Guidance for residential aged care facilities on the public health management of acute respiratory infections (including COVID-19, influenza, and respiratory syncytial virus)

Revision history

Version	Date published	Summary of amendments

1.5	5 September 2023	• Overview: Addition of information on mild and atypical symptoms
		• Preparedness: Addition of preparedness advice for vaccination and pre-assessment (including antivirals)
		• Initial actions – updates to overview of initial action for new ARI symptoms in a resident flowchart
		• Step 2: Addition of guidance for testing type for initial and subsequent cases, guidance for false positive results
		• Step 3: Guidance on historic case management
		• Step 4: Updates to cases and contact management table
		  ○ To align with CDNA, exclusion for asymptomatic staff cases before day 10 removed
		  ○ Additional precautions for staff cases returning to work
		  ○ Updates to resident case isolation advice
		• Step 6: Clarified what it means to be up to date with COVID-19 and influenza vaccinations
		• Step 8: Additional guidance for declaring an outbreak over
		• Resident choice around isolation – addition of advice on ventilation
		• Appendix 1: Key documents- infection control resources, information about COVID-19 vaccination and antivirals
		• Appendix 2:
		  ○ Changes to definition of low and high-risk categories
		  ○ Changes to frequency and type of test (PCR/RAT)
		  ○ Removal of moderate risk.

1.4	09 November 2022	• Step 4: table 1 updated:
		  ○ Added ‘See advice to RACFs on entry restrictions’ for visitors who are cases
		  ○ Added “if symptomatic” as a reason for visitors to not visit
		• Step 5: Notification and reporting updated:
		  ○ Added reasoning for registering a RAT
		• Step 6: PPE updated:
		  ○ N95/P2 respirator mask for staff if caring for residents with COVID-19
		  ○ Surgical mask and eye protection to be worn for all respiratory infections other than COVID-19
		• Step 7: Communicate: additional communication for family, carers, and staff
		• Step 8: Activate outbreak management plan: aligned with the Joint Protocol.

1.3	14 October 2022	• Specific inclusion of Respiratory Syncytial Virus (RSV)
		• Change of isolation period for residents who are cases from 10 days to 7
		• Changed screening requirements to entry restrictions during an outbreak
		• Updated Case and contact management table:
		  ○ Resident case isolation period changed from after 10 to 7 days
		  ○ Visitor case can visit facility changed from after 10 to 7 days
		  ○ Addition of visitor contact section

		○ Addition of contact management advice for Influenza and RSV • Recommendation for masks during essential offsite appointments for cases/contacts leaving facility • Removed facility may arrange virtual visits • Updated link to CDNA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities • Updated links in Appendix 1 • Updated visitor guidance during outbreak in accordance with CHO advice.
1.2	27 June 2022	• Table 1 - Updated isolation requirements from a minimum of 7 days to 10 days.
1.1	17 June 2022	• Overview of initial actions flow chart – updated information regarding respiratory panel PCR test, local triggering of OMP, and testing of symptomatic residents • Appendix 2 – residents assessed as moderate-risk to remain in wing, and high-risk staff to follow NSW Health close contact guidelines and RAT/ PCR before returning to work • Table 1 - Updated isolation requirements from 10 days to a minimum of 7 days • Added link to Antiviral Guidance • Added link to Managing RACF staff returning to work after exposure to COVID-19 guidance • Clarification on PPE requirements; notification, including updates to grammar and wording • Removed responsibility of local public health unit to report influenza outbreaks to the Commonwealth • Removed CDNA threshold for COVID-19 outbreaks.
1.0	12 May 2022	Original document Replaces the following documents: • Public Health Actions – recommended guidance following a Residential Aged Care Facility (RACF) COVID-19 outbreak or exposure (published 4 March) • COVID-19 Guidance to support risk assessment of workers, residents, and visitors in Residential Aged Care (version 1.1 March 2022) • NSW Flu-Info Kit (25 October 2018).

Table of Contents

Purpose

To provide guidance to residential aged care facilities (RACF) on the management of exposures, single cases, and outbreaks of acute respiratory infections (ARI) including COVID-19, influenza, respiratory syncytial virus (RSV) and other viral respiratory infections.

For additional information please refer to the resources in Appendix 1.

Overview

- ARI is defined in this document encompass a range of infections caused by respiratory viruses, including COVID-19, influenza, and respiratory syncytial virus (RSV).
- ARI transmission is primarily via droplet and aerosol spread when infected individuals cough, sneeze, talk or shout.
- Many ARIs can be spread before symptoms appear in an infected person, meaning facilities must have systems for the clinical assessment of residents, and response systems at the first sign of symptoms to contain any potential further spread.
- Symptoms of ARIs are often similar regardless of the virus causing illness and therefore testing residents with symptoms is essential to diagnose an index case.
- Outbreaks in RACFs can be caused by the spread of more than one respiratory virus. A resident may be infected with more than one respiratory virus at once. This may require use of more than one management pathway as outlined below.
- ARI definition: Recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion with or without other symptoms (see box below).

Other symptoms:

- Headache, muscle aches (myalgia), fatigue, nausea or vomiting and diarrhoea. Loss of smell, taste and appetite can also occur with COVID-19 but may be less common with new variants of the disease
- Fever (≥37.5°C) can occur, however is less common in elderly individuals
- In the elderly, other symptoms to consider are new onset or increase in confusion, change in baseline behaviour, falling, or exacerbation of underlying chronic illness (e.g., increasing shortness of breath in someone with congestive heart failure).

Residents with non-respiratory symptoms should be assessed for appropriateness of testing for respiratory pathogens, especially if there are already ARI cases in the facility.

- Respiratory viral infections can vary from no symptoms to severe disease and death. Antiviral treatments are available for COVID-19 and influenza and therefore early recognition, testing and diagnosis are important for individual patient management as well as for preventing spread to others.
- The RACF should ensure staff, family and residents are aware of these symptoms and the need to report them. Note that residents may experience mild symptoms, particularly in a vaccinated population. Residents may have atypical symptoms including behaviour change and may not develop a fever. Ideally, staff should monitor residents to detect subtle changes in condition or behaviour.

Preparedness

All RACFs should have appropriate preparedness plans in place to ensure a prompt and early response to a facility ARI outbreak. A preparedness plan should cover the following:

☐ Promoting vaccination of residents, staff, visitors, and contractors for seasonal influenza, and COVID-19 vaccination as per ATAGI advice

☐ Encourage general practitioners (GPs) to regularly review residents to assess vaccination status, arrange a pre-filled pathology form for respiratory viral testing and assess suitability for antiviral treatment

☐ Facilities should maintain systems for monitoring and recording vaccination status of residents and staff for COVID-19 and influenza

☐ Maintain stocks of antiviral treatments or identify methods to access rapidly

☐ Plan for potential cohorting of residents and staff with zoning of the RACF

☐ Appropriate infection prevention and control strategies, including regular staff training, remaining up to date with staff infection control and outbreak management competency assessment (donning, doffing and outbreak response) and monitoring

☐ Arrangements for increased PPE, hand hygiene and cleaning supplies

☐ Establishing workforce surge capacity

☐ Ensure adequate supply of RATs or identify procurement methods

☐ Identifying and establishing a working relationship with a local private pathology provider who can assist in specimen collection, preparing relevant consent from residents/guardians, pre-filled pathology forms, and considering logistical arrangements

☐ Promoting regular resident and family communication in an outbreak situation

☐ Alternate arrangements for resident leisure and lifestyle maintenance in an outbreak situation

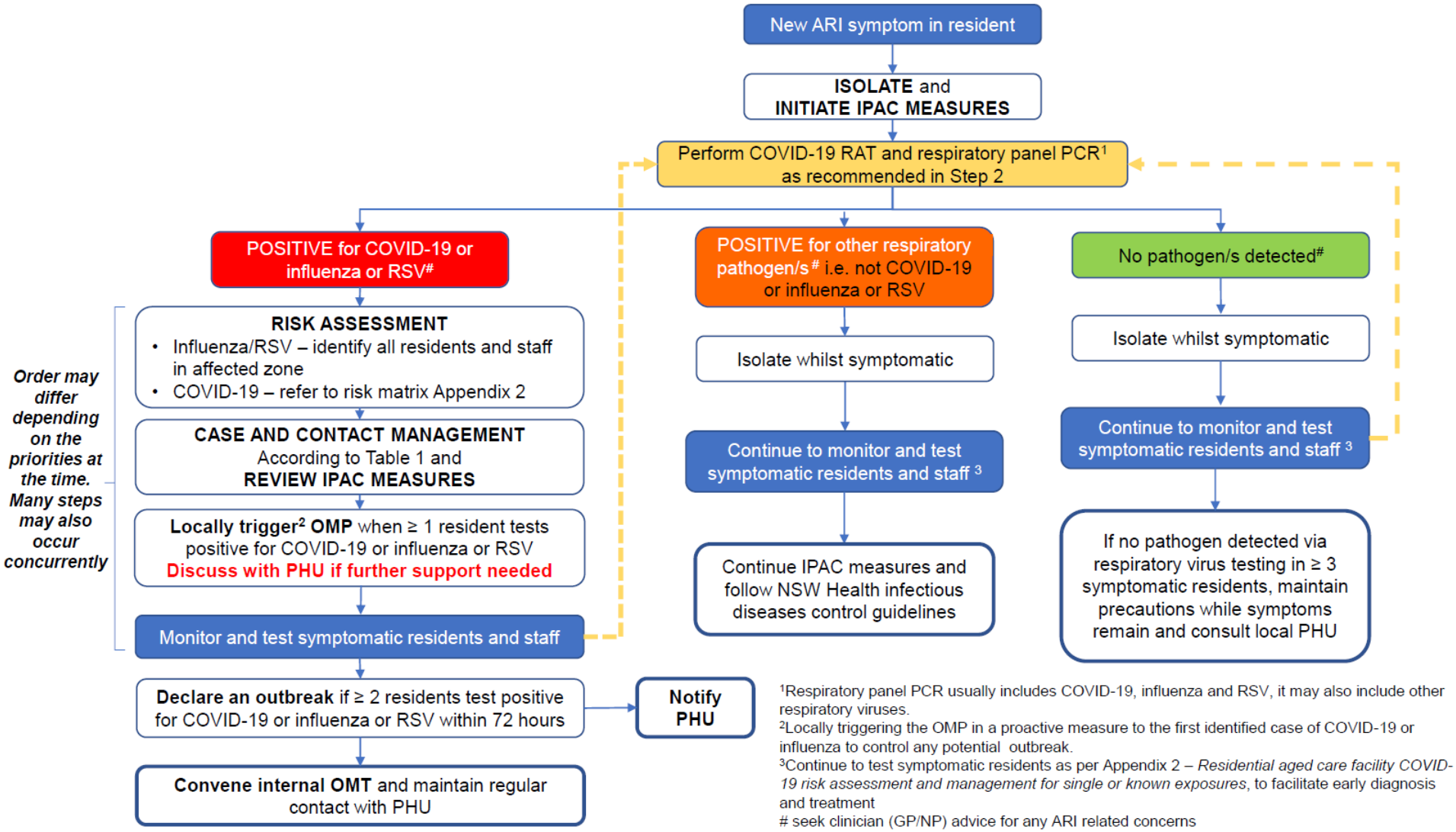
☐ Ensure alternate arrangement for clinician engagement (e.g., virtual care) as required in an outbreak situation

Refer to the Commonwealth Department of Health Prevent and prepare for COVID-19 in residential aged care for more detailed guidance.

Responding to ARI symptoms in a RACF resident, staff member or visitor

RACF should consider the Advice to residential aged care facilities (RACFs) in relation to entry restrictions for visitors and staff.

Overview of initial actions – New ARI symptoms in a resident



[1]Respiratory panel PCR usually includes COVID-19, influenza and RSV, it may also include other respiratory viruses.
[2]Locally triggering the OMP in a proactive measure to the first identified case of COVID-19 or influenza to control any potential outbreak.
[3]Continue to test symptomatic residents as per Appendix 2 – *Residential aged care facility COVID-19 risk assessment and management for single or known exposures*, to facilitate early diagnosis and treatment
seek clinician (GP/NP) advice for any ARI related concerns

Initial actions – New ARI symptoms in a resident

The Steps outlined below are a guide only and the Step-by-Step order may differ depending on the priorities at the time. Many Steps may also occur concurrently.

Step 1: ISOLATE the symptomatic resident immediately in their own room if possible and implement initial infection prevention and control (IPAC) measures including airborne and droplet precautions for staff in affected areas.

Step 2: TEST the symptomatic resident as soon as possible.

Early diagnosis of COVID-19, influenza and RSV means earlier treatment and outbreak control.

- Facilities should work with the GP on a process to ensure residents are tested quickly; this may include having pre-ordered pathology forms in the event a resident is symptomatic.
- The first symptomatic resident in a facility should be tested with both a COVID-19 RAT and full respiratory panel PCR to establish the pathogen (or COVID-19, influenza, and RSV PCR as a minimum). Ensure the pathology order forms include the name of the RACF and the doctor's details.
- Ensure any symptomatic resident remains isolated until initial testing is complete, and a diagnosis is known. Subsequent symptomatic residents during a COVID-19 outbreak should be tested with a COVID-19 RAT.
    - If the COVID-19 RAT is negative, the resident should have a respiratory panel PCR test.
    - If the COVID-19 RAT is positive, the resident should be managed as a COVID-19 case.
- If a false positive RAT result is suspected, the facility should consult with the resident's GP and the PHU.
- If no pathogen is detected for three or more symptomatic residents, facilities should contact their PHU for advice.

Step 3: RISK ASSESS resident, staff, and visitor contacts.

- Trigger the outbreak management plan (step 8) with the **first** resident who has tested positive for COVID-19, influenza or RSV while awaiting additional test results of other residents.
- Review contacts of the symptomatic resident for ARI symptoms. Isolate and test symptomatic residents as per Step 1 and Step 2. For symptomatic staff, test (RAT), furlough and direct to their GP.
- Establish a red zone as per IPAC measures (Step 6). Review the measures that have been implemented and identify and address any gaps.
- Once the diagnosis is known, cases and contacts should be managed according to Step 4.
- If the diagnosis is COVID-19 and the source is unknown, all residents in the affected zone should be tested by RAT or PCR (depending on availability) to find cases, irrespective of whether they have symptoms*. Generally, where an exposure is unknown or unclear, residents in the affected zone should be considered high risk.
- **COVID-19 risk matrix** (Appendix 2) provides information to support assessment and management of contacts of a positive COVID-19 case for known or single exposures. This matrix should be used where there has been a known exposure, or when there is a single case with a known source. In outbreaks with multiple resident cases, the risk assessment can be discussed with the local PHU upon notification, as the management of contacts may differ.
- In assessing contacts of a positive influenza or RSV case, RACFs should identify all staff and residents in the affected zone and ensure they monitor for symptoms and limit movement in the facility (see Step 4).

* Testing or isolation is not required for residents if it has been less than 4 weeks since recovery from their previous COVID-19 infection unless they become symptomatic. If symptomatic, they should isolate, even if they receive a negative result

Step 4: CASE AND CONTACT MANAGEMENT

Table 1 – Case and contact management for COVID-19, influenza, and other confirmed respiratory pathogens

			COVID-19	Influenza	Another confirmed respiratory pathogen including RSV
CASE	Resident	Case isolation	7 days from symptom onset, or test date if asymptomatic	5 days from symptom onset	While symptoms remain. There may be guidelines available for specific pathogens, available from the NSW control guidelines
		Release from isolation	After day 7 if substantial resolution of acute symptoms and no fever for 24 hours. No testing required†	After 5 days from symptom onset, or until they are symptom-free, whichever is longer, or 72 hours after antivirals commenced regardless of symptoms. No testing required	Once symptoms resolve. No testing required
		Antiviral treatment	COVID-19 antivirals (via treating clinician) See Antiviral guidance	Influenza antivirals (via treating clinician) See Antiviral guidance	Seek guidance from treating clinician
	Staff	Return to work	After day 7 if no symptoms for 24 hours, with no testing required. If symptoms continue, return when substantial resolution of acute respiratory symptoms and no fever for 24 hours*	After 5 days from symptom onset, or until they are symptom-free, whichever is longer or 72 hours after antivirals commenced. No testing required for return to work	Once symptoms resolve. No testing required
	Visitors	Visitors to facility	Can visit facility after day 7 if no symptoms. Visitors are strongly recommended to wear a mask between day 8 and 10. See Advice to RACFs for entry restrictions	After 5 days from symptom onset, or until they are symptom-free, whichever is longer, or 72 hours after antivirals commenced	Exclude if symptomatic
CONTACTS	Resident	Contact testing (initial round of testing)	All residents in the affected zones (likely wing). As per risk matrix at Appendix 2 if single/known exposure	Symptomatic residents in the same zone (likely wing)	Symptomatic residents in the same zone (likely wing)
		Contact isolation	See Appendix 2 risk matrix if single/known exposure	Residents in same zone(s) should avoid communal areas, group activities and moving between different zones	Nil
		Contact post-exposure prophylaxis (PEP)	Nil	Influenza antivirals can be considered in an outbreak See Antiviral guidance	Nil
	Staff	Return to work	See Appendix 2 risk matrix	Immediately if no symptoms. Must wear mask and other PPE when at work	Immediately if no symptoms.
	Visitors	Visitors to facility	Should not visit facility for at least 7 days after close contact with a COVID-19 case or if they are symptomatic. See Advice to RACFs on entry restrictions	If symptomatic, do no visit the facility until 5 days after symptom onset, or until symptom-free, whichever is longer, or 72 hours after antivirals commenced	If symptomatic, should not visit the facility.

- A resident who has tested positive for an ARI should isolate away from other residents. Cases can share a room with another case with the same pathogen. Residents with ARIs should receive ongoing daily care onsite (e.g.,
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*This minimum standard aims to balance the risk with the impact of prolonged isolation on individuals and communities. A small proportion of cases may still be infectious when released from isolation. Staff with substantial improvement of symptoms returning to work who test positive on a RAT after day 7 should take additional precautions (e.g. P2/N95) until RAT negative or day 10, whichever occurs sooner.

mobilisation, allied health services, time sensitive pathology tests, routine catheter changes and wound reviews etc).

- Essential off-site appointments also should continue (e.g., dialysis), with negotiation with the service provider if the resident has COVID-19 or influenza or has been exposed to COVID-19 or influenza. Facilities should ensure that residents and transport providers are provided with a mask and appropriate mask wearing advice if they leave the facility.
- Residents' GPs will continue to provide their routine primary care as needed either onsite and/or virtually.
- Residents in the green zone can attend external appointments.
- Consider relocating residents who are on a palliative care pathway and require additional supports (e.g., compassionate care/visiting, symptom control) to an area where they are less at risk of further exposure (or if they are a case, plan for how the resident could be supported with visits).
- Facilities should promptly discuss the need for antiviral medications with the treating GP. See Antiviral guidance. Staff returning to work following a RACF exposure to COVID-19 or influenza should not move between their section and other areas of the facility, in line with basic IPAC principles.
- During a confirmed influenza outbreak, staff who are unvaccinated are at higher risk of acquiring influenza, therefore they are recommended to work only if asymptomatic, wearing a mask, and taking appropriate antiviral prophylaxis, in keeping with the RACF influenza outbreak management policy. Any antiviral use by staff should be documented. Refer to the CDNA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities for more detailed information on influenza prophylaxis and treatment.
- If practical, where more than one resident case is positive (with the same pathogen) the residents should be cohorted together for ease of management. Residents who are identified as contacts with similar exposure can also be cohorted together. Please refer to Resident choice around isolation.
- Where residents cannot be effectively isolated, more frequent testing may be required.

Step 5: NOTIFICATION AND REPORTING

- Facilities can discuss with the local **PHU** (1300 066 055) when one resident has tested positive for COVID-19, influenza, or RSV, if required.
- Notify the local **PHU** of an OUTBREAK when 2 or more residents test positive to COVID-19, influenza, or RSV, within a 72-hour period.
- Where PCR test results are delayed and a COVID-19 RAT is negative, discuss with the local **PHU** when 2 or more residents have ARI symptoms in a 72-hour period.
- Notify the **Australian Government Department of Health** via the My Aged Care provider portal of positive COVID-19 cases. The RACF will receive an email confirming the level of support available.
- Notify **other care facilities and hospitals** where residents have had a high-risk exposure and have subsequently been transferred or require immediate transfer for care.
- Record and report details of each resident and staff who tests positive.
- Check with the local PHU on preferred data format and template. Facilities must complete required information for all affected residents and staff, this will include vaccination status, symptom onset, test results and other identifying information.

Step 6: IMPLEMENT INFECTION PREVENTION AND CONTROL (IPAC) MEASURES

- **Vaccination**
    - Review vaccination status (COVID-19 and influenza) of residents and staff (e.g., as part of contact reporting).
    - Consider supporting vaccination for those who have not received a seasonal influenza vaccine or are not up to date with recommended COVID-19 vaccinations. For information on recommended COVID-19 vaccine doses see the latest ATAGI advice.

- **Cohort, zone and relocate**
    - Identify the areas of the facility that are at risk. Where the whole RACF is impacted whole-of-facility action should be taken. Where only a wing or floor of the RACF is impacted **only** that area should be managed as an outbreak site. Identify crossover areas at risk of transmission, such as shared lifts.
    - Apply the risk assessment outcomes and test results to confirm areas in the facility that:
        - are staff only e.g., nurses' station, medication room, kitchen, reception area (blue zone)
        - are likely to be completely unaffected and can be staffed with non-exposed staff and managed separately (green zone)
        - have been affected due to exposures (amber zone) or
        - cases (red zone)
    - Set up donning/doffing areas as per outbreak management plan.
    - Allocate staff to colour zone for the duration of the outbreak.
    - Cohort staff to work in only one part of the facility.
- **PPE**
    - P2/N95 respirator (mask) and eye protection to be worn by staff when caring for residents with **ARI symptoms until diagnosis.**
    - Surgical mask and eye protection to be worn by staff caring for residents with **confirmed influenza, RSV,** and all other respiratory infections except COVID-19.
    - P2/N95 respirator (mask), eye protection, (gown and gloves as per standard precautions) to be worn by staff caring for residents with **confirmed COVID-19**.
    - Where possible and where able, residents who are isolating should wear a surgical mask particularly when staff members or visitors are in their room.
- **Environmental cleaning and disinfection**
    - Allocate trained staff for cleaning of affected areas – ensure they are skilled to perform routine, additional and terminal cleaning.
    - Schedule daily cleaning in line with Environmental cleaning and disinfection principles for COVID-19. This cleaning practice is also applicable to RSV, and influenza.
- Refer to COVID-19 Infection Prevention and Control Manual for more information.

Step 7: COMMUNICATE

- Ensure all affected **residents** are aware of their diagnosis, exposure status, testing and isolation requirements. Individual communication strategies need to be considered for residents who may have difficulty following instructions due to cognitive impairment or language barriers.
- Ensure the residents' **family and carers** are aware of the exposure/outbreak at the RACF. Ensure family and carers are informed of the status of individual residents with resident's/guardian's consent, including their diagnosis and management. Maintain confidentiality of the identity of any residents who have tested positive as far as possible.
- Ensure **staff** are aware of the exposure/outbreak at the RACF and remain on high alert monitoring themselves and residents for ARI symptoms. Ensure that they know what to do if they or other residents develop symptoms.
- Ensure **visitors** are aware of the exposure/outbreak at the RACF and that **visitors** are permitted to continue to visit affected residents, including those considered to be high risk and in designated red zones. Visitors should comply with RACF entry requirement, as outlined in the Advice to residential aged care facilities (RACFs).
- Put up notices of the outbreak at all entrances including information to minimise unnecessary visits that may lead to inadvertent transmission. Signage should also be displayed outside the room of affected residents on any PPE requirements or other precautions.

Step 8: ACTIVATE OUTBREAK MANAGEMENT PLAN (OMP)

- See Outbreak management planning in aged care for information on how to develop an OMP.
- The facility should activate their RACF OMP on identification of the **first** resident who has tested positive for COVID-19, influenza, or RSV while awaiting additional test results of other residents.
- **An outbreak should be declared if 2 or more residents test positive within a 72-hour period for:**
    - **COVID-19 OR**
    - **Influenza OR**
    - **RSV**
- Once an outbreak has been declared, the facility should convene a meeting of the internal outbreak management team (OMT) and confirm the:
    - Outbreak management leader and
    - Infection prevention and control leader
- The RACF, LHD and/or Australian Government Department of Health representative will determine if an inter-agency OMT is required. The local PHU can be consulted if advice is required.

Step 9: DECLARING AN OUTBREAK OVER

A decision to declare the outbreak over should be made by the internal OMT, in consultation with the PHU. This should be when at least 7 days have passed since the last date of identified transmission.

Outbreak closure should not occur if there are pending PCR test results for contacts or symptomatic residents. Where there is extensive or poorly understood transmission, or where there are a significant number of residents non- or under-vaccinated, the PHU may advise the RACF to undertake additional testing or measures in the 7 days following an outbreak being declared “over”.

- After the outbreak closure, facilities should remain on high alert and:
    - test anyone with new symptoms
    - carefully monitor residents with high-risk exposure for atypical symptoms such as behavioural changes, lack of appetite and lethargy, and test for COVID-19
    - ensure visitors are aware that there has been a recent outbreak.
- Individual cases should remain in isolation for the required period (as per Step 4) even if the outbreak has been declared over.
- Once an outbreak is over, facilities should evaluate the response and management of the outbreak to identify strengths and areas for improvement. Consider conducting a facility debrief with all employees and contractors involved.

Other considerations relevant to an outbreak situation

New and returning residents to RACF from hospital or the emergency department

- The presence of an outbreak should not prevent new and returning residents from being admitted/re-admitted to the facility when appropriate infection prevention and control measures are in place. Decisions should be based on the advice of the local OMT and in consultation with the PHU, residents, and their representatives.

Resident choice around isolation

Consumer dignity and choice is a foundational standard in the National Quality Standards.

Residents should be given the choice to self-isolate while the outbreak is active, or to mix with people with similar exposure. Their preferences should be recorded in their care plan and regularly reviewed. Residents should be made aware that if they choose not to isolate during an outbreak that this increases their risk of contracting or transmitting the infection. Continued implementation of appropriate IPAC measures should continue.

Where practical, and the facility can manage this risk by considering the following:

- Residents with the same ARI being permitted to engage in social activities together if they are well enough to do so and if they can be kept separated from residents who are unaffected.
- Exposed residents may choose to leave their rooms to eat in shared dining rooms and participate in social activities with other residents from the affected area. Exposed residents should be supported to not socialise with positive cases or unexposed residents.
- Unexposed residents can leave their rooms to participate in shared activities and dining with other unexposed residents (i.e., with dedicated staff, dining room, social room).
- Where possible, visits to affected residents should occur in an area with good ventilation. The Aged Care Act 1997, the Charter of Aged Care Rights and the Aged Care Quality Standards provide further information for this requirement.

Appendix 1 - Key documents

Aged Care Quality and Safety Commission

- Quality Standards – The Commission expects organisations providing aged care services in Australia to comply with the Quality Standards.
- Outbreak management planning in aged care – Guidance to support COVID-19 outbreak management planning and preparation in residential aged care facilities.

Australian Government

- Prevent and prepare for COVID-19 in residential aged care measures RACFs should always have in place to prevent and prepare for an outbreak.
- PPE and RAT supply for RACF COVID-19 Outbreak or Exposure– link to the Commonwealth Department of Health ordering form for PPE and RAT supply.
- National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities
- First 24 Hours Checklist – Managing COVID-19 in a Residential Aged Care Home
- Preparedness Checklist for major infectious disease outbreak
- Ensuring safe visitor access to residential aged care
- **COVID-19 Oral Treatments**
    - The Australian Department of Health and Aged Care has information on Oral treatments for COVID-19, which includes links to an Information sheet for residents in residential aged care facilities and their families – COVID-19 oral medicines and a COVID-19 medicines – Easy read document.
- **COVID-19 Vaccination**
    - The Australian Department of Health and Aged Care has Information for residents in aged care facilities about COVID-19 vaccines, Information for residential aged care workers about COVID-19 vaccines, Information for aged care providers about COVID-19 vaccines, and Information for in-home and community aged care recipients, workers and providers

NSW Health

- Caring for the wandering person during COVID-19
- COVID-19 and delirium

Clinical Excellence Commission

- COVID-19 Infection Prevention and Control Manual - Clinical Excellence Commission (nsw.gov.au)

Further resources

Infection prevention and control

- The Australian Commission on Safety and Quality in Health Care's (ACSQHC) has published posters on standard and transmission-based precautions.
- The Australian Commission on Safety and Quality in Health Care's (ACSQHC) NHHI Learning Management System has a series of online learning modules on hand hygiene and infection prevention and control.
- The Australian Guidelines for the Prevention and Control of Infection in Healthcare has detailed guidance about standard and transmission-based precautions, including:
    - 3.1.1 Hand hygiene (p36 –)
    - 3.1.3 Routine management of the physical environment – including
    - environmental cleaning (p62 –)
    - 3.1.5 Respiratory hygiene and cough etiquette (p99)
    - 3.1.7 Waste management (p105 –)
    - 3.1.8 Handling of linen (p106)
- The Infection Prevention and Control Expert Group (ICEG) has endorsed a collection of resources for infection prevention and control.

Personal protective equipment

- The Australian Department of Health and Aged Care has published factsheets and videos on use of PPE.

Environmental cleaning

- ACSQHC has resources including:
    - Environmental cleaning: information for cleaners
    - Principles of Environmental Cleaning Product Selection factsheet
    - Flowchart - The process and product selection for routine environmental cleaning
    - COVID-19 Environmental cleaning and disinfection principles for health and residential care facilities factsheet.

Appendix 2 – Residential aged care facility COVID-19 risk assessment and management for single or known exposures

	Low risk	High risk
Requirements for staff	**Definition** Where staff have had transient, limited contact that: - Does not meet the definition of high-risk contact. **Management** - Continue to work with the following: ➢ Monitor for symptoms, test (RAT initially, if negative proceed to PCR if available), and isolate immediately if symptomatic. ➢ Daily RATs (until day 7).	**Definition** Where a worker has been exposed to COVID-19 at work and exposure is defined as high-risk. Considerations for high-risk exposure include: - staff who were not wearing airborne precautions (P2/N95 respirators, eye protection) where aerosol generating behaviours or procedures have been involved; - have had at least 15 minutes face to face contact where both mask and eyewear were not worn by exposed person and the case was without a mask; or - greater than 2 hours within the same room with a case with inadequate PPE. • If a worker has been exposed to COVID-19 in the community follow the advice for people exposed to COVID-19 factsheet. **Management** Review affected staff to assess risk of exposure. If staff furloughing is not an option and staff must continue to work the following risk mitigation strategies should be in place: ➢ Monitor for symptoms, test (RAT initially, if negative proceed to PCR if available), and isolate immediately if symptomatic. ➢ Daily RATs (until day 7). ➢ Avoid staff redeployment to unaffected areas to minimise risk of potential spread. ➢ Do not enter shared space or meal rooms. ➢ Work in P2/N95 masks for the first 7 days following exposure.
Requirements for residents	Where a resident has had transient, limited contact that - Does not meet the high-risk contact definition; or - Based on facility and/or PHU risk assessment is not assessed as a high-risk contact. **Management** - Close monitoring for symptoms. If symptoms develop, isolate immediately and test. - Regular RAT testing in the first 7 days if deemed appropriate by facility and/or PHU. - Other risk mitigation strategies deemed appropriate.	Where a resident has been exposed to a COVID-19 case: - in a shared defined area (e.g., prolonged contact during activity, co-located in a wing of a facility); and/or - who have had household-like exposure with a case during their infectious period; or - outbreak-related contact (e.g., cases in the same ward / wing / shared area with unknown exposure). **Management** - Isolate for 7 days. - Test (PCR or RAT) day 2 and day 6. OR - Consider allowing residents to leave their room after risk assessment, wearing a mask and with ➢ Baseline and day 6 PCR, or ➢ RAT at least every second day from day 0-7. - If symptoms develop, isolate, and do a RAT and, if negative, do a PCR test. - Release from isolation: ➢ After day 7 with a day 6 negative result and asymptomatic.
Requirements for visitors	• Follow Information for people exposed to COVID-19 factsheet.	• Follow Information for people exposed to COVID-19 factsheet.

This risk matrix does not replace the CEC application of PPE guide: Infection Prevention and Control Manual COVID-19 and other acute Respiratory Infections (Version V4.1) (nsw.gov.au)

Appendix 3 – Glossary of terms

Acronym	Definition
ARI	Acute respiratory infection
ATAGI	Australian Technical Advisory Group on Immunisation
CHO	Chief Health Officer
COVID-19	Coronavirus disease 2019
IPAC	Infection prevention and control measures
OMP	Outbreak management plan
OMT	Outbreak management team
PCR	Polymerase chain reaction
PHU	Public health unit
PPE	Personal protective equipment
RACF	Residential aged care facility
RAT	COVID-19 rapid antigen test