Guidance for Disability Care Facilities on the public health management of Acute Respiratory Infections (including COVID-19 and Influenza)

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Guidance for Disability Care Facilities on the public health management of Acute Respiratory Infections (including COVID-19 and Influenza)

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Purpose

To provide guidance to Disability Care Facilities (DCF) on the management of exposures, single cases and outbreaks of acute respiratory infections (ARI) including COVID-19, influenza and other respiratory viral infections.

The key resources used in the development of this document are included in Appendix 1.

Context

This guidance recognises that there are different care settings provided for people with disability, also that people with disability are diverse in age range, medical vulnerability to acute respiratory infections and ability to access mainstream health care.

In managing ARI within disability settings, it is important to balance the level of intervention with the level of risk to the individual and those that they live with.

People with disability

The term 'people with disability' refers to diverse group of people. Disability includes intellectual disability as well as musculoskeletal (physical), sensory, and psycho-social disability. Disability may result from impairment from birth or is acquired through illness, accident, or the ageing process, and can affect a person's vision, hearing, learning or application of knowledge, communicating, thinking, mental health or social relationships.

Disability Care Facilities (DCF)

- DCF include:
  - Supported independent living and/or specialised disability accommodation provided under the National Disability Insurance Scheme (NDIS)
  - Disability group homes
  - Assisted boarding houses
- DCFs with up to 6 residents can be considered and managed as households, and follow:
  - *NSW Health household and close contact guidelines*
  - *Additional precautions for people vulnerable to respiratory illness*
  - *COVID-19 self-isolation guidelines*.

  Where residents are managed as household contacts, they cannot visit high-risk settings (including other disability care facilities) for 7 days from the last time someone in the facility was diagnosed with COVID-19. Exceptions are where the resident requires care or there are particular circumstances and have obtained the permission of the facility to visit (e.g., end of life visits)

- DCFs with up to 6 residents may also choose to follow the guidance provided in this document, particularly where residents are at increased medical risk.
- Some residents may be at higher risk of severe illness from ARI, it is important that DCF providers are aware of these risks. A person with a disability or medical condition that affects their lungs, heart or immune system may be particularly vulnerable to ARI. Additional measures to protect these individuals may be required.

Overview

- ARI encompass a range of infections caused by respiratory viruses, including COVID-19 and influenza.
- Respiratory infections can transmit easily between people sharing common areas. An outbreak occurs when there is spread of the infection in a facility.
- ARI transmission is primarily via droplet and airborne spread when infected individuals cough, sneeze, talk or shout.
- COVID-19 and influenza vaccinations are important for the prevention of severe illness.
- Many ARIs can be spread before symptoms appear in an infected person, meaning facilities must have systems for the clinical assessment of residents, and must respond at the first sign of symptoms to contain any potential further spread.

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- Symptoms of ARI are often similar regardless of the virus causing illness and therefore testing someone with symptoms is essential to diagnose the first case of illness in the facility.
- Outbreaks can be caused by the concurrent spread of more than one respiratory virus, similarly a resident may be infected with more than one respiratory virus. This may require the use of more than one management pathway at the same time (e.g., precautions for COVID-19 and influenza at the same time). In these complex situations DCF can consult the local Public Health Unit for advice.

ARI definition = Recent onset of new or worsening cough, runny nose, breathing difficulty, and/or sore throat with or without other symptoms (see box below).

Other non-respiratory symptoms:

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

When illness is present in a facility, DCF Residents with new non-respiratory symptoms should be tested for respiratory viruses.

- Respiratory viral infections can vary from no symptoms to severe disease and death. Anti-viral 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.

Outbreak Preparedness

All DCFs must have appropriate plans in place to ensure a prompt response to an ARI outbreak.

The plan should cover the following:

- Promoting vaccination and monitoring vaccination status of staff, visitors and residents for influenza and COVID-19
- Plan for potentially cohorting of residents and staff and zoning of the DCF, where possible.
- Work with residents' General Practitioners (GPs) to ensure that there are plans in place for clinical management and ARI treatment
- Work with residents' GPs to have a plan in place to appropriately assess and test residents
- Infection prevention and control strategies and documentation, including regular staff training, practice and monitoring. Records should be kept of staff training. It is recommended staff undergo annual infection prevention and control training. This may be more frequent e.g., in an exposure or an outbreak staff may be required to have refresher training.
- Arrangements for supply of appropriate personal protective equipment (PPE), hand hygiene products and cleaning supplies
    - Consultation with waste provider for additional delivery of bins and waste removal
    - Arrangements for the delivery of meals and food onsite
- Annual staff training on ARI outbreak preparedness and response (including fit testing and use of PPE)
- Arrangements and strategies for supply and management of workforce capacity
- Plan for resident and family communication
- Alternate arrangements for resident leisure and lifestyle maintenance
- Plan for management of residents with behaviours of concern during an outbreak, see NDIS Quality and Safeguards Commission guidance.

See Management and operational plan for people with disability for more information

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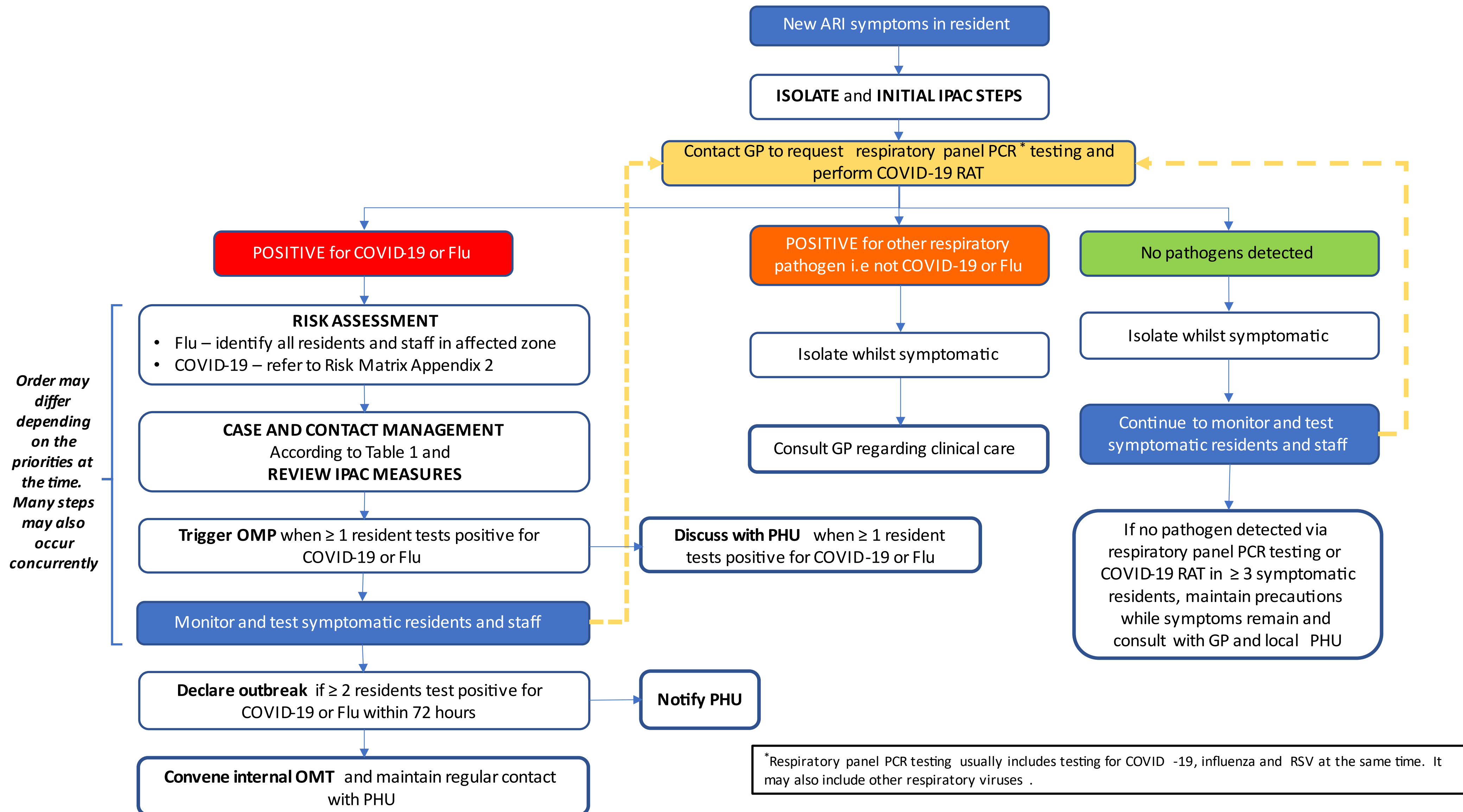
Overview of initial actions – New ARI Symptoms in a Resident



*Respiratory panel PCR testing usually includes testing for COVID -19, influenza and RSV at the same time. It may also include other respiratory viruses .

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Initial actions – New ARI symptoms in a resident

The steps outlined below are a guide only and the order may differ depending on the priorities at the time. Many steps may also occur at the same time.

The steps in this document should not stop DCF staff seeking urgent medical assistance if a resident's health is deteriorating. Staff should continue to be vigilant in monitoring residents and should refer to the person's care plan for guidance on management of health conditions.

Step 1: ISOLATE the resident who has symptoms immediately in their own room if possible and begin infection prevention and control (IPAC) steps including airborne and droplet precautions for staff in affected areas. Hand hygiene must be practiced as per Five moments for Hand hygiene.

Required PPE:

- Surgical mask/ N95/P2 respirator mask and eye protection when caring for residents with ARI until diagnosis.
- Surgical mask and eye protection to be worn by staff caring for residents with confirmed influenza and all other respiratory viruses except COVID-19.
- N95/P2 respirator mask, eye protection and gown/apron (impervious, non-fabric) to be worn by staff caring for residents with confirmed COVID-19.

An impervious, non-fabric gown or apron, and nitrile gloves are applied when direct care (contact) is being provided and exposure to blood of body substances is anticipated.

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

Early diagnosis of COVID-19 and influenza means earlier treatment and control of any potential outbreak.

Facilities should work with the clients' GPs on a process to ensure the resident/s are tested quickly; this may include having tests pre-ordered on pathology forms in the event a resident develops symptoms of a respiratory infection.

- Perform a COVID-19 RAT on the person with symptoms. Regardless of the RAT result, make sure the person is then tested by PCR for COVID 19 and influenza. Identification of COVID-19 and influenza virus is a priority.
    - Work with the resident's GP to determine the best care plan and most appropriate test for the individual and whether test requests should as a minimum be for COVID and influenza or also include other respiratory viruses given multiple viruses may be circulating in the general community.
    - Clearly identify the name of the DCF on the order form and ensure the requesting doctor's details are complete.
    - Some people with disability may experience difficulty when having a test, work with the GP to consider how to manage any barriers to testing and retesting of these individuals.
- Encourage all residents with symptoms to remain isolated until initial testing on these residents is complete and a diagnosis is known.
    - If the COVID-19 RAT is negative, the resident should remain isolated until the PCR result is known.
    - If the COVID-19 RAT is positive, the resident should be managed as a COVID-19 case.
- If no pathogen is detected by PCR for three or more symptomatic residents, facilities should contact their PHU for advice. Providers are advised to also contact residents General Practitioner.

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

This step maybe done at the same time as Step 4.

- Implement the outbreak management plan (Step 8) with the **first** resident who has tested positive for COVID-19 or influenza while awaiting additional test results of other residents.
- Review residents and staff contacts of the symptomatic resident for ARI symptoms. Isolate if able and test symptomatic residents as per Step 1 and Step 2; furlough and test symptomatic staff.
- If possible, establish a red zone for residents that test positive to COVID-19 or influenza as per IPAC measures (step 6). Review measures implemented and identify and address any gaps.

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- Once the diagnosis is known, cases and contacts should be managed according to Step 4 below.
- If the diagnosis is COVID-19 and the source of infection is unknown, all residents should be tested by PCR and RAT to find cases, whether or not they have symptoms. Generally, where an exposure is unknown or unclear residents should be considered moderate risk.
- **COVID-19 risk matrix** (Appendix 2) provides information for 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 (e.g. a staff member tests positive for COVID-19 after caring for several residents), or when there is a single case with a known source (e.g. a resident returns from a family event where people in attendance are identified as having COVID-19). **For multiple cases among residents, consult the local PHU as assessment and management of contacts may differ**.
- Staff identified as close contact or household contacts must follow the NSW Health household and close contact guidelines and must not enter a DCF for 7 days after the last person in their household had a positive COVID-19 test. If a staff member is critical to service delivery and their absence would compromise delivery of care to residents, the DCF may discuss with the PHU whether a return to within 7 days maybe allowed with additional risk mitigating measures such as regular RAT and additional PPE use.
- In assessing contacts of a positive influenza case, DCF should identify all affected staff and residents and ensure they monitor for symptoms and limit movement in the facility (see Step 4).

Step 4: CASE AND CONTACT MANAGEMENT

Cases and contacts should be managed according to the diagnosis, as shown in Table 1.

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

			COVID-19 (RAT or PCR)	Influenza (PCR)	Other confirmed respiratory pathogen
CASE	Resident	Case isolation	Minimum** of 7 days from symptom onset or test date if asymptomatic	5 days from symptom onset	Whilst symptoms remain
		Release from isolation	Minimum** after day 7 or if no symptoms for 24 hours. If the person is immunosuppressed liaise with their GP regarding release from isolation.	After 5 days from symptom onset, or until they are symptom-free, whichever is longer. No testing required	Once symptoms resolve. No testing required
		Antiviral treatment	COVID antivirals (via GP)	Flu antivirals (via GP)	Nil – seek guidance from GP on clinical management
	Staff	Return to work	Day 8 with negative RAT^	After 5 days from symptom onset. No testing required	Once symptoms resolve. No testing required
	Visitors	Visitors to facility	After Day 10 if no symptoms	Exclude from facility for 5 days from symptom onset	Exclude if symptomatic
CONTACTS	Resident	Contact testing	All affected residents. As per risk matrix at Appendix 2 if single/known exposure	Symptomatic residents	Symptomatic residents
		Contact isolation	See Appendix 2 Risk Matrix if single/known exposure	Residents in same zone(s) should avoid communal areas and group activities	
		Contact post-exposure (action to prevent infection)	Nil	Flu antivirals to be considered in outbreak	
	Staff	Return to work	See Appendix 2 Risk Matrix	Immediately if no symptoms. Must wear	

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				mask and other PPE at work	

** DCFs with up to 6 residents may choose to follow the NSW Health household and close contact guidelines, and the COVID-19 self-isolation guidelines and the Additional precautions for people vulnerable to respiratory illness*
***Can be up to 10 days if the resident is immunocompromised or at higher risk of severe illness.*
^If staff test positive by RAT on day 7, staff member should be excluded until after day 10, and may return on day 11 if symptom free and with suitable precautions (e.g.N95/P2 mask) until day 14.

- The case should continue to isolate in their own room (or shared room with another case) and receive ongoing daily care.
- Essential off-site health appointments (e.g., for renal dialyses or administration of medication) should continue, after consultation with the service provider if the resident has COVID-19 or influenza or has been exposed to COVID-19 or influenza.
- Residents' GPs should continue to provide routine primary care as needed either onsite and/or virtually.
- Residents in the green zone (see step 6) are able to attend external appointments.
- Where a person is a sole resident and is a high risk contact they should be permitted to leave for social and/work commitments and must follow the NSW Health household and close contact guidelines. Where there is more than one household/high-risk contacts consideration should be given as to how they can leave the residence for work/social activities without putting other high-risk contacts at risk (e.g. separate transport, leaving at different times).
- Staff should be reminded of appropriate use of PPE when returning to work after being exposed to COVID-19 or influenza and when moving between caring for residents that are affected (COVID-19 or influenza positive) and those not affected.
- Facilities should promptly discuss the resident's need for antiviral medications with the prescribing GP.
- During a confirmed influenza outbreak, staff who are not up to date with their vaccination are recommended to work only if asymptomatic and wearing a mask, in keeping with the DCF influenza outbreak management policy. Any antivirals use by staff should be documented. Refer to the CDNA Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia for more detailed information on current influenza management.

Step 5: NOTIFICATION AND REPORTING

- Discuss with the local **public health unit** if advice or support is needed when one resident has tested positive for COVID-19 or influenza.
- Notify the local PHU of an OUTBREAK when 2 or more residents test positive to COVID-19 or influenza within a 72-hour period.
- Register positive Rapid Antigen Test with Service NSW.
- Exposures to residents, visitors or staff should be managed as per the matrix at Appendix 2.
- Where PCR test results are delayed, and COVID-19 RAT is negative, notify the local **public health unit** when 2 or more residents have ARI symptoms in a 72-hour period.
- Notify the NDIS Quality and Safeguards Commission of positive COVID-19 case(s) by completing the notification of event form online (for registered providers) or call 1800 035 544.
- 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 case to the local PHU.

Check with the PHU on preferred data format and template. Information will include vaccination status, symptom onset, test results and other identifying information.

Step 6: INFECTION PREVENTION AND CONTROL (IPAC) MEASURES should be implemented

- **Vaccination**
    - Review vaccination status (COVID-19 and influenza) of residents and staff (e.g. as part of contact reporting) and prioritise vaccination of those not up to date.

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- **Cohorting and Zoning**
  - Apply the risk assessment outcomes and test results to confirm areas in the facility that:
    - are cases (Red zone)
      - e.g., a red zone can be the positive resident's room, if possible, to also have a designated bathroom/ensuite.
      - Residents with different viruses should not cohort together.

    OR

    - are likely to be completely unaffected and can be managed separately (Green zone)
      - e.g., a green zone could be all other areas of the DCF except the red zone.
  - Correct signage displayed throughout the DCF.

- **PPE**
  - N95/P2 respirator mask and eye protection to be worn 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** and all other respiratory infections except COVID-19.
  - N95/P2 respirator mask, eye protection, (gown and gloves as per standard precautions) to be worn by staff caring for residents with **confirmed COVID-19**.
  - Staff should be reminded to change PPE between contact with residents.
  - Where possible and where able, isolating residents should wear a surgical mask particularly when staff members or visitors are in their room.
  - During a COVID-19 outbreak, if the DCF is unable to access sufficient PPE from their usual or other commercial suppliers, Providers can request additional emergency stock from the National Medical Stockpile via NDISCOVIDPPE@health.gov.au
- **Environmental cleaning and disinfection**
  - Allocate 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 applicable for COVID-19 or influenza viruses.

Refer to COVID-19 Infection Prevention and Control Manual for more information.

Step 7: COMMUNICATE

- Ensure all affected **residents** are aware of their diagnosis (this may be via their GP), exposure status, testing and isolation requirements. Individual strategies may need to be used to meet the communication needs of some residents.
- Ensure all affected resident's **GPs** are aware of the residents diagnosis.
- Ensure residents' **family and carers** are aware of the exposure/outbreak at the DCF and status of individual residents, including their diagnosis and management. Maintain confidentiality of the identity of the case as far as possible.
- Ensure **staff** are aware of the exposure/outbreak at the DCF and remain on high alert monitoring themselves and residents for ARI symptoms.
- Ensure **visitors** are aware of the exposure/outbreak at the DCF. Visitors must comply with DCF entry requirements, including RAT, PPE use and vaccination as outlined in the Chief Health Officer Advice. Where possible visits to affected residents should occur outdoors or in an area with significant natural ventilation.
- The DCF may arrange virtual (e.g., iPad) or contactless visits for unvaccinated visitors. (e.g., window visits)

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- Put up notices of the outbreak at all entrances including information about any visitor restrictions that may lead to transmission. Signage should also be displayed outside the room of affected residents.

Step 8: ACTIVATE OUTBREAK MANAGEMENT PLAN FOR MAINTENANCE PHASE

See Management and operational plan for people with disability for information on how to develop an OMP. This should be done well before an outbreak and should be updated with latest advice regularly.

- The facility should activate their DCF Outbreak Management Plan (OMP) with the **first** resident who has tested positive for COVID-19 or influenza while awaiting additional test results of other residents.
- **An outbreak should be declared if:**
  - **2 or more residents test positive for COVID-19 within a 72-hour period OR**
  - **2 or more residents test positive for influenza within a 72-hour period.**

  Note that the threshold as per the CDNA Guidelines for the prevention and control of COVID-19 outbreaks in residential care facilities is two or more residents with 5 days OR five or more staff/visitors/residents within 7 days.
- Once an outbreak has been declared, the facility/provider should convene an internal outbreak management team (OMT) meeting and confirm their staff members who will be:
  - Outbreak Management Lead and
  - Infection Prevention and Control lead
- The facility should remain in regular contact with the PHU where assistance is required.
- The DCF, NDIA and/or NDIS Quality and Safeguards Commission representative/s and the PHU in consultation will determine if an inter-agency OMT is required.

Step 9: DECLARING AN OUTBREAK OVER

- A decision to declare the outbreak over should be made in consultation with the PHU.
- **Generally, this may be when at least 7 days have passed since the last case tested positive or 7 days have passed since the last date of identified transmission.** However, additional testing or measures may be recommended by the PHU in the 7 days following an outbreak being considered "over". Facilities should remain on high alert and:
  - test anyone with new symptoms, no matter how mild
  - carefully monitor residents with high-risk exposure for behavioural changes, lack of appetite, and lethargy and test for COVID-19, even for these atypical symptoms
  - ensure visitors (who may be at higher risk of COVID-19 themselves) are aware that there has been an outbreak.
- Individual cases should remain in isolation for the required period (as per Step 4) even if the outbreak has been declared over for the DCF.
- Where there is extensive or poorly understood transmission, or where there are significant numbers of residents not up to date with immunisations, the PHU may advise the DCF to continue to manage as an outbreak until at least 14 days have passed since the last case tested positive.
- Once an outbreak is over, facilities/providers should evaluate the response to and management of the outbreak to identify strengths and weaknesses. Consider conducting a facility debrief with all employees and contractors involved with the outbreak.

Other considerations relevant to an outbreak

Considerations around isolation for residents

There may be circumstances where isolation poses a risk to residents (due to behavioural or other issues) and subsequently a risk to the staff caring for them. Where there is difficulty for residents to remain in their rooms, ask the local public health unit for advice about managing the resident.

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Appendix 1 - Key documents

Australian Government

- CDNA national guidelines for the prevention, control, and public health management of COVID-19 outbreaks in residential care facilities in Australia
- CDNA Disability Supplement
- Management and operational plan for people with disability

NSW Health

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

Clinical Excellence Commission

- COVID-19 Infection Prevention and Control Manual

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Appendix 2 - Disability Care Facility COVID-19 Risk Assessment for Single or Known Exposures

Note: Where the source of infection is unknown or there are multiple cases among residents in a facility, contact assessment and management (including isolation and testing regimes) may differ from this document. Contact local PHU for advice in these situations.

PPE worn during contact between contact and case	CONTACT TYPE – for staff, resident or visitor: **Transient Contact – Low Risk Scenarios** Transient, limited contact that does not meet the definition of face-to-face contact	**Medium Risk Scenarios** Face-to-face contact within 1.5 metres for less than 4 hours OR Based on agreed documented risk assessment including assessments of occupational exposures and of the physical environment	**Highest Risk Scenarios** Face-to-face contact within 1.5 metres for 4 hours or greater OR Case with aerosol generating behaviour (AGB) e.g. cough /undergoing an aerosol generating procedure (AGP) such as using a nebuliser
Contact: No effective mask or PPE worn **Case:** No effective mask or PPE worn	Moderate Risk	Moderate Risk OR High Risk	High Risk
Contact: Surgical mask only i.e. no eye protection **Case:** No effective mask or PPE worn OR **Contact:** No effective mask or PPE worn **Case:** Surgical mask only	Low Risk	Moderate Risk	High Risk
Contact: Surgical mask only i.e. no eye protection **Case:** Surgical mask	Low Risk	Low Risk	Moderate Risk OR High Risk
Contact: Surgical mask and eye protection **Case:** No mask or effective PPE **worn**	Low Risk	Low Risk	Moderate Risk OR High Risk
Contact: Surgical mask and eye protection **Case:** Surgical mask	Low Risk	Low Risk	Low Risk (if no AGP/AGB) OR Moderate Risk
Contact: P2/N95 mask and eye protection **Case:** With or without PPE OR **Contact:** With or without PPE **Case:** P2/N95 mask +/- eye protection	Low Risk	Low Risk	Low Risk

For residents & staff, use table below. For visitor risk exposure, follow the Information for people exposed to COVID-19 factsheet

This risk matrix does not replace the CEC Application of PPE Guide https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0018/644004/COVID-19-IPAC-manual.pdf

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Actions based on risk classification for exposure at a Disability Care Facility			
	Low risk	**Moderate risk**	**High risk**
Requirements for staff*	Continue to work, monitor for symptoms, test and isolate immediately if they occur. Work in surgical mask or P2/N95 for the first 7 days following exposure. Do not use shared meal rooms, smoking areas or car pool.	Continue to work with risk management plan. If not participating in regular surveillance testing, RAT Day 0, 2, 4 and 6. **For 14 days post exposure:** Consider redeployment to lower patient risk area if possible Wear surgical or P2/N95 respirator at all times Do not enter shared spaces including meal rooms. Monitor for symptoms, test and isolate immediately if they occur.	Immediately furlough for 7 days (unless critical to service delivery)** • Day 1 and Day 6 PCR • Return to work (RTW) after Day 7 if Day 6 test result returns negative and asymptomatic • After RTW, RAT at least every second day until day 14 • Continue to monitor for symptoms until day 14 and immediately isolate and test if symptomatic. PCR testing is recommended if symptomatic and RAT negative • Use P2/N95 respirator for 7 days post RTW • Apply additional requirements as per below **Additional requirements:** Do not enter shared spaces including meal rooms. Limit work to single site/area. RAT/PCR before work and travel to work via own transport or individual ride.
Requirements for residents	Follow Information for people exposed to COVID-19 factsheet	• Isolate for 7 days • Baseline and Day 6 PCR **OR** • Consider residents to leave room after risk assessment, with • Baseline and Day 6 PCR • RAT at least every second day from Day 0-7	• Isolate for 7 days • Baseline and day 6 PCR • Day 8-14 de-isolate, RAT every 2-3 days (e.g. Day 8, 10, 12, 14 OR Day 8, 11, 14. If symptoms develop RAT and PCR During outbreaks isolation and testing regimes may differ. Contact the local PHU for outbreak management advice
Requirements for visitors	Follow Information for people exposed to COVID-19 factsheet	Follow Information for people exposed to COVID-19 factsheet Do not attend DCF until after day 7 if negative Day 6 RAT.	Follow Information for people exposed to COVID-19 factsheet Do not attend DCF for the next 7 days after leaving isolation.

* Household contacts of COVID-19 cases will still need to isolate in line with the Self-Isolation Order and NSW Health household and close contact guidelines. More information can be found within the NSW Health factsheet

** Critical risk to service delivery requires consultation with PHU and senior management risk assessment

If required testing is unavailable, staff must not attend the workplace for 7 days post exposure.

Note: Cohorting of residents based on level of risk may be required depending on the facility lay out. Where residents cannot be effectively isolated, more frequent testing may be required.

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