>
6. Preiss B & Eddie R. Coronavirus Australia: COVID-19 fears rise in disability homes after two deaths. *The Age*, 11 August 2020. Available at: <https://www.theage.com.au/national/victoria/coronavirus-fears-rise-in-disability-homes-after-two-deaths-20200811-p55km3.html>
7. Henriques-Gomes L. More than 30 residential disability services linked to COVID-19 outbreaks in Victoria. *The Guardian*, 7 August 2020. Available at: <https://www.theguardian.com/australia-news/2020/aug/07/more-than-30-residential-disability-services-linked-to-covid-19-outbreaks-in-victoria>
8. Henriques-Gomes L. Victoria calls on federal help to contain COVID-19 outbreaks in residential disability care. *The Guardian*, 16 August 2020. Available at: <https://www.theguardian.com/australia-news/2020/aug/16/victoria-calls-on-federal-help-to-contain-covid-19-outbreaks-in-residential-disability-care>
9. Jenkins S. COVID-19 disability response centre established in Victoria. *The Mandarin*, 21 August 2020. Available at: <https://www.themandarin.com.au/138028-covid-19-disability-response-centre-established-in-victoria/>
10. Communicable Diseases Network of Australia. Disability Supplement to the CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia. Canberra; 2021.
11. Kavanagh A, Dimov S, Shields M, McAllister A, Dickinson H, Kavanagh M. *Disability Support Workers and COVID-19 vaccine hesitancy and communication needs- Research Report*. April 2021, Melbourne: University of Melbourne. <https://doi.org/10.26188/14456577>

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