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

Publishing history			
Version	**Date**	**Reason / Changes**	**Endorsed by**
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	
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, and it has been noted by the Australian Health Protection Principal Committee (AHPPC). The guideline has been adapted by the CDNA from the CDNA guideline 'National Influenza Outbreaks in Residential Care Facilities (RCF) in Australia', Australian state and territory guidelines for respiratory illness outbreak management in RCF, documents and guidelines from the Australian Department of Health and other Australian health agencies. It includes information from various international health authorities. This includes the World Health Organization, Centres for Diseases Control and Prevention, and the Public Health Agency of Canada.

This guideline provides best practice information to prevent and manage COVID-19 outbreaks in RCF. It is written to assist:

- administrators of facilities
- employees of facilities
- health 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 the interpretation and application of these guidelines.

Membership of CDNA and AHPPC, and the Commonwealth of Australia as represented by the Department of Health (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 contained in the guideline.

TABLE OF CONTENTS

1. Introduction

This guideline applies to all residential care facilities (RCF) 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 residents are provided with personal care or health care by facility staff. This includes:

- residential aged care
- residential physical or mental disability care
- community based residential health facilities (e.g. drug and alcohol services)
- long stay hospital wards and rehabilitation hospitals
- other similar accommodation settings in Australia.

Because advancing age is a risk factor for severe disease from COVID-19, the guidelines have a strong focus on residential aged care facilities. Individuals should be aware of risk factors for severe disease.

Appendix 1 provides a summary of COVID-19 management in RCF in Australia.

Legal Framework

It is the responsibility of RCF to identify and comply with relevant legislation and regulations. RCF must fulfil their legal infection control responsibilities by adopting standard and transmission-based precautions as directed in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (2019) and by state/territory public health authorities. RCF are also required to operate under the *Aged Care Act 1997* to be accredited and be eligible for funding. Accreditation requires adherence to infection control standards. The Aged Care Quality and Safety Commission expects organisations providing aged care services in Australia to comply with the *Aged Care Quality Standards*.

COVID -19 is a notifiable condition under the Australian National Notifiable Diseases List (NNDL).[1] This means that in all Australian states and territories, either the medical officer requesting the test and/or the laboratory performing the test, are required to notify the relevant jurisdictional public health authority of the COVID-19 case, as per local legislative requirements.

Roles and Responsibilities

[1] Australian National Notifiable Diseases List (NNDL) is available at: https://www.legislation.gov.au/Details/F2018L00450

Residential Care Facilities

The primary responsibility of managing COVID-19 outbreaks lies with the RCF, in their responsibility for resident care and infection control. All RCF should have access to infection control expertise, whether in-house or not, and outbreak management plans in place.

RCF must:

- detect, declare and notify outbreaks to state/territory health departments.
- self-manage outbreaks in accordance with this guideline, the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (2019), and the *Australian Health Sector Emergency Response Plan for Novel Coronavirus* (2020).
- follow advice on infection control measures and appropriate use of personal protective equipment (PPE),
- declare an outbreak at onset and when an outbreak is over.

Residential care facilities are supported in their response to an outbreak by different government departments/agencies. The assistance provided by each of these is listed below.

The State/Territory Department of Health

State/territory public health section in the Departments of Health will act in an advisory role to assist RCF to detect, characterise and manage COVID-19 outbreaks. This includes:

- assisting facilities to confirm outbreaks
- providing advice on obtaining testing samples
- providing guidance on outbreak management
- monitoring for severity of illness (record deaths and hospitalisations)
- informing relevant stakeholders of outbreaks
- informing clinical care providers in the local health district.

Australian Aged Care Quality and Safety Commission

The Aged Care Quality and Safety Commission (the Commission) is the national regulator of aged care services. It takes a proportionate risk-based approach in responding to situations such as the COVID-19 situation. The role of the Commission is to:

- independently accredit, assess and monitor aged care services against the *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 delivery of aged care services
- provide education to providers, including with respect to best-practice infection prevention and control.

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

For Residential Aged Care Facilities (RACF) that receive funding from the Commonwealth, the Commonwealth will work collaboratively with the overall management of the response to support the viability and capacity of the RACF to access services including;

- allocation of a state based 24/7 case manager who will connect the RACF to all available Commonwealth support
- access to, if requested, a First Nurse Responder who can assess infection prevention and control and ensure this is robust, provide ongoing oversight and training.
- surge workforce support including clinical and non-clinical staff
- access to primary health care including GPs and allied health services via the Primary Health Network.

2. Understanding COVID-19

It can be difficult to tell the difference between a respiratory illness such as COVID-19 and one caused by other viruses based on symptoms alone. Residents with new symptoms of respiratory infection should be tested for COVID-19. While waiting for the test result, the person should be kept in isolation.

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.

The most common signs and symptoms include:

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

Other symptoms can include:

- shortness of breath
- sputum production
- fatigue
- sore throat
- loss of taste
- loss of smell
- diarrhoea
- nausea or vomiting.

Less common symptoms include:

- headache
- myalgia/arthralgia
- chills
- nasal congestion
- haemoptysis
- conjunctival congestion.

Older people may also have the following symptoms:

- confusion or behavioural change
- worsening chronic conditions of the lungs
- loss of appetite.

Staff should be cognisant of these symptoms and note that the majority of cases experience mild symptoms. If any staff member (including casual, domestic, hospitality and volunteer workers) develops any symptoms, they must isolate and get tested to prevent transmitting the virus to other staff members or residents.

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 changes in behaviour. RCF should consider seeking medical review to test residents with any new respiratory symptom, even if they are not typical of COVID-19. In RCF, the relevant public health unit (PHU) may consider testing asymptomatic contacts to inform management of the outbreak.[2]

Disease Transmission

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.

Routes of Transmission

The virus that causes COVID-19 most commonly spreads through:

- Direct contact with droplets from an infected person's cough or sneeze. This can be minimised by cough etiquette and physical distancing.
- Close contact with an infectious person.
- Touching objects or surfaces (e.g. bed rails, doorknobs or tables) that have been contaminated with respiratory droplets from an infected person and then touching the face, especially mouth, nose or eyes.

Faecal shedding of the virus has been demonstrated in some patients, and viable virus has been identified in some cases. 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 RCF; as such, cases with ongoing diarrhoea or uncontained faecal incontinence who may have limited capacity to maintain standards of personal hygiene should continue to be isolated until 48 hours after the resolution of these symptoms.

Airborne spread may occur during certain aerosol-generating procedures conducted in health care settings[3].

[2 & 3] See the Communicable Diseases Network Australia *COVID-19 National Guidelines for Public Health Units*

[3] Examples of Aerosol Generating Procedures can be found in the Infection Control Expert Group document here PPE in hospital settings

Nebulisers have been associated with a risk of transmission of respiratory viruses and their use should be avoided. A spacer and puffer should be used instead.

Complications

Most people with COVID-19 have mild disease and will recover. Some people can develop complications which may be life-threatening and can result in death.

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
- multi-organ dysfunction/failure.

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

3. Preparedness, Prevention and Early Detection

Preparation

RCF must ensure that they are prepared for outbreaks of COVID-19 including for the occurrence for their first case of COVID-19. The basis for an effective infection prevention and control (IPC) response is a well-functioning program that works in concert with an effective occupational health program.

Train staff

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

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 history
- hand hygiene, sneeze and cough etiquette

- appropriate use of PPE such as gloves, gowns, eye protection and masks, including how to put on and remove PPE correctly
- what to do if experiencing symptoms of COVID-19 (be tested, do not work or visit an RCF)
- handling and disposal of clinical waste
- processing of reusable equipment
- environmental cleaning
- safe handling and laundering of linen
- safe food handling and cleaning of used food utensils
- collection and handling of respiratory swabs, where appropriate and in alignment with the staff's prior training and skillset.

Online training modules for workers in residential care are available at COVID-19training.gov.au. All staff should undergo regular refresher training on infection prevention and control measures.

Ensure supplies

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

- personal protective equipment (gloves, gowns, masks, eyewear)
- hand hygiene products (alcohol based hand rub, liquid soap, paper hand towel)
- diagnostic materials (swabs)
- cleaning supplies (detergent and disinfectant products). See *TGA list of disinfectants for use against COVID-19*, *or* a TGA-listed hospital-grade disinfectant with activity against viruses (according to label/product information) or a chlorine-based product such as sodium hypochlorite. See the Department of Health website for advice on cleaning.

To effectively monitor stock levels, facilities should:

- undertake regular stocktake (counting stock)
- use an outbreak kit/box.

In support of preparation efforts, the Australian Government Department of Health has arranged for additional supplies of PPE from the National Medical Stockpile, a surge capacity of additional workforce if required, and a pathology provider to test residents if requested. This will be coordinated by the state office of the Commonwealth when cases are reported to agedcareCOVIDcases@health.gov.au

Ensure Standard Infection Prevention and Control Precautions are in place

Review the recommendations from the Infection Control Expert Group (ICEG), a subcommittee of the Australian Health Principle Protection Committee *COVID-19 guidelines for IPC in RCF (Infection Control Expert Group)*

Extract from *COVID-19 guidelines for IPC in RCF (Infection Control Expert Group)*: Standard Precautions

> Standard Precautions are IPC practices used routinely in healthcare. They should be used in RCFs with a suspected or proven COVID-19 outbreak and **apply to all staff and all residents.**
>
> 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.
> - **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**.
> - **Provision of alcohol-based hand sanitiser** at the entrance to the facility and other strategic locations.

Prepare 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. Facilities should have adequate telecommunication facilities for teleconferences with multiple agencies.

The prevention strategies outlined in this guideline should be included in the RCF outbreak management plan. A checklist to assist in outbreak preparedness can be found in Appendix 2.

Assumptions

It is important to note that assumptions about the epidemiology and impact of COVID-19 may change as new knowledge emerges.

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

Pandemic plans developed by individual RCF need to be:

- coordinated with the plans of other organisations in their communities and local/regional pandemic plans; and
- consistent with the Australian Government Department of Health Australian Health Sector Emergency Response Plan for Novel Coronavirus (2020).

A vaccine will not be available for some time. Once available, a vaccine will be in short supply and high demand.

The number of health care workers available to provide care may reduce by up to one-third. This is due to personal illness, concerns about transmission in the workplace, and family/caregiving responsibilities.

RCF will need effective ways to communicate with residents' family and friends. This is in order to meet their needs for information but reduce the demands on staff.

Requirements for documentation will be high. RCFs should ensure documentation of visitor's name and contact phone number, patient's location, staff rostering and attendance, locations of work and section of work, to assist with contact tracing. All staff and visitors should supply up to date contact details.

Plan for an Outbreak Management Team

Consider who in the RCF will perform the different functions outlined in the outbreak management team. Having these roles assigned ahead of an outbreak enables staff to consider the details of the duties they will need to undertake ahead of time.

Workforce

Review policies for sick leave to enable employees to stay home if they have relevant symptoms. Have a staff contingency plan in the event of 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. Workers may also require exclusion from the workplace if they have recently travelled.

Plan for a surge workforce. The workforce management plan should be able to cover a 20-30% staff absentee rate. Develop and maintain a contact list for casual staff members or external nursing agencies to enable timely activation of a surge workforce should an outbreak occur. Surge workforce staff should be appropriately educated and orientated to the function of the unit prior to 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.

Consider the risks of when utilising casual or external agency workforces. During an outbreak, staff should not work at other facilities. Every effort should be made to maintain consistent staff in each RCF.

Cohorting

Plan how to cohort residents together into rooms or a wing. When more than one resident has confirmed COVID-19, they should be cared for together in an area away from residents who are not affected. This means that re-arrangement of rooms and re-purposing of other areas needs to be considered ahead of an outbreak. Decanting well residents to other safe

locations for quarantine may be a way to facilitate space requirements for managing an outbreak. This would need to be done with advice from the PHU.

Communications

Develop a list of contact details including the local public health unit, Australian government email address, attending general practitioners and the primary health network.

Prepare a wide communications plan. 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. RCF 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
- identified communication channels such as email, phone numbers, webinars, website and social media
- pre-prepared and informative signs
- email templates and talking points focused on 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 and staff 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

The *Older Persons Advocacy Network* can assist with communications with residents and families.

Prevention

There is currently no vaccination to prevent COVID-19. Avoidance of exposure is the single most important measure for preventing COVID-19 in RCF.

Prevent introduction of the virus

The general strategies recommended to prevent the spread of COVID-19 in RCF are the same strategies used for other respiratory viruses like influenza.
RCF should work to prevent introduction of the 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. The following actions should be taken to prevent introduction of disease:

Educate staff, residents and their families to inform their behaviour

Clear information needs to be provided to residents and families regarding 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 can be found at Appendix 10.

Signage and other forms of communication (e.g. 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 to not enter.

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 in each resident's room.

Screen for symptoms before entry

A regular program for screening staff should be developed. 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 (e.g. leave policies), to exclude themselves from work and seek testing when they have symptoms clinically compatible with COVID-19 Staff should notify the facility if they have been told they are a confirmed or probable COVID-19 case. Casual staff should also notify their agency if they become unwell and be supported to exclude themselves from working.

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

Apply restrictions if appropriate

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

Note that protracted restrictions on visitors is likely to have detrimental impacts for resident's wellbeing. The personal welfare and mental health of residents is of vital importance. Visitors including family and friends provide support for resident wellbeing, and 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. Refer to the recommendations about access to aged care facilities in particular at *AHPPC residential aged care facilities 19 June 2020* .

Early Detection

Monitor staff and residents

RCF should establish systems to monitor staff and residents for COVID-19 with a high level of vigilance and have a low threshold for investigation. Surveillance for fever or acute respiratory illness (ARI, with or without fever) can detect possible cases of COVID-19. Effective surveillance will facilitate early recognition and management of cases.

Identification of a resident or staff member with ARI (including loss of smell or taste) or fever should be followed by a prompt phone call to a clinician. The treating clinician may consider testing for COVID-19 and other respiratory infections in residents with any new respiratory symptom and/or atypical signs and symptoms of COVID-19. If specimens for COVID-19 are collected, alert the public health unit by phone.

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*. Once requested by a medical officer, 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.

Procedures for specimen collection are at Appendix 4. 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*.

While waiting for a test result

- Immediately isolate ill residents and minimise interaction between other residents.[4]
- Provide PPE supplies to staff.
    - Make PPE, including facemasks, eye protection, gowns and gloves available immediately outside of the resident's room.

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

    - Place a disposal receptacle near the exit inside the resident's room, to make it easy for staff to discard PPE before leaving the room.
    - Place alcohol-based hand rub near the exit of the resident's room
    - Post signs on the door or wall outside the resident's room advising that contact and droplet precautions are needed.
- Avoid aerosol generating procedures (such as nebulisers).
- Review all residents and staff for symptoms and document the results of this review. Arrange testing for anyone with symptoms compatible with COVID-19.

A droplet and contact precautions sign must be placed 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: *https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/infection-control-signage.*

4. Notify positive test

A positive test – Immediately Notify State/Territory Department of Health

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 is obligated to notify the infection to the jurisdictional communicable disease authority, depending on local legislative requirements; this notification is confidential. See a sample reporting template at Appendix 5.

PHU review

One positive case **confirmed by the public health unit** constitutes an outbreak in an RCF and triggers an outbreak management response. In situations where there is little or no disease in the community, and the laboratory and/or the PHU suggest more consideration of the result is required, a PHU may seek to confirm the positive test by retesting the original sample and/or collecting a second sample. While this confirmation is being sought, depending on the circumstances at the time, the case needs to be isolated and the PHU may suggest waiting for confirmation of the test result before taking further public health action. Alternatively, the PHU may suggest the aged care facility declare an outbreak while investigated the test result. If the diagnosis is not confirmed, the PHU will ask the facility to stand down the response. Clear and wide communication of these decisions will be important. The process of confirming the result, if required, would usually occur within 24 hours. For information on false positive tests see here.

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

State/territory Public Health Unit Contact details

State	Contact Details
Queensland	13 432 584 (13 HEALTH) https://www.health.qld.gov.au/system-governance/contact-us/contact/public-health-units
New South Wales	1300 066 055
Australian Capital Territory	Business Hours: 02 5124 9213 After Hours: 02 9962 4155
Victoria	1300 651 160
Tasmania	1800 671 738
South Australia	1300 232 272
Western Australia	08 9222 8588 or 1300 316 555 (if confirmed COVID-19)
Northern Territory	08 8922 8044

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

Within 24 hours, report the case to the Australian Government at agedcareCOVIDcases@health.gov.au.

5. Declare an outbreak

A COVID-19 outbreak is defined as **a single confirmed case of COVID-19 in a resident, staff member or frequent attendee of a RCF.**

This definition does not include a single case in an infrequent visitor of the facility. To determine whether someone is a frequent or infrequent visitor consider the frequency of visits, time spent in the setting, and number of contacts within the setting.

The PHU will assist the RCF in management of the outbreak as outlined in the national guideline and summarised below. More detail can be found at *CDNA COVID-19 National Guidelines for Public Health Units.*

Extract from the national guideline for public health units –steps in investigation

High-risk settings – steps in investigation

There are several initial steps that public health unit staff need to take when responding to an outbreak of COVID-19 in high-risk settings. Further details for each step are provided below.

1. Define the setting.
2. Confirm and declare a COVID-19 outbreak with one confirmed case.
3. Identify those most at risk of severe disease.
4. 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.
5. 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.
6. Advise staff about enhanced implementation of infection control measures. Determine if staff have worked at any other aged care facility or provided in home care in the last 14 days.
7. Collate information onto a line list that describes people infected in terms of time, place and person.
8. In a residential facility, ensure the staff form an outbreak management team that meets within hours of the identification of a case. The team should not be part of day-to-day facility management.
9. Identify and inform relevant internal and external stakeholders.
10. 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.
11. 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.
12. Identify suitable sites where individuals may be cohorted together into either: isolation of the sick OR quarantine the exposed.

Establish an Outbreak Management Team to Meet Within Hours

The RCF is responsible for managing the outbreak and should take a strong leadership role with 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, and to discuss outbreak management roles and responsibilities.

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

Outbreak Management Team Membership and Roles

OMT Role	OMT Function
Chair RAC executive * (PHU co-chair where feasible)	The CEO, facility manager or other who can report on operational issues and has authority to implement the directions of the OMT.
Secretary*	The RACF allocates a secretary who organises OMT meetings, records and distributes action items and minutes.
Public Health Unit lead*	Assigned by the Public Health Unit to arrange testing and make decisions around isolation and cohorting of patients (This person may also be the co-chair from public health).
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 including IPC strategy, PPE usage, Staff training and compliance, service processes and systems. This could be an employee skilled in IPC, an IPC Practitioner organised by the PHU/local health district or a First Nurse Responder organised by the Commonwealth Department of Health.
Public Health unit Contact Tracer	Feedback progress on contact tracing, testing and isolation of healthcare workers, external visitors, contractors, volunteers, allied health professionals, doctors, agency staff etc.
Public Health unit Epidemiologist	Provide expert opinion on containment plans, epidemiological links to other aged care facilities, epidemiological links to the community, integrate 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
Communications officer* from RACF	Follows the communication plan to inform staff, families as required
Australian Government Department of Health Case officer *	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, supplementary testing.
Aged Care Quality and Safety Commission Case officer	Provide primary point of contact for providers and consumers in relation to quality of care. Provide education on infection control Monitors compliance education on infection control Provides access to the Chief Clinical Advisor for the ACQSC and supports care for all residents impacted in RACFS
Clinical oversight manager	A person from the facility who ensures ongoing clinical management is provided for all residents in the facility based on the advice of the OMT. For the COVID-19 patient/s, this includes ensuring clinical assessment and management occurs including considering hospitalisation, hospital in the home or other model of care. For all residents this means ensuring usual clinical care and managing the additional deconditioning and mental health risks associated with isolation. The clinical manager will notify the Primary Health Network**, liaise with the state/territory coordinator for local district health services and the Australian Government Department of Health case officer to ensure appropriate medical and allied medical continue to access residents.
Infectious disease physician	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.

*** Essential members in the first 24 hours**

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

Activate the Communication Plan

A dedicated staff member, on the OMT should be responsible for communication according to the plan devised by the RCF (Section 3).

Ensure Ongoing Clinical Care for All

All residents require their usual ongoing medical care, including essential allied health care, while an outbreak is occurring. All visiting GPs should be informed at the start of the outbreak and provided with the contact details of the clinical oversight manager from the facility on the team. A sample letter for GPs can be found in Appendix 6.

In addition to a letter to GP's, the facility should also notify the Primary Health Network. The Primary Health Network will liaise with those providing primary medical and allied health care in the local area. They can assist in sourcing practitioners to attend facilities to ensure ongoing continuity of care.

Enhance Infection Prevention and Control

Review Standard Precautions

Ensure that standard precautions are in place in all areas of the facility (see Appendix 10). Regular, scheduled **cleaning** of all resident care areas is essential during an outbreak. Frequently touched surfaces and those closest to the resident, including door handles and light switches, should be cleaned more often. 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 available in the Commonwealth Department of Health factsheet – COVID-19 *Environmental cleaning and disinfection principles for Health and Residential Care Facilities*. Disinfectants registered with the TGA as effective against the virus (SARS-CoV-2) are listed here *TGA disinfectants use against COVID-19* .

Implement Transmission-based Precautions

Implement additional transmission-based precautions for cases, residents who are unwell with respiratory symptoms and residents who are well but are placed in quarantine. For COVID-19 transmission is primarily through droplets from the respiratory tract which may be inhaled if close to the patient or contaminate the environment. Contact and Droplet

precautions are therefore required. Airborne spread may occur during aerosol generating procedures but these are unlikely in RCF. Refer to the *COVID-19 guidelines for IPC in RCF (Infection Control Expert Group)* for more information.

Extract from Infection Prevention and Control for COVID-19 Guidelines for RCF – 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. Contact and Droplet precaution key elements are:

- **Standard precautions** (as above).
- **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.
- **Isolation of ill residents** in a single room. If a single room is unavailable see: "Placement of residents with suspected or proven COVID-19" (above).
- **Enhanced cleaning and disinfection** of the ill resident's environment.
- **Limit 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). Eye protection is optional. If the resident later develops symptoms or is confirmed to have COVID-19, staff who did not wear eye protection do not need to quarantine if they:

- Followed all other precautions
- Remain well
- Had no direct contact with respiratory secretions (i.e. a cough or sneeze directly into to the face).

Ensure staff are competent in the proper use of PPE. 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. Staff must remove PPE in a way that prevents contamination of the HCW's clothing, hands, and the environment. Staff should:

- immediately discard PPE into appropriate waste bins
- use good hand hygiene before putting PPE on, and immediately after removing PPE. See Appendix 10 for useful educational and promotional material on the proper use of PPE.

Isolate and Cohort

RCF should refer to the *COVID-19 guidelines for IPC in RCF (Infection Control Expert Group)* for detailed information on the placement of residents within 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. Where possible, 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. Staff escorting residents should wear a surgical mask, gowns, eye protection and gloves in addition to observing hand hygiene.

With guidance from the PHU, if there is more than one case, place residents with COVID-19 together in one area of the facility (cohorting).

Manage Staff

Once resident isolation or cohorting measures are in place, allocate specific RCF staff to the care of residents in isolation. Doing this will further reduce the risk of transmission.
The RCF should ensure there are sufficient registered nurses at the facility to allow this, which may require surge staffing. RCFs should maintain a register of staff members caring for patients with COVID-19.

Ensure that staff members:

- do not move between their allocated room/ section and other areas of the facility, or care for other residents
- 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, until the outbreak is declared over.

Continue to check 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 staffing levels are of concern, contact the Australian Government at agedcareCOVIDcases@health.gov.au for assistance.

Limit Admissions and Transfers

The *COVID-19 guidelines for IPC in RCF (Infection Control Expert Group)* provide detailed information on the management of admissions and transfers during an outbreak.

New admissions

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

Re-admissions of confirmed cases

The re-admission of residents who have been moved to hospital needs to be considered on a case-by-case basis, in particular for those cases who are still required to be isolated from others. It needs to balance the best care for the resident along with the potential for ongoing transmission from the case, the ability of the residential facility to continue to safely isolate the case, level of community transmission, as well as 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 public health unit, treating clinicians, residential care facility as well as the resident and family.

Generally, patients will have been required to have had at least 10 days from the onset of symptoms and 3 days completely symptom free to be released from isolation. However, refer to the **CDNA Release from Isolation** requirements in the *CDNA COVID-19 National Guidelines for Public Health Units*.

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. If non-cases are re-admitted, the resident and their family must be informed about the current outbreak and adequate outbreak control measures must be in place. Families may wish to make alternative arrangements (e.g. family care) until the outbreak is over.

Unaffected residents

In some circumstances, it may be feasible to transfer residents who are not symptomatic, 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 family or receiving facility should be made aware that the resident may have been exposed and is at risk of developing disease. They should be provided with information regarding the symptoms of COVID-19 and the use of appropriate personal protective measures. **Note:** In Residential Aged Care settings, security of tenure provisions of the *Aged Care Act 1997* will need to be considered.

Transfers

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 4) must be completed. Ensure the Advanced Care Directive accompanies the resident to hospital if one has been prepared.

Restrict Visitors and Communal Activities

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

Facilities should implement the following:

- suspend all group activities, particularly those that involve visitors (e.g. musicians).
- postpone visits from non-essential external providers (e.g. hairdressers)
- ask regular visitors and families of residents of the COVID-19 outbreak to only visit for essential reasons. Discourage visits by young children as they are generally unable to comply with standard precautions and PPE requirements. Record the name and phone number of visitors on a register. Screen any visitors for respiratory 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 resident's room and the facility.

Monitor Progress of the Outbreak

Increased and active observation of all residents for the signs and symptoms of COVID-19 is essential in outbreak management. This will enable the 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.

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
- where feasible, commencing a program of repeat testing for those in quarantine.

The information in the line list should be updated 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. If a death occurs during the outbreak, telephone the PHU to notify this.

Declare the Outbreak Over

The time from the onset of symptoms of the last case until the outbreak is declared over can vary. Repeat PCR testing of the quarantined cohort allows for close observation of the outbreak. It will also help determine when it can be declared over. In most circumstances, a COVID-19 outbreak can be declared over if no new cases occur within 14 days (maximum incubation period) following the date of isolation of the last case. The OMT should declare the outbreak over in consultation with the PHU. Once the outbreak is over, provide reports of the relevant stakeholders and ensure that data is appropriately summarised.

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 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.

6. Review the Outbreak

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

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

Use a tool 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, and a template for trigger questions. This tool enables agencies like RCF to assess their outbreak response against best practice. You can find this tool at *Outbreak Investigation Audits*.

Provide a report on the outbreak to the PHU and the Commonwealth to assist other providers with lessons learned.

7. Appendices

Appendix 1. Flow Chart for COVID-19 Management in RCF

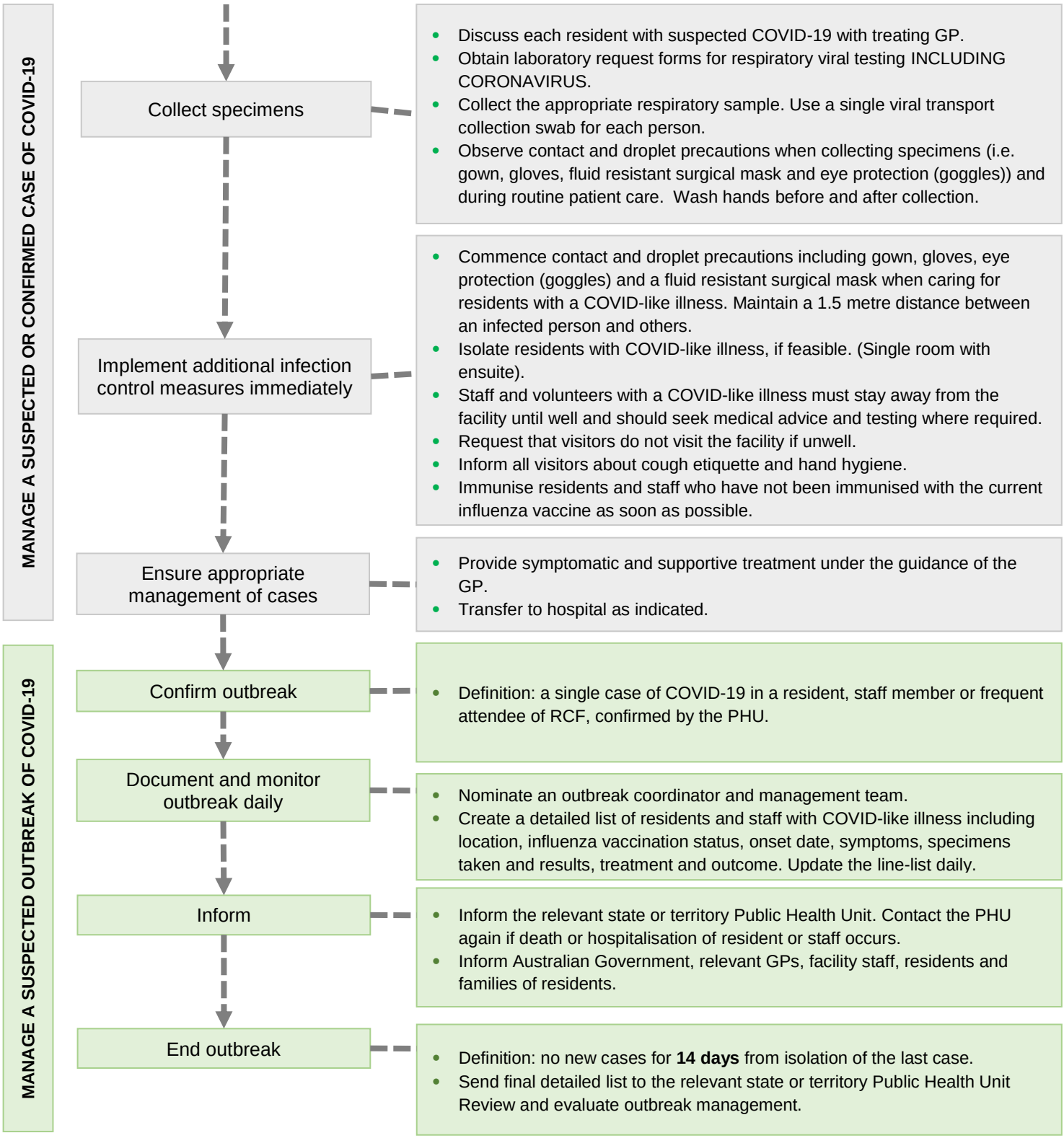
Flowchart for COVID-19 Management in Residential Care Facilities in Australia

This guideline is intended for use within residential care facilities in Australia and has been adapted from *CDNA COVID-19 National Guidelines for Public Health Units*.

Note: the case definition may change over time

RISK ASSESSMENT FOR COVID-19

TASK	ACTION / INFORMATION
Plan for cases	• Develop a facility management plan • Ensure all staff and general practitioners (GPs) who attend the facility are aware of this plan.
Vaccinate all residents and staff against influenza	• Ensure all staff, residents and volunteers are aware of the importance of annual influenza vaccination and pneumococcal vaccine where appropriate. • Ensure staff are aware of mandatory requirements for vaccination and provide free and accessible vaccination at times that cater for all shifts. • Encourage GPs to vaccinate residents against influenza and pneumococcus. • Create a list of staff and residents by influenza vaccination status; ensure it is kept updated and accessible.
Infection control preparedness	• Provide refresher infection control training to all staff that includes information about COVID-19 • Ensure personal protective equipment (PPE), hand washing facilities and alcohol-based hand rubs are widely available.. • Encourage frequent and appropriate hand hygiene at all times (5 Moments). • Ensure infection control signage is available for use and is in place. • Consider how case isolation and quarantine of contacts will be managed. • Develop contingency staffing plans in event of staff illness and isolation. • Ensure stocked respiratory hygiene stations are at each visitor entrance
Assess residents for signs & symptoms of COVID-19	**1. Risk Assessment for COVID-19:** • Staff and management should keep up to date with the latest guidelines on who should be tested for COVID-19, by reviewing their state or territory Health Department website. • Staff should be aware that they are working in a high risk environment and should not attend work if they feel unwell, to protect themselves and residents. • Staff should be vigilant in monitoring for COVID-19. **2. Identify signs/symptoms of COVID-19:** **CLINICAL CRITERIA** Fever (≥37.5°C) or history of fever OR acute respiratory infection (e.g. cough, shortness of breath, sore throat). The treating clinician may consider investigating residents with atypical signs and symptoms of COVID-19.


MANAGE A SUSPECTED OR CONFIRMED CASE OF COVID-19
Collect specimens
Discuss each resident with suspected COVID-19 with treating GP.
Obtain laboratory request forms for respiratory viral testing INCLUDING CORONAVIRUS.
Collect the appropriate respiratory sample. Use a single viral transport collection swab for each person.
Observe contact and droplet precautions when collecting specimens (i.e. gown, gloves, fluid resistant surgical mask and eye protection (goggles)) and during routine patient care. Wash hands before and after collection.
Implement additional infection control measures immediately
Commence contact and droplet precautions including gown, gloves, eye protection (goggles) and a fluid resistant surgical mask when caring for residents with a COVID-like illness. Maintain a 1.5 metre distance between an infected person and others.
Isolate residents with COVID-like illness, if feasible. (Single room with ensuite).
Staff and volunteers with a COVID-like illness must stay away from the facility until well and should seek medical advice and testing where required.
Request that visitors do not visit the facility if unwell.
Inform all visitors about cough etiquette and hand hygiene.
Immunise residents and staff who have not been immunised with the current influenza vaccine as soon as possible.
Ensure appropriate management of cases
Provide symptomatic and supportive treatment under the guidance of the GP.
Transfer to hospital as indicated.
MANAGE A SUSPECTED OUTBREAK OF COVID-19
Confirm outbreak
Definition: a single case of COVID-19 in a resident, staff member or frequent attendee of RCF, confirmed by the PHU.
Document and monitor outbreak daily
Nominate an outbreak coordinator and management team.
Create a detailed list of residents and staff with COVID-like illness including location, influenza vaccination status, onset date, symptoms, specimens taken and results, treatment and outcome. Update the line-list daily.
Inform
Inform the relevant state or territory Public Health Unit. Contact the PHU again if death or hospitalisation of resident or staff occurs.
Inform Australian Government, relevant GPs, facility staff, residents and families of residents.
End outbreak
Definition: no new cases for **14 days** from isolation of the last case.
Send final detailed list to the relevant state or territory Public Health Unit
Review and evaluate outbreak management.

Appendix 2. COVID-19 Outbreak Preparedness Checklist

Planning actions	☑
Does your RCF have a respiratory outbreak plan that covers all the areas identified below?	
Has your RCF updated its respiratory outbreak 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 (see section 3 for suggested content)?	
Has your RCF provided resident families with information regarding prevention of transmission?	
Staffing actions	
Does your RCF have a staffing contingency plan in case 20% to 30% of staff fall ill and are excluded for 14 days? Are you cohorting staff to limit the number of close contacts if someone becomes unwell?	
Has your RCF developed a plan for cohorting staff in an outbreak (see section 5 for detail)?	
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 respiratory illness, particularly for fever or cough (with or without fever)? Do you document changes in residents 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 and Human Services as soon as practicable (and within 24 hours) of 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 (e.g. facility GPs and infection control consultants)?	
Does your RCF have a plan for communicating with staff, residents, volunteers, family members and other service providers (e.g. cleaners) during an outbreak?	
Does your RCF have a plan to restrict unwell visitors entering the facility as well as limitation of well visitors during an outbreak to reduce risk of transmission both within the facility and externally (e.g. 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?	

Appendix 3. Letter to Families – Preventing Spread of COVID-19

[Facility Letterhead]

……/……/……

Dear family member

There is local transmission of Coronavirus Disease 2019 (COVID-19) in the community. COVID-19 primarily causes respiratory illness in humans, and while all types of respiratory viruses can cause sickness in the elderly, COVID-19 is a particularly contagious infection that can cause severe illness and death for vulnerable people.

COVID-19 Pandemic

COVID-19 has caused outbreaks of illness in the Australian community, and local transmission has occurred in some communities. Residential care facilities are particularly susceptible to COVID-19 outbreaks. Even when facilities actively try to prevent outbreaks occurring, many external may lead to residents or staff contracting the COVID-19 and outbreaks in residential care facilities.

Families play an important role in protecting their relatives from community viruses. Practical steps you can take to prevent COVID-19 from entering 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.

Follow any restrictions the residential care facility has put in place

Facilities will post signs at entrances and within their units to inform you if an outbreak is occurring so look out for these warning signs when entering the facility.

It is important to follow the infection control guidelines as directed by the facility staff. This may include wearing a disposable face mask and/or other protective equipment (gloves, gowns) as instructed. Certain group activities may be postponed during an outbreak.

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 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 self-isolation.

Limit your visit

If there is an outbreak in the residential care facility, we ask that you only visit the person you have come to see and keep children away if they or your resident family member is

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 residential care 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 4. Swab Collection Procedure

Swab Collection Procedures

Guidance on the collection of upper respiratory specimens from the Public Health Laboratory Network (PHLN) is available on the Department of Health website.

Detailed guidance on laboratory testing for SARS-CoV-2 (the virus that causes COVID-19) from the PHLN is available on the Department of Health website.

1. Before performing swab

IMPORTANT NOTES:

- Contact your laboratory provider for current local advice about swabs.
- Do not use bacterial swabs for specimen collection. If in doubt, check!
- To conserve swabs, the same swab that has been used to sample the oropharynx should be utilised for nasopharynx/deep nasal sampling.

Obtain required materials:

- Personal protective equipment (PPE) for the health care worker taking the swab, including, gloves, eye protection (goggles or face shield), surgical mask, and gown, if necessary.
- One dry, sterile, flocked swab or one viral culture swab with viral culture medium.
- Tongue depressor.

Performing the swabs

IMPORTANT NOTES:

- *Choose an area for the procedure where the patient can rest their head against a wall or on a high-backed chair with room for you to stand beside (not in front of) the patient.*
- *Ensure the area is well lit, with hand washing and infectious waste disposal facilities.*
- *Remember to **WASH AND DRY HANDS** before and after the procedure!*
- *Gloves, surgical mask and eye protection **MUST** be worn when collecting nose and throat swabs. The need for a gown or apron is based on risk assessment.*[5]
- *Masks should **NOT** be touched during wear and should **NOT** be worn around the neck at any time. When removed, handle the mask by the ties of the mask only.*

Preparation:

1. Perform hand hygiene.
2. Don PPE in the order of gown, surgical mask, eye protection, and gloves.
3. Explain the procedure to the patient and obtain consent.
4. Place patient standing or sitting with head tilted at 70^0, supported against a bed, chair or wall.

[5] See the *ICEG guidance on use of PPE in non-inpatient health care settings during the COVID-19 outbreak* for additional information on PPE during specimen collection.

After performing the swab

Labelling and storage of specimen:

1. Label the tube or bottle containing the swabs with the patient's full name, date of birth, specimen type and date of collection. The accompanying request form should include the RCF facility name.
2. Remove PPE safely (remove gloves, perform hand hygiene, remove goggles or face shield, gown and mask and perform hand hygiene again).
3. Specimens should be ***sent on the day of collection***. Refrigerate the specimen until it is sent to the laboratory (do NOT freeze the specimen). Specimens should be packaged in a small insulated bag/box (with ice bricks) for transport to the pathology laboratory.

IMPORTANT NOTE: Dispose of gloves, gowns and masks in an infectious (biohazard) waste bag.

Appendix 5. Initial RCF report to a PHU – COVID-19 Outbreak

Date/time: _____ Public Health Officer:_____

Contact details:
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				
Nurse				
Carer / Care Assistant				

Agency				
Other (specify)				

Appendix 6. Letter to GPs – COVID-19 Outbreak

[Facility Letterhead]

……/……/……

Respiratory outbreak at [Facility Name]

Dear Doctor,

There is an outbreak of acute respiratory illness affecting residents at the facility named above. The outbreak may involve some of your patients who may require review.

It is important to establish if the outbreak is caused by **SARS-CoV-2**. Coronavirus Disease 2019 (COVID-19), caused by SARS-CoV-2, is a notifiable condition.

We recommend that you:

- Establish if any of your patients are affected
- Help determine if the outbreak is caused by SARS-CoV-2:
  - Obtain/order appropriate respiratory samples from residents who meet the case definition, for respiratory PCR testing.
- Ensure that your patients are vaccinated against influenza, if there are no contraindications
- Ensure that you observe hand hygiene procedures and use appropriate PPE when visiting your patients.

Limit the use of antibiotics to patients with evidence of bacterial superinfection, which is uncommon. There is significant evidence that antibiotics are over-prescribed during the institutional respiratory illness outbreaks.

Control measures that the facility has been directed to implement include:

- Isolation of symptomatic residents
- 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.

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

If you require any further information or advice please contact [insert details].

.

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

Appendix 7. 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 **confirmed case of COVID-19**

Resident details: _____ _____
Given name Surname

Date of birth:

Name of originating facility:

Name of contact person:

Phone number:

Appendix 8. COVID-19 Outbreak Management Checklist

	✓
Identify	
Identify if your facility has an outbreak using the definition in the guideline	
Screen staff for symptoms at the start of each shift	
Implement infection control measures	
Isolate / cohort ill residents	
Implement contact and droplet precautions	
Place additional supplies of alcohol-based hand rub at room entrance/exit points to encourage hand hygiene	
Provide PPE outside room	
Display sign outside room	
Exclude ill staff until symptom free (or if confirmed cased of COVID-19, until they meet the release from isolation criteria)	
Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility	
Display outbreak signage at entrances to facility	
Increase frequency of environmental cleaning (minimum twice daily)	
Collect respiratory specimens	
Collect appropriate respiratory specimens from ill residents or staff, or from asymptomatic residents who are quarantined if undertaking repeat testing	
If it is likely that the case acquired infection in the facility, all members of the facility should be tested initially	
Notify	
The state/territory Health Department	
Contact the GPs of ill residents for review	
Provide the outbreak letter to all residents' GP's	
Inform families and all staff of outbreak	
Restrict	
Restrict movement of staff between areas of facility (e.g. to ensure staff caring for patients who are isolated and patients who are quarantined are kept separate) and between facilities	
Avoid resident transfers if possible	
Restrict ill visitors, unless absolutely necessary	

Cancel non-essential group activities during the outbreak period	
Monitor	
Monitor outbreak progress through increased observation of residents for fever and/or acute respiratory illness and undertake repeat testing, where feasible	
Update the case list daily at the facility and provide to the public health unit daily	
Add positive and negative test results to case list	
Declare	
If a repeat testing strategy has been employed, in most circumstances the outbreak can be declared over when there are no new cases 14 days from the date of isolation of the most recent case.	
Review	
Review and evaluate outbreak management – amend outbreak management plan if needed	

Appendix 10. Infection Prevention and Control

The *COVID-19 guidelines for IPC in RCF (Infection Control Expert Group)* , provide detailed information on IPC precautions relating to visitors to RCF.

Standard Precautions

Standard precautions are a group of infection prevention practices always used in healthcare settings and must be used in RCF with a suspected or confirmed COVID-19 outbreak. Standard precautions include performing hand hygiene before and after every episode of resident contact (5 moments), the use of PPE (including gloves, gown, appropriate mask and eye protection) depending on the anticipated exposure, good respiratory hygiene and regular cleaning of the environment and equipment (see Figure 1 for more information).

Standard precautions consist of:

- hand hygiene, as consistent with the 5 moments for hand hygiene
- the use of appropriate personal protective equipment
- respiratory hygiene and cough etiquette
- the safe use and disposal of sharps
- regular cleaning of the environment and equipment
- reprocessing of reusable medical equipment and instruments
- aseptic technique
- waste management
- appropriate handling of linen.

Standard precautions should be used in the handling of: blood (including dried blood); all other body substances, secretions and excretions (excluding sweat), regardless of whether they contain visible blood; non-intact skin; and mucous membranes.

Source: adapted from *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (2019).

Hand Hygiene

COVID-19 can spread by contaminated hands. It is important to use good hand hygiene. This refers to any act of hand cleaning, such as:

- hand washing with soap and water
- hand rubbing with an alcohol-based hand rub.

Washing with soap and water is preferred but alcohol-based hand rubs are suitable when hands are not visibly soiled. If hands are visibly soiled or have had direct contact with body fluids, they should be:

- washed with liquid soap and running water
- dried thoroughly with disposable paper towel.

Online hand hygiene courses are available. Encourage staff, in particular healthcare staff, to complete refresher training. Staff, residents and visitors must have ready access to hand hygiene stations. These might be alcohol-based hand rub or hand basins with liquid soap,

water and paper towel. Make sure you stock and maintain these. Where possible, have hand basins that are hands-free (for example, elbow operated). This facilitates good hygiene practices and prevents re-contaminating hands when turning taps off. Ensure staff and residents are aware of good hand hygiene technique and why it's important.

Encourage residents and visitors to use good hand hygiene. Ensure hand hygiene products are available to residents and opportunities to perform hand hygiene are offered to them. This is important to prevent transmission of infectious organisms. Residents should wash their hands:

- after toileting
- after blowing their nose
- before and after eating
- when leaving their room.

Remind visitors to perform good hand hygiene when they enter and leave the resident's room and the facility.

Using gloves is not an alternative to good hand hygiene. Good hand hygiene should be used before putting on gloves and immediately after removing them.

PPE

Staff must wear appropriate PPE when caring for infected residents. They may need a gown, eye protection, mask and gloves depending on the level of precaution required.

Facility health staff must change their PPE and perform good hand hygiene after:

- every contact with a resident
- when moving from one room to another.

Respiratory etiquette

This is about precautions to reduce the spread of virus via droplets produced during coughing and sneezing. Encourage everyone to practise good respiratory etiquette. This includes:

- coughing or sneezing into the elbow or a tissue
- disposing of the tissue
- then performing good hand hygiene.

Environmental Cleaning and Disinfection

Regular, scheduled **cleaning** of all resident care areas is essential. Frequently touched surfaces are those closest to the resident, door handles, and light switches should be cleaned more often.

During an outbreak, cleaning AND disinfection is recommended. 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 available in the Commonwealth Department of Health factsheet – COVID-19 Environmental cleaning and disinfection principles for Health and Residential Care Facilities.

The following principles should be adhered to:

- Well resident's rooms and communal areas should be cleaned daily.
- Frequently touched surfaces should be cleaned more frequently. These include:
  - bedrails, bedside tables, light switches, remote controllers, commodes, doorknobs, sinks, surfaces and equipment close to the resident.
  - Walking frames, sticks
  - Handrails and table tops in facility communal areas, and nurses station counter tops
- Rooms of ill residents should be cleaned AND disinfected. This includes cleaning AND disinfecting:
  - frequently touched surfaces at least daily
  - equipment after each use
  - surfaces that have been in direct contact with, or exposed to, respiratory droplets
- Rooms should undergo a 'terminal clean' when an ill resident is moved or discharged.
- Cleaners should:
  - Wear appropriate PPE, including impermeable disposable gloves and a surgical mask plus eye protection or a face shield while cleaning. If there is visible contamination with respiratory secretions or other body fluid, the cleaners should wear a full length disposable gown
  - adhere to the cleaning product manufacturer's recommended dilution instructions and contact time
  - use a TGA registered disinfectant https://www.tga.gov.au/disinfectants-use-against-covid-19-artg-legal-supply-australia or a chlorine-based product such as sodium hypochlorite. The manufacturer's instructions for dilution should be followed.

Equipment and items in patient areas should be kept to a minimum. Ideally, reusable resident care equipment should be dedicated for the use of an individual resident. If it must be shared, it must be cleaned and disinfected between each resident use.

Place signs at entrances and other strategic locations within the facility to inform visitors of the infection prevention control requirements. Ensure a droplet and contact precaution sign is placed outside symptomatic resident's rooms to alert staff to follow transmission-based precautions.

Minimise equipment and items in patient areas. Any reusable care equipment should only be used for the individual. If it must be shared, clean and disinfect between each use.

Wash and sanitise linen using hot water (>65 degrees Celsius for 10 minutes). Use a standard laundry detergent. Dry linen in a dryer on a hot setting. There is no need to separate the linen for use by ill, from the linen used by others. Use appropriate PPE when handling soiled linen.

Wash crockery and cutlery in a hot dishwasher. If a dishwasher is not available, wash by hand using hot water and detergent. Rinse in hot water and dry.

Transmission-based Precautions

Transmission based precautions are infection control precautions used in **addition** to standard precautions to prevent the spread of COVID-19. COVID-19 is most commonly spread by contact and droplets. Airborne spread is less common but may occur e.g. during aerosol generating procedures[6] or care of severely ill patients.

Contact and Droplet precautions are the additional infection control precautions required when caring for people with suspected or confirmed COVID-19.

Contact and Airborne precautions, including the use of a P2/N95 mask which has been fit-checked, are required when conducting aerosol generating procedures.[7]

For more information see Section 5 and ICEG guidelines at https://www.health.gov.au/resources/publications/coronavirus-covid-19-guidelines-for-infection-prevention-and-control-in-residential-care-facilities

[7] Aerosol-generating procedures include manual ventilation before intubation, tracheal intubation, non-invasive ventilation, tracheostomy suctioning, cardiopulmonary resuscitation, bronchoscopy and high flow nasal oxygen.

Recommended PPE for health workers in clinical units

Context	Disposable gloves	Disposable plastic apron	Disposable fluid-resistant gown	Surgical mask fluid-resistant (Level 1, 2 or 3)	P2/N95 mask	Eye protection[1]
Working in an inpatient area with probable or confirmed case(s)[2] (not within 1.5m). Use standard precautions.	✗	✗	✗	✗	✗	✗
Performing a single aerosol-generating procedure (AGP) on probable or confirmed case(s)[2].	✓ Single use[3]	✗	✓ Single use[3]	✗	✓ Single use[3]	✓ Single use[3]
Working in any inpatient area with probable or confirmed case(s)[2] - direct patient care (within 1.5m), no AGPs.	✓ Single use[3]	✓ Single use[3] - application as per risk assessment[4] OR	✓ Single use[3] - application as per risk assessment[4]	✓ Single use[3] - application as per risk assessment[4]	✗	✓ Single use[3]
All individuals transferring probable or confirmed case(s)[2] (within 1.5m).	✓ Single use[3]	✓ Single use[3] - application as per risk assessment[4]	✗	✓ Single use[3]	✗	✗
Primary care, ambulatory and outpatient areas with probable or confirmed case(s)[2] - direct patient care (within 1.5m).	✓ Single use[3]	✓ Single use[3] - application as per risk assessment[4] OR	✓ Single use[3] - application as per risk assessment[4]	✓ Single use[3]	✗	✓ Single use[3]
Protection for vulnerable patient groups during COVID-19.	✓ Single use[3]	✓ Single use[3]	✗	✓ Single use[3]	✗	✗

1. This may be a single or reusable face/eye protection/face shield, mask visor, safety glasses or goggles.
2. A case is any individual who meets the current definition for a probable or confirmed case of COVID-19 as provided in *CDNA National Guidelines for Public Health Units Coronavirus Disease 2019 (COVID-19)*.
3. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator after each patient and/or following completion of a procedure, task or session. PPE should be disposed of after each use or earlier if damaged, soiled, moist or uncomfortable.
4. Risk assessment refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets, or blood or body fluids.

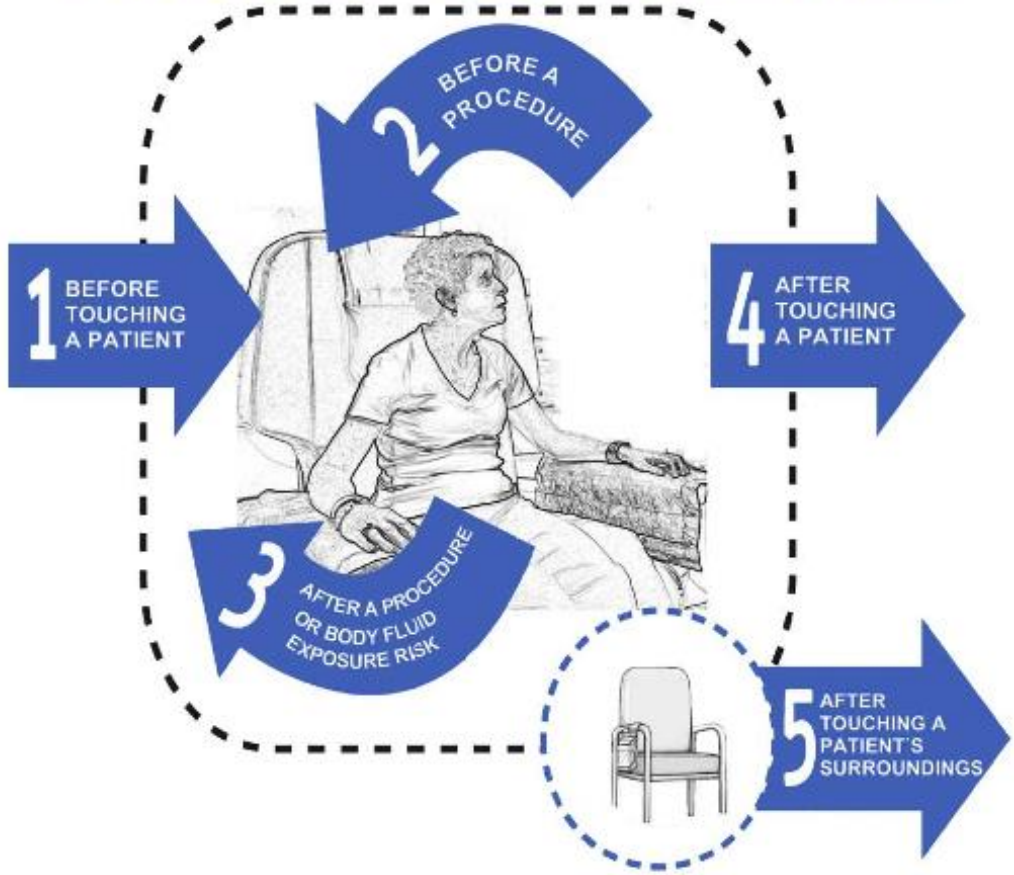
The contribution of the Clinical Excellence Commission, NSW Health in this work is acknowledged

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Extract from PPE for clinical care in COVID-19

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

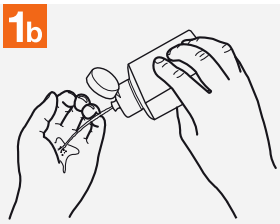
How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

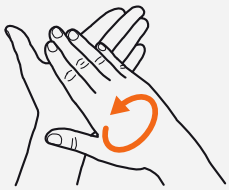
1a

1b



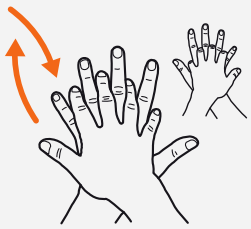
Apply a palmful of the product in a cupped hand, covering all surfaces;

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;

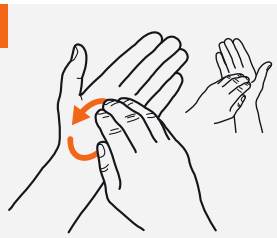
5

Backs of fingers to opposing palms with fingers interlocked;

6

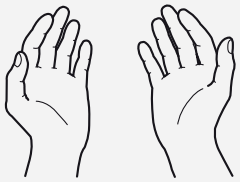
Rotational rubbing of left thumb clasped in right palm and vice versa;

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

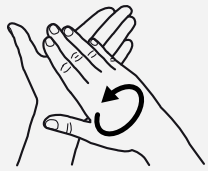
0

Wet hands with water;

1

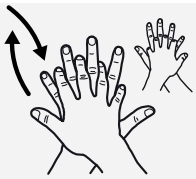
Apply enough soap to cover all hand surfaces;

2



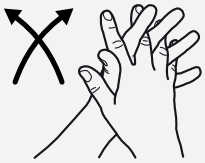
Rub hands palm to palm;

3



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

4

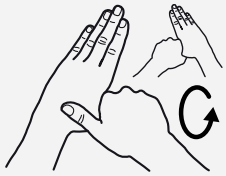


Palm to palm with fingers interlaced;

5

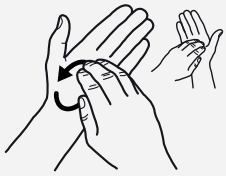
Backs of fingers to opposing palms with fingers interlocked;

6



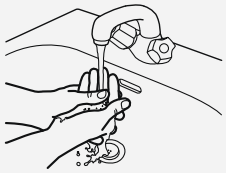
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



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

8

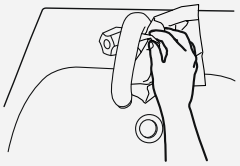


Rinse hands with water;

9

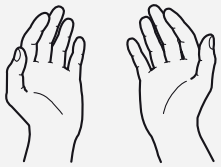
Dry hands thoroughly with a single use towel;

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

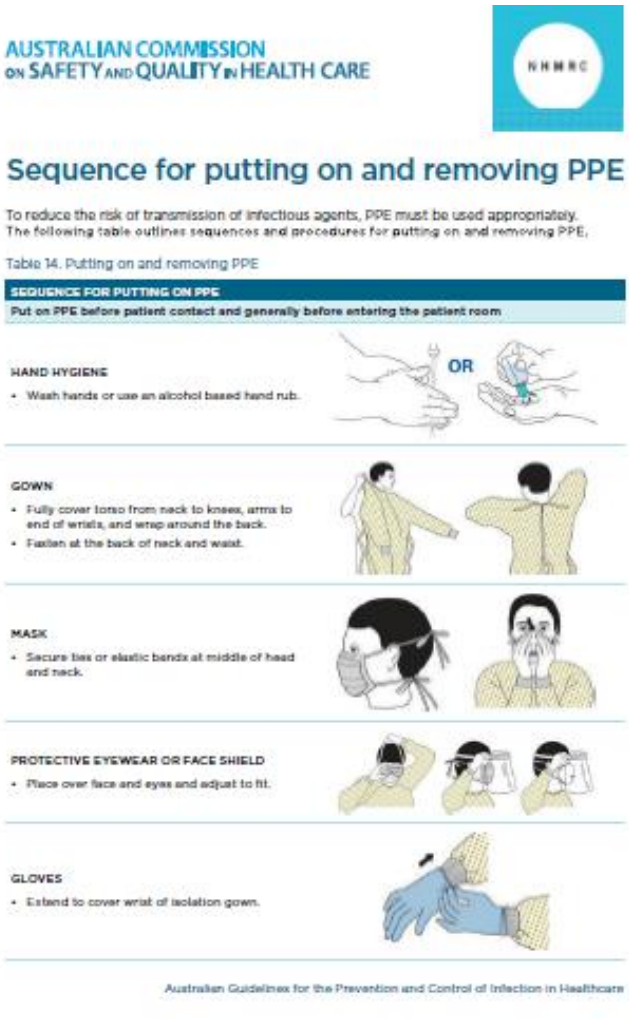
WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009

Source: Hand Hygiene Australia, adapted from '5 Moments for Hand Hygiene', 'How to Handwash', and 'How to Handrub' © World Health Organization 2009. All rights reserved.

Proper Use of Personal Protective Equipment (PPE)

- Full page posters can be downloaded from safetyandquality.gov.au



AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NHMRC

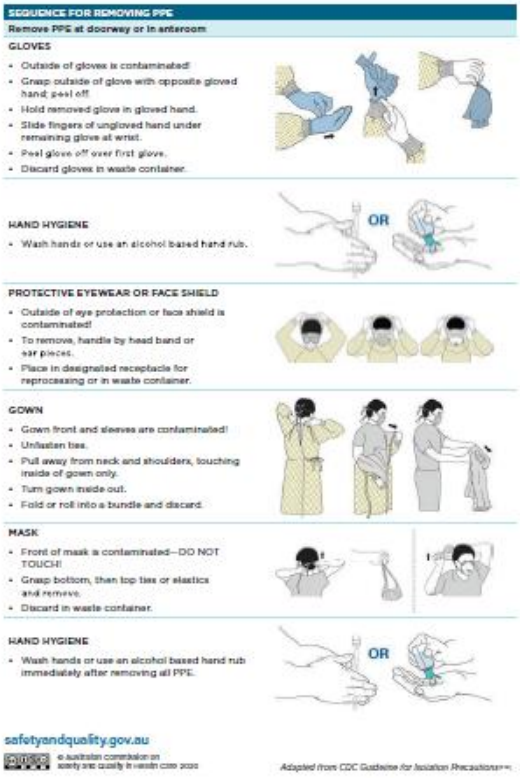
Sequence for putting on and removing PPE

To reduce the risk of transmission of infectious agents, PPE must be used appropriately. The following table outlines sequences and procedures for putting on and removing PPE.

Table 14. Putting on and removing PPE

SEQUENCE FOR PUTTING ON PPE Put on PPE before patient contact and generally before entering the patient room	
HAND HYGIENE • Wash hands or use an alcohol based hand rub.	OR
GOWN • Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back. • Fasten at the back of neck and waist.	
MASK • Secure ties or elastic bands at middle of head and neck.	
PROTECTIVE EYEWEAR OR FACE SHIELD • Place over face and eyes and adjust to fit.	
GLOVES • Extend to cover wrist of isolation gown.	

Australian Guidelines for the Prevention and Control of Infection in Healthcare



SEQUENCE FOR REMOVING PPE Remove PPE at doorway or in anteroom	
GLOVES • Outside of gloves is contaminated! • Grasp outside of glove with opposite gloved hand; peel off. • Hold removed glove in gloved hand. • Slide fingers of ungloved hand under remaining glove at wrist. • Peel glove off over first glove. • Discard gloves in waste container.	
HAND HYGIENE • Wash hands or use an alcohol based hand rub.	OR
PROTECTIVE EYEWEAR OR FACE SHIELD • Outside of eye protection or face shield is contaminated! • To remove, handle by head band or ear pieces. • Place in designated receptacle for reprocessing or in waste container.	
GOWN • Gown front and sleeves are contaminated! • Unfasten ties. • Pull away from neck and shoulders, touching inside of gown only. • Turn gown inside out. • Fold or roll into a bundle and discard.	
MASK • Front of mask is contaminated—DO NOT TOUCH! • Grasp bottom, then top ties or elastics and remove. • Discard in waste container.	
HAND HYGIENE • Wash hands or use an alcohol based hand rub immediately after removing all PPE.	OR

safetyandquality.gov.au

Adapted from CDC Guideline for Isolation Precautions

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.