

Incident Action Plan for a public health response to a confirmed case of COVID-19 in an Aged Care Facility



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Revision history

Version	Date	Changes
1.0	24/05/2020	Initial Release
1.1	12/6/2020	Updates following PHU consultation and hyperlink corrections
1.2	20/07/2020	Updates to references to CDNA Guidelines

Purpose

The [CDNA guidelines of outbreaks in Residential Care Facilities](#) provides the background and overall approach to an outbreak of COVID-19 in a Residential Aged Care Facility (ACF). This Incident Action Plan should be used in conjunction with the [CDNA Guidelines](#), where detail of approaches is provided. The operational elements of the response, described herein, are supported by concurrent governance oversight, executed through the Senior Intergovernmental Oversight Group.

The purpose of this document is to **guide public health operations** and prevent further transmission by rapidly supporting the Aged Care Facility (ACF) with clear **public health advice** after a confirmed case of COVID-19 is identified associated with an ACF.

In a parallel and support arrangement, a Senior Intergovernmental Oversight Group (SIOG) is also convened to provide advice on governance and coordinate intergovernmental support. The SIOG includes NSW Health and the Commonwealth (Department of Health, Aged Care Safety and Quality Commission (ACSQC)). A protocol to frame the functions of this group has been developed. The Outbreak Management Team (OMT), detailed in this document, will be represented on the SIOG through the public health representative nominated by the Head of public health operations COVID-19. While not having a technical role, the SIOG addresses issues that impact on the public health response and clinical care and safety.

The gravity of COVID-19 infections in ACFs cannot be understated. Residents live in close proximity, many with multiple pre-existing morbidities. Fatalities from COVID-19 have chiefly been in the aged. By March 2020, all-cause mortality in ACFs in the United Kingdom had increased by 159% since the start of the COVID-19 epidemic. During a two-week period in March 2020 in northern Italy, it is estimated that upward of 9% of residents in ACFs died as a result of COVID-19. The outcomes are determined to a large extent by the duration and infectivity of COVID-19 case and hence the importance of the preventative symptom screening for staff and visitors and low threshold for testing residents and staff.

Principles

1. **Be prepared:** ACFs, in collaboration with LHDs, are to have in place measures to prevent and be ready for an outbreak. At a minimum this includes:
 - a. Have current plans, expertise and resources for infection prevention control, outbreak management, and workplace health and safety;
 - b. Staff education and training about infection control principles;
 - c. Exposure prevention, including self-screening of staff, active surveillance of ILI and non-pharmaceutical measures to prevent infection; and
 - d. Staff and clinical surge capacity.
2. **Respond rapidly and comprehensively:** Stepping back is possible when there is confidence that the situation is controlled.
3. **Intervene early:** A low threshold for investigation and intervention upon any notification of respiratory illness in an ACF is critical. A single confirmed case of COVID-19 will trigger the use of this Incident Action Plan.
4. **Ensure authority is exercised:** ACFs are charged with the authority of managing the outbreak, in using the same processes as for an influenza outbreak under the Aged Care Act 1997. A supportive environment for strong decision making is needed. Strong leadership and management and follow through of agreed actions is essential. Unresolved issues must be rapidly elevated to senior management and/or oversight agencies and raised at the SIOG.
5. **Test widely to identify other cases:** Undertake broad, early and sometimes repeated testing to identify associated cases in this setting. The risk of ongoing transmission may necessitate prolonged periods of isolation and must be monitored by early and repeated testing of residents

and staff¹.

6. **Maintain the clinical and welfare needs of residents as a priority:** Primary health care needs remain of high importance to maintain health in a frail population. Engage clinicians within the ACF if access to usual supports are limited. The SIOG should support the ACF in addressing the clinical care needs within the facility. SIOG protocol available at Appendix 5.

Outbreak Management Team

This IAP focusses on the public health actions within the context of the health and aged care sector response. It recognises that the Outbreak Management Team (OMT) is operationally focused, and both informs and is informed by agencies responsible for governance, standards, and logistics support.

The time critical and ongoing operational requirements of the outbreak necessitate regular meeting of the Outbreak Management Team to support the facility in their response. The primary objective is to interrupt any ongoing transmission, control the environment to avoid any further disease and ensure resident and staff clinical and welfare needs are met.

<p>Outbreak Management Team (meet at least daily until the outbreak is controlled) Lead: Aged Care Facility Manager/PHU director or delegate</p>		
Approved Provider of the Aged Care Facility	Manager, clinical supervisor, Agency CEO	As relevant
Local Health District	Public Health Unit – Director or senior delegate Clinical representative Infection Prevention and Control (IPC) clinical lead	Email: Use specific PHU address Phone: 1300 066 055
Public Health Response Branch (PHRB)	Deputy Controller, Operations team	PHRB Operations Email: moh-pheooperations@health.nsw.gov.au moh-deputycontroller@health.nsw.gov.au Phone: 02 9391 9542

¹ There are several reasons for this:

- ACF residents are at high risk of serious illness and death from COVID-19. This is a high consequence setting for an outbreak.
- There is a broad range of COVID-19 symptomatology:
 - ACF residents may not report or display classic symptoms of respiratory infection. More subtle signs such as behaviour disturbance, low grade temperature, loss of appetite and tiredness may not be immediately identified as indicating acute illness.
 - ACF staff may experience very mild symptoms or be asymptomatic, while still posing a transmission risk

ACF staff may experience barriers and even disincentives to report symptoms or seek testing. Media scrutiny of previous ACF staff cases, lack of access to paid leave entitlements and fear of repercussions may contribute to hesitancy to seek testing. ACF staff should be supported to access early and repeated testing as required.

Health and Social Policy Branch (HSPB)	Director or delegate	Email: MOH-HSPB@health.nsw.gov.au Phone: 02 9391 9512
NSW Health Clinical Excellence Commission (CEC)	Senior Manager, Healthcare Associated Infections (HAI), or delegate	Email: CEC-COVID19@health.nsw.gov.au Phone: 02 9269 5500
Commonwealth Department of Health	State Manager NSW and ACT, Department of Health, or delegate	Email: AgedcareCOVIDcases@health.gov.au Phone: 02 6289 1555

Roles and responsibilities

Details of the roles and responsibilities of public health stakeholders. The Outbreak Management Team has a focus on the public health and clinical elements of the response.

The OMT and the SIOG will convene on the basis of a single confirmed case of COVID-19 in a resident or a staff member who worked while infectious within an Aged Care Facility.

Approved Provider of Aged Care Facility (AP)²

Role

To manage the outbreak as required by the Aged Care Act 1997³

Tasks

- Direct, monitor and oversee the outbreak response within the facility.
- Co-chair daily meetings of the Outbreak Management Team.
- Liaise with the PHU.
- Commence Outbreak Management Plan as per CDNA Guidelines for outbreaks in residential care facilities [<https://www.health.gov.au/resources/publications/coronavirus-covid-19-guidelines-for-outbreaks-in-residential-care-facilities>] and Quality Standard 3 ACQSC [<https://www.agedcarequality.gov.au/providers/standards/standard-3>]
- Immediately institute infection prevention and control measures. These include:
 - Isolating all cases and separating residents in a way that minimizes potential for transfer of
- _____
- ² The Approved Provider of an Aged Care Facility executes its role under the Commonwealth legislation (Aged Care Act 1997). Approved providers are expected to meet a series of quality standards. Standard 3 specifies that consumers can expect to receive a standard of care concomitant with need, and the organisation meet its obligation to 'deliver safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer's needs, goals and preferences to optimise health and well-being'.

³ The Aged Care Act 1997 is the overarching legislation that outlines the obligations and responsibilities that Approved Providers of aged care facilities must follow to receive subsidies from the Australian Government.

infection (“cohorting”). Nursing and carer staff are allocated to specific wings of the facility without roles across wings.

- The senior clinical lead (for example, clinical supervisor) to instruct on PPE/hand hygiene/environmental cleaning [see standard precautions [CDNA guidelines p. 19](#) and [CEC Infection Prevention and Control Guidance for Residential and Aged Care Facilities](#)].
 - Institute contact and droplet precautions [see standard precautions [CDNA guidelines](#) and [CEC Infection Prevention and Control Guidance for Residential and Aged Care Facilities](#)]. Full assessment of facility to ensure infection control occurs throughout the facility (e.g. food trolleys, medication trolleys).
 - Visible signage throughout the facility [see signage [CDNA guidelines](#)].
 - Request the designation of a compliance officer role (to be provided by the LHD – IPC Lead). If required, will seek support through CEC to support adherence to PPE.
 - The ACF clinical lead to certify that all staff entering the facility are aware of the outbreak response and trained in the use of PPE prior to working their shift.
- Ensure proper regularly cleaning throughout [see standard precautions [CDNA guidelines](#) and [CEC Infection Prevention and Control Guidance for Residential and Aged Care Facilities](#)]. Review kitchen and food deliveries to patients to ensure procedures are in place to prevent transmission.
 - Restrict visitors and all other people entering the facility (including health workers) to minimal essential requirements. Non-essential visitors will be precluded from face to face meeting residents [detailed in [CDNA Guidelines](#) and [CEC Infection Prevention and Control Guidance for Residential and Aged Care Facilities](#)]. Keep a log of all visitors entering the facility, including areas and residents visited.
 - Manage staff, including isolation measures for exposed staff.
 - Ensure sufficient staffing including engaging surge workforce.
 - Monitor and maintain resident welfare and well-being.
 - Proactively regularly communicate with residents and their families.
 - In coordination with the Senior Inter-governmental Oversight Group liaise with GP and allied health personnel to ensure approach to acute and chronic disease is addressed, and de-conditioning, grief and psychiatric sequelae of isolation and loss are addressed.

Local Public Health Unit (PHU)

Role

Lead the public health response and support the ACF in executing its role

Tasks

- Notify the PHRB of any confirmed cases associated within an ACF (thus triggering this Incident Action Plan).
- Establish Outbreak Management Team immediately, convene as soon as possible, and subsequently arrange daily meetings until outbreak is closed.
- Co-chair daily meetings of the Outbreak Management Team.
- Active surveillance, investigation and management of cases in staff and residents. Interview the case(s), with NCIMS case questionnaire, and confirm swab results. Sample script for case (staff and resident) interview is provided in appendix 4.

- Undertake contact tracing and management of contacts outside the ACF.
- Advise the ACF on management of contacts within the ACF.
- Support and instill confidence in the ACF manager to respond to the outbreak.
- Ensure that public health and initial infection control measures are implemented to control the outbreak. If barriers are identified escalate to Senior Inter-governmental Oversight Group to ensure appropriate resourcing and outcomes.
- Where the PHU has limited capacity to respond, the PHU should escalate to the LHD CE about surge support and discuss with PHRB.
- Regularly liaise with the PHRB on the response and seek support immediately where containment issues are identified.
- Develop a plan for on-going testing of residents and staff following assessment of the initial rounds of testing.

Public Health Emergency Operations Centre (PHRB)

Role

- Supporting the local PHU
- PHRB operations team are the key liaison point for public health response

Tasks

- Support the PHU in its initial action in a) convening Outbreak Management Team, and b) ensuring effective management of the public health aspects of the incident.
- A PHRB Deputy Controller/Senior Medical Adviser and Operations team member will be assigned to assist in the management of the outbreak.
- Liaison will encompass:
 - Communication with other LHDs.
 - Share information with Senior Inter-governmental Oversight Group, and other stakeholders, in support of PHU.
 - Provision of regular updates to the Chief Health Officer.
 - Clarity and accuracy of messaging to government and external media requests.
- Notify the Aged Care Quality and Safety Commission of all cases, deaths, and when the outbreak is closed.
 - Contact: Ann Wunsch, Executive Director COVID-19 Taskforce, M: 0409 977 061, E: ann.wunsch@agedcarequality.gov.au
- Notify the Department of Health of confirmed cases associated within an ACF.
 - Contact: AgedcareCOVIDcases@health.gov.au and Lisa Peterson, State Manager HGND NSW and ACT Branch lisa.peterson@health.gov.au

Local Health District (LHD)

Role

- Establish clinical outreach team, infection control and testing requirements
- And support clinical governance within the ACF

Tasks

- Determine clinical lead and outreach model (GP/HITH sell out/geriatric outreach model) with specialist clinician support (e.g. geriatrics, infectious diseases, palliative care) to maximise clinical care of residents both COVID-19 positive and negative.
- Determine, through the LHD Clinical Governance mechanisms, the level and type of specialist and support care required (for example,
 - infectious disease, palliative care, geriatrics, allied health).
- Assist the ACF, through the support of clinical staff and laboratory resources, to achieve swabbing of all residents and staff (See appendix 3). Support for phlebotomy may also be needed.
- Support staff/GPs to provide appropriate patient-centred care, and develop advance care plans for residents (if not in place already).
- Liaise regularly and provide clinical advice and support to GPs.
- Determine processes for clinical deterioration: care in ACF/transfer to hospital.
- Provision of expert advice to ACF for initial infection prevention and control, with support for monitoring as needed. (Clinical Excellence Commission may be consulted).
- Facilitate testing through provision of staff and laboratory processing.

Tasks of the Outbreak Management Team

The Outbreak Management Team must be convened by the PHU as soon as the case is confirmed and adopt a regime that ensures a rigorous and comprehensive approach early, and persists until there is confidence that a level of withdrawal concomitant with the progress of the outbreak can begin.

Establish strong management structures and process to manage the outbreak

- Support the ACF to assume control of the Incident. If the ACF is lacking that capability or implementation gaps are evident, the PHU (supported if needed by PHRB) should raise this concern at first opportunity with Senior Inter-governmental Oversight Group to take appropriate action to support implementation.
- Perform an initial assessment of risk of spread through the facility and conduct a site visit⁴.
- Meet at least once daily. Undertake regular communication with other agencies as appropriate, including the NSW Health media team.

Implement control measures

- The detail and breadth of measures are provided in the CDNA guidelines pp 16 – 20. These include restriction of visitors, restricting the movement of residents and ceasing group activities, cohorting
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⁴ Initial site visits enables establishing relationships and deepening understanding of the site. Any entry into the precinct of the facility must be undertaken with the highest consideration of PPE.

cases and staff. Signage, hand hygiene resources and PPE should all be available with vigilant oversight of infection prevention and control activity by the clinical lead. Implement prescribed cleaning and waste disposal measures. Staff are to have a health and temperature check on arrival, and advised of the risk they pose if working at other residential settings. Redesign all food preparation and distribution, and handling of crockery and cutlery, processes to avoid droplet/fomite transmission.

Identify and investigate all cases

- All staff and residents to undergo testing (bilateral oropharyngeal and bilateral nasal swab – single swab). The technique is described in the [CDNA guidelines](#) Appendix 4. Changes to this recommendation should be checked against any update of the [CDNA guidelines](#). The Local Health District is to assist with resources to assist in initial testing rounds if required.
- Confirm laboratory capacity and processes to ensure expedited testing and results (including negative results) communication. Specimens should be labelled as priority (ACF outbreak) and the microbiologist notified of urgent testing requirement.
- The ACF will maintain a line list of cases of in residents and staff.
- Use Commonwealth-supported private laboratories [<https://www.dhm.com.au/covid-19/aged-care-facility-acf/>] if local laboratory capacity is inadequate. Maintain all testing within the one laboratory.
- Confirm swab results and communicate results. Staff are to be notified directly of their results through usual mechanisms; resident results will be communicated through facility managers to residents and/or their families.
- Complete case questionnaire for staff (TBA; see appendix 4). Consider the need for resident case questionnaire (standard form is attached TBA).
- Develop a program of testing for each affected and non-affected resident and staff member until the outbreak is considered controlled. The PHU will determine frequency of the testing regime, based upon the circumstances of the incident. Typically, all residents in affected wings will be tested 2 – 3 times weekly, and in non-affected sections of the facility with similar frequency, although diminishing with control measures established.

Resident welfare and appropriate management of cases

Resident welfare and appropriate management of cases is maintained by the clinical teams, including virtual care service, HITH, Allied Health, Nursing and General Practice. The ACF Clinical Lead will coordinate this process. Actions will include:

- Establish a communication strategy for staff, each resident and their family.
- Confirm clinical care plans, including Advance Care Plans, are established for all residents, including appropriate isolation. Ensure appropriate level of clinical monitoring for all residents with COVID-19.
- Find additional cases through regular clinical review, in addition to the testing regimen. A high level of vigilance is required for any symptoms, low grade fever, or subtle deterioration of condition (e.g. off food, fatigue, loss of balance). Regular observations, with intensity tailored toward the level of risk, should be implemented.
- Ensure regular medical needs are addressed for all residents. Consideration should be given to engagement of general practitioners and other allied health practitioners to address these
- requirements. Establish communication arrangements with residents' usual GPs.
- Document sentinel indicators of resident deterioration, for example, falls, weight loss, pressure sores.
- Identify and advise on resident mobilisation.

Process

1. Notification of suspected or confirmed cases

- 1.1. The PHU or PHRB receives notification of a suspected or confirmed COVID-19 case in an ACF. The PHU informs the PHRB or vice versa and the PHU establishes the OMT. The PHU and PHRB should confirm with each other the lead response agency and the respective roles and responsibilities of PHRB and PHU.
- 1.2. The PHU informs the ACF manager of the positive test result and includes the ACF's senior leadership and PHRB in initial planning. If ACF is aware of possible or suspect case, outbreak measures should already have been implemented.
- 1.3. PHRB notifies the Aged Care Quality and Safety Commission (ACQSC).

2. Immediate response

- 2.1. The PHU advises the ACF to establish and implement processes for an influenza-like-illness (ILI) outbreak. This includes daily updates of the line listing (see attachment), reporting all deaths, and implementing infection prevention and control measures.
- 2.2. The PHU works with the ACF to consider immediate risk management activities to mitigate potential risk while public health investigations are ongoing, such as PPE and hand hygiene stations for staff, and suspension of group activities and visitors.
- 2.3. If the case is a resident, the ACF should isolate the case in a single room with a private ensuite. If not available, alternative accommodation arrangements are required. All staff who need to enter the room should wear full PPE (gown, gloves, eye protection and mask – surgical or P2/n95 depending on the degree of resident illness and care delivered). Hand hygiene stations should be established throughout the facility to increase routine hand hygiene, particularly before and after entering the affected resident's room. The resident should not attend communal meals, but rather have their meals and any other care needs managed in their room. They should not share their bathroom facilities. Any items that are removed from their room that may be contaminated with body fluids should be treated as infectious.
- 2.4. Conduct a teleconference of the Outbreak Management Team within 12 hours of notification. The primary goals are to identify the respective team members involved, clarify the ACF's responsibilities and plan for the outbreak management. All members of the OMT should attend if possible, but if not, essential participants include: the ACF's local and organisational management (co-chair); PHU (co-chair); PHRB Ops; infection control specialists (e.g. IPC CNC, Clinical Excellence Commission (if available)).

3. Situational assessment

- 3.1. Where possible, key response personnel undertake a site visit (for example, PHU +/- PHRB, clinical and infection prevention and control (IPC) staff) to enable assessment of facility layout (understanding pathways of infection, cohorting possibilities), personnel and roles, standards of infection prevention and control, etc. The required personnel of the initial site visit will be determined at the initial meeting of OMT. The site visit should be restricted to essential staff, and any staff attending onsite should have a current influenza vaccination. A site visit may pose challenges in regional areas; alternatives in these settings should be considered (for example, linking with a local health facility).
 - 3.1.1. Site assessment will gather maps of the facility, dining charts for communal areas, resident's clinical progress notes (to support identification of any earlier symptoms, this should go back at least 4 weeks prior to the first identified case), staff contact lists and rosters.
- 3.2. An onsite IPC assessment by the LHD is required in the early phase of the response. Identifying IPC expertise and consultation early is a priority, to prevent ongoing transmission between residents, residents and staff, and between staff. Ideally this should be identified within the staff of the ACF or alternatively sourced through the Commonwealth's surge initiatives. This can be

supported by the Clinical Excellence Commission.

- 3.3. The following risks are considered and addressed for site visit:\
 - 3.3.1. Consider information provided prior to attending the facility and methods of minimising the risk of transmission to any field staff.
 - 3.3.2. Ensure that appropriate personal protective equipment (PPE) is available and that all field staff are trained in use.
 - 3.3.3. Consider ways to minimise risk to field staff if interviewing potential cases or contacts face-to-face.
 - 3.3.4. Field staff should be prepared to collect swabs and arrange testing, if required.
- 3.4. If the ACF requires support in accessing appropriate PPE resources, this should be escalated to the Senior Intergovernmental Oversight Group.
- 3.5. The PHU conducts the case interview and determines all close contacts. All residents identified as close contacts should be isolated in their own single room, preferably with a private ensuite, for 14 days and managed with the same infection control procedures as a confirmed case. Any staff members who are close contacts should be sent home immediately to isolate for 14 days. This may have a substantial effect on safe rostering in an ACF. The ACF should be supported to identify surge staff resourcing, including escalating to the Commonwealth if required.
- 3.6. If the ACF is unable to isolate cases or contacts appropriately, such as because of a lack of single rooms, consideration should be given to alternative accommodation (for example, hospital) for residents to enable isolation. This will be a discussion by the OMT, with assessment of capacity for alternative accommodation with the LHD and the SIOG. The decision needs to be balanced with the negative health impacts of moving residents to an alternative facility, the clinical needs of the residents, and the potential ongoing public health risks within the ACF and alternative facility.
- 3.7. Broad baseline PCR testing is undertaken. This includes all staff and residents of the facility. An alternative to full resident and staff testing should be considered by exception only, where there is documented evidence that there is no risk of transmission to others (for example, non-infectious while at ACF, evidence of rigorous use PPE). This may need to be repeated at staggered periods over the course of the outbreak. If repeat nasal testing is contributing to unacceptability of ongoing testing, consideration can be given to an alternative of oropharyngeal swabs only. This decision needs to be made in discussion with the ID physician and PHRB Deputy Controller.
 - 3.7.1. Testing of symptomatic persons should include both COVID-19 and respiratory virus multiplex screen on initial presentation of symptoms.
 - 3.7.2. Testing can be supported through collaboration with LHD COVID-19 Clinic staff. Onsite swabbing of staff and residents should be prioritised early in the outbreak response. Specimen collectors should use Appendix 3 Laboratory Request Form to support prioritisation and rapid interpretation of results.
 - 3.7.3. All results (positive and negative) need to be returned as quickly as possible. These should in the first instance be returned to the PHU. All resident results will be forwarded to ACF. Staff results will be communicated directly by laboratory (text message for negative results) and/or PHU.
 - 3.7.4. Assess the capacity of the local laboratories to undertake the screening required. Alternative support through Douglass Hanley Moir Pathology (Sullivan and Nicolaidis Pathology in Northern NSW) is available [contact number 1800 570 573] if demand exceeds local capacity. It is important that a single location of specimen testing prevails throughout the outbreak. Use of multiple laboratories is discouraged. If DHM or S&N are engaged, they should continue to handle all specimens.
 - 3.7.5. GeneXpert testing may be preferred testing if available and the timeliness of its results will

direct immediate action.

3.7.6. If any other resident of the ACF becomes symptomatic or dies during the outbreak, they should be tested urgently. If this occurs between planned large scale testing, NSW Health Pathology courier can collect a sample collected by ACF staff to facilitate urgent testing. The Appendix 3 PHRB Laboratory Request Form should still be used.

3.7.7. Serology testing may be requested for specific residents or staff if necessary, for example to assist with the investigation of source of infection or to confirm a test result.

4. Ongoing response

- 4.1. Residents with COVID-19 should remain in the facility if possible and if this is consistent with their wishes, or in accordance with their Advance Care Directive. The resident should be transferred to hospital if clinically indicated. If any resident needs to be transferred to hospital, the ACF should advise the ambulance and hospital beforehand that the resident is from a facility with a COVID-19 outbreak. The ACF should provide the PHU with relevant clinical notes of cases and close contacts, and other relevant information such as contact details of staff, residents and visitors, and staff rosters and visitor logs.
- 4.2. Ongoing infection prevention and control (IPC) support is vital to reduce ongoing transmission. This is best achieved through the presence of onsite IPC staff, allocated by the ACF, who monitor the use of PPE and provide ongoing education and reinforcement of best practice. The initial onsite assessment to support the public health investigation will address capacity (by local Infectious Disease or IPC staff, or PHRB). PHRB or the LHD may advise the Commonwealth that urgent support to provide oversight is needed. Consultation with the Clinical Excellence Commission [Email: CEC-Info@health.nsw.gov.au] is advised.
- 4.3. If any subsequent cases are identified, the PHU/PHRB will manage public health follow-up including further contact tracing.
- 4.4. PHUs also manage contact tracing for close contacts who are not ACF staff or residents. The PHU should provide details of close contacts in other LHDs to PHRB for forwarding to the relevant PHU. If the PHU states that they are not able to reach close contacts for tracing, assistance can be requested from the Centralised Contact Tracing Team (within PHRB).
- 4.5. Close contacts will be followed up on a regular basis by the PHU or the Centralised Contact Tracing Team. Close contacts will be entered onto NCIMS.
- 4.6. Regular contact should be maintained between PHU, PHRB, and the ACF until the outbreak is declared over via the daily OMT meetings and in between these as required. PHU and PHRB should plan for relevant communication activities including media. PHRB should provide relevant updates to ACQSC.
- 4.7. Communication: a daily running sheet of decisions and directions determined at the OMT is maintained by the ACF. PHRB operations team can assist with this documentation if needed. All verbal advice (for example, given by phone) will be confirmed by email, and tabled at the next OMT meeting.
- 4.8. Death certification: Any deaths that occur are to be certified by the treating medical team or the resident's general practitioner. The certifier should assess whether COVID-19 was a primary cause of death, a precedent to the primary cause of death, or an incidental co-morbidity. The certifying medical officer should be familiar with [WHO International Guidelines for Certification and Classification \(Coding\) of COVID-19 as a cause of death \(April 2020\)](#). All deaths in an ACF should receive a post-mortem COVID-19 swab unless collected in the 12 hours prior to death.
- 4.9. Phase out strategy: A number of infection prevention and control measures are utilised to assist the opening up of the facility as the incident comes under control. The risk of resident de-conditioning is balanced against infection transmission. The PHU (with support of PHRB if needed) will develop a matrix of actions around resident isolation, mobility, visitor contact, staff movement, and testing regime, giving careful consideration to risk of transmission at every increment.

- 4.10. Release from hospital: If a case has been transferred to hospital and is ready clinically for hospital discharge, then they can be discharged to isolation at the ACF in line with the CDNA Guidelines. Immediately institute infection prevention and control measures (if not already implemented) and designate staff and carers to the person to limit transmission. ACF residents must not be released from hospital to a facility unless they can be isolated from other residents and managed appropriately. A risk assessment should be done in consultation with the PHU.
- 4.10.1. Release from isolation: The case can be released from ACF isolation if they meet all of the following criteria: At least 10 days have passed since hospital discharge; and
- 4.10.2. There has been resolution of all symptoms of the acute illness for the previous 72 hours; and
- 4.10.3. The case has had two consecutive respiratory specimens negative for SARS-CoV-2 by PCR taken at least 24 hours apart at least 7 days from symptom onset.

5. Closure of the outbreak

- 5.1. The PHU should declare the outbreak over 14 days after the last confirmed case is effectively isolated (consistent with CDNA guidelines). Contact all stakeholders including ACQSC.
- 5.1.1. Depending on the scale of the outbreak, the PHU may consider allowing two incubation periods (28 days) after the last confirmed case is effectively isolated before declaring the outbreak over.
- 5.2. The Outbreak Management Team should consider conducting a debrief with all parties involved. This provides an opportunity to identify strengths and weaknesses in outbreak response and investigation processes, and provide information to help improve the management of similar outbreaks in the future.

Appendix 1 - Template letter, close contact

Dear

Re: COVID-19 at <NAME OF ACF>

You have been identified as a close contact of a person who was recently diagnosed with COVID-19. A close contact has spent significant time either face-to-face (15 mins) or in an enclosed space (two hours or more) with a person infectious with COVID-19.

NSW Health is working closely with the <ACF> to ensure the health and safety of all residents and staff is maintained.

You should remain in home isolation until <DATE>, which is fourteen days from last possible contact. More information about COVID-19 and home isolation is included in the attached fact sheet.

If you develop any symptoms such as a fever, cough, sore throat or shortness of breath, please:

See a doctor (call ahead to alert your doctor about the possibility of COVID-19 before visiting, and take this letter along). As a close contact, you should undergo a throat and nasal swab.

Alternatively, you can attend a COVID-19 Clinic for testing: <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/clinics.aspx>

Please call the aged care facility to let them know that you have developed symptoms and are being tested.

If you have a health condition or complex health needs, please discuss this with your medical specialist.

A COVID-19 close contact fact sheet is available from NSW Health at <https://www.health.nsw.gov.au/Infectious/factsheets/Pages/advice-for-contacts.aspx>.

More information and updates is available at <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/default.aspx>. If you have any further questions that aren't addressed in the NSW Health resources please contact 1800 022 222.

Yours sincerely

<PHU>

<date>

Appendix 2 - Template letter, casual contact

Dear

As you may be aware, a resident/staff member at <ACF> has recently been diagnosed with COVID-19.

NSW Health are working closely with the aged care facility service provider to ensure the health and safety of all residents and staff is maintained. This work includes identifying close contacts of the confirmed case(s). A close contact is someone who has spent significant time either face-to-face (15 mins or more) or in an enclosed space (two hours or more) with a person infectious with COVID-19.

We do not have reason to believe that you are a close contact of the confirmed case. However, you have been identified as a casual contact. Because of your potential exposure to the virus, please be mindful of any symptoms such as fever, cough, sore throat or shortness of breath. If you develop these symptoms, including mild symptoms, please see a doctor (call ahead to alert your doctor about the possibility of COVID-19 before visiting, and take this letter along). Alternatively, you can attend a COVID-19 Clinic for testing: <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/clinics.aspx>. Please let the aged care facility of your current and recent (last 2 weeks) working arrangement know if you develop symptoms and are being tested.

As you have not been identified as a close contact, there is no requirement for isolation at this time, unless you develop symptoms. There is no need for a swab to check for COVID-19 at this time, unless otherwise advised by the investigating team.

If you have a health condition or complex health needs, please discuss this letter with your medical specialist.

Further information and updates are available at <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/default.aspx> If you have any further questions that aren't addressed in the NSW Health resources please contact 1800 022 222.

Yours sincerely

<PHU>

<date>

Appendix 4 – Staff case questionnaire/Resident case Questionnaire

To be inserted.

Appendix 5 – Senior Intergovernmental Oversight Group Protocol to support joint management of a COVID-19 outbreak in a residential aged care facility (RACF) in NSW

To be inserted.

