Australian Government
Department of Health and Aged Care

Outbreaks of Acute Respiratory Infection in Disability Residential Services

Communicable Disease Network of Australia

National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Disability Residential Services

Disclaimer

The Communicable Diseases Network Australia (CDNA) has developed this guideline in consultation with jurisdictions and the disability sector. The Australian Health Protection Principal Committee (AHPPC) has endorsed this guidance on 9 February 2023. Where guidance differs from state and territory policies, disability residential services (DRS) should follow local state or territory requirements.

This guidance recognises the need for providers to move to a risk-based approach for the early identification of acute respiratory infection and management of outbreaks, supported by specific resources and tools provided by jurisdictions and guidance from their local public health unit. This guidance proposes to support DRS to take a more proportionate approach in managing the risk of respiratory infection with consideration of residents' wellbeing, recognising the detrimental effects of social isolation and inactivity.

This document captures the knowledge of experienced professionals and the sector. It provides guidance on good practice, based on evidence available at the time of completion. It is intended to provide nationally consistent risk and principles-based guidance.

This guideline incorporates information adapted from:

- Australian state and territory guidelines for outbreak management in DRS
- documents and guidelines from the Australian Government Department of Health and Aged Care (herein called the Commonwealth) and other Australian health agencies
- international health authorities, including the World Health Organization, the Centers for Disease Control and Prevention (USA), and the Public Health Agency of Canada.

This guideline can assist the following groups in providing best practice information on preventing and managing Acute Respiratory Infection (ARI) outbreaks in DRS:

- administrators of DRS
- staff of DRS
- health and disability support workers
- public health authorities.

Readers should not rely solely on the information contained within this guideline. Readers should use discretion while following these guidelines and seek advice from persons with relevant clinical expertise, as needed. The information within does not replace advice from other relevant sources including more detailed guidance from jurisdictions and/or advice from a health professional.

This guidance is not meant to be exhaustive but instead aims to supplement more detailed guidance available at a state, territory, and institutional level. Where this guidance differs from state and territory policies, local state or territory guidance and policies should be followed. This guidance does not replace existing obligations of providers for the delivery of safe, quality supports and services to people with disability, including obligations of National Disability Insurance Scheme (NDIS) providers under the NDIS Code of Conduct and the NDIS Practice Standards and Quality Indicators. DRS providing clinical care should read these guidelines in conjunction with the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021).

While every effort has been made to ensure the accuracy and completeness of the contents of the guideline at the time of publication, members of CDNA and the Australian Health Protection Principal Committee (AHPPC), and the Commonwealth do not warrant or represent that the information in the guideline is accurate, current, or complete. CDNA, AHPPC and the Commonwealth do not accept any legal liability or responsibility for any loss, damages, costs, or expenses incurred by the use of, reliance on, or interpretation of, the information in the guideline.

Revision history			
Version	Date	Reason / Changes	Endorsed by
1.0	09/02/23	Initial Release	AHPPC

Contents

1. Background

1.1 Purpose

The information in this guideline applies to all Disability Residential Services (DRS) in Australia and can be used to help services with planning, preparation, detection and management of cases and outbreaks of acute respiratory infection (ARI).

This guideline can assist the following groups in providing best practice information on preventing and managing ARI outbreaks in DRS:

- administrators and staff of DRS
- health and disability support workers
- public health unit (PHU)/communicable diseases unit.

This guidance does not apply to residential aged care facilities, long stay hospital wards or rehabilitation hospitals.

Note: This guidance supersedes the CDNA National Guidelines for the Prevention and Management of COVID-19 Outbreaks in Disability Residential Services (also known as the Disability Supplement). The CDNA has published separate national guidelines for the prevention, control and public health management of acute respiratory infections (including COVID-19 and influenza) in residential care facilities.

1.2 Disability Residential Services

A DRS is any public or private service providing accommodation and disability support services to two or more people with disability. This includes:

- supported independent living supports provided in shared disability living arrangements that are funded under the NDIS
- group homes funded outside of the NDIS
- supported residential services (SRS)
- assisted boarding houses, and
- other similar accommodation settings in Australia.

Lower-risk settings

Where a DRS is a lower-risk setting (e.g. a setting with a small number of residents who do not have multiple comorbidities or other risk factors that increase their risk of serious outcomes from respiratory infection and lower staff numbers) providers may choose to follow state or territory guidance on managing COVID-19 at home. These household requirements typically specify actions around testing, isolating and/or limiting movements of symptomatic people and close contacts.

In determining whether a DRS is a lower-risk setting and whether they should follow local household requirements, providers should consider:

- state and territory guidance
- residents' preferences (i.e. whether they would prefer the service to follow household requirements), and
- input from residents' health care providers on the risk ARI poses to them

2. Key Principles

2.1 Acute Respiratory Infections

Acute respiratory infection (ARI) means recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion with or without other symptoms (see box below).

- Acute respiratory infections (ARI) as defined in this document encompasses a range of infections caused by respiratory viruses, including but not limited to, COVID-19, influenza, and respiratory syncytial virus (RSV).
- ARI transmission is primarily via respiratory droplet and aerosol spread when infected individuals cough, sneeze, talk or shout.
- Many ARI can be spread before symptoms appear in an infected person, therefore early identification of cases and early implementation of infection control procedures, testing and treatment are essential to contain spread and minimise the chance of serious illness or death.
- Symptoms of ARI are often similar regardless of the virus causing illness and therefore testing residents with symptoms is essential to confirm the diagnosis and guide management.

Symptoms of acute respiratory infection

New or worsening acute respiratory symptoms:

- cough, breathing difficulty, sore throat, or runny nose/nasal congestion
- 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.
- fever (≥37.5°C) can occur, however is less common in some people with disability, and those who are frail or elderly.
- other symptoms to consider are change in baseline behaviour, new onset or increase in confusion, mobility, or exacerbation of underlying chronic illness (e.g., increasing shortness of breath in someone with congestive heart failure).

Clinical syndromes resulting from 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.

Severity of ARI can be increased in people with multiple comorbidities. Some populations are at especially high risk of severe disease (e.g. people with intellectual disability, people with Down syndrome) and rapid deterioration.

2.2 Identifying Acute Respiratory Infections in Clients with Disability

Some people with disability may have difficulty making their communication of ARI symptoms understood by people who support them. For some people with disability changes in behaviour will be a communication that they are unwell.

People who are up to date with vaccination against COVID-19 and influenza may experience milder symptoms from these illnesses.

Providers should check in with residents daily to monitor for symptoms or signs of ARI or changes in behaviour. When cases are present in a DRS these checks should occur more often.

DRS should also ensure that staff, family and residents are aware of:

- ARI symptoms
- the possibility that a person with disability may communicate the presence of an ARI through changes in behaviour, and
- the need to report any changes to provider staff when observed.

A resident's general practitioner (GP), behaviour support practitioner (if one is engaged) and family members may be able to advise whether specific changes in behaviour could be an indication of ARI and what further investigation may be required.

2.3 An Inclusive and Proportionate Approach to Managing the Risk of Acute Respiratory Infection

Providers should adopt an inclusive and proportionate approach to managing the risks of ARI which is considerate of resident wellbeing.

An inclusive and proportionate approach to management of the risk of respiratory infections will be different between services due to the diversity between DRS and the people they support. These differences will also mean that providers may apply the guidance in this document in different ways, in order to best support the health and wellbeing of their clients.

An inclusive approach is where:

- providers consult with residents (and their families and/or substitute decision makers) on their approach to ARI outbreak prevention and management.
- providers understand the needs and preferences of each individual resident (it may be appropriate to involve a resident's GP and/or behaviour support practitioner), and
- the preferences of residents should shape key decisions made by the provider, especially those relating to more substantial infection prevention and control measures (e.g. approaches to isolation and visitation restrictions).

When engaging with residents on these topics and when implementing infection prevention and control measures, providers will need to tailor communications to make them accessible to individual residents.

A proportionate approach to the management of the risks respiratory infections pose to residents is one that is considerate of the detrimental effect some infection prevention and control measures (e.g. isolation) can have on the health and wellbeing of residents. In other words, providers should take a holistic approach when assessing the risks ARI poses to residents and the impact of measures aimed at reducing that risk.

That approach requires consideration of the:

- likelihood of ARI being introduced and transmitted within the DRS
- severity of consequences should residents become ill, and
- measures that can be safely introduced to reduce likelihood of spread and mitigate potential consequences (e.g. precautionary separation or isolation of residents while test results are awaited) and the impact those measures will have on residents.

The support needs and risk factors for individual residents will need to factor into this assessment and decision making.

3. Preparedness and outbreak management planning

Each DRS should have a tailored, current, and comprehensive:

- ARI preparedness and prevention plan, and
- Outbreak management plan, which can be activated when a single case of ARI is suspected.

Each plan should specify:

- relevant measures needing implementation (what needs to be done)
- the steps required to achieve these measures (how will these things be done)
- the role (and person holding that role) responsible for the implementation of each measure (who is responsible for what). A backup individual to implement each measure should also be identified in case the lead is unavailable.
- what resources will be required, including workers and consumables (what we will need to achieve this)
- considerations specific to the support needs of residents
- how the plan will be reviewed and updated, including measures to ensure the plan keeps up to date with changing local state or territory public health guidance.[1]

Providers should consult with residents when undertaking ARI preparedness and outbreak management planning. Residents should be encouraged to consider and communicate what an outbreak will mean to them. Their preferences on outbreak prevention and management approaches should shape the development and implementation of plans.

Providers should also consider how preparedness and outbreak management planning is addressed in organisational risk management policies and procedures.

3.1 Preparedness and prevention plan

A preparedness and prevention plan should cover routine activities to prevent the entry and spread of ARI (in the absence of any known cases) and ensure that DRS are ready to respond to suspected and confirmed cases when they arise.

This plan should cover the following:

- Planning
    - Review capacity to implement standard precautions (as a baseline measure) and transmission-based infection prevention and control (IPC) precautions. The Australian Commission on Safety and Quality in Health Care has published useful posters on standard and transmission-based precaution.

[1] Such plans are consistent with obligations of registered NDIS providers under the NDIS Practice Standards and Quality Indicators.

    - Identify how residents can isolate[2] and be cohorted (if possible or appropriate),[3] or follow close contact requirements
    - Plan for management of residents with behaviours of concern during an outbreak.
    - Engage residents and substitute decision makers in key decisions prior to an outbreak.
    - Prepare regular visitors by providing PPE donning and doffing education before outbreaks.
    - Regularly review the outbreak management and surge capacity plans to ensure they align with current advice, public health directions and guidelines.
- Vaccination
    - Review and implement the latest jurisdictional vaccination requirements for staff and visitors.
    - Promote COVID-19 and influenza vaccination among residents, staff and visitors. This may require efforts to reach out to family members and substitute decision makers for residents who may have substitute decision making processes in place. The Department has published guidance for providers on what to do if a substitute decision maker says no to vaccination.
    - Monitor and record vaccination status of residents, staff and visitors for COVID-19 and influenza.
- Supply of key materials, including:
    - personal protective equipment (PPE),
    - rapid antigen tests
    - hand hygiene, waste and cleaning supplies and equipment, and
    - other consumable materials
- Waste management
    - Identify local clinical waste disposal arrangements and requirements and plan for their use.
- Case identification and testing
    - Establish a systematic method for detecting and recording the development of ARI symptoms among residents, such as fever or cough.
- Clinical management
    - Establish clinical management, treatment, and referral pathways for residents.
        - Ensure staff can support residents to complete COVID-19 RATs.
        - Identify further testing pathways for COVID-19 and other ARIs.
        - Work with residents' GPs to plan how ARI can be best managed for each resident.
            - Encourage GPs to pre-assess residents for antiviral treatment including the most appropriate drug and any dose adjustment required because of renal impairment. Where possible, this assessment should be undertaken pre-emptively during routine appointments.
        - Obtain an indication of treatment preference and consent from residents or their substitute decision makers.
        - Identify pathways to access anti-viral treatments rapidly, when required.
- Workforce

[2] In planning and implementing isolation measures, providers must: consult and engage with residents and their supporters or substitute decision makers; have regard to the individual communication needs of each affected resident in explaining actions to be implemented; and have regard to requirements for the use of regulated restrictive practices. The NDIS Commission has produced information and resources in relation to behaviour support and restrictive practices due to COVID-19 isolation.

[3] See step 4: Case Management for more information on isolation and cohorting.

    - Ensure enhanced infection prevention and control (IPC) training for staff including appropriate use of PPE and recognition of ARI symptoms.
    - Ensure staff are trained in responding to an ARI outbreak response.
    - Establish policy on furloughing of staff to be implemented in the event of ARI cases or an outbreak. This policy should reflect local jurisdictional guidance.
    - Ensure workforce continuity by establishing workforce surge capacity and undertaking contingency planning for staff absenteeism. This may include:
        - maintaining a list of workers who can be reallocated to direct support or care roles if needed, or
        - partnering with other local providers to support each other in the event of major staff disruptions.
- Ventilation
    - The spread of certain respiratory diseases such as COVID-19 in indoor environments may be limited through improved ventilation.
    - Where possible, air flow should be optimised to reduce viral load within a room to minimise the risk of exposure to airborne infectious material. This may be achieved through methods such as opening windows to increase natural ventilation and the use of mechanical ventilation systems such as portable air purifiers with high efficiency particulate (HEPA) air filters.[4]
- Communications
    - Providers should ensure that residents, their families and substitute decision makers/guardians (if applicable), staff and regular visitors are aware of expectations in the event of ARI cases or outbreaks.
    - Providers should consider and prepare information that can be efficiently provided to relevant stakeholders in the event of an ARI case or outbreak in a DRS.

3.2 Outbreak management plan

An outbreak management plan should address how the DRS will implement the measures outlined in Part 4 and who will be responsible for implementing those actions.

This will include actions taken by the provider to respond to suspected cases of ARIs, to minimise transmission to residents, workers and visitors, and to continue providing necessary services to all residents, including meeting the increased needs of residents who are isolating and those who have tested positive for an ARI.

This plan should answer questions such as:

- What do we need to do if a client, worker or visitor reports ARI symptoms or tests positive for an ARI?
- How would worst case scenarios be managed (e.g. an ARI has spread throughout a DRS putting multiple residents at risk and a large proportion of staff are unavailable for work due to infection)?
- How will outbreak management measures impact other clients or workers, and how could these impacts be minimised?
- How will important information about the outbreak and its management be communicated to relevant stakeholders?

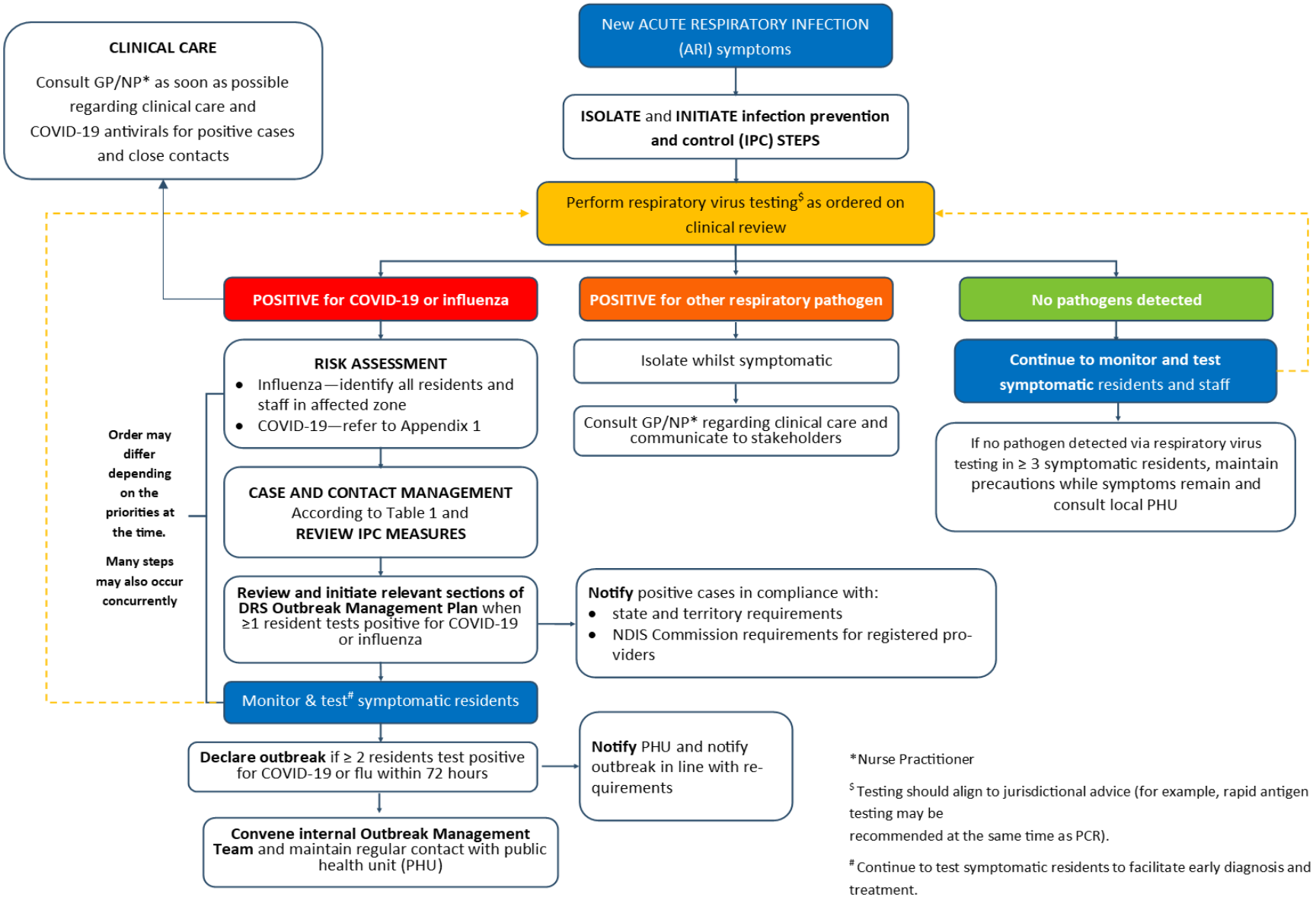
[4] For more information on ventilation see: Ventilation and COVID-19: Information for disability providers and The Australian Health Protection Principal Committee's statement on the role of ventilation in reducing the risk of transmission of COVID-19.

4. Responding to 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. Some steps may need to occur concurrently.

DRS must consider current advice (Public Health Unit, Department of Health or equivalent) in relation to screening of visitors and staff prior to entry into the service and use of PPE.

Figure 1. Overview of initial actions – New Acute Respiratory Infection (ARI) Symptoms



*Nurse Practitioner

$ Testing should align to jurisdictional advice (for example, rapid antigen testing may be recommended at the same time as PCR).

Continue to test symptomatic residents to facilitate early diagnosis and treatment.

Step 1: Isolate and step-up infection prevention and control

Isolation definition:

For the purposes of this document the term 'isolate' means keeping residents separate from other residents, which may involve keeping residents in their own room. It can include ensuring mask wearing when residents are moving between rooms such as moving to a shared bathroom, in communal areas or when there are other people around. Where possible residents should wear a mask for up to 10 days after they test positive to COVID-19, particularly when there are other people around and in communal areas.

(a) Where symptoms identified in resident

Key tasks for providers if a resident displays ARI symptoms:

- Isolate
    - Symptomatic residents should isolate immediately in their own room, where possible, to prevent opportunity for ARI spread within the DRS.
        - See page 23 for information on resident choice relating to isolation and page 7 for more information in the importance of an inclusive and proportionate approach to outbreak management.
    - Allocate separate staff to support symptomatic residents and limit cross over with staff supporting non-symptomatic residents (cohort staff and residents).
- IPC
    - Implement initial IPC measures including transmission-based precautions – contact, droplet and airborne precautions (e.g. N95/P2 respirator mask, eye protection, gown and gloves to be worn by staff caring for symptomatic resident/s)[5]
    - Post signs on the door or wall outside the resident's room advising entrants to use standard and transmission-based precautions – contact, droplet and airborne precautions.
    - Set up dedicated donning/doffing area with signage, PPE and hand hygiene:
        - make sure that appropriate and sufficient PPE is available outside of the resident's room,
        - store additional stock onsite in an appropriate and accessible location and
        - place a lined disposal receptacle near the exit inside the resident's room, to make it easy for staff to discard PPE before leaving the room
    - Where possible and if tolerable, isolating residents should wear a surgical mask:
        - when staff members or visitors are in their room, or
        - if they need access shared area (e.g. a bathroom)
    - Avoid using aerosol generating procedures (such as nebulisers) on symptomatic residents if clinically safe. The resident's GP should be consulted on the safety of any changes to these procedures.
- Vaccination

[5] N95/P2 respirator mask, eye protection, (gown and gloves as per standard precautions) to be worn by staff caring for residents with confirmed COVID-19. 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.

    - Review vaccination status (COVID-19 and influenza) of residents and staff and prioritise vaccination of those not up to date.
- Environmental cleaning, disinfection and waste disposal
    - Schedule daily cleaning in line with environmental cleaning and disinfection principles for COVID-19.[6]
    - Allocate trained staff for cleaning of affected areas and waste disposal – ensure they are skilled to perform routine and additional cleaning and waste disposal.

(b) Where symptoms identified in staff or visitors

- Attendance
    - Staff or visitors should not attend a DRS if they have ARI symptoms – even if they have tested negative.
    - If symptoms develop or are identified in staff or visitors while at a DRS, they should be instructed to leave the premises. Steps should be taken to ensure that resident care and support needs are still met if staff or visitors are requested to leave.
    - Symptomatic staff or visitors should seek COVID-19 testing in line with jurisdictional recommendations or consult their GP for respiratory pathogen testing. Staff or visitors should inform the DRS of the outcome of testing.
- Environmental cleaning and disinfection should occur in areas symptomatic staff or visitors attended.

Step 2: Testing and clinical review

Testing for ARI is critical for establishing a diagnosis and facilitating early treatment. It also enables early planning and control of any potential outbreak.

Symptomatic person/s should be tested as soon as possible.

Initial cases of ARI within a DRS should be tested by RAT and PCR to establish the pathogen. PCR should include COVID-19, influenza A and influenza B. A wider panel of respiratory viruses should be tested as clinically indicated.

DRS should consult with a general practitioner (GP) or nurse practitioner (NP) regarding clinical review and testing of all residents with ARI symptoms and soon as possible.

Where **residents** have symptoms of acute respiratory infection, providers can use the following pathway:

- Test for COVID-19 on the person with symptoms using a rapid antigen test (RAT) or arrange a PCR.[7] Testing by RAT may be preferable due to availability and quick turnaround.
    - If COVID-19 RAT or PCR is **positive** commence on the positive result pathway (see figure 1).
    - If COVID-19 RAT is **negative**:
        - Local jurisdictional advice may recommend that a negative RAT is followed up with a PCR test for COVID-19 (PCR testing for influenza may be provided alongside a COVID-19 PCR).

[6] Additional cleaning will include at least twice daily cleaning of high touch point areas (e.g. door handles, bathroom taps, kettle, kitchen surfaces).

[7] See step 6 for information on case notification and reporting.

- Regardless of the outcome of COVID-19 testing seek clinical review by GP or NP to assess clinical status of the patient and arrange further testing for respiratory pathogens, including influenza, if required.
- In the absence of clear diagnoses in symptomatic residents, precautions (isolation and other IPC measures) should be maintained while residents are symptomatic and the PHU or a GP contacted for further advice.

DRS should take steps to ensure access to appropriate testing services and clinical review before testing is required.

DRS should work with clients' GPs (and other primary care providers) to ensure that residents can be quickly tested at the onset of symptoms and that advice on testing can be accessed efficiently. This may include:

- discussing barriers to testing and how they should be managed, and
- having tests pre-ordered on pathology forms in the event a resident develops symptoms of a respiratory infection.

Where **staff** report symptoms of ARI, they should be directed to their primary care provider.

Step 3: Assess risk of ARI spread

When dealing with suspected or known ARI cases, providers will need to make decisions to manage and mitigate the risk of ARI spread. Sometimes these decisions will need to be made with incomplete information (e.g. uncertainty about who has been exposed to a virus that causes ARI, or what ARI is spreading in a DRS).

When assessing the risk of ARI spread and how to respond to that risk DRS should consider:

- the **likelihood** of spread (e.g. the closeness of residents during the infectious period, whether masks were worn, the duration of contact, and other factors such as aerosol-generating behaviours and procedures)
- the **consequences** of spread (e.g. a large, uncontrolled outbreak, spread to residents who are at greater risk from ARI), and
- the **measures** that can be safely introduced to reduce likelihood of spread and mitigate potential consequences (e.g. precautionary separation of residents while test results are awaited) and the impact those measures will have on residents.

The DRS' outbreak management plan (OMP) should support DRS to determine what measures can be introduced to mitigate risks.

Assessing risk once a case of COVID-19 or influenza has been confirmed

Where a case of COVID-19 or influenza is confirmed in anyone who has spent time in the service while they were infectious, providers should assess the risk to residents and manage close contacts according to local jurisdictional guidance (see Step 5).

Other critical actions will include:

- Trigger relevant sections of the DRS' outbreak management plan (OMP)
- Review IPC measures and identify and address any gaps.
- Assess and manage risk from symptomatic staff. Furlough symptomatic staff and direct them to their GP.

Step 4: Case management

Immediately escalate to management if a resident tests positive for influenza or COVID-19 where they have been at the DRS during their infectious period.

(a) Residents

- Treatment
    - On diagnosis, DRS should promptly contact the resident's GP or NP regarding clinical assessment, care, and eligibility for treatment.
    - Residents' GP/NP will continue to provide their routine primary care as needed either onsite and/or virtually.
- Isolation and cohorting
    - The positive resident should continue to isolate (as established prior to testing) and receive ongoing daily care.

    - Cases should be managed according to the diagnosis, as shown in Table 1. Jurisdictions may implement additional requirements above these recommendations.
    - Residents who have tested positive for the same virus can cohort together for social and/or management benefit. This may be necessary if they cannot isolate in their own room.
    - Residents with different viruses should not cohort together.
    - Residents who have been exposed to or tested positive for COVID-19 or influenza should still attend essential off-site appointments (e.g. dialysis), in consultation with the off-site service provider and in accordance with local jurisdictional requirements.
- IPC Measures
    - Maintain standard and transmission-based precautions – contact, droplet, and airborne precautions (N95/P2 respirator mask, eye protection, gown and gloves to be worn by staff caring for symptomatic resident/s).
    - Identify the areas of the DRS that are at risk. Where the whole DRS is impacted or at risk, whole-of-service actions should be taken.
    - Apply the risk assessment outcomes and test results to confirm areas in the DRS that:
        - are staff only e.g., kitchen, reception area (e.g., Blue zone)
        - are likely to be completely unaffected and can be staffed with nonexposed staff and managed separately (e.g., Green zone)
        - have been affected due to exposures or cases (e.g., Amber Zone)
        - cases (e.g., Red zone)
    - Where possible, allocate staff to one zone for the duration of the outbreak.
    - Donning and doffing stations and clinical waste disposal bins should be set up with appropriate signage for use by staff or visitors entering areas where positive residents are isolating or cohorting.

(b) Staff or visitors

- Isolation
    - Positive cases among staff or visitors should isolate at home.
    - When they are permitted to return to the service will depend on local jurisdictional requirements (see Table 1).
- Vaccination[8]
    - During a confirmed influenza or COVID-19 outbreak, staff who are not up to date with their vaccination are recommended to work only if asymptomatic and wearing a mask. See local jurisdictional guidance.

[8] States and territories may have vaccination requirements for disability support workers. Providers should monitor local vaccination requirements.

Table 1 – Recommended case management for COVID-19, influenza, RSV and other confirmed respiratory pathogens.

			COVID-19 (RAT or PCR)	Influenza (PCR)	Other confirmed respiratory pathogen including RSV
C A S E	**Resident**	Case isolation*	At least 7 days from positive test date, until asymptomatic. Case can cohort with other COVID-19 positive residents.	5 days from symptom onset. Case can cohort with influenza positive residents.	The resident should isolate whilst symptoms remain. Resident can cohort with residents with same confirmed pathogen.
		End of isolation*	After day 7 if substantial resolution of acute respiratory symptoms and no fever for 24 hours. No testing required.[9]	After 5 days from symptom onset, or until they are symptom-free, whichever is longer **or** 72 hours after antivirals commenced. No testing required.	Once symptoms resolve. No testing required.
		Antiviral treatment	COVID-19 antivirals and other disease modifying therapies as indicated (via clinical review)	Discuss treatment options with patient's GP.	Nil/seek guidance from GP on clinical management.
	Staff	Return to work	After 7 days (minimum) if no symptoms for 24 hours, no testing required. If symptoms continue, return when substantial resolution of acute respiratory symptoms no fever for 24 hrs.[1]	5 days from symptom onset, or until symptom-free, whichever is longer or 72 hours after antivirals commenced. No testing required.	Once symptoms resolve. No testing required.
	Visitors	Visitors to DRS	Can visit DRS after 7 days (minimum) if no symptoms.	Exclude from DRS for 5 days from symptom onset or until symptom-free, whichever is longer.	Exclude if symptomatic.

*Isolation for the purpose of this document includes keeping residents separated from other residents, which may involve keeping residents in their own room or mask wearing when residents are moving between rooms such as moving to a shared bathroom, in communal areas or when there are other people around.

Note: Jurisdictions may implement additional requirements and/or recommendations.

[9] This minimum standard aims to balance this risk with the impact of prolonged isolation on individuals and communities. A small proportion of cases may still be infectious when released from isolation.

Step 5: Contact management

- Following an exposure, DRS should undertake exposure assessment to determine if any staff or residents have been exposed to the case and develop an agreed management plan based on the degree of assessed risk.
- In assessing contacts of a positive case, the DRS should identify all staff and residents who have been potentially exposed. In small DRS (e.g. group homes), it is possible that all residents will have been exposed.
- To support assessment and management of staff and resident contacts of a positive COVID-19 case (for known exposures or single case with a known source), refer to Appendix 1.
- Ensure contacts who are residents are monitored for symptoms and limit movement within the DRS.
- All residents in the identified zone (the area or areas where people may have been exposed to the virus) should be tested to find cases, irrespective of whether they have symptoms. See Appendix 1. In smaller DRS (e.g. group homes) it might be appropriate to test all residents.
- Seek advice from the treating GP and/or public health unit on the use of influenza antivirals during influenza outbreaks as post exposure prophylaxis for residents in the affected zone.
- It is important that DRS 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 through application of the least restrictive controls appropriate.

Table 2 – Contact management for COVID-19, influenza, and other confirmed respiratory pathogens.

			COVID-19 (RAT or PCR)	Influenza PCR	Other confirmed respiratory pathogen
CONTACTS	**Resident**	Contact testing	For smaller DRS (e.g. group homes) testing for all residents is recommended. For larger DRS, all residents in affected zones (e.g. wings)	Symptomatic residents in the same zone (likely wing).	Test based on clinical advice.
		Contact isolation	Limit movement while test results pending and risk assessment completed. See Appendix 1.	Residents who are in same zone(s) should avoid moving between different zones.	Nil
		Contact post-exposure prophylaxis	Nil	Discuss prophylaxis options with resident's GP and the PHU.	Nil
	Staff	Return to work	See Appendix 1.	Immediately if no symptoms or once symptoms have resolved. Must wear a mask and other PPE as required when at work. Unvaccinated staff should not work in affected areas.	Immediately if no symptoms or once symptoms have resolved.
		Post-exposure prophylaxis	Nil	Staff who are unvaccinated or staff at higher risk of severe disease due to existing conditions should discuss the use of influenza antivirals with their GP.	Nil
	Visitors	Return to DRS	Can attend from Day 8 if no symptoms.	Immediately if no symptoms.	Immediately if no symptoms.

Note: Jurisdictions may implement additional requirements and/or recommendations.

Step 6: Notification and reporting

(a) Notify state/territory health department as required by local guidance

Providers may be required to notify their relevant state or territory health department of a COVID-19 or influenza case among a staff member, resident or visitor. Providers must be aware of local reporting requirements as these vary between jurisdictions.

Notify the local PHU of an OUTBREAK when 2 or more residents test positive to COVID-19 or influenza within a 72-hour period.

Up to date local state and territory health department contact details are available on the Commonwealth Department of Health website.

(b) Notify the NDIS Commission

Registered NDIS providers must notify the NDIS Commission of certain changes and events, especially those which substantially affect the provider's ability to provide the supports and services they are registered to provide.

Providers should notify the NDIS Commission of positive cases of COVID-19 including any changes to service delivery arrangements or inability to meet their conditions of registration using the Notification of event form – COVID-19.

More information on providing notice of changes and events can be found on the NDIS Commission's website: Notice of changes and events.

(c) Notify others

Notify important people identified by the resident, any substitute decision maker or guardian of a resident (if known), other support providers and disability services, hospitals where residents have had a high-risk exposure and have subsequently been transferred or require immediate transfer for care.

Step 7: Declaring an Outbreak and Convening Outbreak Management Team

An outbreak should be declared if:

- 2 or more residents test positive for COVID-19 within a 72-hour period or
- 2 or more residents test positive for influenza within a 72-hour period

Jurisdictional public health guidance may vary. It is important to ensure your approach is based on local guidance.

- As noted in step 3, the DRS should activate their DRS 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.
- Once an outbreak has been declared, the DRS should convene an internal outbreak management team (OMT) meeting and confirm the DRS staff members who will be designated:
  - Outbreak Management Lead (and their backup) and
  - Infection Prevention and Control lead (and their backup).
- The OMT should meet and communicate regularly, with decisions documented.
- The DRS 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.

During the outbreak

- IPC measures
    - Use the DRS OMP plan to establish isolation and cohort, where possible. Ensure all areas:
        - are clearly designated with clear signage in place.
        - have an adequate number of sites for hand sanitiser, ideally at each bed space, and entrance/exit to the home.
        - have hand hygiene, PPE station and waste disposal at entry if appropriate. Donning and doffing area should be separate.
        - are decluttered as much as possible to make cleaning and disinfection easier.
        - have limited entry/access to each cohort.
    - Have separate break areas for staff where physical distancing can be maintained.
    - For detailed information on risk assessment for appropriate PPE use and IPC for healthcare workers, see the Infection Control Expert Group guidelines and refer to local public health advice.
    - A risk assessment should inform the appropriate level of PPE for staff providing direct care or working within the resident zone.
    - The assessment should consider controls already in place and also the residents' pre-existing likelihood of COVID-19, resident factors that enable transmission, nature of the care episode and physical location.
- Increase the frequency of cleaning and disinfection.
    - Frequently touched surfaces and those closest to residents should be cleaned more often. These surfaces include:
        - equipment
        - door handles
        - trays
        - tables
        - handrails
        - chair arms
        - light switches
        - patient care equipment (e.g., commodes, lifter slings, etc)
    - Activate strategies established for increases in clinical and general waste storage and removal and linen cleaning and supply.
- Resident movement during an outbreak
    - Essential off-site appointments also should continue (e.g., dialysis), with negotiation with the service provider if the resident has been exposed to COVID-19 or influenza.
    - Any transfers (other than on the basis of clinical need) should be planned and coordinated with hospital services and in consultation with the resident, their family or alternative decision-makers and public health units. The receiving hospital must be informed about the outbreak at the DRS, regardless of whether the resident being transferred is a case or not.
    - If practical, residents of similar exposure or the same diagnosis can also be cohorted together.
    - Residents in unaffected zones are able to attend external appointments.
    - Consider relocating residents who are on a palliative care pathway and require additional supports (e.g., compassionate care / visiting, symptom

control) to an area where they are less at risk of further exposure (or if cases, plan for how resident could be supported with visits).

- Staff considerations
  - During a confirmed influenza outbreak, staff who have not received the influenza vaccination are at higher risk of acquiring influenza, therefore they are recommended to work only if asymptomatic, wearing a mask. The use of antivirals prophylaxis should only on advice of a clinician and should be discussed with the PHU. Any antiviral use by staff should be documented.
  - Contingencies (e.g. alternative staffing options) should be in place for any staff who do not meet this criteria.
  - Staff who are higher risk contacts should not move between their section and other areas of the DRS, in line with basic IPC principles.

Other considerations relevant to an outbreak

- New and returning residents to DRS from the community, hospital, or emergency department.
  - The presence of an outbreak should not prevent new and returning residents from being entering or returning home to the DRS with appropriate IPC measures in place. Decisions should be based on the advice of the local OMT and in consultation with the PHU, residents and their representatives.
  - Residents and families entering the DRS during an outbreak should be informed of the current situation, as well as any associated restrictions (e.g., visitor limitations).
- Resident choice regarding isolation
  - Consumer dignity and choice are foundational standard 1 in the National Quality Standards for Disability Care. The NDIS Code of Conduct requires workers and providers who deliver NDIS supports to act with respect for individual rights to freedom of expression, self-determination, and decision-making in accordance with relevant laws and conventions. Participant independence and informed choice is also a Core Module outcome of the NDIS Practice Standards.
  - Residents should be given the choice to self-isolate while an outbreak is in progress or to mix with people with the same condition or exposure. Their preferences should be recorded in their support plans and regularly reviewed.
  - Exposed residents should not socialise with positive cases or residents from unaffected areas.
  - Residents who have not been exposed, are not symptomatic or positive for ARI should be given the choice to self-isolate if they desire to do so.
- Where it is practical, and the DRS can manage this subject to resident preferences:
  - Residents with the same condition or exposure should be allowed to engage in social activities and eat together if they are well enough to do so and if they can be kept separated from residents who are exposed or unaffected.
  - Residents exposed to the same pathogen may choose to leave their rooms to eat in shared dining rooms and participate in social activities with other residents from the exposed area[10]. Exposed residents should not socialise with positive cases or residents from unaffected areas. Unexposed residents can leave their rooms to participate in shared activities and dining with other unexposed residents (e.g., with dedicated staff, dining room, social room).
  - Where possible, visits to affected residents should occur in an area with good ventilation (see Appendix 2).

[10] Jurisdiction may require the testing of exposed residents prior to leaving their room.

Step 8: 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. These should be recorded in the resident's support plan.
- Ensure residents' family and carers are aware of the exposure/outbreak at the service and status of individual residents, including their diagnosis and management.
- Ensure staff are aware of the exposure/outbreak at the service and remain on high alert monitoring themselves and residents for ARI symptoms
- Ensure visitors are aware of the exposure/outbreak at the service. State and territory guidance on visitation should be followed (see appendix 2 for information on visitation during exposure/outbreak in a DRS).
- Put up notices of the outbreak at all entrances informing entrants of the exposure/outbreak at the service. Signage should also be displayed outside the room of affected residents. This will help minimise unnecessary visits that may lead to inadvertent transmission.

Step 9: Declaring an outbreak over

- A decision to declare the outbreak over should be made by the PHU or OMT. Generally, this is:
    - when no new cases occur within 8 days following the onset of symptoms in the last resident influenza case.
    - 7 days after the last COVID-19 case tests positive **OR** the date of isolation of the last COVID-19 case in a resident, whichever is longer.
- However, additional testing or measures may be recommended by the PHU in the 7 days following an outbreak being considered "over".
- DRS should remain on high alert and:
    - seek clinical review and appropriate testing for anyone with new symptoms, no matter how mild; and
    - carefully monitor residents with high-risk exposure for behavioural changes, lack of appetite, and lethargy; and
    - ensure visitors (who may be at higher risk 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 DRS.
- 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 DRS 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, DRS should evaluate the response to and management of the outbreak to identify strengths and weaknesses. Consider conducting a DRS debrief with all employees and contractors involved with the outbreak.

Appendices

Appendix 1: COVID-19 exposure and outbreak management

Appendix 2: Visitation during an outbreak

Appendix 3: Key documents and resources

Appendix 1: Examples of risk assessment and response for COVID-19 exposures and outbreaks

Table 3. Suggested actions based on classification of high-risk COVID-19 exposure*

High-risk exposure (close contact)	Suggested actions based on classification of high-risk exposure (close contact)
Staff Where a worker has been exposed to COVID-19 case in a workplace setting where the risk of exposure is defined as high. High-risk exposure include: - staff who were not wearing PPE (N95/P2 masks and eye protection) where aerosol generating behaviours or procedures have been involved - have had at least 15 minutes face to face contact where both mask and eyewear were not worn by exposed person and the case was without a mask, - greater than 2 hours within the same room with a case during their infectious period, where masks have been removed for this period.	• Review affected staff to assess exposure and risk. • Staff who if absent will have a high impact on services, will be able to continue attending work with specific requirements in place: - Continue to work with negative Day 1 PCR/RAT - RAT test every working day, until Day 7 result clear (prior to commencement of workday) - Monitor for symptoms, test (RAT and if negative PCR), and isolate immediately if symptoms develop. Additional mitigation steps: - Work in a surgical mask or P2/N95 respirator for the first 7 days following exposure - No shared break areas - Limit work to a single site/area - Consider redeployment to an area with lower risk residents.
Residents If a resident has been exposed to a COVID-19 case: - in a shared defined area (e.g., prolonged contact during activity, co-located in a wing of a DRS) 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 wing / zone with unknown exposure). **Note: the risk of transmission should be managed whilst balancing the risk related to social isolation through application of the least restrictive controls appropriate.**	• Isolation or separation for 7 days. • Test (PCR/RAT) Day 2 and Day 6 **OR** Consider allowing residents to leave room after risk assessment, <u>with</u> - Baseline and Day 6 PCR, or - RAT at least every second day from Day 0-7

*Responses to situational risk should be based on a risk assessment which considers the risk cases of ARI pose to residents and staff. Jurisdictions may implement additional requirements and/or recommendations.

Table 4. Examples of situational risk and response in the context of outbreak of COVID-19 in DRS*

Outbreak Situation	Testing, isolation, IPC and closure
Simple Cases arising from single / known exposure and/or limited to a few cases in one area of the DRS and/or limited secondary transmission.	- Cases isolate for 7 days as per Table 1 (Case and Contact Management) and CDNA Series of National Guidelines (SoNG) on COVID-19. - Baseline and Day 6 (D6) PCR for defined at-risk residents, stay in room for 7 days OR allow at-risk residents to leave room as long as they remain with residents of similar risk but with RAT testing every second day. - If no cases detected from D6 PCR in at-risk residents release from quarantine after 7 days and outbreak may be declared over.
Complex Poorly understood exposure, or multiple cases affecting multiple areas, or ongoing transmission, or difficultly isolating residents.	- Cases isolate for 7 days as per Table 1 (Case and Contact Management) and CNDA Series of National Guidelines (SoNG) on COVID-19. - At-risk residents in affected areas should remain in quarantine. Develop a regular schedule of testing in the affected zone for negative at-risk residents every 72 hours by RAT (or PCR) and continue until 7 days after the last case. - Declare outbreak over 7 days after the last positive resident case detected or 7 days after the last positive infectious resident case was effectively isolated (whichever is longer). - Continue to monitor residents for symptoms in affected zone for a further 7 days after the outbreak declared over. - Staff maintain higher standard of PPE for a further 7 days (P2/N95) after the outbreak declared over.

*Responses to situational risk should be based on a risk assessment which considers the risk cases of ARI pose to residents and staff. Jurisdictions may implement additional requirements and/or recommendations.

Appendix 2. Visitation

Visitor restriction and resident wellbeing

Restrictions on visitation to DRS are likely to have detrimental impacts on resident wellbeing. Changes to visitation, staff, and usual routines can also have a major impact on residents. This may lead to expressions of distress including through changes in behaviour among people intellectual disability, developmental disability and acquired brain injury.

Deterioration in the mental health of residents can impact on behaviour and the ability of residents to safely protect themselves and others. Accordingly, providers should establish strategies (such as the use of video calls) to enable residents to remain as connected as possible to friends, family, carers, supporters, medical and allied health professionals. These strategies should be easily introduced if there is an outbreak or public health order or advice which results in visitation being limited.

Visitors and isolation

Where a case or outbreak has occurred in DRS, state and territory public health guidance on visitation should be followed.

Ensure any visitors are aware of the exposure/outbreak at the service. The level of PPE visitors wear will be dependent on the COVID-19 or influenza status of the resident and whether the visit is indoors or outdoors.

Communal activities of non-infected residents that do not conflict with the isolation of positive cases should go ahead in unaffected zones.

DRS Providers should plan for how visitor access will be managed in consultation with participants, as part of their planning to manage the impact of COVID-19 and associated risks.

Appendix 3. Further resources

Infection prevention and control

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

Personal protective equipment

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

Environmental cleaning

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

Communicable Diseases Network Australia National Guidelines for Public Health Units

- CDNA National Guidelines for Public Health Units. Coronavirus Disease 2019 (COVID-19)

- Superseded Guidelines:

    - CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia (2022). Contains useful background information and resources.

    - CDNA national guidelines for the prevention and management of COVID-19 outbreaks in disability residential services - The Disability Supplement (2021). Contains useful background information.

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 people with disability – COVID-19 oral medicines and a COVID-19 medicines – Easy read document.

COVID-19 Vaccination

- The Australian Department of Health and Aged Care has Information for people with disability about COVID-19 vaccines, Information for disability workers about COVID-19 vaccines, and Information for disability service providers about COVID-19 vaccines.

NDIS Commission

- The NDIS Quality and Safeguard Commission has a range of resources for NDIS participants and NDIS providers. This information is to inform and support NDIS providers to continue to deliver quality and safe supports and services to NDIS participants during the pandemic in accordance with their obligations under the NDIS Act: COVID-19 resources and information | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)