Guidance for Residential Aged 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 Residential Aged Care Facilities (RACF) on the management of exposures, single cases and outbreaks of acute respiratory infections (ARI) including COVID-19, influenza and other viral respiratory infections.

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

Overview

- Acute respiratory infections (ARI) as defined in this document encompasses a range of infections caused by respiratory viruses, including COVID-19 and influenza.
- ARI transmission is primarily via droplet and aerosol spread when infected individuals cough, sneeze, talk or shout.
- Many ARI 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 ARI are often similar regardless of the virus causing illness and therefore testing residents with symptoms is essential to diagnose an index case.

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 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, 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 tested 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. 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.

Preparedness

All RACFs must have appropriate preparedness plans in place to ensure a prompt response to a facility ARI outbreak.

A preparedness 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 RACF
- Clinical management and treatments for residents
- Laboratory testing arrangements
- Enhanced infection prevention control strategies, including regular staff training and monitoring
- Arrangements for increased PPE, hand hygiene and cleaning supplies
- Staff training on ARI outbreak response
- Establishing workforce surge capacity
- Promoting resident and family communication
- Alternate arrangements for resident leisure and lifestyle maintenance

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

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

See section above for ARI symptoms

RACF must consider the Chief Health Officer Advice in relation to screening for visitors and staff prior to entry into the facility.

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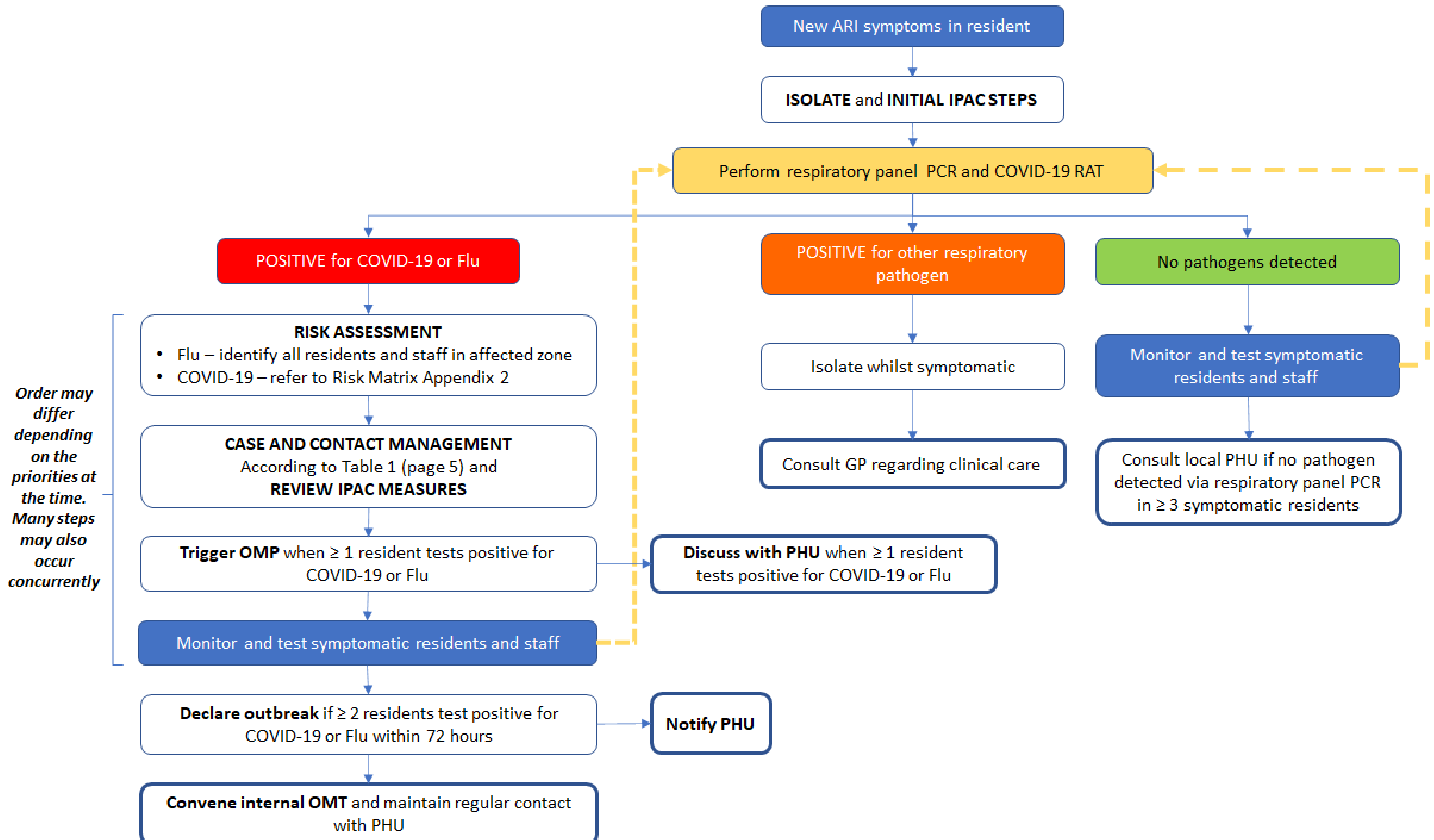
Overview of initial actions – New ARI Symptoms in a Resident



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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 symptomatic resident immediately in their own room if possible and implement initial infection prevention and control (IPAC) steps 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 and influenza means earlier treatment and control of any potential outbreak.

Facilities should work with the GP on a process to ensure residents are tested quickly; this may include having tests pre-ordered on pathology forms in the event a resident is symptomatic.

- Initial testing of residents with ARI symptoms should be respiratory virus testing by PCR with a COVID-19 Rapid Antigen Test (RAT) done at the same time.
  - Facilities should consult with their laboratory provider to establish what types of respiratory viral testing is available
  - Facilities should consult the GP on whether test requests should be for COVID and influenza or COVID and respiratory viruses.
  - Facilities should clearly identify the name of the RACF on the order form and ensure the requesting doctor's details are complete.
- Ensure all symptomatic residents remain isolated until initial testing on these residents is complete and 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 via respiratory panel PCR for three or more symptomatic residents, facilities should contact their PHU for advice.

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

This step maybe performed concurrently with Step 4.

- Trigger 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 and test symptomatic residents as per Step 1 and Step 2; furlough and test symptomatic staff.
- Establish a red zone as per IPAC measures (step 6). Review measures implemented and identify and address any gaps.
- 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 in the red zone should be tested by PCR and RAT to find cases, irrespective of whether they have symptoms. Generally, where an exposure is unknown or unclear residents in the red zone should be considered moderate 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. **For single cases with no clear source of infection, or multiple cases among residents, consult the local PHU as assessment and management of contacts may differ**.
- In assessing contacts of a positive influenza case, RACF 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).

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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	10 days from symptom onset or test date if asymptomatic	5 days from symptom onset	Whilst symptoms remain
		Release from isolation	After day 10 if no symptoms for 24 hours. No testing required. Refer to CDNA guidance for other scenarios	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** OR Day 10 if no symptoms for 24 hours (no testing)	After 5 days from symptom onset. No testing required	Once symptoms resolve. No testing required
	Visitors	Visitors to facility	Can visit facility after Day 10 if no symptoms	Exclude from facility for 5 days from symptom onset	Exclude if symptomatic
CONTACTS*	Resident	Contact testing (initial round of testing to find cases where case pathogen confirmed)	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	
		Contact post-exposure prophylaxis (PEP)	Nil	Flu antivirals to be considered in outbreak	
	Staff	Return to work	See Appendix 2 Risk Matrix	Immediately if no symptoms. Must wear mask and other PPE when at work	

** Staff members who worked or other residents within the same zone as confirmed case.*

*** If test positive on 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 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 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), with negotiation with the service provider if the resident has COVID-19 or influenza or has been exposed to COVID-19 or influenza.
- Residents' GPs will continue to provide their routine primary care as needed either onsite and/or virtually.
- Residents in the green zone (see step 6) are able to attend external appointments.

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- 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 cases, plan for how resident could be supported with visits)
- Facilities should promptly discuss the need for antiviral medications with the prescribing GP.
- Staff returning to work following 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 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.
- If practical, where more than one resident case is positive (with the same organism) the residents should be cohorted together for ease of management. Residents of similar exposure can also be cohorted together.

Step 5: NOTIFICATION AND REPORTING

- Discuss as required with the local **public health unit** when one resident has tested positive for COVID-19 or influenza.
- Notify the local **public health unit** of an OUTBREAK when 2 or more residents test positive to COVID-19 or influenza within a 72-hour period. It is the is the responsibility of the local **public health unit** to report Influenza outbreaks to the Commonwealth.
- Register positive Rapid Antigen Test with Service NSW
- Cases of COVID-19 or influenza in staff members are not a trigger for an outbreak response. Exposures to residents, visitors or other staff should be managed as per the matrix at Appendix 2.
- Where PCR test results are delayed, notify local **public health unit** when 2 or more residents have ARI symptoms in a 72 hour period.
- Notify the **Commonwealth** via the My Aged Care provider portal of positive COVID-19 case. The Commonwealth does not need to be notified of influenza positive case.
- 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:

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: 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.
- **Cohort, zone and relocate**
  - Identify the areas of the facility that are at risk. Where the whole RACF is impacted whole-of-facility actions should be taken. Where only a wing or floor of the RACF is impacted **only** that area should be managed as an outbreak site.
  - 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

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- Allocate staff to colour zone for the duration of the outbreak
  - Cohort staff to work in only one part of the facility
- **PPE**
  - N95/P2 respirator mask, eye protection, gown and gloves to be worn by staff caring for positive residents with ARI
  - Where possible and where able, isolating residents should wear 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 applicable when either COVID-19 or influenza viruses are circulating.

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 communications strategies need to be considered for residents who may have difficulty following instructions due to cognitive impairment or language barrier.
- Ensure residents' **family and carers** are aware of the exposure/outbreak at the RACF and status of individual residents, including their diagnosis and management.
- Ensure **staff** are aware of the exposure/outbreak at the RACF and remain on high alert monitoring themselves and residents for ARI symptoms.
- Ensure **visitors** are aware of the exposure/outbreak at the RACF and that **essential visitors** are permitted to continue to visit affected residents, including those considered to be high risk and in designated red zones. Essential visitors include: carers and usual 'partners-in-care', named visitors, people who provide personal care; those visiting a resident who is at/approaching end of life. Visitors must comply with RACF entry requirement, including RAT, PPE 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 Aged Care Act 1997, the Charter of Aged Care Rights and the Aged Care Quality Standards include specific responsibilities that provide a legislative basis to this requirement. See More Information
- The RACF may arrange virtual (e.g. iPad) or contactless visits for unvaccinated visitors. (e.g. window visits)
- 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.

Step 8: ACTIVATE OUTBREAK MANAGEMENT PLAN

See Outbreak management planning in aged care for information on how the develop an OMP.

- The facility should activate their RACF 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 or 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. This threshold will have to be met to access Commonwealth supports.
- Once an outbreak has been declared, the facility should convene an internal outbreak management team (OMT) meeting and confirm the RACF staff members who will be designated:
  - Outbreak Management Lead and
  - Infection Prevention and Control lead
- The facility should remain in regular contact with the PHU.
- The PHU will determine whether an inter-agency OMT meeting is required in a COVID-19 outbreak.

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Where an inter-agency meeting is required to manage a COVID-19 outbreak, facilities should refer to the Protocol to support joint management of a COVID-19 outbreak in a residential aged care facility in NSW.

Step 9: DECLARING AN OUTBREAK OVER

- A decision to declare the outbreak over should be made by the OMT, 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 RACF.
- 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 RACF 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 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 situation

New and returning residents to RACF from hospital or emergency department

The presence of an outbreak should not prevent new and returning residents from being admitted/re-admitted to the facility with appropriate infection prevention and control measures in place. Decisions should be based on the advice of the local OMT and in consultation with the PHU, residents and their representatives. For more information, refer to Additional public health advice for residential aged care facilities (RACF)

Resident choice around isolation

Consumer dignity and choice is foundational standard 1 in the National Quality Standards

Residents should be given the choice to self-isolate while the outbreak is in progress or to mix with people with similar exposure. Their preferences should be recorded in their care plans and regularly reviewed. Residents should be made aware that if they choose to not isolate during an outbreak this may increase their risk of catching the infection.

Where it is practical, and the facility can manage this:

- Residents with the same condition should be allowed 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 exposed or 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 exposed area. Exposed residents should not socialise with positive cases or residents from unaffected areas. COVID-19 exposed residents should perform daily RAT before leaving their room.

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).

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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 practical 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.
- Emergency PPE and RAT supply for RACF COVID-19 Outbreak or Exposure– link to the Commonwealth Department of Health ordering form for emergency PPE and RAT supply.
- CDNA national guidelines for the prevention, control, and public health management of COVID-19 outbreaks in residential care facilities in Australia
- CDNA national guidelines for the prevention, control and public health management of influenza outbreaks in residential care facilities in Australia
- First 24 hours Checklist
- Being Prepared Outbreak Checklist
- Ensuring safe visitor access to residential aged care

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 - Residential Aged 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
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

Actions based on risk classification for exposure at a Residential Aged 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.	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 space or 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 space or meal rooms. Limit work to single site/area. Continue to isolate in community until negative Day 6 RAT/PCR 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 RACF until after day 7 if negative Day 6 RAT.	Follow Information for people exposed to COVID-19 factsheet Do not attend RACF 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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