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
1.7	5 May 2025	• Clarification of guidance on cohorting and zoning
1.6	5 September 2024	• Changes to align with the updated national outbreak management guidelines for ARI in residential care homes • Disclaimer added acknowledging ARI outbreak management is unique to institutions and dictated by governing regulatory bodies involved. Clarifying roles of the Commonwealth, NSW Health, and aged care providers in managing an ARI outbreak. • Included links to Commonwealth and NSW Health RACF advice and resources • Updated ATAGI advice on COVID-19, influenza and RSV vaccines • Isolation arrangements should consider a risk-based approach and take into account the resident's dignity, choice, and continuity of care • Inclusion of combination RATs for testing • Case and contact management: updated advice on isolation following COVID-19 diagnosis for staff and residents, inclusion of post exposure prophylaxis advice for contacts, and visitation advice for influenza contacts • Testing in contacts with a recent COVID-19 infection • Updated COVID-19 exposure and suggested actions - Appendix 2

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 1: Isolate resident
		• 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

Disclaimer

The Australian Government is responsible for the development and implementation of aged care policy in Australia and manages funding and administration for Australian Government-subsidised aged care services. Providers of residential aged care need to balance their responsibilities to reduce the risk of COVID-19, influenza, RSV, and other infections entering RACFs while meeting the physical, social, and emotional needs of residents.

NSW Health works closely in partnership with the Australian Government Department of Health and Aged Care to support residential aged care facilities to manage outbreaks of acute respiratory infections (ARI) including COVID-19, influenza, respiratory syncytial virus (RSV) and other viral respiratory infections.

The guidance provided in this document may not wholly reflect the individual and unique circumstances of each residential aged care facility in the event of an outbreak, and responses may differ according to the situation, local policies, and procedures. Providers may consult their local public health unit (PHU) if specific advice is required about the local situation.

Residential aged care facilities are encouraged to refer to this guidance in conjunction with advice from the Australian Government Department of Health and Aged Care, National Guideline for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection in Residential Aged Care Homes. Readers should not rely solely on the information contained within this guideline and should use clinical judgement and discretion while following these guidelines.

Purpose

To provide guidance to residential aged care facilities (RACF) on the planning for and 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

Key resources for RACFs

- For Commonwealth Department of Health and Aged Care resources, refer to Managing COVID-19 in aged care
- For all relevant NSW resources on management of ARI in RACFs, refer to the Advice for aged care services webpage.

- ARI as 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 or during interventions that increase aerosolisation of respiratory particles (e.g. using a nebuliser or continuous positive airway pressure (CPAP)).
- Many ARIs can be spread before symptoms appear in an infected person. 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 the 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 simultaneously with more than one respiratory virus. Where there is a mixed outbreak, follow the more restrictive quarantine and isolation guidance.

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.

Other symptoms:

- Headache, muscle aches (myalgia), fatigue, nausea or vomiting and diarrhoea. Loss of smell, taste and appetite can also occur with COVID-19.

- 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. Clinical processes should be in place to identify clinical changes, and screening of uninfected residents should be escalated when there are cases in the RACF. 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:

Planning for clinical care (including vaccination and antiviral medications)

☐ Promoting vaccination of residents, staff, visitors, and contractors for seasonal influenza and COVID-19 vaccination as per Australian Technical Advisory Group on Immunisation (ATAGI) advice

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

- Residential aged care providers are required to offer an influenza vaccination program for all service staff and volunteers.

☐ Encourage residents to discuss RSV vaccination with their general practitioner (GP). RSV vaccination is available for people aged 60 years and older, at a cost (see advice).

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

☐ Maintain stocks of COVID-19 and influenza antiviral treatments or identify methods to access rapidly.

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

Infection prevention and control activities

☐ Appropriate infection prevention and control (IPC) strategies, in line with the Aged Care Quality Standards, including regular staff training, remaining up to date with staff infection control and outbreak management competency assessment (donning, doffing and outbreak response) and monitoring.

- All RACFs should have an IPC lead nurse, who is supported by management and has adequate time, training and resources to oversee IPC capability across the service.

☐ Arrangements for increased PPE, hand hygiene and cleaning supplies.

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

- Identify suitable areas of the facility where residents could be cohorted.
- Plan for staff rosters to cover required zones.

☐ Optimise methods to improve indoor air quality and reduce transmission of ARI through mechanical or natural ventilation.

Testing

☐ 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 laboratory testing and logistical arrangements, including timely methods for receiving results.

☐ Ensure adequate supply of unexpired RATs or identify procurement methods.

☐ Ensure staff are trained in the use of RATs, collection of appropriate specimens for testing and interpretation and recording of test results.

Workforce planning

☐ Establishing workforce surge capacity and contingency planning for staff absenteeism.

Resident wellbeing

☐ Promoting regular resident and family communication in an outbreak situation

☐ Engage residents and their representatives in key decisions prior to an outbreak, including resident choices regarding isolation, and if temporary relocation during an outbreak is appropriate and consented to.

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

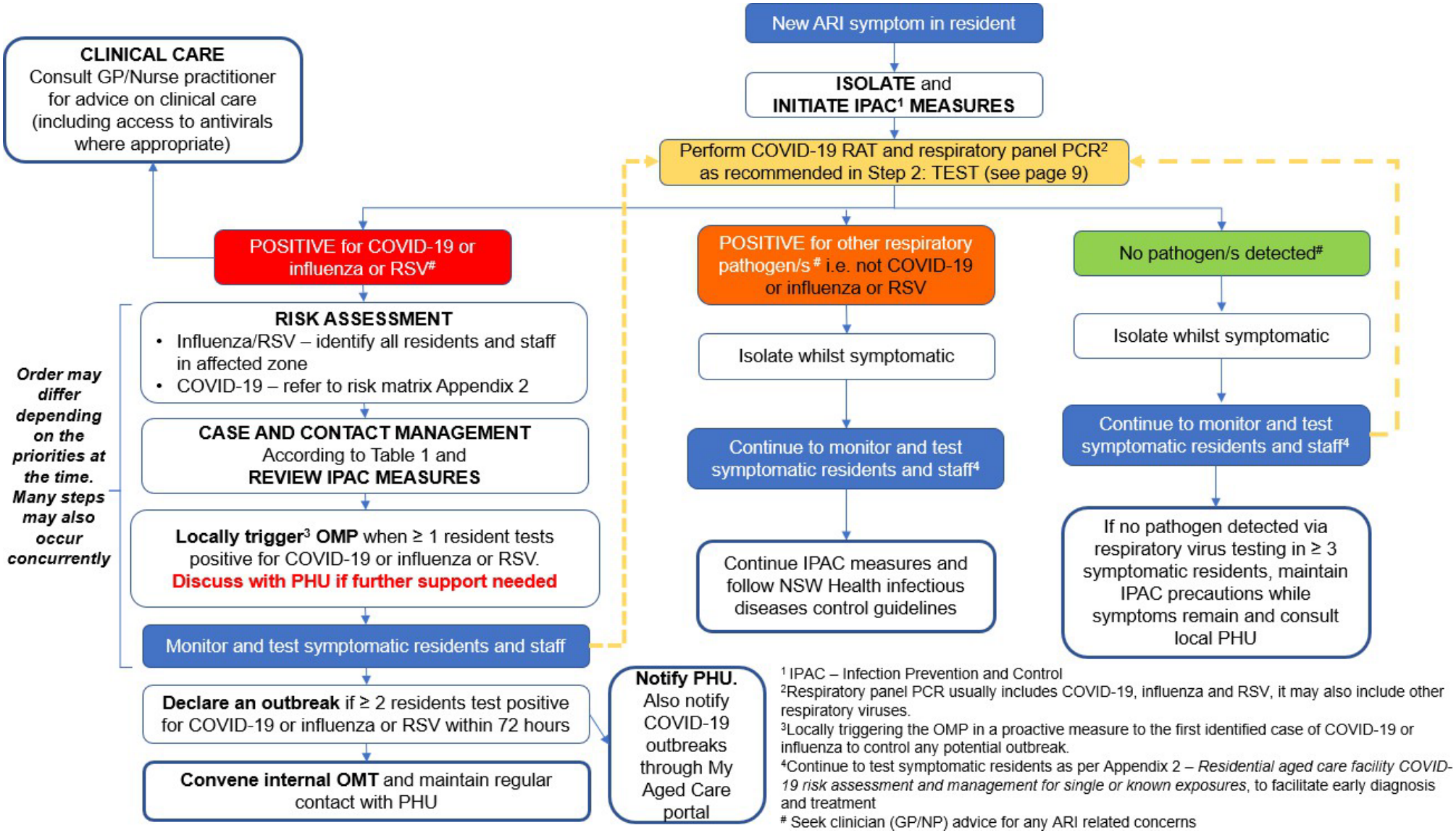
☐ Develop a communication plan to ensure regular communication with staff, residents, family and visitors during an outbreak, including strategies to support residents to stay connected with their families and friends.

Refer to the Australian Government Department of Health and Aged Care Prevent and prepare for COVID-19 in residential aged care and the sector code for visiting in aged care homes for more detailed guidance to assist preparedness planning.

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] IPAC – Infection Prevention and Control
[2]Respiratory panel PCR usually includes COVID-19, influenza and RSV, it may also include other respiratory viruses.
[3]Locally triggering the OMP in a proactive measure to the first identified case of COVID-19 or influenza to control any potential outbreak.
[4]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 order may differ depending on the priorities at the time. Note: steps may occur concurrently.

Step 1: ISOLATE the symptomatic resident

- Isolate the symptomatic resident immediately in their own room with designated bathroom if possible and implement initial infection prevention and control (IPAC) measures including airborne and droplet precautions for staff in affected areas.
  - If possible, limit the number of staff caring for the symptomatic patient to minimise exposure and reduce transmission risk.
- **Note**: Isolation arrangements should take into account the resident's dignity, choice, and continuity of care, and only after an individual risk assessment has been completed.

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.
- Symptomatic residents in a facility should be tested with a COVID-19 RAT (or a combination RAT, if available. See Appendix 3 for definition.). If a pathogen is not detected, a respiratory panel PCR should be conducted 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.
  - 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 required.
- If no pathogen is detected by PCR for three or more symptomatic residents, precautions should be maintained while residents are symptomatic and facilities should contact their PHU for advice.

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

- Trigger the outbreak management plan **(Step 7)** 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**. Test symptomatic staff using a RAT, direct to their own GP and follow guidance as per **Table 1**.
- Establish a red zone as per IPAC measures **(Step 4).** 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 5**.
- If the diagnosis is COVID-19, 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. A risk-based approach to resident care is recommended in ARI outbreak management and

*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

should include risk factors such as patient vulnerability (examples include but not limited to immune compromised, immunodeficiency or transplant recipients).

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 5**).

Step 4: 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 vaccinations, see the latest ATAGI advice.

Cohorting, zoning and relocating in an outbreak (Refer to Step 1 when managing a single case)

- 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.
- When isolating cases during an outbreak, cases with the same pathogen may be cohorted together.

PPE

- P2/N95 respirator (mask) and eye protection to be worn by staff when caring for residents with **ARI symptoms or who have been exposed 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 and risk assessment) 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.
- Staff exposed to a case within a RACF should refer to Appendix 2 for PPE requirements
- Visitors recommended to wear PPE – surgical mask (Minimum).

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 Infection Prevention and Control Manual - COVID-19 and other Acute Respiratory Infections for more information.

Step 5: 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**	Release from isolation	After day 5‡ since symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved, and COVID-19 RAT is negative **OR** After day 7 if substantial resolution of acute symptoms and no fever for 24 hours. No testing required Note: During isolation, case can cohort with COVID-19 positive residents	After day 5 from symptom onset, or until they are symptom-free, whichever is longer **OR** 72 hours after antivirals commenced regardless of symptoms. No testing required Note: During isolation, case can cohort with influenza positive residents	Once acute symptoms resolve. No testing required Note: During isolation, case can cohort another case with the same pathogen
		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 5 since symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved, and COVID-19 RAT is negative **OR** 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

† Note that in an outbreak, RACFs may implement visitor restrictions. In exceptional circumstances (including visiting persons undergoing end-of-life care), it may be appropriate for persons who are cases or contacts to enter a RACF. This should occur on a case-by-case basis in discussion with the RACF, with additional mitigations in place to minimise the risk of transmission to staff and residents. There may be guidelines available for specific pathogens, available from the NSW control guidelines.

‡ Note Day 0 is the day when the onset of symptoms is identified or day of testing if asymptomatic. Testing and isolation are 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 so, test for other viruses in addition to COVID-19.

§ 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.

			COVID-19	Influenza	Another confirmed respiratory pathogen including RSV
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	Residents in same zone(s) should avoid communal areas, group activities and moving between different zones
		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.
		Contact post-exposure prophylaxis (PEP)	Nil	Consider influenza antivirals for unvaccinated staff and staff with comorbidities or pregnancy at higher risk of more serious disease (via treating clinician).	Nil
	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	Immediately if no symptoms. If symptomatic, do not visit the facility until 5 days after symptom onset **OR** until symptom-free (whichever is longer) **OR** 72 hours after antivirals commenced. A mask should be worn for 7 days from last exposure if visiting the RACF.	If symptomatic, should not visit the facility.

Management of residents – refer to Table 1 for isolation periods for resident cases and contacts

- A resident who has tested positive for an ARI should isolate away from other residents.
    - On diagnosis, facilities are obliged to promptly contact the resident's GP regarding clinical assessment, care, and treatment (including antiviral medications).
- Cases can share a room with another case with the same pathogen. Residents with ARIs should receive ongoing daily care onsite (e.g., 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), following negotiation with the service provider if the resident has tested positive or has been exposed to an ARI. Facilities should ensure that residents and transport providers are provided with a mask and appropriate mask wearing advice if they leave the facility. Transport providers should be notified of positive results for ARI.
- Residents' GPs will continue to provide their routine primary care as needed either onsite and/or virtually.
- Residents in the green zone (see **Step 4**) can attend external appointments.

**Testing and isolation are 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 so, test for other viruses in addition to COVID-19.

- 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.
- If practical, where more than one resident case is positive with the same pathogen, the residents may be cohorted together for ease of management. If necessary, residents who are identified as contacts with similar exposure can also be cohorted together. Please refer to Resident choice around isolation.
- It is important that RACF use a risk-based approach to contact assessment and management. The risk of transmission should be managed whilst balancing the risk related to social isolation by using the least restrictive controls appropriate.
- Where residents cannot be effectively isolated, more frequent testing may be required.

Management of staff - refer to Table 1 for isolation periods for staff cases and contacts

- Staff who have cared for residents with COVID-19, influenza or RSV should not move between the affected 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 antiviral prophylaxis if considered appropriate, in keeping with the RACF influenza outbreak management policy. Any antiviral use by staff should be based on individual risk assessment and documented. Refer to the CDNA National Guideline for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection in Residential Aged Care Homes for more detailed information on influenza prophylaxis and treatment.
- In the event of critical staff shortages, liaise with the Australian Government Department of Health and Aged Care if serious concerns regarding continuity of care or resident welfare.
    - The Australian Government have a range of supports for aged care providers and workers, including a surge workforce program which can be initiated by emailing AgedCareCOVIDEnquiries@health.gov.au.

Step 6: 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.
- Notify the **Australian Government Department of Health and Aged Care** 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 or have a confirmed ARI 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 7: ACTIVATE OUTBREAK MANAGEMENT PLAN (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.
- See Outbreak management planning in aged care for information on how to develop an OMP.

Step 8: 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 requirements, 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. See the Australian Commission on Safety and Quality in Health Care for resources.

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. Generally, this is 7 days after the last case tests positive or the date of isolation of the last case in a resident, whichever is longer.

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 5**) 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, 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, Influenza and RSV) in Residential Aged Care Homes
- First 24 Hours Checklist – Managing COVID-19 in a Residential Aged Care Home
- Infection prevention and control lead/s – Further information on the role of an IPC lead in RACF
- 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.

Vaccination

- The Australian Technical Advisory Group on Immunisation (ATAGI) - Advice on the National Immunisation Program and immunisation.
- Australian Immunisation Handbook – Clinical advice on the safe and effective use of vaccines in practice.

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

Influenza Vaccination

- Australian Government Department of Health and Aged Care. Influenza (flu) vaccine. Information about the influenza vaccine, who it is recommended for, how and where to get vaccinated.

RSV Vaccination

- Australian Immunisation Handbook: Respiratory syncytial virus (RSV)

NSW Health

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

Clinical Excellence Commission

- Infection Prevention and Control Manual - COVID-19 and other Acute Respiratory Infections - 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 Healthcare has developed a series of resources for aged care services providers on infection prevention and control in aged care.
- 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 COVID-19 exposure and suggested actions

RACFs may implement additional mitigation strategies for contacts of COVID-19 cases, including mask wearing and avoiding common areas.

Staff	Residents
Exposure Definition A worker has been exposed to a COVID-19 case within or outside the residential aged care facility • no adequate PPE (N95/P2 masks, eye protection) during aerosol generating procedures or behaviour • at least 15 minutes face to face contact where both mask and protective eyewear were not worn by exposed person and the case did not wear a mask **OR** • greater than 2 hours of exposure in the same room with a case with inadequate PPE	**Exposure Definition** A resident or residents have been exposed to a COVID-19 case within or outside the residential aged care facility • 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 • Review affected staff to assess risk of exposure. • If staff exclusion* 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), ➢ Daily RATs (until day 7). ➢ Isolate immediately if symptomatic or testing positive even if asymptomatic ➢ Avoid staff redeployment to unaffected areas to minimise risk of potential spread. ➢ Avoid shared space or meal rooms. ➢ Work in P2/N95 masks for the first 7 days following exposure.	**Management** • **If resident chooses to isolate** • Isolate for up to 7 days. • Test↑ (PCR if available, or RAT) day 2 and day 6. OR **If resident chooses not to isolate** • Consider allowing residents to leave their room after risk assessment, and with ➢ Baseline and day 6 PCR, or ➢ RAT at least every second day from day 0-7. • If RAT negative, enable socialisation by choice of resident with others who have similar exposure level in the affected area or wing. • If symptoms develop, isolate, and do a RAT and, if negative, do a PCR test. • Resume normal activities after day 7 with a day 6 negative result and asymptomatic.

Note: 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 V4.3) (nsw.gov.au)

*Staff should talk to their employer about their return to work and take additional risk mitigation measures in line with industry guidelines and local policies

↑Testing and isolation: Individuals are not considered a contact if the exposed staff, patient, or visitor has recovered from COVID-19 infection, is not immunocompromised and the exposure has occurred within 5 weeks of the previous test. However, immunocompromised individuals (staff or patients) may be requested to meet the criteria below:

- Negative RAT on at least two consecutive respiratory specimens collected at least 24 hours apart, after 7 days have passed since the first positive test; OR
- Negative RAT on at least two consecutive respiratory specimens collected at least 24 hours apart, after 14 days have passed since the since the first positive test.

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 (including combination RAT)	Rapid antigen test. Combination RAT – rapid antigen tests that can detect multiple respiratory viruses e.g. COVID-19, Influenza A and Influenza B.