Coronavirus Disease 2019 (COVID-19) Outbreaks in Residential Care Facilities

CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia

Revision history			
Version	**Date**	**Reason / Changes**	**Endorsed by**
4.0	15/03/21	Revision Incorporation of lessons learned from outbreaks in 2020	CDNA
3.0	14/07/20	Revision Update outbreak identification and management guidance Update of roles and responsibilities of government agencies Additional members for Outbreak Management Team	CDNA
2.0	30/04/20	Revision Update clinical presentation in older people Update Infection Prevention Control Guidance	CDNA
1.0	13/03/20	Initial Release	CDNA

The Communicable Diseases Network Australia (CDNA) developed this guideline in consultation with the aged care sector. It has been noted by the Australian Health Protection Principal Committee (AHPPC). Where the guideline differs from state and territory protocols, the local requirements in the state or territory should be followed.

The guideline has been adapted by the CDNA from:

- Australian state and territory guidelines for COVID-19 outbreak management in residential care facilities (RCFs)
- documents and guidelines from the Australian Government Department of Health (herein called the Commonwealth) and other Australian health agencies.

It includes information from various international health authorities. They include the World Health Organization, the Centers for Disease Control and Prevention (USA), and the Public Health Agency of Canada.

This guideline provides best practice information to prevent and manage COVID-19 outbreaks in RCFs to assist:

- administrators of facilities
- staff of facilities
- health and aged care workers
- public health authorities.

This guideline captures the knowledge of experienced professionals. It provides guidance on good practice, based on the available evidence at the time of completion. Readers should not rely solely on the information contained within this guideline. Guideline information is not a substitute for advice from other relevant sources including advice from a health professional. Clinical judgement and discretion may be required in using these guidelines.

While every effort has been made to ensure the accuracy and completeness of the contents of the guideline at the time of publication, members of CDNA and AHPPC, and the Commonwealth of Australia as represented by the Department, do not warrant or represent that the information in the guideline is accurate, current or complete. CDNA, AHPPC and the Department do not accept any legal liability or responsibility for any loss, damages, costs or expenses incurred by the use of, reliance on, or interpretation of, the information in the Guideline.

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1. Introduction

This guideline applies to all RCFs in Australia. It provides information to enable facility staff to plan, prepare, detect and respond to COVID-19 outbreaks.

The facility can be any public or private service where facility staff provide residents with personal care or health care. This includes:

- residential aged care
- residential disability care
- community based residential health facilities (for example, drug and alcohol services)
- long stay hospital wards and rehabilitation hospitals
- other similar accommodation settings in Australia (for example, retirement villages)

RCFs are complex environments that can be at high risk for transmission of COVID-19.

Although the guidance applies to all RCFs, there are particular features of aged care that place residents at higher risk of infection with SARS-CoV-2 and adverse outcomes from COVID-19. Therefore, these guidelines have a strong focus on residential aged care facilities (RACFs).

Features that make aged care facilities higher risk include:

- a large number of residents on site
- a large number of people who enter facilities enabling introduction of disease
- a large number of frequently touched surfaces by people on site
- a predominantly elderly population of residents, with age over 70 years and high comorbidity being strong risk factors for severe illness and mortality
- some staff with limited health backgrounds and/or limited experience in infection prevention and control (IPC) and personal protective equipment (PPE) use
- staff shortages which require use of agency staff. These staff may not be familiar with the facility, its processes and residents. They may be working at short notice and at times with limited experience
- working and living arrangements which involve close proximity to others in a densely populated environment
- shared use of equipment and spaces
- residents who may be unable to remember or comply with isolation and infection control processes
- centralised processes operating across all areas
- difficulty with scaling up actions more readily undertaken in smaller outbreak settings

RCFs are not established to be like hospitals. This may limit or restrict the ability of facilities to practise rigorous environmental infection control, and some surfaces may be harder to decontaminate.

More guidance for disability residential services (DRS) is in the *Disability Supplement to the CDNA Guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia.*

1.1. Legal Framework

It is the responsibility of RCFs to identify and comply with relevant legislation and regulations. RCFs must fulfil their legal infection control responsibilities by adopting standard and transmission-based precautions. These are directed in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (2019) and by state/territory public health authorities.

Commonwealth subsidised aged care facilities are also required to operate under the *Aged Care Act 1997* to be accredited. Accreditation requires adherence to infection control standards and management of high impact risks. The Aged Care Quality and Safety Commission ensures Commonwealth subsidised organisations providing aged care services in Australia are complying with the *Aged Care Quality Standards*.

All RCFs are required to operate under the relevant Work Health and Safety legislation in their jurisdiction.

COVID-19 is a notifiable condition under the Australian National Notifiable Diseases List (NNDL).[1] In all Australian states and territories, the medical officer requesting the test and/or the laboratory performing the test must notify the relevant jurisdictional public health authority of the COVID-19 case, as per local legislative requirements. RCFs must also report cases.

1.2. Roles and Responsibilities

1.2.1. Residential Care Facilities

Providers are required to provide quality care and ensure the safety and well-being of residents in their care. Providers are required to follow state/territory government directions and decisions and advice from the public health unit (PHU). The provider has responsibility for:

- adhering to applicable quality standards
- complying with public health orders, resident care, staff work health and safety (WHS), and infection control in their facility

A list of processes and systems RCFs need to prevent and prepare for potential COVID-19 outbreaks is at Appendix 1.

RCFs have responsibilities to:

- detect, declare and notify cases to the state/territory health departments or PHUs, and the Commonwealth Department of Health
- notify residents and families of any COVID-19 cases and, when an outbreak is declared, actions being taken as part of the response, residents' health status and when the outbreak is over
- assist the PHU with contact tracing
- follow jurisdictional directions and advice on outbreak management measures. This includes recommended infection control and appropriate use of PPE
- adhere to quarantine requirements for close contacts
- adhere to workplace directions
- tell residents and families how to access independent free and confidential aged care and disability advocacy supports.
- tell residents and families about options available to take residents home.
- manage the outbreak in consultation with the PHU and according to their Outbreak Management Plan.

[1] Australian National Notifiable Diseases List (NNDL)

- maintain quality care and resident safety and well being for all residents whether positive or negative for COVID-19

A number of government departments and agencies support RCFs in their response to an outbreak.

1.2.2. The State/Territory Department of Health

The public health sections of State/territory departments of health and/or the local PHUs are responsible for preventing and minimising public health risks to the community and leading the public health response for a COVID-19 case or outbreak.

They will support the RCFs to detect, characterise and manage COVID-19 outbreaks by:

- declaring outbreaks at facilities
- issuing directions about the infection control measures for cases and outbreaks, in line with jurisdictional requirements
- providing directions on testing requirements including testing scope and frequency, and assisting to arrange tests and testing plans
- providing guidance on outbreak management and IPC
- monitoring outcomes (case numbers, record deaths and hospitalisations)
- determining close contacts and quarantine requirements for close contacts
- informing relevant stakeholders of outbreaks and informing clinical care providers in the local health district
- declaring an outbreak over and determining when public health actions can be stood down

1.2.3. Aged Care Quality and Safety Commission

The Commission is the national regulator of Commonwealth subsidised aged care providers. It takes a proportionate risk-based approach to ensuring aged care providers are meeting their requirements under the Aged Care Act. The role of the Commission is to:

- independently accredit, assess and monitor Commonwealth subsidised aged care providers against the Aged Care Act and *Aged Care Quality Standards*
    - including the requirement to minimise infection-related risks through implementing standard and transmission based precautions to prevent and control infection
- resolve complaints about the providers' responsibilities, including the delivery of aged care services
- provide education to providers, including best-practice IPC

The Commission, as part of the accreditation process, will have regard to evidence relating to IPC lead staff members when assessing compliance with the Standards. This includes:

- their role in the facility
- their qualifications
- additional training they have undertaken to ensure currency of skills

1.2.4. Australian Government Department of Health (herein referred to as the Commonwealth)

The Commonwealth provides funding to residential aged care facilities. The Commonwealth will assist and support Commonwealth subsidised aged care facilities that have COVID-19 cases or outbreaks. These supports include:

- allocating a state based 24/7 case manager who will connect the aged care facility to all available Commonwealth support
- providing access to, if requested, a First Nurse Responder (or 'Clinical First Responder') who can assist in:

    - assessing workforce requirements
    - providing IPC guidance in consultation with the jurisdiction
- ensuring surge workforce support including clinical and non-clinical staff
- facilitating access to the National Medical Stockpile for supplies of personal protective equipment (PPE) when commercial supplies are exhausted
- in collaboration with PHUs, arranging access to pathology services
- establishing minimum standards for infection control training
- providing information and data to states and territories to support preparatory action and prevention
- developing and distributing COVID-19 guidance materials in consultation with the jurisdiction
- facilitating access to primary health care, including GPs and allied health services, through Primary Health Networks

2. Understanding COVID-19

It is impossible to tell the difference between a respiratory illness such as COVID-19 and one caused by other viruses based on symptoms alone. Test residents with new symptoms of respiratory infection, for COVID-19. Consider testing for COVID-19 if residents have any new symptoms and there has been COVID-19 cases in the region. While waiting for the test result, isolate the person with a private bathroom and staff attending the tested resident should wear appropriate PPE. Testing for other respiratory viruses at the same time is a clinical decision that medical practitioners can advise on or may be recommended as routine by the jurisdiction.

2.1. Recognising COVID-19

COVID-19 is a contagious viral infection that in most cases causes respiratory illness in humans. Presentation can range from no symptoms (asymptomatic) to severe illness with potentially life-threatening complications. Atypical presentations are common in the elderly.

The most common signs and symptoms include:

- fever (though this may be absent in the elderly)
- dry cough

Other symptoms and signs can include:

- shortness of breath, increased respiratory rate, drop in oxygen saturation
- sputum production
- fatigue
- sore throat
- loss of taste
- loss of smell
- diarrhoea
- nausea or vomiting

Less common symptoms include:

- headache

- myalgia/arthralgia (muscle/joint aches and pains)
- chills
- nasal congestion
- haemoptysis (coughing up blood)
- conjunctival congestion (red eyes)

Older people may also have the following symptoms:

- confusion or behavioural change
- worsening chronic conditions of the lungs
- loss of appetite
- vague changes: 'not their usual self', 'looks unwell', 'pale'

Staff should be aware of these symptoms and note that most cases experience mild symptoms, especially at first. Elderly patients often have atypical symptoms including behaviour change and may not develop a fever. Ideally, staff should know residents well so that they can detect subtle changes in condition or behaviour.

See Monitor staff, residents and visitors for more information on monitoring symptoms in residents and staff to enable cases to be detected and managed early.

2.1.1. Testing for COVID-19

New tests for COVID-19 are being developed and easier ways to collect samples are being evaluated. In the meantime, the most widely used test is the polymerase chain reaction (PCR) test. This involves taking a swab deep in the nose and back of the throat. See Test for COVID-19 for more information.

RCFs should consider seeking early medical review to test residents with any new respiratory symptoms, even if they are mild or not typical of COVID-19.

If any staff member (including casual, domestic, hospitality and volunteer workers) develops symptoms, they must stay at home and get tested. They must do this even if the symptoms are very mild. The aim is to prevent transmitting the virus to other staff members or residents. They will be unable to attend the RCF until they have received a negative test result and their symptoms have completely resolved. See Monitor staff, residents and visitors for more information.

If there is an outbreak at a facility, the public health unit will ask all staff and residents to be tested. See Routine testing during an outbreak for more information. Staff who are close contacts of a case will be required to quarantine at home or another suitable accommodation for 14 days from date of last contact even if they test negative.

If there is COVID-19 in the community staff may be asked to be tested, even if they do not have symptoms. This is called asymptomatic screening. It is used to prevent introduction of COVID-19 into a facility by a staff member who is not aware that they have the infection. If in consultation with the jurisdictional health authority the Commonwealth determines that an asymptomatic testing program is required in an aged care facility, it will be funded with no associated charges for the facility or staff. Staff tested as part of an asymptomatic screening program do not need to stay home until they get their test result.

A graphic showing what actions staff need to take while waiting for their test result is at Appendix 2.

2.2. Disease Transmission

2.2.1. Incubation period

People with COVID-19 generally develop signs and symptoms 5-6 days after exposure to the virus (mean incubation period 5-6 days, range 1-14 days). In rare cases, the incubation period may exceed 14 days.

2.2.2. Infectious period

People are likely to be more contagious to others when they have a lot of virus present in their respiratory tract. This is called a high viral load. For most people, the viral load is highest from a day or two before until at least a week after symptoms start.

Some people never develop symptoms but may still be able to pass the virus onto others. This is why good IPC needs to apply at all times

The PHU will determine whether a person working or visiting the facility was likely to be infectious when they were at the facility. In most circumstances, this includes a period of 48 hours before the onset of symptoms as well as the days the person had symptoms and was in the facility. The PHU may consider a large number of people to be close contacts and they will be required to quarantine. This is because of the nature of RCF contacts and the risk of severe disease, particularly in elderly residents.

For more information on the infectious period see the *CDNA COVID-19 National Guidelines for Public Health Units*.

2.2.3. Routes of transmission

The virus that causes COVID-19 most commonly spreads through droplets via direct and close contact with an infected person. The risk of transmission by this route can be minimised by:

- cough etiquette and physical distancing
- gathering outdoors instead of indoors
- avoiding activities such as singing when there is community transmission

Transmission is also possible by touching contaminated objects or surfaces (e.g. bed rails, doorknobs or tables), then touching your face. Objects and surfaces become contaminated with respiratory droplets from an infected person. The risk of transmission by this route can be minimised by:

- frequent hand hygiene
- regular cleaning of surfaces

There is some evidence COVID-19 infection may lead to intestinal infection and the virus can be present in the faeces of infected people. Although the faecal-oral route does not appear to be a driver of COVID-19 transmission, if diarrhoea is a feature of the COVID-19 illness it may become important in RCFs. Isolate residents with ongoing diarrhoea or uncontained faecal incontinence who may have limited capacity to maintain standards of personal hygiene until 48 hours after resolution of symptoms and until cleared as a case.

There may be potential for aerosol transmission, particularly during certain aerosol-generating procedures (AGPs) conducted in health care settings[2]. Nebulisers, continuous positive airway pressure (CPAP) and suctioning are examples of AGPs that have been associated with a risk of transmission of respiratory viruses. Avoid their use for residents with COVID-19 and their contacts. Use a spacer and puffer where possible instead of a nebuliser. If there is a clinical need for AGPs as part of a resident's care, consider transferring the resident to hospital.

[2] See the Communicable Diseases Network Australia *COVID-19 National Guidelines for Public Health Units*

There has been anecdotal evidence of a link between health and care worker infection and challenging behaviour, especially during the first week of infection. This is when viral load may be high. Such behaviour includes shouting and patients/residents who are agitated or find instructions hard to follow. In areas with significant community transmission of COVID-19, health and care workers may consider using contact and droplet precautions (gown, gloves and protective eyewear) with a particulate filter respirator (PFR). See Box 3 and the Infection Control Expert Group *Recommended minimum requirements for the use of masks and respirators by health and residential care workers in areas with significant community transmission of COVID-19* for more information.

2.3. Quarantine and isolation

Both quarantine and isolation require people to stay away from others to prevent transmission. The practical difference between quarantine and isolation is the time period people need to stay away from others. People who are well, but may have been exposed and are incubating the disease, are required to quarantine for 14 days. If a person has been infected, this allows time for the virus to grow and be detected through symptoms and/or testing.

Place people who have the disease in isolation until they meet the release from isolation criteria.

By definition, well people are quarantined away from others, sick people are isolated away from others.

2.4. Complications

Most people with COVID-19 have mild disease and will recover. Some people can develop complications which may be life-threatening and can lead to death. If severe disease occurs, the deterioration can be rapid and distressing.

There is good evidence that advancing age is a risk factor for severe disease. In addition, some chronic conditions place people at higher risk of serious illness from COVID-19. See advice here.

Complications include:

- pneumonia (interstitial pneumonitis, secondary bacterial infection)
- respiratory failure
- septic shock
- organ failure
- blood clots

Elderly residents may experience a worsening of chronic health problems, for example congestive heart failure, asthma and diabetes.

3. Preparedness

RCFs must ensure that they are prepared for outbreaks of COVID-19 including for the occurrence of their first case of COVID-19. The basis for an effective IPC response is a well-functioning program that works in concert with:

- an effective occupational health program
- resident and visitor education

RCF providers need to consider how they would separate staff if an outbreak was in a facility, minimising staff interaction between shifts and ensuring a designated workforce to residents.

3.1. Staff education

Each facility is responsible for ensuring the staff are trained and competent in all aspects of outbreak management before an outbreak. Staff should know the signs and symptoms of COVID-19. This will help them identify and respond quickly to a potential case.

Topics for staff education and training should include:

- symptoms and signs of COVID-19
- exposure risk levels for COVID-19, including being aware of geographical areas of risk and the importance of travel and contact history
- hand hygiene, sneeze and cough etiquette, distancing awareness in all settings
- infection prevention and control (IPC) principles including:
    - standard and transmission-based precautions
    - appropriate use of PPE such as gloves, gowns, eye protection (face shields, eye shields, goggles or safety glasses) and masks (surgical and P2/N95)
    - competency-based training in how to put on (don) and remove (doff) PPE correctly
- what to do if experiencing even mild symptoms of COVID-19 (get tested and stay home while awaiting test results)
- what to do if in contact with a known or suspected case (quarantine if a close contact)
- requirement to notify cases to PHUs
- identifying, safe handling and disposing of clinical and non-clinical waste[3]
- processing of reusable equipment
- environmental cleaning
- safe handling and laundering of linen
- food handling and cleaning of used food utensils
- collection and handling of respiratory swabs, where appropriate and in alignment with the staff's previous training and skillset

3.2. Infection Prevention and Control training

All staff (including casual, domestic, hospitality and volunteer workers) need to understand the RCF infection control guidelines and be competent in implementing these measures during an outbreak. The guidelines are here *COVID-19 guidelines for infection prevention and control in residential care facilities (Infection Control Expert Group)*. Staff should also be aware of and follow any additional jurisdictional requirements.

The Commonwealth now requires Commonwealth subsidised residential aged care facilities to employ an IPC clinical lead who is a member of the nursing staff and has completed a recommended IPC course.

To implement a sustainable IPC program the following are required:

- appropriate physical and administrative controls
- adequate financial resources
- professional support
- continuing staff education and training

[3] Clinical waste includes waste from patients known to have or suspected of having a communicable disease including COVID-19 (such as PPE, bandages, wound dressings). Clinical waste should be disposed of in clinical waste streams. Non-clinical waste should be disposed of into general waste streams. This includes food waste, disposable items such as cups, and PPE that has not come into contact with a suspected or confirmed case of COVID-19. Definitions of clinical waste vary across jurisdictions. Check jurisdictional guidance for further information.

Incorporate enhanced IPC training and resource requirements into the facility's outbreak preparedness plan.

3.2.1. PPE training

Online training modules for workers in residential care are available at COVID-19training.gov.au. These modules are introductory and should not be the only training provided. RACFs should ensure staff also receive face-to-face training that provides hands-on practical experience of the hierarchy of IPC action and of using PPE

All staff, including agency and casual staff, should undergo regular refresher training on IPC measures. Training is not "once only" but a continuous process for maintaining competency in IPC, including PPE use.

Hold routine drills for all staff in the practical skills of IPC and the safe and appropriate use of PPE.

Train staff in observing each other to ensure safe and effective use of PPE.

3.2.2. Understanding Standard Precautions

Standard Precautions are IPC practices routinely implemented in healthcare and RCFs. They should be used in RCFs with a suspected or proven COVID-19 outbreak and **apply to all staff and all residents.**

Box 1. Standard Precautions

Key elements are:

- **Hand hygiene** before and after each episode of resident contact and after contact with potentially contaminated surfaces or objects (even when hands appear clean).
  - Gloves are not a substitute for hand hygiene. Staff should perform hand hygiene before putting gloves on and after taking them off.
- **Provision of alcohol-based hand sanitiser** at the entrance to the facility and other strategic locations.
- **Use of PPE** if exposure to body fluids or heavily contaminated surfaces is anticipated (gown, surgical mask, protective eyewear, and gloves).
- **Cough etiquette and respiratory hygiene.**
  - Cough into a tissue (and discard the tissue immediately) or into the bend of the elbow; perform hand hygiene.
- **Regular cleaning of the environment and equipment**.
- **Safe handling of linen and waste.***

Note: RCFs should **train all staff in the correct use of PPE,** appropriate to their role. Incorrect removal of PPE increases the risk of personal contamination and spread of infection.

Extract from *COVID-19 guidelines for infection prevention and control in residential care facilities (Infection Control Expert Group).*The last dot point (*) has been added from the *Australian Guidelines for the Prevention and Control of Infection in Healthcare 2019 (NHMRC/ACSQHC*)

3.2.3. Vinyl gloves

The Infection Control Expert Group (ICEG) does not recommend vinyl gloves for the clinical care of patients or residents in the context of COVID-19. Powder-free latex or nitrile gloves are accepted as superior in clinical care and are less likely to be breached compared with vinyl gloves. Gloves should be selected and worn in line with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (2019).

3.2.4. Masks

Providers and staff should adhere to local guidelines about the appropriate use of masks depending on the disease level in the local community.

Consider particulate filter respirators (PFRs) such as P2/N95 respirators, when one or both of the following apply:

- for the clinical care of residents with suspected or confirmed COVID-19, who have cognitive impairment, are unable to cooperate, or exhibit challenging behaviours
- where there are high numbers of suspected or confirmed COVID-19 residents AND a risk of challenging behaviours and/or unplanned aerosol-generating procedures

For more information see the *COVID-19 guidelines for infection prevention and control in residential care facilities (Infection Control Expert Group).*

3.3. Ensuring supplies

Facilities should ensure that they hold stock levels of all consumable materials required during an outbreak. They should have an effective process in place to review stock levels and obtain more stock from suppliers as needed.

Supplies to consider include:

- personal protective equipment (gloves, gowns, masks, eyewear)
- hand hygiene products (alcohol based hand rub, liquid soap, paper hand towel)
- diagnostic materials (swabs) or immediate access to in-reach testing
- cleaning supplies (detergent and disinfectant products):
    - a disinfectant on the *TGA list of disinfectants for use against COVID-19*
    - a TGA-listed hospital-grade disinfectant with activity against viruses (according to label/product information) or
    - a chlorine-based product such as sodium hypochlorite
- clinical waste bags
- medical supplies such as oxygen and equipment such as IV stands and subcutaneous syringe drivers
- an imprest pharmacy system to allow rapid access to restricted medications that may be required

Supplies stored onsite should be sufficient for an immediate facility-wide commencement of care while extra supplies are arranged through usual suppliers or the National Medical Stockpile. This amount of PPE will differ for each facility. As a guide, a facility provider should calculate:

- the number of times staff members (including cleaners) access a resident's room (for example, 20 times per day)
- add in the number of times this access needs to be 2 carers (for example, +3 times per day)
- multiply this total by the number of residents in the facility

A 100 resident facility would need to have on site 2,300, (20+3) multiplied by 100, sets of PPE (mask, gloves and gown) for one day. This represents 16,100 sets for 7 days. To effectively monitor stock levels, facilities should regularly count stock and review usage.

If cases occur in residential aged care facilities and providers cannot access PPE from their usual suppliers, they can request PPE from the National Medical Stockpile. They can do this by submitting an online application. The application will be actioned during weekday business hours. It will be coordinated by the state office of the Commonwealth when cases are reported to agedcareCOVIDcases@health.gov.au.

3.4. Preparing an Outbreak Management Plan

Preparing an Outbreak Management Plan will help staff identify, respond to, and manage, a potential COVID-19 outbreak. It will protect the health of staff and residents and reduce the severity

and duration of outbreaks if they occur. It will identify specific actions and specific responsibilities, with up to date key personnel contact details.

Include the prevention strategies outlined in this guideline in the RCF Outbreak Management Plan. A checklist to assist in outbreak preparedness is available in Appendix 3.

3.4.1. Assumptions

The following public health assumptions are relevant to developing a plan.

Vaccination of aged care and disability care residents and staff for COVID-19 commenced in Australia on 22 February 2021. The vaccine is effective in preventing severe disease. It is not yet known how widespread vaccination will affect the risk of transmission in residential care. Monitoring of the results of vaccination will be needed over the next few months before any decisions can be made on how vaccination will affect the advice in these guidelines. **CDNA highly recommends vaccination for both residents and staff**. All RCFs should document which residents and staff have been vaccinated. This information should be available to the Outbreak Management Team if an outbreak occurs.

Outbreak Management Plans developed by individual RCFs need to be:

- site specific, and regularly tested and practised to ensure they are fit for purpose
- coordinated with the plans of other organisations in their communities and local/regional pandemic plans
- developed in collaboration / consultation with
    - staff
    - health professionals including primary care/general practice
    - service providers
    - other community organisations, and in consultation
    - residents and their representatives
- consistent with the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)*

The number of health care workers available to provide care may be significantly reduced. This may be due to:

- isolation resulting from COVID-19 illness
- quarantine of close contacts
- personal illness or vulnerabilities
- concerns about transmission in the workplace
- family/caregiving responsibilities

RCFs will need to effectively communicate with staff, residents, residents' family and friends during an outbreak. RCFs should develop a proactive communication strategy ready for immediate activation in the event of an outbreak. This is in order to meet their needs for information but reduce the demands on staff. RCFs should assume that they will not be able to communicate with residents and families in the normal manner. All Outbreak Management Plans should document additional communication mechanisms, such as phone, email, Zoom, Facebook and mail. RCFs should anticipate needing to accommodate an increased number of enquiries and contacts. External call centres can be pre-engaged to undertake communications on behalf of facilities. In addition, facilities should have adequate telecommunication facilities for teleconferences with multiple agencies.

Aged care facility providers will be familiar with the *Industry Code for Visiting Aged Care Homes during COVID-19*. Include the capacity to support adherence to the Code in Outbreak Management

Plans. Where the exceptional circumstances described in Principle 7 of the Code apply, aged care facilities should be able to facilitate access by visitors during an outbreak.

RCFs are required to collect contact information from visitors, staff and contractors for the purpose of contact tracing. This includes in facilities where there are separate or dispersed residences without a main entrance (such as facilities based in larger retirement villages). RCFs should document:

visitors' names, time and date of visitation and contact phone numbers

- residents' locations
- staff rostering and attendance,
- staff locations of work internal and external to the RCF

All staff and visitors should supply up to date contact details. RCFs may choose to use digital resources such as QR codes to collect contact information. This can be particularly useful in settings where there is not a main entrance or housing is dispersed. Some jurisdictions require visitors to use specific contact tracing apps.

Some processes can be complex to implement during an outbreak. The Outbreak Management Plan needs to determine in advance how these processes will be implemented. For example, the initial testing of residents for COVID-19 may be best arranged through the local PHUs in some jurisdictions rather than through the residents' usual GPs or vice versa.

The Outbreak Management Plan needs to consider and plan for the ongoing medical care for residents during the outbreak. Some GPs may not be available to provide this care or only offer telehealth consultations and more onsite GP support may be needed.

RCFs need to:

- understand in advance which GPs will be prepared to attend during an outbreak
- offer telehealth services
- make contact with the local Primary Health Network (PHN) who can assist with identifying alternate GPs who can attend

The Plan also needs to plan for how routine allied health services will be able to be provided during the outbreak.

In an outbreak, the RCF may have staff, GPs and other health professionals who have not worked at the facility before. In addition there may be no staff available who can access the electronic management and resident care systems. The Outbreak Management Plan needs to include consideration of how these systems will be accessed and utilised by those who need to do so. This includes whether case notes will be able to be accessed remotely. The Plan needs to identify who will provide back-up IT services. Access to electronic systems should have been addressed in the RCF Business Continuity Plan and reference to this may be sufficient. Keep resident care plans updated in electronic systems so that new staff have access to records, and include resident photographs. In an outbreak, consider ID wrist bands to assist new staff to identify residents. Picture boards of residents may also help staff who are unfamiliar with the facility to assist during outbreaks.

3.4.2. Plan for an Outbreak Management Team

The Plan needs to clearly identify who in the RCF will perform the different functions of the Outbreak Management Team. Having these roles assigned ahead of an outbreak enables staff to understand the details of the duties they will need to undertake ahead of time. The Plan should include up to date after hours contact details of the team. It is also recommended to have alternates or processes in case a member is quarantined.

3.4.3. Plan for impacts on workforce

Establishing workforce monitoring is an essential aspect of outbreak management planning.

During periods of no community transmission, RCFs need to document where staff are working in the facility and where else they usually work. They also need to prepare for and educate about staff screening procedures and prepare for activation of single site working. See Workforce monitoring for more information.

To manage staff absences:

- Review policies for sick leave to enable staff to stay home if they have relevant symptoms without being disadvantaged.
- Have a staff contingency plan for an outbreak where unwell staff members need to be excluded from work for a prolonged period.
- Consider the current nature of the pandemic and ongoing outbreaks when planning leave.

Workforce management planning should include plans for surge capacity.

- Plan to cover a moderate staff absentee rate.
- Develop and maintain a contact list for casual staff members or external nursing agencies. This will enable timely activation of a surge workforce should an outbreak occur.
- Educate and orientate surge workforce staff to the function of the unit before commencing work.

Structure the workforce management plan to minimise the movement of staff across multiple areas. Staff caring for residents with COVID-19 should not be caring for other residents who are not showing signs of the illness. Staff may need incentives to come back to work, to work in COVID-19 positive zones, or to work in a facility with an outbreak.

Workforce plans must include arrangements for handover to replacement staff, if a significant proportion, or all, of the staff are quarantined or furloughed.[4] Such arrangements must properly support replacement staff, and ensure the facility retains control. The facility must make available current residents' care/clinical records and operational information required to ensure that the safety of residents and staff is not compromised.

Consider the risks of utilising casual or external agency workforces. During an outbreak, staff should not work at other facilities. Follow jurisdictional requirements for directions on workplaces. Make every effort to maintain consistent staff in each RCF, including maximising permanent and minimising casual workforce. Information and guidance on practical steps to prepare for and implement a single site workforce in an aged care facility is in the *National COVID-19 Aged Care Plan: Appendix H*.

3.4.4. Plan to cohort/zone residents

Cohorting/zoning refers to grouping individuals with the same status in the same location. Outbreak Management Plans should include floor-maps which have been colour coded and labelled with instructions for how to cohort/zone in response to infection patterns. See Appendix 4 for more information.

A clear priority in managing an outbreak is proactively limiting spread to unaffected staff and residents. This requires removing ongoing risk of exposure.

- Avoid proximity to and contact with COVID-19 cases.
- Avoid proximity to potentially contaminated areas, systems, equipment and surfaces.
- Shared rooms, bathrooms and equipment present a particular risk for COVID-negative residents.

[4] The term 'furloughing' is used in some jurisdictions to describe staff being quarantined according to relevant legislation.

Known exposure of a resident should not lead to the assumption that they are already infected as they may not be. They should continue to be actively protected from exposure unless they are a confirmed COVID-19 case.

Plan how to cohort/zone residents together into rooms, zones or a separate wing or building. It may be helpful to communicate to families in advance that temporary cohorting/zoning may occur if there is an outbreak. When more than one resident has confirmed COVID-19, care for them together in an area away from residents who are not known to be infected, preferably in single rooms. Consider re-arrangement of rooms and re-purposing of other areas ahead of an outbreak. If possible, identify areas that can be used for isolation. Transferring well residents to other safe locations, including home care in the community, for quarantine may facilitate space requirements for managing an outbreak.

Some states and territories require all COVID-19 positive residents to be managed in a hospital, refer to jurisdictional guidance for more information. See Limit admissions and transfers.

Cohorting/zoning should be done in collaboration with the PHU or other experts. However, some general principles are outlined below.

Ideally, there should be four zones:

Green zone	Individuals who have met the release from isolation criteria or who have been released from quarantine following a risk assessment. Note: in the initial stages of an outbreak all residents are usually considered close contacts and will be in quarantine.
Amber zone	Individuals who have met the close contact or suspected case definition and are in quarantine.
Red zone	Individuals who have confirmed COVID-19.
Blue zone	Buffer areas between potentially contaminated and non-contaminated zones. For example, nurses station, corridors, staff lunchrooms, meeting rooms, drug rooms. Blue zones also include transition points from one zone to another where staff must don or doff PPE.

When setting up zones, RCFs should consider:

- Amber and red zones should be geographically separated.
- Red and amber zones should be decluttered as much as possible to make cleaning and decontamination easier.
- There should be limited entry/access to each zone.
- Dedicated staff should be assigned to each zone for the entire shift.
- There is a need for spacious and separate break areas for staff.
- Where possible, individuals should be cared for in single rooms with their own bathroom.
- If individuals need to be placed in shared rooms, consideration should be given to transferring residents where possible, to allow single occupancy in a room.
- If individuals must be placed in shared rooms, they should be separated by 2 metres. Wherever possible, privacy screens or barriers that can be wiped clean should be used to physically separate individuals.
- Alcohol based hand rub should be available at each bed space.
- Zoning should ideally be implemented after the first round of testing is completed, to better inform decisions.
- Dedicated areas where staff can change before leaving work should be allocated.
- Plans to de-escalate as individuals recover are needed.

Other aspects RCFs need to consider are:

- PPE storage and access points
- waste disposal points
- food service and linen pathways

See isolation and cohorting/zoning for more information.

3.4.5. Develop a communications plan

Develop a list of contact details for people and organisations who will need to be contacted if here is an outbreak. These include:

- the local PHU
- the Commonwealth email address (agedcareCOVIDcases@health.gov.au)
- attending general practitioners and allied health professionals
- the primary health network
- the local health department
- geriatric in-reach services

Contact attending general practitioners during planning, to determine if they would attend the facility in an outbreak or would relinquish routine care to another doctor. Contact allied health professionals who routinely provide services to consider how they can provide care.

Prepare a clear, proactive communications plan, ready for immediate activation to provide timely, accurate information for residents, their families and the general public. During an outbreak, residents, families and staff are likely to experience high levels of anxiety and uncertainty about how they will be impacted and how risks will be managed. Contact lists for families need to be more extensive than the usual primary contact(s) to avoid the risk that family members find out information through the media first. Regular and effective communication is essential, especially if family and friends are unable to visit their loved ones.

RCFs should have a communication plan in place to support provision of clear, consistent and timely information to all groups. The plan should include the following elements:

- dedicated staff to manage communications and capacity to manage high volume inbound and outbound communications
- identified communication channels such as email, phone numbers, webinars, website and social media
- pre-prepared and informative signs including for designated zones and for donning and doffing PPE stations
- email templates and talking points, including in languages other than English where appropriate:
    - with a focus on the initial announcement of the outbreak and what residents, families and staff should expect during the outbreak period
- a strategy for providing information to residents, families, staff and other visitors (e.g. government and non-government external providers) during the outbreak period including:
    - messaging for staff on how infection risks are managed and support for staff who are identified as infected or as close contacts
    - how families will be updated on the status and welfare of individual residents
    - options for connecting residents with families during extended periods of isolation, such as window visits, video calls and phone calls
- protocols for managing media enquiries in liaison with the state health media

For RACF, the Older Persons Advocacy Network (OPAN) can assist with communications with residents and families. The OPAN *COVID-19 Communications Toolkit* provides resources to assist RACFs plan and implement their COVID-19 outbreak communications. These include a video aimed at informing residents about what will need to happen in an outbreak.

The Commonwealth case lead will ensure that RACF residents are provided with Commission resources on what they can expect during an outbreak.

Aspects to consider in developing the communications plan are described below.

- A very high volume of inbound and outbound calls should be expected during an outbreak. RCFs need to consider if they will have the capacity to handle this volume. Where a facility does not have capacity, arrangements can be made to use a call centre. For Commonwealth subsidised aged care facilities, call centre support can be provided through the Commonwealth Department of Health.
- A dedicated registered nurse or appropriately qualified individual (for example, social worker) will be needed for providing updates and liaison with frontline carers who are behind the quarantine line.
- Staff who have been trained in IPC precautions and PPE use to facilitate phone and video calls with the resident, family and aged care advocates during the outbreak.
- Facebook groups, email lists, Zoom groups and templates should be set up in the preparation phase to pre-communicate with residents and families and ensure they can be utilised during the outbreak.
- The plan needs make allowance for residents or family members who are not computer literate. Providing a link to a letter or other communication may not be useful. A phone number they can ring and/or other form of communication should be provided.
- OPAN organisations support consumers and their families and representatives to effectively access and interact with Commonwealth funded aged care services and have their rights protected. They provide advocacy support under the National Aged Care Advocacy Program (NACAP). Information about OPAN and how to contact the organisation should be provided to all residents and their families. This information should be provided as part of the preparation for an outbreak and in communications during the outbreak. Residents and families may be asked if their details can be shared with OPAN if there is an emergency.

3.4.6. Plan for resident transfers

When there are COVID-19 cases in the community, but not in the facility

Facilities should work with families and carers to plan in advance for resident care. If there is an outbreak in a local community, families may elect to take a resident home. If residents are going to be moved from the facility, they should be moved early. Residents and families need to be aware that, if the resident returns when there is community transmission, they may be required to undergo quarantine. Also see Unaffected residents for further details.

When there are COVID-19 cases in the facility

Facilities should be aware that *ad hoc* decisions to initiate emergency transfers of resident without appropriate medical indications may cause great distress and potential harm to residents. Any transfers (other than on the basis of clinical need) should be planned and coordinated with hospital services.

In an outbreak, the family (if resident is to be cared for at home) or receiving facility should be made aware that the resident may have been exposed and is at risk of developing disease. Some jurisdictions will not allow residents to be moved out of the facility because of the risk of spreading the disease further. In some settings, movement of residents may be recommended to enable greater physical distancing within the facility. All moves require PHU notification or approval.

Before moving a resident, the family or receiving facility will need to consider the following.

- The resident will need to quarantine at home for at least 14 days.
- Carers of residents will need to use appropriate PPE during the quarantine period and should avoid leaving the home.
- Dedicated carers may be required to quarantine, and if so, will need to remain separate from other household members.
- The resident may not be able to return to the RCF during the outbreak.
- Should the resident become positive during the required quarantine period they pose a risk to others caring for them.
- Anyone in the household is at risk of transmission from the person.
- The resident will need to be tested if they become symptomatic and at the end of the quarantine period (depending on jurisdictional requirements).
- The family/carer should consider the care needs of the resident including what equipment is needed and who will oversee medical care and access to medications.
- If the resident is positive for COVID-19 or returns a positive result during quarantine:
    - there should be no people in the household who are vulnerable to severe disease (vulnerable individuals should arrange to live elsewhere during the quarantine period)
    - carers should understand that the resident may get worse quickly and know what to do if this occurs.

See *Taking a resident home from residential aged care in an outbreak* for more information.

Note: In residential aged care settings, residents who take emergency leave do not use any of their social leave entitlements. This means they can move in with their family during the emergency without losing their aged care place.

4. Prevention

Vaccination in residential aged and disability care commenced on 22 February 2021. Vaccination is effective in preventing severe disease and **vaccination of residents and staff is highly recommended**. It is not yet known how effective the vaccine is in preventing transmission of infection. Avoidance of exposure continues to be the most important measure for preventing COVID-19 in RCFs.

Key messages

- Every time a person touches a surface they may leave virus behind or pick it up and spread it further. *Hand hygiene and surface cleaning are effective.*
- Each person in the facility may be incubating the virus or have asymptomatic COVID-19. *Physical distancing and limiting numbers of contacts are effective.*
- People not appropriately following hand hygiene and physical distancing are at increased risk of acquiring the virus, and introducing and transmitting the virus in a RCF. *Culture, behaviour change, oversight and sustained monitoring are effective.*

RCFs should work to prevent introduction of COVID-19 into the facility. Staff, family members of residents, and other visitors (including visiting workers) can transmit SARS-CoV-2 (the virus that causes COVID-19) to residents. High density living, frequent close personal care contact, complex centralised systems and frequently used surfaces and areas all contribute to RCFs being at

particularly high risk. Therefore RCFs need to ensure they have appropriate screening measures in place on entry to a facility.

4.1. Clinical Governance

Effective leadership, management and clinical governance structures are required to meet the challenge of COVID-19.

Clinical governance is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms. They are implemented to support safe, quality clinical care and good clinical outcomes.

The Aged Care Quality Standards require aged care facilities that provide clinical care to demonstrate the use of a clinical governance framework (Standard 8, 3(e)).

In a COVID-19 environment, it is critical that services have established systems and processes to:

- identify and manage clinical risks
- prevent harm and
- improve the processes of clinical care

The systems and processes must be supported by a clearly defined command and control structure.

The leadership team should seek and act on expert advice and collaborate, openly, with external agencies.

4.2. COVIDSafe Behaviours

4.2.1. Provide education and communications

Clear information needs to be provided to residents and families about their role in preventing introduction of disease. Everyone should be made aware of early signs and symptoms of COVID-19**.** They need to know about respiratory hygiene and cough etiquette, physical distancing and hand hygiene.

Visitors and staff must monitor themselves for symptoms of COVID-19, specifically fever and acute respiratory symptoms. They must know the importance of not visiting if they:

- have any symptoms of COVID-19
- are in quarantine as a contact of a known case or
- have recently travelled from a geographical area of risk

A sample letter outlining the steps families and visitors can take to reduce the risk of bringing COVID-19 into the facility is at Appendix 5.

Signage and other forms of communication (for example, factsheets) must be used to convey key messages. This includes actions the facility is taking, and explaining what everyone can do, to protect themselves and residents. Signage should remind anyone who is unwell not to enter.

4.2.2. Provide hygiene resources

Facilities must ensure that adequate hand washing supplies, alcohol-based hand rub, tissues and lined disposal bins are available for visitors to use. These must be, as a minimum, at the entrance of the facility, in the visitor area and at the entrance to each resident's room.

4.2.3. Establish a COVIDSafe workplace

Outbreaks in residential facilities have shown that transmission can occur between staff. Consideration should be given to minimising staff contact during shift change or ensuring staff shifts do not overlap. Staff should be engaged in considering how and where they come together in the facility and encouraged to follow COVIDSafe practices. Areas to consider include offices, staff bathrooms and break rooms.

All rooms should be labelled with how many people can be in the room at one time. The number needs to meet the state or territory density restrictions, such as 2 or 4 square metres per person.

Lunch rooms and tea break rooms should have:

- a sign for the number of people who can be in the room
- a PPE doffing station outside the room with hand sanitiser
- a register for attendees with entry and exit time
- hand sanitiser in the room
- cleaning equipment readily available to clean tables and other frequent touch points immediately after use
- surgical masks near the exit of the room for donning before leaving the area
- signage to encourage staff to avoid sharing food and drinks

4.3. Screen staff and visitors for symptoms before entry

A regular program for screening staff for symptoms should be developed. See Monitor staff, residents and visitors. Advice for screening those entering facilities is provided by the Aged Care Quality and Safety Commission *Screening advice*.

Staff, including casual, domestic, hospitality and volunteer workers, must not come to work if symptomatic and must report their symptoms to the RCF. Staff should be supported (for example, with leave policies) to exclude themselves from work, stay home and seek testing when they have symptoms clinically compatible with COVID-19. Staff should tell the facility if they have been notified by the PHU that they are a confirmed or suspected COVID-19 case. Casual staff should also notify their agency if they become unwell and be supported to exclude themselves from working.

A graphic showing what actions staff need to take while waiting for their test result is provided at Appendix 2.

Visitors must be asked about symptoms and be instructed not to enter the RCF until all symptoms have resolved.

4.4. Apply restrictions if required

Facilities must comply with all Commonwealth, and State or Territory directions on restrictions to visitors to RCFs.

Protracted restrictions on visitors are likely to have detrimental impacts on the wellbeing of residents. The personal welfare, physical and mental health and quality of life of residents is of vital importance. Visitors including family and friends provide support for resident wellbeing. External service providers such as allied health and personal care are an important component of person-centred residential care. As Australia moves towards becoming COVID Safe, these factors must be balanced against the significant risks of COVID-19 outbreaks in facilities. RCFs should adhere to jurisdictional guidance on restrictions to visitation in RCFs.

5. Detecting a Case

5.1. Monitor staff, residents and visitors

RCFs should establish systems to monitor staff, residents and visitors (including contractors) for COVID-19. A high level of vigilance and low threshold for investigation is needed. Surveillance for fever or acute respiratory illness (ARI), and for atypical presentations in the elderly, can detect possible cases of COVID-19. Effective surveillance will facilitate early recognition and management of cases. Facilities should have systems to monitor staff, residents and visitors, including daily checks and prompt action for any change in status. It is recommended facilities use a screening tool to assist

in identifying residents and staff with symptoms. See also Screen staff and visitors for symptoms before entry.

Providers of residential care need to have a process to test residents and staff for COVID-19 as soon as any respiratory symptoms or fever occur. Staff in these circumstances should leave the facility, get tested and stay home until they receive the test result (see Appendix 2). Staff must notify their manager of the test result. If it is positive they must isolate as directed by the PHU. If the test is negative they must stay home until their symptoms have resolved. They may then return to work unless otherwise advised by the PHU. Depending on jurisdictional guidance, if specimens for COVID-19 are collected the RCF may need to alert the PHU by phone.

Delays in testing staff or residents may delay case-detection, contact tracing, appropriate quarantine and cohorting/zoning of residents and staff. To avoid delays, RCFs should:

- advise all staff of the requirement to notify cases to the PHU, and the Commonwealth Department of Health
- develop the capacity to provide resident information in the format required by local pathology laboratories
- liaise with clinical staff servicing the RCF, and ensure that resident's pathology results are provided urgently to the facility manager

5.1.1. Testing staff

When disease in the community is high, periodic and comprehensive testing of staff and residents including asymptomatic staff may be undertaken.[5] See testing for COVID-19.

In some settings routine testing strategies can provide benefit to reduce transmission in high-risk environments. Increased testing frequency may be required in addition to other control strategies.[6]

Staff and visitors may avoid testing when they have symptoms because of fear of isolation requirements. Regular, clear messaging around the need for timely testing and strict adherence to isolation/quarantine should be undertaken to mitigate this risk, particularly if there is community transmission. Messaging should be accompanied by other supports where possible.

For more information about what staff should do after they have been tested, see Appendix 2.

5.2. Test for COVID-19

The recommended tests and methods of sampling for COVID-19 are outlined in the *CDNA COVID-19 National Guidelines for Public Health Units*. Specimens should be collected by an appropriately trained health care professional or pathology collector using transmission-based precautions. Residents do not need to be transferred to hospital for testing for COVID-19.

Depending on the location, saliva as a sample for testing may, or may not be, appropriate. Refer to *PHLN statement on use of saliva as an alternative specimen.*

5.2.1. Difficulties collecting a sample for testing

It can be difficult to undertake the required testing in some circumstances, including:

- cognitive resistance or impairment – inability for resident to comprehend the process
- sensory deficit or dysphasia – inability to understand the explanation of the process or the rationale for testing

[5] Modelling studies estimated that weekly PCR testing to screen health care workers and other high-risk groups irrespective of symptoms, would reduce their contribution to SARS-CoV-2 transmission by 23%. Imperial College COVID-19 Response Team Comparison of Molecular Testing Strategies for COVID-19 Control : a mathematical modelling study Lancet Volume 20, Issue 12, December 2020

[6] Chin ET, Huynh BQ, Chapman LAC, Murrill M, Basu S, Lo NC. Frequency of routine testing for COVID-19 in high-risk healthcare environments to reduce outbreaks. MedRxix. Preprint. Doi: 10.1101/2020.04.20.20087015

- communication barrier – people from non-English speaking backgrounds who may require a translator to understand the testing process or rationale and people with hearing deficits
- objection resistance – claimed right to refuse test expressed by resident (or advocate) or staff member
- behavioural resistance due to other issues or a combination of those described above

All options to facilitate testing of residents should be explored, for example:

- leaving a swab for familiar staff members to use at a later time
- supervised self-testing
- alternative modes of testing such as saliva testing if verified in the facility's jurisdiction

If no test can be undertaken due to lack of consent, resistance or distress the resident should be treated as though they had tested positive. The resident should have care provided in isolation until a test can be undertaken or an appropriate period of isolation has been completed.

5.2.2. Actions while awaiting a resident's test result

- Immediately isolate the resident and minimise interaction between other residents.[7]
- Provide PPE supplies to staff and check practical skills capability in use of PPE for each staff member using it.
- Make PPE, including surgical masks, eye protection, gowns and gloves available immediately outside the resident's room.
- Place a disposal receptacle near the exit inside the resident's room, to make it easy for staff to discard PPE safely before leaving the room.
- Place alcohol-based hand rub near the entry/exit of the resident's room
- Place a 'droplet and contact precautions' sign outside symptomatic residents' rooms to alert staff and visitors to the requirement for transmission-based precautions. Signs are available at the Australian Commission for Safety and Quality in Health Care website.
- Avoid aerosol generating procedures (such as nebulisers, CPAP and suction).
- Review all residents and staff for symptoms and document the results of this review.
- Continue to monitor all residents.
- Arrange testing for anyone else with symptoms compatible with COVID-19.

5.3. Provide notification of positive test results

Immediately notify State/Territory Health Departments of positive test results, and the Commonwealth Department of Health where required.

If COVID-19 is diagnosed by laboratory testing, the local state/territory Department of Health must be notified immediately. Laboratory confirmed COVID-19 is a notifiable disease in all Australian states and territories. The requesting medical officer and/or the testing laboratory must notify the infection to the jurisdictional communicable disease authority, depending on local legislative requirements; this notification is confidential.

RCFs should notify the PHU of the case as soon as possible. See a sample reporting template at Appendix 6.

[7] Refer to Infection Control Expert Group *COVID-19 Infection Prevention and Control for Residential Care Facilities*

For cases in residential aged care facilities, report the case as soon as possible (maximum 24 hours) to the Commonwealth at agedcareCOVIDcases@health.gov.au. For further information see the *First-24 hours – managing COVID-19 in a residential aged care facility*.

5.3.1. Public Health Unit review

While awaiting the test result, the case needs to be isolated and managed as potentially infectious. See Actions while awaiting a resident's test result.

One positive case **confirmed by the PHU** constitutes an outbreak for investigation (see Investigate and declare an outbreak). If the case is a staff member or visitor, the initial investigation will determine if the person attended the facility while infectious.

All residents and staff in the facility will be tested if the case is a resident, staff member or visitor who attended while infectious. When there is little or no disease in the community, a PHU may seek to confirm the positive test by retesting the original sample and/or collecting a second sample.

If a diagnosis of COVID-19 is confirmed in a staff member, the staff member must be isolated away from the facility. Isolation must continue until they meet the criteria for release from isolation outlined in the *CDNA COVID-19 National Guidelines for Public Health Units* (see Release from isolation). The RCF must make appropriate notification to the relevant authorities.

If the diagnosis is not confirmed, the PHU will inform the facility. Clear and wide communication of these decisions will be important. Confirming the result, if required, would usually occur within 24 hours. For information on false positive tests see PHLN guidance on nucleic acid test result interpretation here.

State and territory Public Health Unit contact details

Details current at the time of publication of these guidelines are provided in Table 1.

Table 1. State and Territory Public Health Unit contact details

State	Contact Details
Australian Capital Territory	Business Hours: 02 5124 9213 After Hours: 02 9962 4155
New South Wales	1300 066 055
Northern Territory	08 8922 8044
Queensland	13 432 584 (13 HEALTH) https://www.health.qld.gov.au/system-governance/contact-us/contact/public-health-units
South Australia	1300 232 272
Tasmania	1800 671 738
Victoria	1300 651 160
Western Australia	For ILI before COVID-19 positive result: 08 9222 8588 (Perth metro; Mon-Fri 8.30am to 5.00pm). After hours: 08 9328 0553 For confirmed COVID-19: 1300 316 555

Up to date local state and territory health department contact details are available on the Commonwealth Department of Health website

6. Activate the Outbreak Management Plan

6.1. Investigate and declare an outbreak

For the purposes of investigation, a COVID-19 outbreak is defined as **a single confirmed case of COVID-19 in a resident, staff member or attendee of a RCF.**[8] This definition includes any confirmed case who attends a high-risk setting during their infectious period.

Discuss with the PHU as soon as possible. The PHU will assist the RCF in management of the outbreak as described in the *CDNA COVID-19 National Guidelines for Public Health Units* and summarised below.

More information on early actions for Commonwealth subsidised aged care facilities is in the *First 24 hours – managing COVID-19 in a residential aged care facility* fact sheet. Information is also available through each jurisdiction's department of health website.

6.1.1. Steps in outbreak investigation in RCFs

The initial steps that PHU staff need to take when responding to an outbreak of COVID-19 in high-risk settings, such as RCFs, are listed in Box 2.

Box 2. Steps in outbreak investigation in RCFs

1. Define the setting.
2. Confirm and declare a COVID-19 outbreak for investigation with one confirmed case.
3. Identify those most at risk of severe disease.
4. Assess vaccination status for all staff and residents.
5. Arrange diagnostic testing for COVID-19 for all members of the setting. If available, consider additional serological tests. If other members of the setting are symptomatic, test these individuals for other respiratory pathogens such as influenza as well as COVID-19.
6. Ensure that the facility managers have notified ALL staff, residents (where applicable) and visitors, as relevant, that cases of COVID-19 have occurred in the setting. Contact all persons who have attended the facility and are deemed to be contacts. These include residents, staff, visitors and contractors. Ensure all contacts are quarantined and can undergo testing.
7. Advise staff about implementation of enhanced infection control measures and develop a process for ongoing IPC observation.
8. Determine if staff have worked at any other RCFs or provided in home care in the last 14 days.
9. Collate information onto a line list that describes people infected in terms of time, place and person.
10. In a residential facility, ensure the staff form an Outbreak Management Team that meets within hours of the identification of a case.
11. Identify and inform relevant internal and external stakeholders.
12. Isolate and treat individuals who test positive. Quarantine, as best as possible, those individuals who test negative and monitor for illness. Persons in this group are considered to be susceptible or incubating. They may become symptomatic or test positive over the next few days but may remain negative. They therefore still require protection from any possible further exposure.
13. Where feasible, commence a program of repeat tests for those (who may be) susceptible or incubating who are in quarantine. This will identify those who are pre-symptomatic to enable rapid removal from the environment. Frequent facility-wide repeat testing of staff

[8] See *CDNA COVID-19 National Guidelines for Public Health Units* for more information.

and residents should continue until it is clear there is no ongoing spread of infection in a facility. Those already identified as positive do not require further testing.

14. Identify suitable sites where individuals may be cohorted/zoned together into either: isolation of the sick or COVID positive OR quarantine of the exposed. These groups should be cared for separately to avoid additional exposure of those in quarantine. Residents who have not been exposed should avoid exposure to both groups. Residents and staff from affected areas, wings or buildings should not be moved to as yet unaffected areas.
15. Ensure enhanced environmental cleaning of the entire RCF and maintain cleaning and disinfection requirements.

Adapted from the *CDNA COVID-19 National Guidelines for Public Health Units*

An Outbreak Management Checklist is provided at Appendix 7.

6.1.2. High risk settings in a RCF

Within a RCF there are several high risk environments that are potentially problematic for outbreak management. There may be additional concern when there is/are:

- shared rooms
- shared bathrooms
- high occupancy (reduces isolation and cohorting/zoning options)
- residents with challenging wandering behaviours
- single building with lack of clear distinct areas or zones
- staff working across many areas, contact with many residents
- extensive outbreak at outset/identification, especially when large numbers of regular staff are isolated or furloughed
- early indications of management struggling or insufficient response
- a Clinical First Responder or IPC specialist with significant early concerns

6.2. Establish an Outbreak Management Team

The RCF provider is responsible for quality of care, safety and well-being of residents and should take a strong leadership role with immediate support from the PHU staff. An Outbreak Management Team (OMT) should be established to direct, monitor and oversee the outbreak. The OMT should meet regularly, usually daily, (in person or by teleconference) at the height of the outbreak to:

- monitor the outbreak
- identify problems
- initiate changes to response measures
- discuss outbreak management roles, responsibilities and priorities

Where feasible, the first meeting of the OMT should be co-chaired by a RCF executive officer and the public health physician/investigator appointed by the local PHU.

An outbreak should be managed as a command and response system. The leader of the response needs to be a senior person from the facility/provider with authority to make decisions and delegate responsibilities. As well as chairing the Outbreak Management Team, the leader needs to be present on site, visible, identifiable and accountable. The leader and others with specific roles in the outbreak need to be clearly identifiable e.g. using different coloured masks or tape on the outside of PPE or hat.

Initially the Outbreak Management Team should meet at least daily. At each meeting they should update:

- new cases

- testing numbers, including staff who are not onsite
- IPC and PPE compliance
- clinical and welfare concerns
- workforce
- communication
- supplies – PPE, food services, laundry

6.2.1. Outbreak Management Team – Example of Membership and Roles

OMT Role	OMT Function
Essential members in the first 24 hours	
Chair Senior RCF leader/ executive	If feasible, the leader of the response needs to be a senior person from the facility/provider with authority to make decisions and delegate responsibilities. Otherwise the Public Health Unit should lead.
Co-chair Public Health Unit lead[9]	Assigned by the Public Health Unit to arrange testing and make decisions around isolation and cohorting/zoning of patients.
Secretary	The RCF allocates a secretary who organises OMT meetings, records and distributes action items and minutes.
Infection Prevention and Control (IPC) Practitioner	Ensures that all infection control decisions of the OMT are carried out, and coordinates activities required to contain the outbreak. This include:s IPC strategy; PPE usage; staff training and compliance; and service processes and systems. The person could be an employee skilled in IPC, an IPC Practitioner organised by the PHU/local health district or a Clinical First Responder organised by the Commonwealth Department of Health.
Communications officer from RCF	Follows the communication plan to inform staff, families and others as required
Commonwealth Department of Health Case manager (if an aged care facility)	May activate a Clinical First Responder. The case officer will liaise with the Clinical Manager to assist access to primary health care and allied health through the Primary Health Network. Provides access to resources to assist in the response including PPE, workforce and supplementary testing.
Clinical oversight manager	A person from the facility who ensures ongoing clinical management of all residents, based on the advice of the OMT and on known clinical risks and needs of individual residents. For the COVID-19 patient/s, this includes ensuring clinical monitoring and management occurs. Care considerations include hospitalisation, geriatric in-reach services, GPs or other locally available models of care. For all residents this means ensuring usual clinical care and managing the rapid deconditioning, nutritional and mental health risks associated with isolation. The clinical manager will notify the Primary Health Network,[10] liaise with the state/territory coordinator for local district health services and the Commonwealth Department of Health case officer to ensure appropriate medical and allied health services are available to residents.
Additional members over time	
Public Health Unit Contact Tracer (if available)	Provides feedback on progress with contact tracing, testing and isolation of healthcare workers, external visitors, contractors, volunteers, allied health professionals, doctors, agency staff etc.
Public Health unit Epidemiologist (if available)	Provides expert opinion on containment plans, epidemiological links to other RCFs and epidemiological links to the community. Integrates multiple lines of information including data on hospitalisation, deaths etc. with existing state databases, prepare reports and advise state health officials on the progress of outbreak
Aged Care Quality and Safety Commission Case officer	Provides primary point of contact for providers and consumers in relation to quality of care. Monitors compliance with the Aged Care Quality Standards. Provides access to the Chief Clinical Advisor for the ACQSC and supports protection, care and wellbeing for all residents impacted in RCFs
Geriatrician or general physician	A person with specialist training and expertise in caring for the health of older people who can advise on the management of all residents during the outbreak. A person with an existing relationship with the facility and the local GPs can provide advice on clinical management and can also liaise with the local infectious disease teams if needed.
Infectious disease physician (if available)	A person with specialist infectious diseases expertise who may attend or advise the attending clinicians on clinical assessment and management of the person with COVID-19.
Local Health District coordinator for health care in the home (State/territory government)	A person from the Local Health District who coordinates the provision of state based in-reach services such as Hospital in the Home and Virtual Aged Care teams. This person has a role to source hospital in-reach capacity to back up clinical care where available.

[9] Public health units may not have sufficient staff to cover all positions and officers may perform more than one function

[10] Contact details for the Primary Health Network can be obtained from the PHU or the Department of Health website.

6.3. Restrict visitors and communal activities

During a COVID-19 outbreak visitor access into and within the facility will be limited.

Facilities should implement the following:

- suspend all group activities, particularly those that involve visitors (e.g. musicians)
- suspend communal dining
- postpone visits from non-essential external providers (e.g. hairdressers)
- restrict visits from regular visitors and families of residents to essential and compassionate reasons
    - young children should not visit as they are generally unable to comply with standard precautions and PPE requirements
- record the name and phone number of visitors on a register and who they visit
- screen any visitors for risks and illness
- instruct visitors to:
    - wear PPE as directed by staff
    - enter and leave the facility directly without spending time in communal areas
    - perform good hand hygiene before entering and after leaving the facility and the resident's room

In compassionate circumstances such as **end of life care**, RCFs should consult with PHUs to permit families, close friends and pastoral carers (emotional and spiritual support) to visit residents. In these circumstances, RCFs should conduct a risk assessment and consider the risk posed to the resident and/or the visitors. Try to mitigate the risk as follows:

- Visitors and residents should use appropriate IPC and PPE.
- Visitors should not have contact with other residents.
- Visitors should be screened on entry and escorted to the resident's room.

6.4. Ensure ongoing clinical care for all residents

All residents require their usual ongoing medical care, including essential allied health and mental health care, during the outbreak and the outbreak recovery period. It is important that services that maintain the physical and emotional wellbeing of residents continue to be provided as much as possible. The Outbreak Management Plan needs to include consideration of how these services can be continued. Some services can be provided through remote monitoring and telehealth and RCFs need to ensure that they have the technology available to support this. Good infection control practices are needed for the safe use of remote monitoring and telehealth equipment, including tablet devices.

All visiting GPs should be informed at the start of the outbreak and provided with the contact details of the clinical oversight manager from Outbreak Management Team. A sample letter for GPs can be found in Appendix 8.

In addition to a letter to GPs, Commonwealth funded aged care facilities should also contact the Primary Health Network. The Primary Health Network may liaise with those providing primary medical and allied health care in the local area. They can assist in sourcing practitioners willing to attend facilities. This will ensure ongoing continuity of care where usual GPs and allied health professionals are unable to do so.

GPs may not be aware of the role they can play during an outbreak and may be more willing to be involved once they are given information about what they can do.

6.5. Enhance Infection Prevention and Control

6.5.1. Review Standard Precautions

Ensure that standard precautions are in place in all areas of the facility.

Regular, scheduled **cleaning** of all resident care areas is essential during an outbreak. Frequently touched surfaces and those closest to the resident should be cleaned more often. These surfaces include:

- equipment
- door handles
- trays
- tables
- handrails
- chair arms
- light switches

During a suspected or confirmed COVID-19 outbreak, an increase in the frequency of cleaning and disinfection is recommended.

Cleaning AND disinfection are recommended during COVID-19 outbreaks. Either a 2-step clean (using detergent first, then disinfectant) or 2-in-1 step clean (using a combined detergent/ disinfectant) is required.

Detailed information on environmental cleaning and disinfection is in the *COVID-19 Environmental cleaning and disinfection principles for health and residential care facilities* factsheet. Disinfectants registered with the TGA as effective against the virus (SARS-CoV-2) are listed here *TGA disinfectants use against COVID-19*.

6.5.2. Implement Transmission-based Precautions

Implement additional transmission-based precautions for:

- cases
- residents who are unwell with respiratory symptoms
- residents who are well but are placed in quarantine.

COVID-19 transmission is primarily through droplets from the respiratory tract which may be inhaled, if close to the infected person, or may contaminate the environment. In RCFs, environmental contamination can be extensive. Contact and droplet precautions are therefore required. Airborne spread may occur during aerosol generating procedures and other circumstances described in Box 3.

The key elements of contact and droplet precautions and airborne precautions are outlined in Box 3.

Box 3. Transmission-based precautions

Transmission based precautions

Transmission-based precautions are IPC practices used ***in addition*** to standard precautions, to reduce transmission due to the specific route of transmission of a pathogen.
Respiratory infections, including COVID-19, are most commonly spread by contact and droplets. Airborne spread may occur during aerosol generating procedures.

Contact and droplet precautions

These precautions apply to:

- health care workers and RCF staff during the clinical consultation and physical examination of residents with suspected or confirmed COVID-19, or who are in quarantine
- all staff when in contact with ill residents.

Key elements are:

- **Standard precautions** (see Box 1)**.**
- **Use of PPE** including gown, surgical mask, protective eyewear, and gloves **when in contact with an ill resident.**
    - Protective eyewear can be in the form of safety glasses, eye shield, face shield, or goggles.
    - Prescription glasses are not considered protective eyewear.
- **Isolation of affected residents** in a single room. If a single room is unavailable, see Plan to cohort/zone residents for more information.
- **Enhanced cleaning and disinfection** of the ill resident's environment.
- **Limiting the number** of staff, health care workers, and visitors in contact with the ill resident.
- **Nebulisers** have been associated with a risk of transmission of respiratory viruses and their use **should be avoided**. A spacer or puffer should be used instead.

Note: When caring for an asymptomatic resident in quarantine, contact and droplet precautions should be followed. PPE includes a gown, surgical mask, protective eyewear, and gloves.

Airborne precautions

Particulate filter respirators (PFRs), such as P2 or N95 respirators, instead of surgical masks, are recommended, **in addition to all other precautions outlined above,** when performing certain high-risk (aerosol generating) procedures (AGPs) on patients with COVID-19. However, AGPs are likely to be performed infrequently in a RCF.

In addition, the use of a **particulate filter respirators (PFR)**, such as P2 or N95 respirator, may be considered when one or both of the following apply:

1. **For the clinical care of residents with suspected or confirmed COVID-19, who have cognitive impairment, are unable to cooperate, or exhibit challenging behaviours**.
2. **Where there are high numbers of suspected or confirmed COVID-19 patients/residents AND a risk of challenging behaviours and/or unplanned aerosol-generating procedures** (e.g. including intermittent use of high flow oxygen).

In these situations, use of a PFR, for up to four hours, if tolerated, will avoid the need for frequent changes of face covering.

Note: PFRs should only be used by staff who have been trained in their use and have been fit-tested. They should be fit checked with each use to ensure an adequate face seal. Unless there are adequate numbers of trained staff to care for residents in these circumstances, consider transferring infected residents who are distressed and exhibiting challenging behaviours to hospital, if possible.

Extract from *COVID-19 guidelines for infection prevention and control in residential care facilities (Infection Control Expert Group)*

Refer to the *COVID-19 guidelines for infection prevention and control in residential care facilities (Infection Control Expert Group)* for more information.

6.5.3. Resident showering

It is important that residents are able to shower or have bed baths to maintain their personal hygiene. Self-independent showering does not pose a risk to others and should be permitted during an outbreak. Staff may need to take additional precautions to assist residents with COVID-19 to shower or bath. For more information see Box 4 and the *COVID-19 guidelines for infection prevention and control in residential care facilities (Infection Control Expert Group)*.

Box 4. Showering or bathing residents with confirmed COVID-19

Health and care workers may continue to shower residents with confirmed COVID-19, unless:

- the resident's medical condition interferes with the ability to shower safely or
- conditions pose an unacceptable risk to staff or other residents.

Provide alternative hygiene care, such as a bed bath, if the risk of a shower is unacceptably high.

All staff assisting with showering or bathing should wear appropriate PPE. For instance, when assisting a resident in showering:

- Wear a surgical mask, face shield, fluid resistant gown and water resistant boots or shoe covers.
- Turn on extractor fans while showering and leave the door open, if possible.
- Use a gentle stream of water from a handheld shower head, to reduce the risk of droplet aerosols.
- Avoid getting the mask wet, as much as possible.
- Replace gowns and masks after the shower and clean and disinfect reusable face shields.

Extract from *COVID-19 guidelines for infection prevention and control in residential care facilities (Infection Control Expert Group)*

6.5.4. Ensuring appropriate use of PPE

Ensure staff are competent in the proper use of PPE. Training should be recent and practical with capability assessment. Online training alone is insufficient. Monitoring of staff maintaining correct use should occur across all shifts, as strict techniques and processes can be hard to maintain. This includes donning (putting on) and doffing (taking off) procedures. New staff must complete training and all existing health staff, including non-clinical support staff, should complete refresher training. Spotters should be used to observe and support donning and doffing, particularly in the early stages of an outbreak. Staff must remove PPE in a way that prevents contamination of the health care worker's clothing, hands, and the environment. Staff should:

- immediately discard PPE into appropriate waste bins
- use good hand hygiene before putting PPE on (donning) and immediately after removing PPE (doffing)

See Appendices 9, 10 and 11 for useful educational and promotional material on hand hygiene and the proper use of PPE.

6.6. Communications and psychosocial support

Activate the RCF Communications plan. A dedicated staff member on the OMT should be responsible for communication according to the plan. For more information see Develop a communications plan.

Outbreaks can be distressing for residents. Restrictions on visitors and communal activities and reduced contact with residents and staff can lead to residents feeling isolated. The mental health and wellbeing of residents is vital.

RCFs should support residents to stay connected with family, friends and the community. Residents and families should be encouraged to interact regularly through phone calls and social media. There are short courses available on Be Connected that may help older Australians learn new technologies such as Skype and FaceTime.

It is important that residents maintain a structured day with activities to fight boredom. Residents may wish to read, engage in crafts and puzzles, watch TV, or listen to music and audiobooks. RCFs should have a process to monitor resident engagement and look for signs of acute changes to mental status. RCFs should have a program to ensure that entertainment resources and equipment are decontaminated between residents.

Resources for aged care facilities are available on the Older Persons Advocacy Network. Aged care facilities should also make residents aware of the Older Australians COVID-19 Support Line.

6.7. Start single site work arrangements

During an outbreak, staff who are working at the facility should not work in other residential facilities. To help with the workforce challenges, the Commonwealth may activate single site arrangements. See guidance on preparing and implementing a single site workforce in the *National COVID-19 Aged Care Plan: Appendix H*

6.8. Detecting cases during the outbreak

Increased monitoring and active observation of all residents for the signs and symptoms of COVID-19 is essential in outbreak management. Staff should be aware of the atypical presentation in the elderly and should actively look for unusual symptoms of COVID-19 (see Recognising COVID-19). See *COVID-19 screening tool for residential aged care services* for an example screening tool.

Close monitoring will enable the early detection of new cases, and daily identification of any ongoing transmission and potential gaps in infection control measures. This will ensure swift infection control measures are implemented or strengthened. This is important to reduce transmission and the duration of the outbreak.

6.8.1. Routine testing during an outbreak

Lessons from outbreaks in Australia have shown that it is vital to have widespread testing in facilities as soon as one case is detected. The *CDNA COVID-19 National Guidelines for Public Health Units* recommends testing all residents and staff when a case is identified. If the response is not consistent with this there needs to a documented reason provided by the PHU to the RCF.

Testing (including repeat testing) and ongoing actions for individuals in the defined setting should be undertaken in line with the *CDNA COVID-19 National Guidelines for Public Health Units.* This includes:

- isolating individuals who test positive
- quarantining individuals who test negative
- commencing a program of repeat testing for those in quarantine

Common testing regimes during an outbreak are described in Table 2.

Note that residents and staff who have tested positive should not be included in subsequent routine screening unless directed to do so by the PHU.

Table 2. Common testing regimes during an outbreak in a facility (in collaboration with PHU staff)

Situation	Testing population
First positive case, resident OR staff member (care provider or other) who worked in infectious period.	All staff (clinical, administrative, cleaning, catering etc.) , residents and visitors who attended while the case was infectious (usually 48 hours prior to symptoms) should be contacted and referred for testing in the community.

Positive case in a staff member who had not worked during their infectious period	For public health consideration. Depending on the time the staff member was last at the facility and their close contacts, the PHU may advise testing to exclude the RCF as the site of acquisition.
Ongoing outbreak	All residents and staff 72 hourly if feasible but NOT those who have already tested positive for COVID-19 within the past three months.
Quarantined or furloughed staff	An early test (approximately day 2) and a late test (approximately day 12) in the quarantine period or as mandated by the PHU.
Stable outbreaks near the end with no ongoing spread evident (as advised by PHU)	Cease 72 hour testing regime when no new cases identified or as directed by the PHU. Test all previously negative staff and residents before exit from quarantine/ furlough as guided by the PHU.
'Mystery staff case' - a staff member who had no clear community source	As advised by Public Health Unit, widespread testing may identify asymptomatic cases in other staff members or residents. If waste water testing is feasible it may be used to determine if COVID-19 is in the facility.

Test results should be provided in a line list daily in the OMT meeting. The line list should be provided to the PHU each day (or as arranged if the PHU attends the meeting) until the outbreak is declared over.

6.8.2. Workforce monitoring

In preparation, the RCF will have documented where staff work (see Plan for impacts on workforce). During an outbreak, additional staff will be required.

Monitoring needs to document staff absence from work:

- date they left
- whether they were
  - isolated because of COVID-19
  - quarantined as a close contact
  - at home waiting for test result
- testing dates and results
- clearance to return to work
- date of return to work

The provider should consider how best to support staff who are isolating or quarantining and maintain their engagement with the workplace.

For information and practical guidance on preparing for and implementing a single site workforce in an aged care facility, see the *National COVID-19 Aged Care Plan: Appendix H*.

6.9. Isolation and cohorting/zoning

RCFs should refer to the *COVID-19 guidelines for infection prevention and control in residential care facilities (Infection Control Expert Group)* for detailed information on the placement of residents in the RCF. A resident with relevant symptoms should be placed in a single room with their own ensuite facilities, if possible, while waiting for a diagnosis. Residents requiring droplet precautions should be restricted to their room. Residents may attend urgent medical or procedural appointments but should wear a surgical mask if tolerated. The service provider should be consulted to determine if the appointment is essential and alert them to the status of the resident. Staff escorting residents should wear appropriate PPE, which may include a surgical mask, gowns, eye protection and gloves, and observe hand hygiene. Transport arrangements should be made in consultation with ambulance services.

With guidance from the PHU and/or other appropriate experts, if there is more than one case, place residents with COVID-19 together in one area of the facility. Consider other available options to assist with cohorting/zoning of residents (see Plan to cohort/zone residents).

6.9.1. Caring for cohorted/zoned residents

The Outbreak Management Plan should outline how to set up the RCF to cohort/zone resident in zones (see Plan to cohort/zone residents).

The following support systems should be in place:

- a system to clean and disinfect reusable PPE and shared equipment
- an increase in the number of cleaning staff to
    - support enhanced cleaning schedules
    - provide daily cleaning and disinfection of individuals' rooms and communal areas
    - provide more frequent cleaning of frequently touched surfaces in amber and red zones based on the number of staff and individuals' movements
- dedicated kitchen staff who do not undertake cleaning roles and do not enter amber and red zones
- the ability to increase clinical and general waste storage and removal
- the ability to increase linen supply
- access to pathology services who provide on-site screening
- a runner to fetch items for staff who are in full PPE

6.9.2. Managing staff

Once resident isolation or cohorting/zoning measures are in place, allocate specific RCF staff to the care of residents in isolation. Doing this will further reduce the risk of transmission.

RCFs should maintain a register of staff members caring for patients with COVID-19 or working in a COVID-positive zone or area (e.g. cleaners).

Ensure that staff members:

- have oversight to support effective PPE use to minimise risks to themselves
- do not move between their allocated room/ section and other areas of the facility, or care for other residents
- do not share common areas with staff from other sections e.g. break rooms, handover
- maintain strict physical distancing from other staff members
- continue to monitor themselves for signs and symptoms of COVID-19 and do not attend work if unwell (even if symptoms are very mild)
- do not work in other facilities, at least until 2 weeks after the outbreak is declared over or as advised by the PHU
- are supported to be accommodated out of their own homes (e.g. onsite, nearby hotels) if they live with other vulnerable people
- avoid moving equipment between zones, where possible

Continue to screen staff for symptoms and fever at the beginning of every shift. Record staff testing details in a register. All staff working on site should participate in any whole-of-facility testing and be regularly screened for symptoms (and tested, if necessary) during an outbreak.

If a staff member refuses screening, they must immediately be excluded from attendance at all RCFs and other high-risk facilities.

If a healthcare worker is exposed to a case, but the healthcare worker and/or the case were using PPE at the time of exposure, a risk assessment should be performed. This will determine whether the contact should be quarantined for 14 days (see Table 3).

Factors that may be considered include:

- case details: presence of symptoms and timing of exposure in relation to symptom onset; high-risk behaviours (e.g. shouting, wandering)
- contact details: physical distancing, length of exposure time either directly to the case or within a shared closed space
- PPE: use of PPE by the case and contact, appropriate PPE use and any reports or suspicion of PPE breaches
- high risk procedures: if aerosol generating procedures were performed
- environment: use of shared equipment (e.g. computers on wheels, pagers) and use of communal spaces (e.g. tea rooms, flight decks, work stations)
- staff mobility: if staff work across multiple facilities or are highly mobile within the facility (e.g. security guards or cleaning staff)

Table 3. Assessing risk of exposure to COVID-19

		Exposure			
		Aerosol generating procedures	Close contact	Working in a RCF where there are COVID-19 cases	Casual contact
Contact PPE	No PPE	High risk	High risk	Conduct individual risk assessment	Conduct individual risk assessment
	Surgical mask only	High risk	High risk	Conduct individual risk assessment	Low risk
	Mask and eye protection only	High risk	Conduct individual risk assessment	Conduct individual risk assessment	Low risk
	Other PPE concerns e.g. incorrect doffing	High risk	Conduct individual risk assessment	Conduct individual risk assessment	Low risk
	Appropriate PPE as per latest guidance	Low risk	Low risk	Low risk	Low risk

Note: exposure must have occurred in the period from 48 hours before onset of symptoms in the case (or first positive PCR test if asymptomatic) until the case is no longer infectious. In some high-risk settings, public health units may opt for a more precautionary approach and use a time period of 72 hours before the case's symptom onset (or first positive PCR test if asymptomatic). Refer to the CDNA COVID-19 National Guidelines for Public Health Units further information and definitions of close and casual contacts.

For Commonwealth supported residential aged care facilities, if staffing levels are of concern, contact the Commonwealth Department of Health Case Manager for assistance at AgedCareCOVIDWorkforce@health.gov.au.

6.10. Limit admissions and transfers

The *COVID-19 guidelines for infection prevention and control in residential care facilities (Infection Control Expert Group)* provide detailed information on the management of admissions and transfers during an outbreak.

6.10.1. New admissions

Admissions of new residents into the facility during an outbreak should be avoided, where possible. Depending upon the extent and stage of the outbreak and the physical layout of the building, restrictions may be applied to one floor, a wing or the entire facility.

6.10.2. Re-admission of confirmed cases

The re-admission of residents who have been moved to hospital needs to be considered on a case-by-case basis. This applies especially for those cases who are still infectious and require isolation from others. A decision to readmit a resident needs to take into account:

- the best care for the resident
- the potential for ongoing transmission from the case
- the ability of the residential facility to continue to safely isolate the case
- the level of community transmission
- hospital capacity

If the isolation period can be completed successfully in the facility, it may be appropriate to return the resident to the facility for care. This will require consultation between the PHU, treating clinicians, residential care facility as well as the resident and family. When a resident is no longer infectious and is COVID-19 cleared or recovered, they can be safely returned to the RCF after other clinical issues have been considered. Generally, patients must have had at least 10 days from the onset of symptoms and 3 days completely symptom free to be released from isolation (refer to Release from isolation).

6.10.3. Re-admission of non-cases

The re-admission of residents who have not been on the COVID-19 outbreak case lists (i.e. are not a known case) should be avoided during the outbreak period, if possible. Re-admission should not occur where an outbreak is uncontrolled and ongoing positive cases are being detected. If non-cases are re-admitted, the resident and their family must be informed about the current outbreak and risk to the resident. Adequate outbreak control measures must be in place. Residents and families may wish to make alternative arrangements (e.g. family care) until the outbreak is over. If the resident returns from the community when there is community transmission, they may be required to undergo quarantine.

6.10.4. Unaffected residents

In some circumstances, it may be feasible to transfer residents who have not been exposed to COVID-19 to other settings (e.g. family care) for the duration of the outbreak. A risk assessment should be done to understand the family circumstances and health status prior to transferring residents. The Public Health Unit may provide advice. Unless there is a Public Health Direction or Order preventing movement of a resident, the final decision rests with the resident or, if they are unable to make the decision, the resident's representative. See plan for resident transfers for more information.

6.10.5. Transfers to hospital

Movement to hospital will depend on the outbreak situation, the needs of the individual resident, and the ability to manage the case on site without placing other residents at risk. If transfer to hospital is required, the ambulance service and receiving hospital must be notified of the outbreak/suspected outbreak verbally. A resident transfer advice form (see Appendix 12) must be completed. Ensure the Advanced Care Directive accompanies the resident to hospital if one has been prepared.

6.11. Monitoring COVID-19 cases

COVID-19 cases should be closely monitored to detect and respond to deterioration and distress.

Inform the PHU of any deaths. Refer to the local PHU as to how they should receive this advice. Depending on the intensity of the outbreak, this may be by phone or email.

6.12. Release from isolation

People who have had COVID-19 need to meet specific criteria to be released from isolation. This ensures they are no longer a risk to others. These criteria are outlined in the *CDNA COVID-19 National Guidelines for Public Health Units*.

A person, staff or resident, who has met the criteria for release from isolation can return to the facility without any adjustments unless otherwise advised by the PHU.

Refer to *COVID-19 National Guidelines for Public Health Units* for release from isolation criteria. The PHU will advise when cases can be released.

Persons who fulfil the appropriate criteria above are not considered to be infectious. Cases returning to RCF can return if the criteria in the guidelines are met. They do not need to meet a higher standard or undergo additional assessment before going into any high-risk settings. This includes persons returning to work in a healthcare setting, living in a RCF, or who regularly attend healthcare settings for any other reason. If a person has met the appropriate criteria in to *COVID-19 National Guidelines for Public Health Units*: it is not necessary for them to:

- undergo isolation or quarantine in another ward, the facility they are returning to, or any other location, or
- have evidence of any negative test results for SARS-CoV-2 prior to returning to residential aged care or any other setting

6.13. Declare the outbreak over

Declaring an outbreak over is a PHU decision. The time to declare it over can vary depending on the case/s.

Generally, an outbreak in a facility would be declared over at least 28 days after the date of isolation of the last case. If there was only one case and the case acquired their infection incidentally in the community, the outbreak may be considered over if there is no evidence of transmission after 14 days since exposure. If there is an ongoing risk the PHU may institute additional monitoring / specific surveillance.

When the outbreak is over, the OMT should consider ongoing surveillance for illness. Consider the need to:

- maintain general infection control measures
- monitor the status of ill residents and communicate with the GP, local medical in-reach supports and/or public health authority if their status changes
- notify any late, COVID-19-related deaths to the PHU

- alert the PHU to any new cases, signalling either re-introduction of infection or previously undetected ongoing transmission
- advise relevant state/territory/national agencies of the outbreak in a RCF, if applicable
- discontinue the restriction of residents to their rooms
- review visitation restrictions

The OMT should provide reports of the relevant stakeholders and ensure that data are appropriately summarised.

7. Review the Outbreak

After declaring an outbreak over, the OMT should consult with the local PHU to consider reflecting on:

- strengths and weaknesses in the response and investigation
- policies, practices or procedures that need to be modified to improve responses for future outbreaks

A tool is useful to complete an audit. Audits are commonly used in clinical medical and nursing practice as part of continuous quality improvement. They can be useful for healthcare workers to review how the outbreak was managed. Australian public health practitioners and researchers have developed an outbreak audit process, with:

- a framework for deciding which outbreak investigations to audit
- an approach for conducting a successful audit
- a template for trigger questions

This tool enables agencies such as RCFs to assess their outbreak response against best practice. The tool can be found at *Outbreak Investigation Audits*.

A document with lessons learned should be provided to the PHU and the Commonwealth to enable ongoing quality improvement in the management of outbreaks.

8. Glossary

AGPs	aerosol generating procedures
AHPPC	Australian Health Protection Principal Committee
ARI	acute respiratory illness
CDNA	Communicable Disease Network Australia
CPAP	continuous positive airway pressure
DRS	disability residential services
GP	general practitioner
ICEG	Infection Control Expert Group
ILI	influenza-like illness
IPC	infection prevention and control
NACAP	National Aged Care Advocacy Program
NNDL	National Notifiable Disease List
OMP	Outbreak Management Plan
OMT	Outbreak Management Team
OPAN	Older Persons Advocacy Network
PCR	polymerase chain reaction
PFR	particulate filter respirator
PHN	Primary Health Network
PHU	Public Health Unit
PPE	personal protective equipment
RACFs	residential aged care facilities
RCFs	residential care facilities

9. Appendices

APPENDIX 1. List of processes and systems RCFs need to prevent and prepare for potential COVID-19 outbreaks

1. Established processes to screen all staff and visitors for symptoms or identify whether they have been in an area where cases have occurred in the last 14 days prior to entry to the facility.
2. Access to infection control expertise, preferably in-house. Note: there are specific requirements regarding IPC staff at aged care facilities, see the Department of Health website for more information.
3. Trained staff in all aspects of outbreak management, including IPC and PPE use.
4. Regular program of re-training in place to review and refresh IPC and PPE skills.
5. Standard IPC precautions in place.
6. Adequate supply of TGA approved PPE available and a reliable source for further supplies (see Ensuring supplies).
7. Established systems to monitor residents and staff for symptoms of COVID-19.
8. Developed outbreak management plans, which are tested and regularly updated.
9. Prepared and operationalised COVIDSafe plans in keeping with state public health orders.
10. Conducted a WHS risk assessment and addressed identified gaps.
11. Prepared organisational personnel and resources for changes in demand and service use at the facility level that may be required to manage the pandemic
    a. Including a surge workforce plan to cater for the significant increase in staff required during an outbreak.
12. Established systems to manage communications and engagement with families of residents and community that support the RCF. This should include consideration of materials in languages other than English.
13. Established communication and access to all health care professionals who provide care to residents.
14. Established linkages and integrated with the applicable state and territory preparedness arrangements.
15. Process for testing.
16. Established clinical models of care for all residents during facility lockdowns and outbreaks.

Note: smaller facilities such as disability residential services may not have access to in-house services, such as a regular training program for IPC and PPE or an existing supply of PPE. Facilities in these circumstances should consider seeking support from local health providers to assist in preparation for COVID-19 outbreaks.

Staff testing in residential care facilities

PURPOSE OF TEST	ACTION WHILE WAITING FOR RESULT
Screening (no symptoms)	Keep working (unless advised not to by PHU*) 
Close contact	Quarantine for 14 days from date of last contact 
COVID-19 symptoms (not close contact)	Stay home until test result and no longer have symptoms 

If test result is positive, person must isolate for at least 10 days until released by the PHU*

*PHU = local public health unit or public health authority

26 November 2020

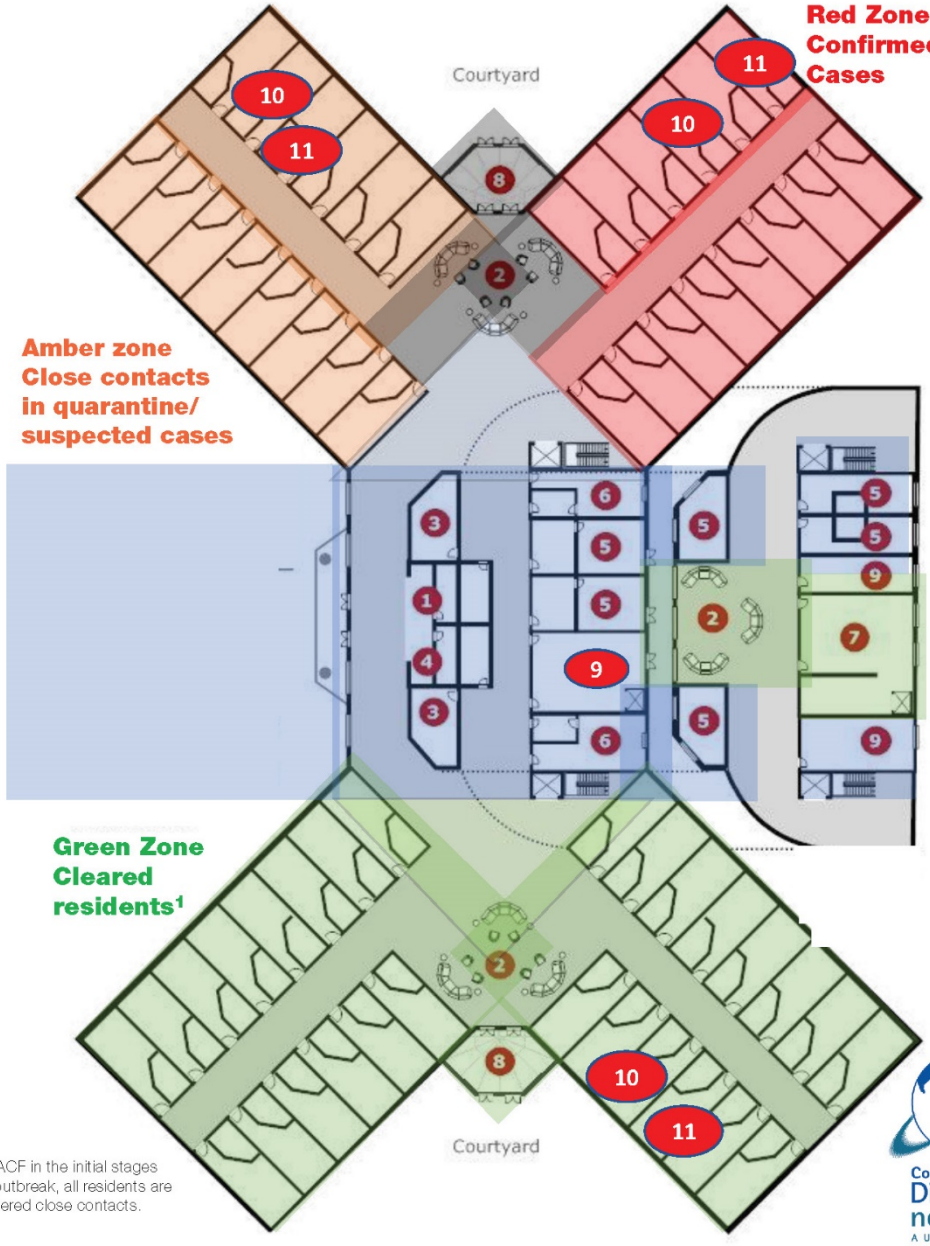
Communicable Diseases network AUSTRALIA

APPENDIX 3. COVID-19 Outbreak Preparedness Checklist

Planning actions	☑
Does your RCF have a COVID-19 Outbreak Management Plan that covers all the areas identified below?	
Has your RCF updated its COVID-19 Outbreak Management Plan this year?	
Have the relevant health care providers/organisations in the community (e.g. associated GPs, infection control consultants) been involved in the planning process?	
Are all RCF staff aware of the plan including their roles and responsibilities?	
Staff, resident and family education	
Has your RCF staff undergone education and training in all aspects of outbreak identification and management, particularly competency in infection control and appropriate PPE use?	
Has your RCF run one or more staff education sessions?	
Has your RCF provided residents' families with information regarding prevention of transmission?	
Staffing actions	
Does your RCF have a staffing contingency plan in case 20% to 50% of staff fall ill or are excluded for 14 days?	
Has your RCF developed a plan for cohorting/zoning staff in an outbreak?	
Stock levels	
Has your RCF acquired adequate stock of PPE, hand hygiene products, nose and throat swabs and cleaning supplies?	
Outbreak recognition actions	
Does your RCF routinely *assess* residents for COVID-19 symptoms, particularly for fever or cough (with or without fever)? Do you document changes in resident's behaviour or health?	
Does your RCF *support and encourage* staff to report COVID-19 symptoms during the pandemic?	
Does a process exist to notify the facility manager and the state/territory Department of Health as soon as practicable (and within 24 hours) when a COVID-19 case is suspected?	
Communication actions	
Does your RCF have a contact list for the state/territory health department and other relevant stake holders (for example, facility GPs and infection control consultants)?	
Does your RCF have a plan for communicating with staff, residents, volunteers, family members and other service providers (for example, cleaners) during an outbreak?	
Does your RCF have a plan to restrict unwell visitors entering the facility and limit well visitors during an outbreak to reduce risk of transmission both within the facility and externally (for example, security, signage, restricted access)?	
Cleaning	
Does the plan identify who is responsible for overseeing increased frequency of cleaning, liaison with contractors or hiring extra cleaners as necessary?	

Zoning in Residential Care Facilities

1. Administration
2. Lounge/donning and doffing station
3. Nurses station
4. Medication room
5. Equipment room
6. Laundry
7. Resident dining room
8. Sunroom
9. Staff lunchroom
10. Satellite lunchroom
11. Satellite nurses station



1 In RACF in the initial stages of an outbreak, all residents are considered close contacts.

Communicable Diseases network AUSTRALIA

Reference: ICEG Coronavirus (COVID-19) guidelines for infection prevention and control in residential care facilities
https://www.health.gov.au/resources/publications/coronavirus-covid-19-guidelines-for-infection-prevention-and-control-in-residential-care-facilities

26 November 2020

APPENDIX 5. Letter to Families

[Facility Letterhead]

……/……/……

Dear family member

Local transmission of Coronavirus Disease 2019 (COVID-19) has been reported in the community around our facility. COVID-19 primarily causes respiratory illness in humans. While all types of respiratory viruses can cause sickness in the elderly, COVID-19 is a very contagious infection that can cause severe illness and death for vulnerable people.

Residential care facilities are particularly susceptible to COVID-19 outbreaks. Many external cases may lead to residents or staff contracting the COVID-19 and enabling outbreaks in residential care facilities to become established.

Families play an important role in protecting their relatives from community viruses. Practical steps you can take to prevent COVID-19 from being introduced into residential care facilities are outlined below.

Avoid spreading illnesses
Washing your hands well with liquid soap and water or using alcohol-based hand rub before and after visiting and after coughing or sneezing will help reduce the spread of disease. Cover your mouth with a tissue or your elbow (not your bare hand) when coughing or sneezing and dispose of used tissues immediately and wash your hands.

Stay away if you're unwell
If you have recently been unwell, been in contact with someone who is unwell or you have symptoms of respiratory illness (e.g. fever, cough, shortness of breath, sore throat, muscle and joint pain, or tiredness/exhaustion) please get yourself tested for COVID-19. Do not visit the facility until your symptoms have resolved. If you have been in contact with a confirmed case of COVID-19 you must stay away until you are released from quarantine.

Limit your visit
We ask that you only visit the person you have come to see and keep children away if they or your resident family member are unwell. Avoid spending time in communal areas of the facility if possible to reduce the risk of spreading infection.

Thank you for your assistance in adhering to these steps. These measures will greatly assist our facilities and protect the health of your relatives in the event of a COVID-19 outbreak.

Should you require further information regarding COVID-19, please refer to the Commonwealth Department of Health website:

https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert

Yours sincerely,

[Name]
[Position]
[Facility/Organisation]

APPENDIX 6. Initial Facility Report to a PHU – COVID-19 Outbreak

Date/time: _____ Public Health Officer:_____

Contact details:

RCF registered name: _____ Trading name (if different):_____

RAC ID number (if relevant): _____

Person notifying outbreak: _____ Position: _____

Telephone number: _____ Email: _____

Case details:

Name _____ Age ___ Sex ___ Current location of the case _____

Facility details:

Name of Facility_____

Address: _____

Facility Manager / Director: _____

Telephone number: _____ Fax number: _____

Email address: _____

Description of facility: _____

Total number of residents: _____ Total number of staff: _____

Age range of residents: _____

Number of units / wings / areas in facility: _____

Attached floorplan with location of case marked : Yes / No

Residents:

Unit name	Resident no.	Long term	Short term / Respite	High Care	Dementia / Secure	Other

RCF Staff:

Staff type	No. of RCF staff	No. agency staff	No. Causal staff	No. volunteers
Management				
Administrator				
Cleaner				
Catering staff				
Nurse				
Carer / Care Assistant				
Agency				
Other (specify)				

APPENDIX 7. COVID-19 Outbreak Management Checklist

Declare an outbreak	☑
Have an Outbreak Management Team meeting within hours of diagnosis of one case	
Identify other cases	
Arrange testing for all residents and staff	
Increase observation of residents to detect symptoms and signs of COVID-19	
Establish a screening system for symptoms in staff at the start of each shift	
Implement infection control measures – for those affected	
Isolate / cohort / zone ill residents in their room	
Display contact and droplet precautions sign outside resident/s' room	
Place alcohol-based hand rub outside resident/s' room	
Provide PPE, signage and appropriate waste bins outside room	
Implement infection control measures – for the entire facility	
Display outbreak signage at entrances to facility	
Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility. Increase access to alcohol-based hand rub	
On advice from public health unit – require all staff to wear surgical masks	
Increase frequency of environmental cleaning (minimum twice daily) and add focus of frequently touched surfaces such as bedrails	
Ensure **all** staff monitor for symptoms and stay away if unwell	
Inform	
The local Public Health Unit	
All residents' GPs	
Activate the communications plan	
If a Commonwealth supported aged care facility - inform the Commonwealth	
Restrict	
Restrict movement of staff between areas of facility	
Consider single site workforce arrangements	
Avoid resident transfers	
Restrict visitors with the exception of those on compassionate grounds	
Cancel non-essential group activities during the outbreak period	
Monitor	
Continue observation of residents for fever and/or acute respiratory illness and undertake repeat testing	
Update the case list daily at the facility and provide to the OMT and public health unit daily	
Add positive and negative test results to case list	
Declare over	
In most circumstances the outbreak can be declared over when there are no new cases 28 days from the date of isolation of the most recent case.	
Review	
Review and evaluate outbreak management – amend Outbreak Management Plan if needed	

APPENDIX 8. Letter to GPs – COVID-19 Outbreak

[Facility Letterhead]

……/……/……

Respiratory outbreak at [Facility Name]

Dear Doctor,

There is an outbreak of COVID-19 at the facility. The outbreak may involve some of your patients who may require review.

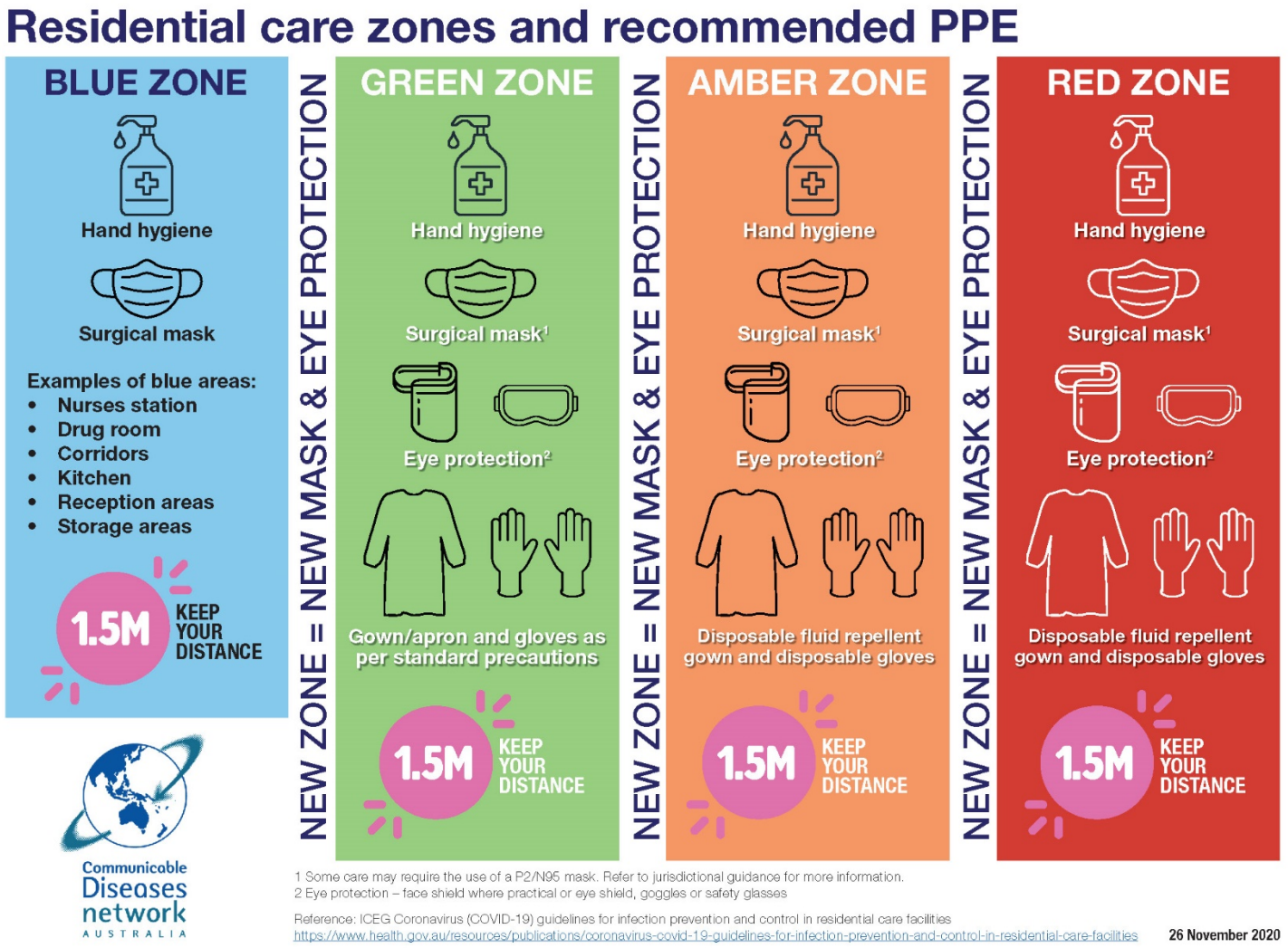
In keeping with national and jurisdictional guidelines and in consultation with the local PHU, the facility has implemented the following control measures:

- Testing of all staff and residents
- Isolation of symptomatic residents and residents who test positive for COVID-19 in consultation with the Public Health Unit
- Use of appropriate PPE when providing care to ill residents
- Exclusion of symptomatic staff from the facility
- Restriction/limitation of visitors to the facility until the outbreak has resolved
- Promotion of thorough hand washing and cough and sneeze etiquette
- Postponement of all non-urgent appointments for persons in isolation.

If you require any further information or advice please contact the clinical oversight manager [insert name and contact details].

Yours sincerely,
[Name]
[Position]
[Facility/Organisation]

APPENDIX 9. Residential Care Zones and Recommended PPE



APPENDIX 10. Donning and Doffing PPE signs

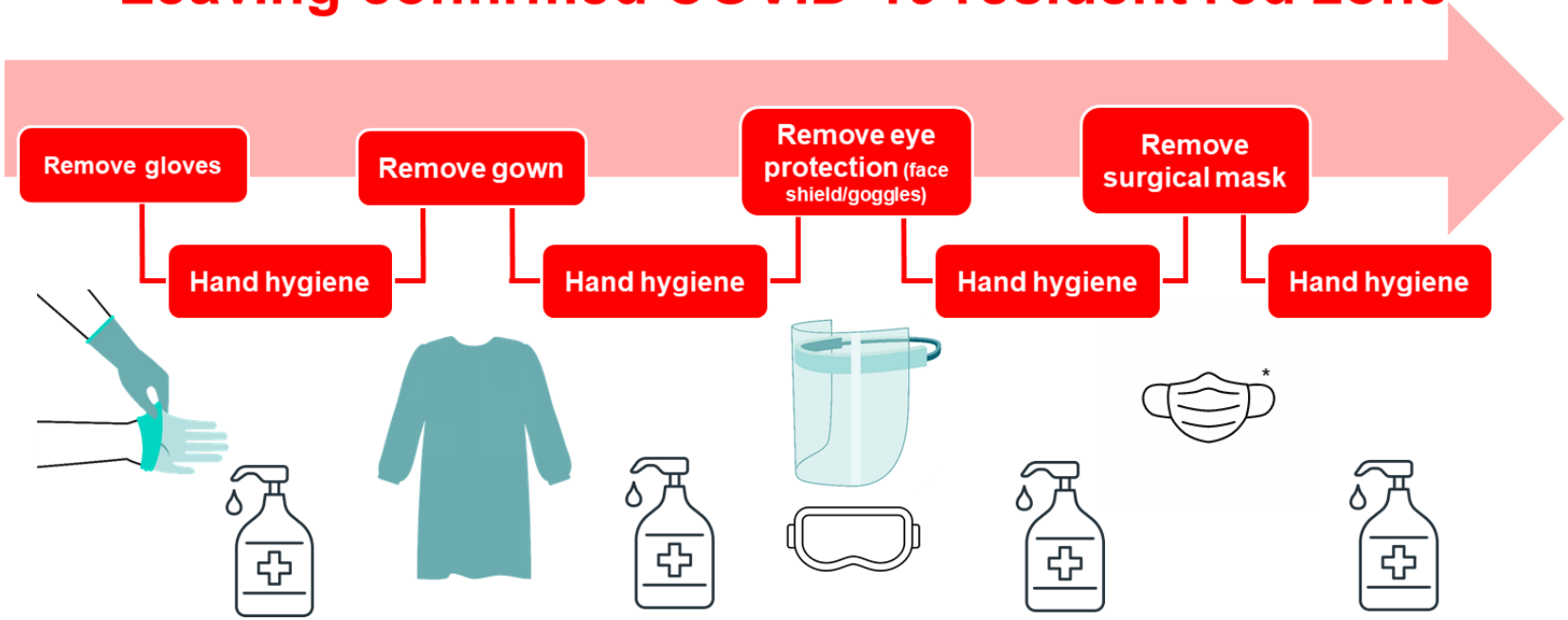
Use of PPE in residential care facilities

Putting on (donning) PPE: Entering confirmed COVID-19 resident red zone

*Some care may require the use of a P2/N95 mask. Refer to jurisdictional guidance for more information
November 26, 2020 V1

Communicable Diseases network AUSTRALIA

Taking off (doffing) PPE: Leaving confirmed COVID-19 resident red zone



*Some care may require the use of a P2/N95 mask. Refer to jurisdictional guidance for more information

November 26, 2020 V1

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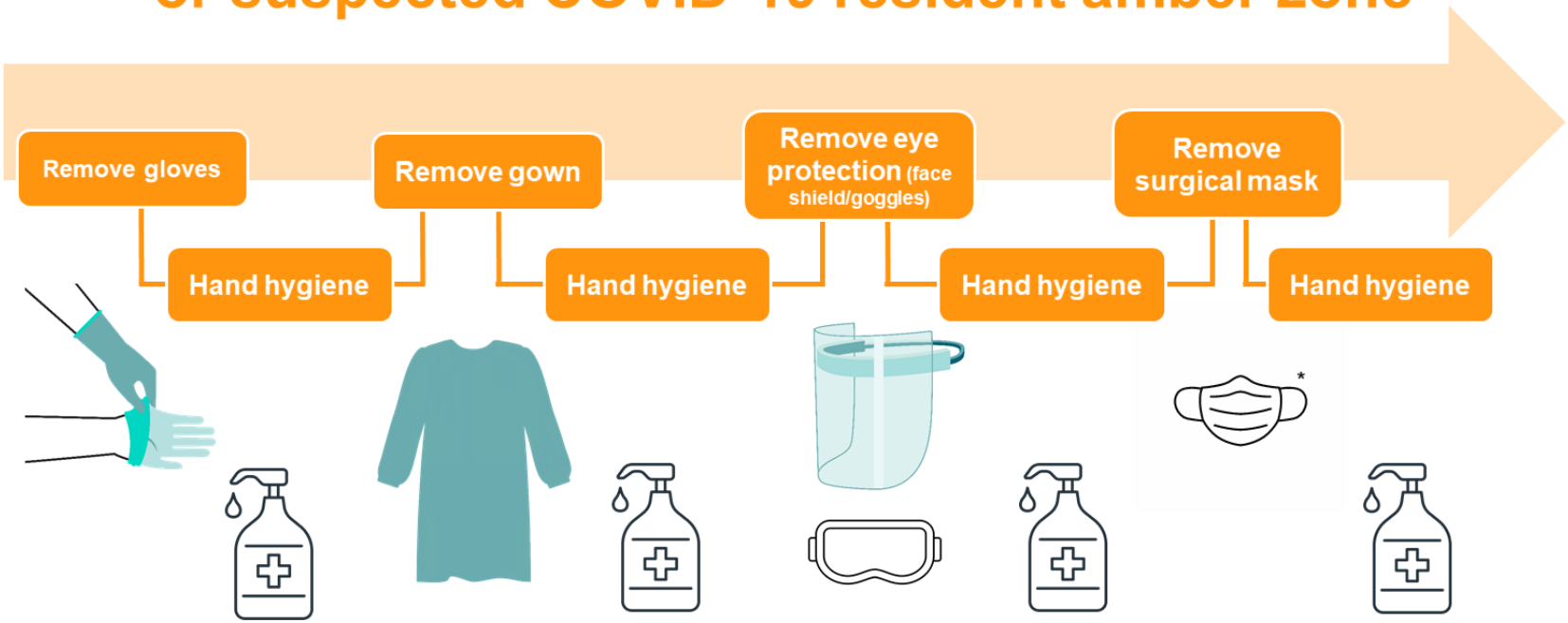
Taking off (doffing) PPE: Leaving close contact or suspected COVID-19 resident amber zone



*Some care may require the use of a P2/N95 mask. Refer to jurisdictional guidance for more information
November 26, 2020 V1

Communicable Diseases network AUSTRALIA

Putting on (donning) PPE: Entering close contact or suspected COVID-19 resident amber zone

*Some care may require the use of a P2/N95 mask. Refer to jurisdictional guidance for more information
November 26, 2020 V1

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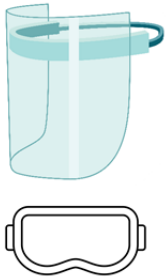
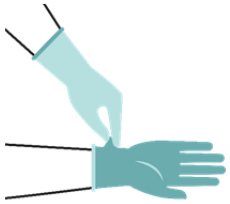
Putting on (donning) PPE: Entering non-COVID-19 resident green zone

Hand hygiene → **Gown[1]** → **Surgical mask** → **Eye protection** (face shield/goggles) → **Gloves[2]** → **Enter zone**





[1] Don gown if anticipating potential exposure to blood or body fluids

[2] Don gloves if anticipating potential exposure to blood or body fluids

*Some care may require the use of a P2/N95 mask. Refer to jurisdictional guidance for more information
November 26, 2020 V1

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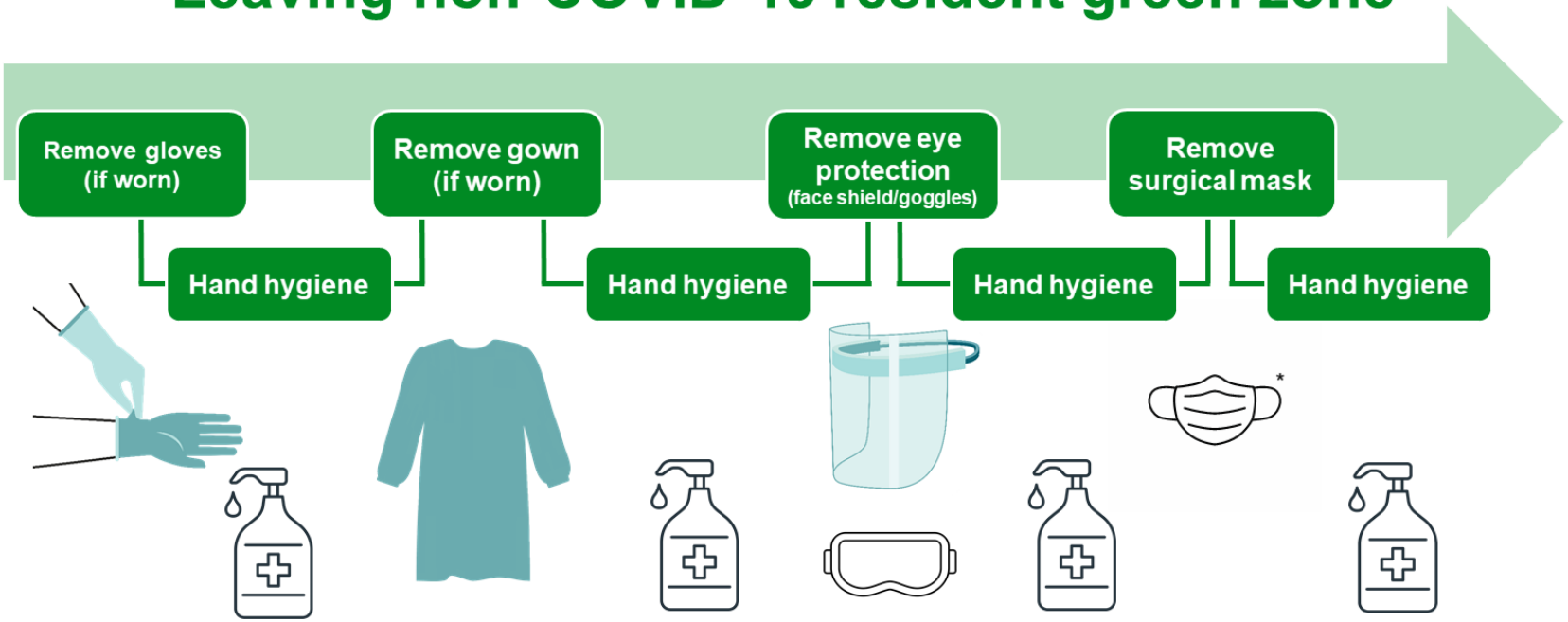
Taking off (doffing) PPE: Leaving non-COVID-19 resident green zone



*Some care may require the use of a P2/N95 mask. Refer to jurisdictional guidance for more information
November 26, 2020 V1

Communicable Diseases network AUSTRALIA

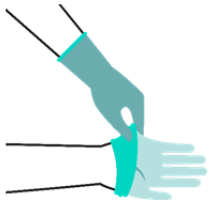
Changing PPE between residents:
Close contacts or suspected COVID-19 in amber zone

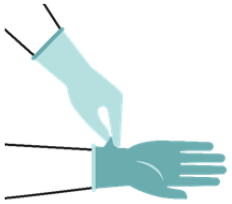
Communicable Diseases network AUSTRALIA

November 26, 2020 V1

Changing PPE between residents: Confirmed COVID-19 in red zone

Finish resident care → **Remove gloves** → **Hand hygiene** → **Don new gloves** → **Move to next resident**





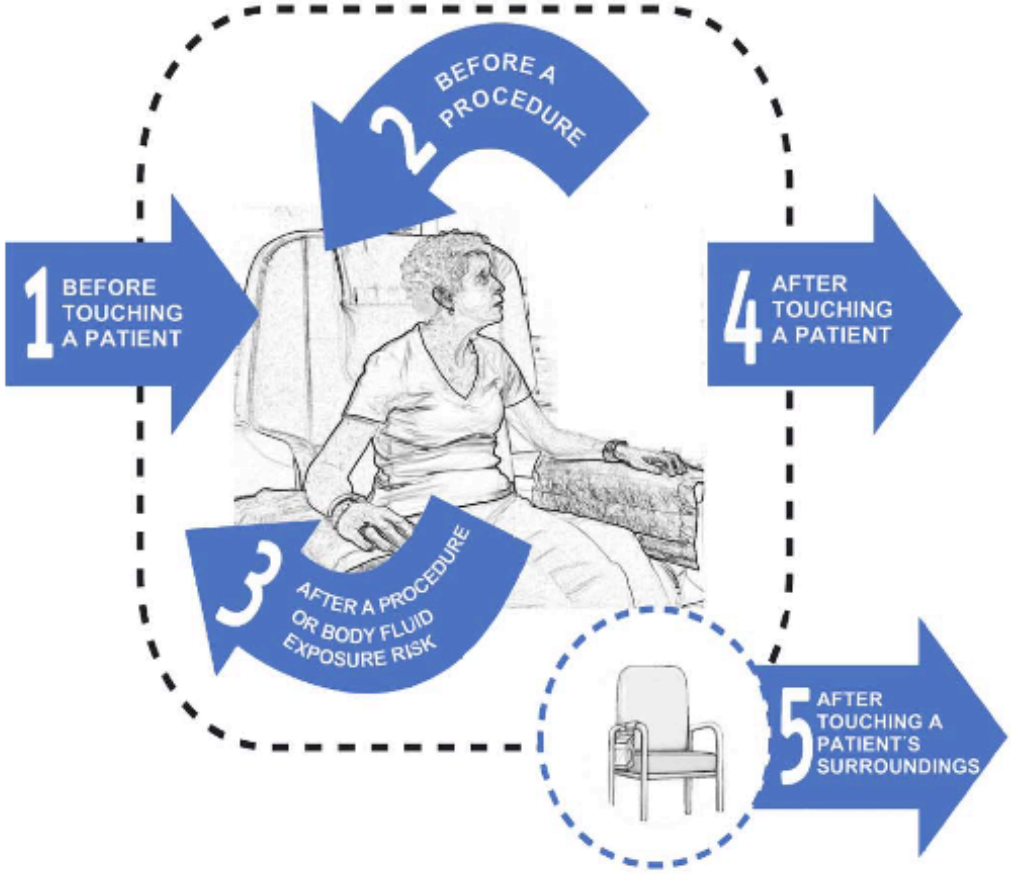
Mask/respirator, eye protection and gown can be worn for up to 4 hours unless visibly soiled, likely contaminated, wet or damaged if going between residents in a dedicated zone with confirmed COVID-19 cases (red zone). If you need to replace your eye protection or mask/respirator you should do so at a safe distance from a resident >1.5 meters.[1]

[1] ICEG Coronavirus (COVID-19) guidelines for infection prevention and control in residential care facilities
https://www.health.gov.au/resources/publications/coronavirus-covid-19-guidelines-for-infection-prevention-and-control-in-residential-care-facilities
November 26, 2020 V1

Communicable Diseases network AUSTRALIA

APPENDIX 11. Hand hygiene and cough etiquette posters

5 Moments for HAND HYGIENE



1 BEFORE TOUCHING A PATIENT	When: Clean your hands before touching a patient and their immediate surroundings. Why: To protect the patient against acquiring harmful germs from the hands of the HCW.
2 BEFORE A PROCEDURE	When: Clean your hands immediately before a procedure. Why: To protect the patient from harmful germs (including their own) from entering their body during a procedure.
3 AFTER A PROCEDURE OR BODY FLUID EXPOSURE RISK	When: Clean your hands immediately after a procedure or body fluid exposure risk. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
4 AFTER TOUCHING A PATIENT	When: Clean your hands after touching a patient and their immediate surroundings. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
5 AFTER TOUCHING A PATIENT'S SURROUNDINGS	When: Clean your hands after touching any objects in a patient's surroundings when the patient has not been touched. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.

Hand Hygiene Australia
www.hha.org.au

Adapted from
World Health Organization

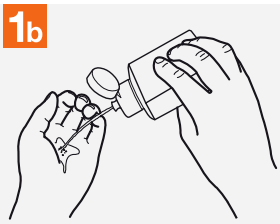
How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

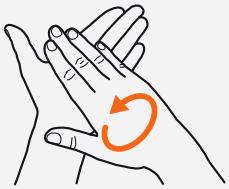
1a

1b



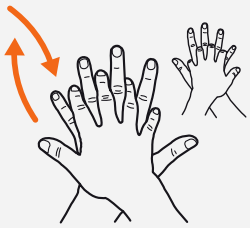
Apply a palmful of the product in a cupped hand, covering all surfaces;

2



Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

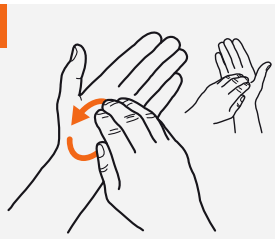
5

Backs of fingers to opposing palms with fingers interlocked;

6

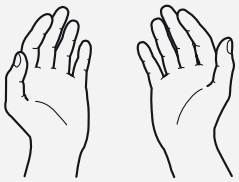
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



Once dry, your hands are safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

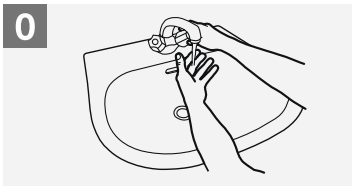
May 2009

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

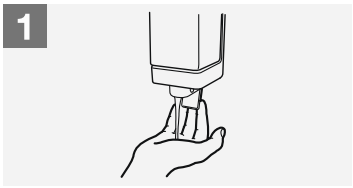
Duration of the entire procedure: 40-60 seconds

0



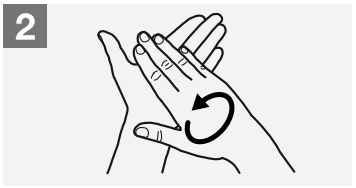
Wet hands with water;

1



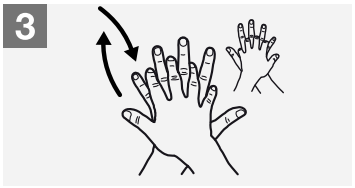
Apply enough soap to cover all hand surfaces;

2



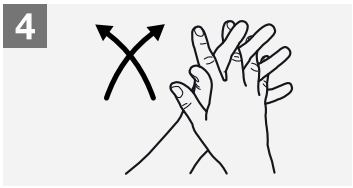
Rub hands palm to palm;

3



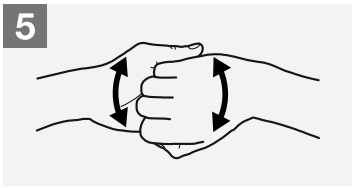
Right palm over left dorsum with interlaced fingers and vice versa;

4



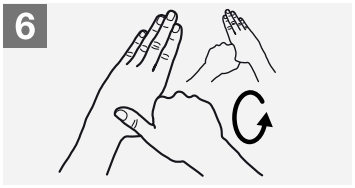
Palm to palm with fingers interlaced;

5



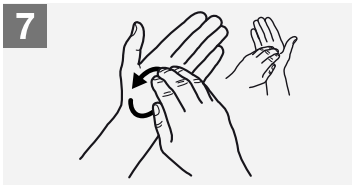
Backs of fingers to opposing palms with fingers interlocked;

6



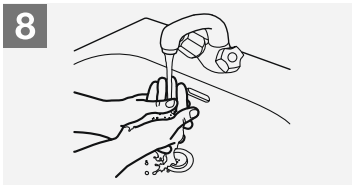
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



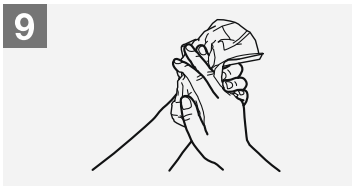
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



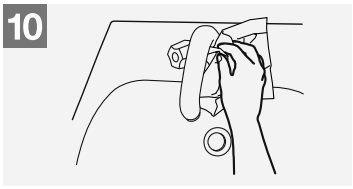
Rinse hands with water;

9



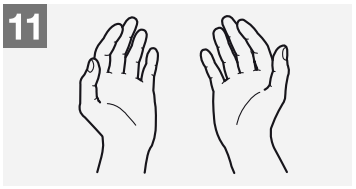
Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11



Your hands are now safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009

Cough and Sneeze Etiquette

- When coughing or sneezing, use a tissue to cover your nose and mouth
- Dispose of the tissue afterwards
- If you don't have a tissue, cough or sneeze into your elbow

- After coughing, sneezing or blowing your nose, wash your hands with soap and water
- Use an alcohol-based hand cleanser if you do not have access to soap and water

Remember:

Hand hygiene is the single most effective way to reduce the spread of germs that cause respiratory disease!

Anyone with signs and symptoms of respiratory infection:

- should be instructed to cover their nose/mouth when coughing or sneezing;
- use tissues to contain respiratory secretions;
- dispose of tissues in the nearest waste receptacle after use; and
- wash or cleanse their hands afterwards.

APPENDIX 12. Transfer Advice Form

[Facility Letterhead]

Date: ……/……/……

To: [Admitting Officer, Facility Name]

Please be advised that: [Resident Name]

is being transferred from a facility where there is a cluster/outbreak of **COVID-19**. At this stage the outbreak is:

☐ suspected

☐ confirmed (date of specimen collection:……..)

Please ensure that **appropriate infection control precautions** are taken upon receipt of this resident.

At the time of transfer:

☐ The resident **does not have** an acute respiratory illness

☐ The resident **has** an acute respiratory illness

☐ The resident is a **suspected case of COVID-19**

☐ The resident is a **confirmed case of COVID-19**

Resident details: _____ _____

Given name Surname

Date of birth:
Name of originating facility:
Name of contact person:
Phone number: