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Infection Control Expert Group

COVID-19 Infection Prevention and Control for Residential Care Facilities

This document was developed by the Infection Control Expert Group (ICEG) and endorsed by the Australian Health Protection Principal Committee. It provides guidance on infection prevention and control (IPC), including the use of personal protective equipment (PPE), in residential care facilities (RCFs) during the COVID-19 pandemic.

For additional guidance on infection prevention and control during the COVID-19 pandemic, see the [Department of Health website](#).

As a national document, the guidance on PPE contained in this document, should be considered as the **minimum standard**. This advice is continually reviewed as the situation changes. Check with your state or territory health department for specific advice for your jurisdiction.

In geographical areas with significant community transmission of COVID-19 (as defined by jurisdictional public health units), in specified clinical settings, health and aged care workers¹ may need to take extra precautions. This may include precautions *above those usually indicated for standard and transmission-based precautions*. See [ICEG guidelines on PPE in areas with significant community transmission](#) for more information.

All PPE should be used in line with the principles in the [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#), whilst acknowledging the unique circumstance of COVID-19.

For current case definitions and testing criteria see the [Communicable Diseases Network Australia National Guidelines for Public Health Units](#).

Background

COVID-19 is an acute respiratory infection caused by the virus SARS-CoV-2. RCFs are vulnerable to outbreaks of respiratory infections. Older people are among those most at risk of severe disease and death from COVID-19.

No COVID-19 vaccine is currently available. Staff, residents and visitors must avoid exposure to reduce the risk of an outbreak occurring in a RCF. IPC measures and physical distancing are central to avoiding exposure and protecting residents and staff if an outbreak occurs.

Additional advice on managing COVID-19 outbreaks in RCFs has been published by the Communicable Diseases Network Australia.²

¹ Includes health care workers, personal care workers and support staff who have direct contact with patients or residents in health and residential care facilities, where the risk of COVID-19 transmission is judged to be significant.

² See Communicable Diseases Network Australia [Guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia](#)

General principles of infection prevention and control in RCFs

- Information about routine IPC should be provided to staff, residents (as far as possible) and visitors (as appropriate).
- All staff should be trained in basic IPC practices, when they begin employment at the facility, and at regular intervals (annually or more frequently, as required, e.g. when the risk of an outbreak is increased by a community outbreak of a highly infectious disease).
- Training should be appropriate to their roles and should include, at least, hand hygiene and the use of PPE.

Routine IPC measures relevant to any infectious disease risk

- **Hand hygiene** using soap and water or alcohol-based hand rub (ABHR) (e.g. after going to the toilet, coughing, blowing the nose and before eating). Additional hand hygiene is required when caring for a resident with a respiratory infection.
- **Appropriate use of PPE**³, especially when caring for a resident with a respiratory infection.
- **Cough etiquette and respiratory hygiene** for staff, residents (if possible) and visitors.
- **Not coming to work if unwell.**
- **Frequent cleaning and disinfection** (at least daily) of floors and surfaces. More frequent cleaning of frequently touched or soiled surfaces.⁴
- **Isolating or cohorting** residents confirmed to have an infection caused by the same pathogen.
- **Annual influenza vaccination** of residents, staff and all visitors to RCFs.
- **Standard, contact and droplet precautions** when caring for a resident with a respiratory infection.
- **Limiting unnecessary movement** of residents and staff within and between facilities.

Spread of COVID-19

COVID-19 most commonly spreads through:

- Direct contact with droplets from an infected person's cough or sneeze. This can be avoided by cough etiquette, respiratory hygiene and physical distancing (see below).
- Close contact⁵ with an infectious person.
- Touching objects or surfaces (e.g. bed rails, doorknobs or tables) that have been contaminated with respiratory droplets from an infected person and then touching the face, especially mouth, nose or eyes.

Collection of respiratory specimens

Specimens for diagnosis of COVID-19 and other respiratory viral infection should be collected by a trained health care professional or pathology collector.

Guidance on appropriate PPE for collection of specimens is available on the [Department of Health website](#).⁶

³ Supplies of personal protective equipment may be limited during a significant outbreak especially if it is prolonged. State and Commonwealth authorities endeavour to secure and distribute adequate supplies. It should be used only as recommended.

⁴ See [Environmental cleaning and disinfection principles for health and residential care facilities](#)

⁵ See the Communicable Diseases Network Australia [COVID-19 National Guidelines for Public Health Units](#)

⁶ Refer to [Coronavirus \(COVID-19\) guidance on use of personal protective equipment \(PPE\) in non-inpatient health care settings, during the COVID-19 outbreak](#)

Placement of residents within the RCF

With appropriate IPC precautions, many RCF residents with COVID-19, and their contacts, can be safely cared for within the facility although this will depend on local jurisdictional response plans and the environmental suitability of the RCF.

Placement of residents with suspected or confirmed COVID-19

Residents with **suspected or confirmed COVID-19** should be **isolated and cared for in single rooms**.

- Residents should be isolated while they are infectious (as determined by the local public health unit).
 - During this period, following a risk assessment, if they are ambulatory and well enough, they may leave the room for exercise. Ideally exercise should take place outside to reduce the chance of transmission. They must be supervised and not come into contact with other residents.
 - If residents leave their room while infectious, they should wear a surgical mask, perform hand hygiene before leaving their room and avoid touching objects or surfaces in communal areas.
 - The person accompanying/supervising them should also wear a surgical mask, perform hand hygiene and avoid touching objects/surfaces.
- Remind staff and residents of the need for cough etiquette and respiratory hygiene.
- Staff and visitors in contact with ill residents should follow standard, contact and droplet precautions (see below).
- Supplies of PPE should be readily available and placed strategically outside the room.
- Special arrangements may be needed for care of residents with dementia who need to be isolated.
- Staff caring for residents who have COVID-19 should be cohorted as far as possible. This reduces the chance of the virus spreading to other staff and residents.

If single rooms are not available, placement of residents with COVID-19, such as cohorting positive residents together, should be based on risk assessment. However, unless there are sufficient staff to adequately care for them, consideration should be given to transferring them to hospital or another facility where they can be isolated in separate rooms.

Placement of residents who are close contacts of a confirmed COVID-19 case

- Any resident who remains well but has been in close contact with a confirmed or probable case, in the period extending 48 hours before symptoms began in the confirmed or probable case, should be quarantined in a single room for 14 days.
- They should be monitored for symptoms of COVID-19 (at least daily).
- Quarantined close contacts should be tested periodically, in consultation with the local Public Health Unit.
- They may leave their room for exercise or activity, with supervision by a staff member, if necessary, to ensure that they avoid contact with other residents.
- If a single room is not available, following a risk assessment, including how likely their original contact was to cause infection. Residents in quarantine may share a room, only if they are able to fully co-operate with the same precautions as for room-sharing by confirmed cases (see above). They should be assessed and tested frequently, and if COVID-19 is confirmed in one of the residents, they should be separated immediately. The resident who has COVID-19 should be isolated, in hospital or another facility, if necessary. The other resident should remain in quarantine.

Hospital transfer of residents with suspected or confirmed COVID-19

- The decision to transfer COVID-19 positive residents from their home or residential care facility to hospital is made case-by-case, taking into account the resident's medical needs, the advice of public health experts and clinicians managing the outbreak, whether the RCF has enough staff to care for them appropriately, and local jurisdictional health care system arrangements.
- The layout and ability of providers to separate / cohort infected and non-infected residents on-site is also a consideration.
- Decisions are made in consultation with the resident and their family or representative and taking account of any advanced care directives and local jurisdictional response plans.
- Some aged care homes across Australia have successfully managed outbreaks of COVID-19 while continuing to care for residents within the facility. However, this requires that staff consistently practice appropriate IPC precautions (including correct use of PPE) to avoid close contact (and therefore the need for quarantined themselves)
- The ambulance service and hospital must be advised, in advance, that the resident is being transferred from a RCF where COVID-19 is suspected or confirmed.
- If the resident needs urgent medical attention, the RCF should call 000 and advise the operator of the COVID-19 risk.

PPE in areas of significant community transmission

In geographic areas with significant community transmission of COVID-19:

- In all settings within the RCF, use **standard precautions** (including eye protection) AND wear a **surgical mask**.

See guidance on the [use of PPE by health care workers in areas with significant community transmission](#) for more information.

IPC measures when a resident has suspected or confirmed COVID-19

Standard Precautions are IPC practices used routinely in health care. They should be used in RCFs with a suspected or proven COVID-19 outbreak and **apply to all staff and all residents**.

Key elements are:

- **Hand hygiene** before and after each episode of resident contact and after contact with potentially contaminated surfaces or objects (even when hands appear clean).
 - Gloves are not a substitute for hand hygiene. Staff should perform hand hygiene before putting gloves on and after taking them off.
- **Use of PPE** if exposure to body fluids or heavily contaminated surfaces is anticipated (gown, surgical mask, protective eyewear, and gloves).
- **Cough etiquette and respiratory hygiene**.
 - Cough into a tissue (and discard the tissue immediately) or into the bend of the elbow; perform hand hygiene.
- **Regular cleaning of the environment and equipment**.
- **Provision of alcohol-based hand sanitiser** at the entrance to the facility and other strategic locations.

Note: RCFs should ensure all staff are **trained in the correct use of PPE**, appropriate to their role. Incorrect removal of PPE increases the risk of personal contamination and spread of infection.

Transmission-based precautions are IPC practices used *in addition* to standard precautions, to reduce transmission due to the specific route of transmission of a pathogen.

Respiratory infections, including COVID-19, are most commonly spread by contact and droplets. Airborne spread may occur during aerosol generating procedures.

A. Contact and droplet precautions

These precautions apply to:

- Health care workers and RCF staff during the clinical consultation and physical examination of residents with suspected or confirmed COVID-19, or who are in quarantine.
- All staff when in contact with ill residents.

Key elements are:

- **Standard precautions** (as above).
- **Use of PPE** including gown, surgical mask, protective eyewear, and gloves **when in contact with an ill resident.**
 - Protective eyewear can be in the form of safety glasses, eye shield, face shield, or goggles.
- **Isolation of affected residents** in a single room. If a single room is unavailable see: "Placement of residents with suspected or proven COVID-19" (above).
- **Enhanced cleaning and disinfection** of the ill resident's environment.⁷
- **Limit the number** of staff, health care workers, and visitors in contact with the ill resident.
- **Nebulisers** have been associated with a risk of transmission of respiratory viruses and their use **should be avoided.** A spacer or puffer should be used instead.

Note: When caring for an asymptomatic resident in quarantine, contact and droplet precautions should be followed (PPE includes a gown, surgical mask, protective eyewear, and gloves).

B. Airborne precautions

Particulate filter respirators (PFRs), such as P2 or N95 respirators, instead of surgical masks, are recommended, **in addition to all other precautions outlined above,** when performing certain high-risk (aerosol generating) procedures (AGPs) on patients with COVID-19.⁸ However, AGPs are likely to be performed infrequently in a RCF.

In addition, the use of a **particulate filter respirators (PFR)** such as P2 or N95 respirator, may be considered when one or both of the following apply:

1. **For the clinical care of residents with suspected, probable or confirmed COVID-19, who have cognitive impairment, are unable to cooperate, or exhibit challenging behaviours.**⁹
2. **Where there are high numbers of suspected, probable or confirmed COVID-19 patients/residents AND a risk of challenging behaviours and/or unplanned aerosol-generating procedures** (e.g. including intermittent use of high flow oxygen).

In these situations, use of a PFR, for up to four hours, if tolerated, will avoid the need for frequent changes of face covering.

⁷ See [Environmental cleaning and disinfection principles for health and residential care facilities](#)

⁸ Refer to [Guidance on the use of personal protective equipment \(PPE\) in hospitals during the COVID-19 outbreak](#)

⁹ There is anecdotal evidence of a link between health and care worker infection and **challenging behaviour**, such as shouting, by patients/residents who are agitated or find instructions hard to follow, especially during the first week of infection, when viral load may be high. However, there are many factors that may contribute to this and there is no direct evidence that the use of a PFR will prevent health or care worker infection.

Note: PFRs should only be used by staff who have been trained in their use. They should be fit checked with each use to ensure an adequate face seal. Unless there are adequate numbers of trained staff to care for residents in these circumstances, consideration should be given to transferring infected residents who are distressed and exhibiting challenging behaviours to hospital, if possible.

Exclusion from work for RCF staff for COVID-19

RCF staff who have **epidemiological risk factors for COVID-19** (besides being a health or residential care worker with direct patient contact) or **symptoms consistent with COVID-19**¹⁰ should:

- Not attend work
- Seek medical advice and be considered for testing
- Remain in quarantine (if required) until cleared.

Preparing for and responding to COVID-19 outbreaks in RCFs

The RCF should form an **Outbreak Management Team** to develop an Outbreak Management Plan.¹⁰ In relation to infection prevention and control, the Plan should:

- Include easily accessible internal policies and procedures on routine, standard and transmission-based IPC precautions (as outlined above).
- Be informed by advice and on-site risk assessment from an IPC professional.
- Ensure adequate supplies of PPE, ABHR and cleaning materials.
- Ensure RCF staff know the symptoms and signs of COVID-19.
- Ensure RCF staff are trained in IPC procedures (as above), including use of PPE.
- Consider the need to extend the use of PPE if the numbers of cases, contacts and/or resident areas or zones affected increase significantly. This may include using PPE beyond the situations recommended in this document.
- Include a systematic strategy for detecting cases and managing residents or staff who develop symptoms consistent with COVID-19.
- Consider the need for a program of repeat tests for those in quarantine.¹¹
- Ensure daily hand-over for ARI monitoring and outbreak detection for staff performing this task.
- Ensure the local Public Health Unit is notified if the RCF suspects an ARI or COVID-19 case.
- Ensure residents have reviewed their Advanced Care Directives, in consultation with relevant family members or persons with medical power of attorney.

Resident movement during an outbreak

- Avoid non-essential resident transfers to minimise spread.
- Limit internal movement of residents, visitors and staff within the facility, as far as possible, to minimise spread.
- Implement physical distancing measures in shared living and dining areas.
- Follow, and keep up to date with, relevant guidelines for outbreak management in RCFs.¹¹

New admissions and readmissions during an outbreak

- RCFs should restrict admission of new residents into the facility. Depending upon the extent of the outbreak and the layout of the building, restrictions may be applied to a floor, a wing or the entire facility.
- Restrictions protect new residents and avoid extending the outbreak.

¹⁰ Communicable Diseases Network Australia [COVID-19 National Guidelines for Public Health Units](#)

¹¹ See Communicable Diseases Network Australia [Guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia](#)

- Residents who are in hospital for any reason, including COVID-19, should, if possible, be readmitted to the RCF as soon as they are well enough to be discharged from hospital. This should be considered case by case, considering both the patient's clinical condition and the circumstances within the facility. If in doubt, a consultant infection prevention and control professional should be consulted.
- Appropriate next steps for placement of the resident should be discussed with the resident, their representative, and the resident's hospital team.
- New and returning residents should be screened for relevant symptoms.

Visitor restriction and signage

Movement of visitors into and within the facility should be limited and physical distancing measures maintained. The following **IPC precautions** should be implemented.

- Follow, and stay up to date with, relevant advice on outbreak management in high-risk settings¹¹ and restrictions to visitors to RCFs.
- If appropriate IPC precautions can be implemented to protect staff and other residents, visiting restrictions may be relaxed in the context of end-of-life palliative care.
- Encourage and facilitate phone or video calls, or visits with physical barrier (e.g. window, balcony or 'see-through' fence) between residents and their friends and family members to maintain social contact while visiting restrictions are in place.
- Ensure all visitors, including essential external providers and visitors:
 - Visit only one resident (or staff member).
 - Go directly to the resident's room or area designated by the RCF, and avoid shared areas.
 - Stay 1.5 metres from residents, if possible.
 - Use ABHR or wash their hands before entering and on leaving the RCF and the resident's room.
 - Practise cough etiquette and respiratory hygiene.
 - If visiting a resident who is in isolation or quarantine, follow contact and droplet precautions, as directed by RCF staff.
- Post signs or posters at the entrance and other strategic locations to remind visitors of the precautions including donning and doffing instructions at PPE stations.
- Screen visitors on entry to the facility for epidemiological (recent travel, contact with a COVID-19 case) and clinical risk factors (acute respiratory infection, fever/history of fever or loss of smell or taste).

Duration of isolation precautions for confirmed COVID-19 patients

- Ceasing isolation precautions for residents who have had COVID-19 should be determined **case-by-case** by the local public health unit.¹²
- Outbreak precautions for the facility should remain in place until at least 14 days after the last case is diagnosed, or on advice from the public health unit.

Environmental cleaning

- During an outbreak, RCFs need to increase cleaning and disinfection of shared areas and residents' rooms.

¹² See Communicable Diseases Network Australia [Guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia](#)

- Frequently touched surfaces should be cleaned and disinfected frequently.
- Any resident care equipment should be cleaned and disinfected between each use or used exclusively for individual residents.¹³

Handling of Linen

- Soiled linen should always be treated as potentially infectious.
- Routine procedures are adequate for handling linen from residents in a RCF with a COVID-19 outbreak. This includes the linen of residents in quarantine or isolation.
- Relatives should not take linen home for laundering.
- Grossly contaminated/soiled linen should be placed in a soluble plastic bag and then placed in the linen skip. Alternatively, the linen skip can be lined with a plastic bag for soiled linen.

Food service and utensils

- The principles of food hygiene should be followed in food preparation and service.
- Staff should perform hand hygiene before preparing or serving food to residents.
- Disposable crockery and cutlery are not required.
- Crockery and cutlery should be washed in a dishwasher, if available. Otherwise wash with hot water and detergent, rinse in hot water and leave to dry.
- Cutlery and crockery from ill residents does not need to be washed separately. Hot water and detergent will inactivate any residual contamination.
- Staff should wash or sanitise their hands after collecting or handling used crockery and cutlery. Trays and utensils can be contaminated with saliva or respiratory droplets.
- Trays and trolleys used for delivery of food should be cleaned and disinfected after use.

Waste Management

- Waste can be managed in accordance with routine procedures.
- Clinical waste should be disposed of in clinical waste streams.
- Non-clinical waste is disposed of into general waste streams.

Management of Deceased Bodies

- Advice for handling of bodies affected by COVID-19 has been endorsed by CDNA and AHPPC.¹⁴
- Normal processes apply to the management of deceased bodies.
- RCFs should follow the same precautions when handling the body as when caring for the resident during life. RCFs should ensure contact and droplet precautions are followed if the deceased person had COVID-19.
- Deceased bodies should be placed in a leak-proof bag. Staff handling deceased bodies should wear a gown, surgical mask, protective eyewear and gloves.

¹³ See [Environmental cleaning and disinfection principles for health and residential care facilities](#)

¹⁴ See [Advice for funeral directors](#)

APPENDIX 1: CONTACT AND DROPLET PRECAUTIONS FOR SUSPECTED OR CONFIRMED COVID-19

Requirements	Contact and Droplet Precautions for COVID-19
Single room	<p>Yes, or cohort with patient with same virus (in consultation with an infection control professional, or infectious diseases physician). Maintain spatial separation of at least 1.5 metres.</p> <p>It is recommended single patient rooms be fitted with en suite facilities. If en suite facilities are not available, a toilet and bathroom should be dedicated for individual or cohort patient use.</p>
Negative pressure*	No
Hand hygiene	Yes
Gloves	Yes, if there is direct contact with the patient or their environment.
Gown/apron	Yes, if there is direct contact with the patient or their environment.
Surgical Mask	Yes. Remove mask after leaving patient's room.
Protective eyewear	Yes. This may be in the form of safety glasses, eye shield, face shield, or goggles.
Special handling of equipment	<p>Single use or, if reusable, reprocess according to manufacturer's instructions before reuse.</p> <p>Avoid contaminating surfaces and equipment with gloves used between tasks.</p>
Transport of patients	<p>Surgical mask worn by carer/health care worker if patient is coughing/sneezing or has other signs and symptoms of an infectious disease spread by respiratory route.</p> <p>Surgical mask for patient (if tolerated) when they leave the room.</p> <p>Patients on oxygen therapy must be changed to nasal prongs and have a surgical mask over the top of the nasal prongs for transport (if medical condition allows).</p> <p>Advise transport staff of level of precautions to be maintained.</p> <p>Notify area receiving the patient.</p>
Alerts	<p>When cohorting patients, they require minimum of 1.5 metres of patient separation.</p> <p>Visitors to patients' rooms must wear a fluid resistant surgical mask and protective eyewear and perform hand hygiene.</p> <p>Remove PPE and perform hand hygiene on leaving the room.</p> <p>Patient Medical Records must not be taken into the room.</p> <p>Infection Control Precautions.</p>
Room cleaning	Enhanced cleaning

APPENDIX 2: RECOGNISING AND MANAGING COVID-19 IN RESIDENTIAL CARE FACILITIES

QUICK REFERENCE GUIDE

Activity	Detail
COVID-19 suspected or Acute Respiratory Illness	<p>Even minor symptoms present (resident or staff member):</p> <ul style="list-style-type: none"> • A cough • Shortness of breath • Fever • Sore throat • Loss of taste or smell <p>Inform your senior nursing staff on duty; symptoms of COVID-19 in the elderly may be atypical</p>
Implement precautions as soon as resident shows acute respiratory illness symptoms	<ul style="list-style-type: none"> • Increase infection prevention and control measures • Contact resident's GP • Isolate resident if possible • Collect swabs as directed by medical officer • Warn visitors of risk
Infection control coordinator	<p>Name:</p> <p>Ph: Pager:</p>
Notify	<ul style="list-style-type: none"> • Your state/territory public health unit • Resident's GP and relatives or representative, all staff, all visiting GPs, allied health workers, volunteers, or anyone in contact with your facility
Document	<ul style="list-style-type: none"> • Details of resident(s) or staff member with symptoms • Onset date of acute respiratory illness symptoms for each resident • Types of symptoms • Their contacts – to identify 'at risk' groups
Manage residents who are ill	<ul style="list-style-type: none"> • Isolate from residents who are well • Dedicated staff where possible • Dedicated equipment: hand basin, towels (laundered daily), en suite bathroom, containers for safe disposal of gloves, tissues, masks, towels • Staff use personal protective equipment • Transfer to hospital if condition warrants or jurisdictional requirement
Restrict contact	<ul style="list-style-type: none"> • Symptomatic staff off work (and seek testing for COVID-19) • Limit staff movement into restricted area • Inform visitors and limit visit times • Suspend all group activities
Prevent spread	<ul style="list-style-type: none"> • Increase infection prevention and control measures • Personal hygiene – ensure good hand hygiene and respiratory etiquette • Environment – enhance cleaning measures • Medical – transfer to hospital if required

HAND HYGIENE BEFORE AND AFTER CONTACT WITH RESIDENTS

Source: Adapted from <https://www.health.gov.au/resources/publications/poster-influenza-kit-for-residential-aged-care>