COVID-19 Outbreaks in Residential Care Facilities

Communicable Diseases Network Australia

National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities
The Communicable Diseases Network Australia (CDNA) has developed this guideline in consultation with the aged care sector, including the Australian Health Protection Principal Committee (AHPPC) Aged Care Advisory Group. The AHPPC has noted this guidance. Where guidance differs from state and territory policies, residential care facilities (RCF) should follow local state or territory requirements.

Updates to this guideline reflect the current context of the COVID-19 pandemic. This includes consideration of the impact of the highly transmissible Omicron variant, widespread community transmission in most jurisdictions and outbreaks in many RCFs. Despite the increased case numbers, infection with the Omicron variant has been associated with lower rates of severe disease. This and the protective effect of high rates of vaccination in RCF residents and staff have been important in informing this update. The changes in this guideline also reflect the current limitations of local public health resources in many jurisdictions and adaptations in approaches to Test, Trace, Isolate and Quarantine (TTIQ) to manage high case numbers. These updates recognise the need for providers to move to a more independent approach in identifying and managing COVID-19 outbreaks, supported by resources and tools provided by jurisdictions and guidance from their local public health unit. This updated guidance proposes to support RCFs to take a more proportionate approach in managing the risk of COVID-19 with consideration of resident’s wellbeing, recognising the detrimental effects on residents, of social isolation and inactivity, in the context of lower rates of severe disease with the Omicron variant.

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 with a focus on roles and responsibilities.

This guideline incorporates information adapted from:

- Australian state and territory guidelines for COVID-19 outbreak management in RCFs
- documents and guidelines from the Australian Government Department of Health (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 COVID-19 outbreaks in RCF:

- administrators of facilities
- staff of facilities
- health and aged care workers
- public health authorities.

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

Any advice on infection prevention and control (IPC) and personal protective equipment (PPE) in this document represents the minimum national recommendations for all staff working within the resident zone,¹ in the context of COVID-19.

RCF should read these guidelines in conjunction with the Australian Guidelines for the Prevention and Control of Infection and Healthcare (2021). This guidance is not meant to be exhaustive but instead aims to supplement more detailed guidance available at a state, territory and institutional level.

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 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.

¹ Includes being in the same room as a resident and in corridors, communal areas and other areas of a facility where residents may enter
## Revision History

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1. Introduction

The information in this guideline applies to all RCFs in Australia and can be used to help facilities with planning, preparation, detection and management of COVID-19 cases and outbreaks.

The RCF can be any public or private service where facility staff provide residents with personal care or health care. This includes:

- residential aged care
- residential disability care
- community based residential health facilities (for example, drug and alcohol services)
- long stay hospital wards and rehabilitation hospitals
- other similar accommodation settings in Australia.

RCFs can be complex environments that have a high risk for transmission of COVID-19. This is due to factors including:

- a large number of residents on site
- residents who require frequent close contact for assistance with activities of daily living
- a large number of people who enter facilities enabling introduction of disease
- staff with variable training and experience in IPC and PPE use
- staff shortages and frequent use of temporary agency staff who may be unfamiliar with the facility, its processes and residents
- many people living and working closely with one another
- shared equipment and spaces which may include shared bathrooms and dining rooms
- residents who may be unable to remember or follow isolation and IPC processes
- difficulty scaling up actions in smaller outbreak settings.

For more guidance on disability residential services (DRS), see the Disability Supplement to the CDNA Guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia.
Legal framework

RCF are responsible for identifying and following relevant legislation and regulations. RCF must fulfil their legal IPC responsibilities by adopting standard and transmission-based precautions. The Australian Guidelines for the Prevention and Control of Infection and Healthcare (2021) and guidance from state and territory public health authorities outline these directions.

Commonwealth subsidised aged care facilities are also required to operate under the Aged Care Act 1997 to be accredited. Accreditation requires adherence to infection control standards and management of high impact risks. The Aged Care Quality and Safety Commission ensures Commonwealth subsidised organisations providing aged care services in Australia are complying with the Aged Care Quality Standards.

All RCF are required to adhere to the relevant Work Health and Safety (WHS) legislation in their jurisdiction.

COVID-19 is a notifiable condition under the Australian National Notifiable Diseases List (NNDL). In all Australian states and territories, the medical officer requesting the test and/or the laboratory performing the test must notify the relevant jurisdictional public health authority of the COVID-19 case, as per local legislative requirements. RCF should also report cases, including those detected via rapid antigen testing.

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2 Australian National Notifiable Diseases List (NNDL)
Roles and responsibilities

Residential care facilities

Providers must:
- provide quality care and ensure the safety and wellbeing of residents and staff, including by adhering to applicable quality standards and work, health and safety (WHS) requirements
- follow state/territory government directions and decisions
- follow the guidance and/or advice from the relevant public health unit (PHU), including complying with public health orders, staff WHS, and infection control requirements in their facility
- develop and maintain a facility specific Outbreak Management Plan (OMP) – include residents, families and staff in the development and maintenance of the plan.

RCF have responsibilities to:
- detect, declare and notify cases to the state/territory health departments or PHU, and the Commonwealth Department of Health and other relevant stakeholders
- recognise when exposures or outbreaks occur through the use of standard definitions
- manage the situation or outbreak in accordance with the facility OMP and guidance and/or advice from the relevant state or territory health department
- maintain quality care and safety of all residents and staff.
- establish and maintain regular communication in appropriate language or modality, with staff, residents and families regarding:
  - any COVID-19 cases in the facility
  - when an outbreak is declared
  - actions being taken as part of an outbreak response
  - options available for families to take residents home, including available supports
  - residents’ health status
  - when the outbreak is over
- as part of the planning and preparation phase, identify exposed and at-risk residents and staff and together develop appropriate mitigations to manage risk of COVID-19 in case of an outbreak or exposure
- follow jurisdictional directions, guidance and advice on outbreak management measures. This includes advice on IPC and appropriate use of PPE and rapid antigen testing (RAT) for screening and diagnosis
  - facility infection prevention and control lead/s to implement IPC actions
- support adherence to quarantine and isolation requirements
- support adherence to workplace directions by jurisdictional public health authorities
- help residents and families access independent, free and confidential advocacy supports.

The state or territory health department

State and territory health departments and/or the local PHU or Local Health District/Network are responsible for preventing and minimising public health risks to the community. They also lead the public health response for a COVID-19 outbreak in communities.

State and territory health departments can provide different levels of support to RCF to help detect, characterise and manage COVID-19 outbreaks and can range from active management to limited support through provision of advice.

Different jurisdictions have different approaches to managing outbreaks. It is essential that RCF staff and lead/s are aware of and follow current guidance around management of COVID-19 outbreaks in RCF for their jurisdiction.

Aged Care Quality and Safety Commission

The Aged Care Quality and Safety Commission (Commission) is the national regulator of Commonwealth subsidised aged care providers. It takes a proportionate risk-based approach to
ensuring aged care providers are meeting their requirements under the Aged Care Act. The role of the Commission is to:

- independently accredit, assess and monitor Commonwealth subsidised aged care providers against the Aged Care Act and Aged Care Quality Standards, including the providers’ responsibility to:
  - minimise infection-related risks by implementing standard and transmission-based precautions to prevent and control infection
  - enable access to appropriate clinical care
- resolve complaints about the providers’ responsibilities, including the delivery of aged care services
- ensure facilities maintain dedicated IPC lead/s who have completed an identified IPC course
- provide education to providers, including best-practice IPC.

The Commission, as part of the accreditation process, will have regard to evidence relating to IPC lead staff members when assessing compliance with the Standards. This includes: their role in the facility, their qualifications and additional training they have undertaken to ensure currency of skills.

**Australian Government Department of Health**

The Australian Government Department of Health (Commonwealth) provides funding to residential aged care facilities. The Commonwealth will assist and support Commonwealth subsidised aged care facilities (RACF) that have COVID-19 cases or outbreaks. These supports include:

- providing resources and advice to each RACF to guide their independent management of the outbreak including:
  - access to the National Medical Stockpile for supplies of PPE and RAT when commercial supplies are exhausted
  - in collaboration with PHU, arranging access to pathology services
  - facilitating access to primary health care, including GPs and allied health services, through Primary Health Networks (PHN).
- assessing the scope of the outbreak, and if required allocating a case manager who will connect the RACF to appropriate Commonwealth support services. This could include:
  - deployment of a First Nurse Responder (or ‘Clinical First Responder’) who can assist in assessing workforce requirements and providing IPC guidance in consultation with the facility IPC lead/s and jurisdiction.
  - assessment of the need for access to surge workforce support including clinical and non-clinical staff
  - deployment of standing nurse teams to provide additional IPC or clinical governance capability.
- Supporting RACF to establish and maintain their preparedness by:
  - establishing minimum standards for IPC training in collaboration with the RCF based IPC lead – each facility should have more than one IPC lead available
  - providing information and data to states and territories to support preparatory action and prevention
  - developing and distributing COVID-19 guidance materials in consultation with the relevant jurisdiction.

**National Disability Insurance Agency (NDIA)**

The roles and responsibilities of the NDIA are outlined in CDNA national guidelines for the prevention and management of COVID-19 outbreaks in disability residential services – The Disability Supplement.
Clinical Governance

Clinical governance is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms. They are implemented to support safe, quality clinical care and good clinical outcomes.

The Aged Care Quality Standards require aged care facilities that provide clinical care to demonstrate the use of a clinical governance framework (Standard 8, 3(e)).

In a COVID-19 environment, it is critical that services have established systems and processes to:

- ensure preparedness and readiness
- identify and manage clinical risks
- prevent harm including those of prolonged isolation
- improve the processes of clinical care
- ensure resident wishes / advance care directive/s are considered and up to date

The systems and processes must be supported by a clearly defined command and control structure. The leadership team should seek and act on expert advice and collaborate, openly, with external agencies.

2. Understanding COVID-19
Recognising COVID-19

COVID-19 is a contagious viral infection that in most cases causes respiratory illness in humans. Presentation can range from no symptoms (asymptomatic) to severe illness with potentially life-threatening complications. Atypical presentations are more common in the older person.

**Most Common - COVID-19 signs and symptoms**
- sore throat (more common with Omicron)
- fever (though this may be absent in an older person)
- cough
- shortness of breath, increased respiratory rate, drop in oxygen saturation
- loss of smell (less common with Omicron)
- loss of taste (less common with Omicron)
- loss of smell (less common with Omicron)

**Other - COVID-19 signs and symptoms**
- headache
- fatigue
- myalgia/arthritis (muscle/joint aches and pains)
- diarrhoea
- nausea or vomiting
- chills
- nasal congestion
- haemoptysis (coughing up blood)
- conjunctival congestion (red eyes).

**Older people - other COVID-19 signs and symptoms**
- confusion or behavioural change
- worsening chronic conditions of the lungs
- loss of appetite
- vague changes: ‘not their usual self’, ‘looks unwell’, ‘pale’
- decline in functional state.

RCF should ensure staff, family and competent residents are aware of these symptoms. Note that most cases will experience mild symptoms, particularly in a vaccinated population. Older patients often have atypical symptoms including behaviour change and may not develop a fever. Ideally, staff should know residents well so they can detect subtle changes in condition or behaviour.

See Monitor staff, residents and visitors for more information on monitoring symptoms in residents and staff to enable cases to be detected and managed early.

In cases where COVID-19 has been excluded, RCFs should investigate and exclude other respiratory illnesses with similar symptoms of COVID-19, including seasonal influenza, in accordance with the CDNA Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia.

Consider that influenza and COVID-19 may cause similar symptoms.
Disease Transmission

Incubation period
People with COVID-19 generally develop signs and symptoms 4-6 days after exposure to the virus. The incubation period for the Omicron variant has been reported as being shorter at 3-5 days. In rare cases, the incubation period may be longer than 14 days.

Infectious period
People are likely to be more contagious when they have a lot of virus present in their respiratory tract. This is called a high viral load. People are considered infectious from 48 hours before symptom onset. Some people never develop symptoms but may still be able to pass the virus onto others. This is why it is important to use good hand and respiratory hygiene, distancing and other IPC measures at all times.

For more information on the infectious period see the [CDNA COVID-19 National Guidelines for Public Health Units](https://www.cdha.ca).  

Routes of transmission
The SARS-COV-2 virus can be spread through:

- aerosols which can vary in size. Larger particles (also called droplets) can be inhaled when a person is close to a case and smaller particles (also called aerosols) can be inhaled after remaining suspended in the air.
- virus that is present on contaminated objects and surfaces and introduced by hands into a person's nose, mouth or eyes.

While it is unclear exactly what proportion of infections occur through each of these routes, those who have been in close contact with a COVID-19 case are at highest risk of developing COVID-19.
Quarantine and isolation

Quarantine and isolation are measures that help prevent transmission by keeping people who may be infected away from others.

Quarantine is the separation from others of a person who is well but may have been exposed to COVID-19.

**Isolation** is the separation from others of a person who is a confirmed or suspected case of COVID-19. People who have COVID-19 like symptoms and are waiting for test results may also be asked to isolate.

Confirmed COVID-19 cases should stay in isolation until they meet the release from isolation criteria. Confirmed COVID-19 cases can be cohorted together and, where appropriate and well enough, engage in social activities and dining together.
Complications

Most people with COVID-19 have mild disease and will recover. Some people can develop complications that are life-threatening and may lead to death. If severe disease occurs, deterioration can be rapid and distressing.

Older age is a risk factor for severe disease. Some chronic conditions also place people at higher risk of serious illness from COVID-19. See advice here. COVID-19 vaccination and boosters provide good protection against severe illness and death, including with the Omicron variant.

3. Preparedness
COVID-19 outbreaks in the presence of vaccination

When there is widespread community transmission, COVID-19 cases and exposures within an RCF are expected. The RCF and the public health response must be proportionate, balancing the risk of COVID-19 with the health and wellbeing of residents. Key issues in decision making regarding public health measures are resident welfare, vaccination status and a risk-based approach to managing quarantine and isolation so as to minimise as far as possible the adverse impacts of social isolation and deconditioning.

The high vaccination levels in residents and staff means that the risk of severe disease related to outbreaks is reduced. Providers should review COVID-19 risk management plans and adjust mitigation measures in response to the benefits associated with high levels of vaccination within the RCF and the lower rates of severe disease associated with the Omicron variant. This requires a transition to a risk-based management approach with a focus on protecting the vulnerable (i.e. residents who are immunocompromised, have comorbidities or are unvaccinated), to more independently respond to and manage COVID-19 outbreaks and a more ‘business as usual’ approach.

In a highly vaccinated population, the response to a COVID-19 outbreak should be proportionate to the risk posed by COVID-19 to the resident population. It is essential that residents are able to maintain physical exercise and social connection, with consideration of the rights of family and friends to visit. In particular, restrictions should be reviewed and adjusted to support visitation of partners of residents and other essential visitors (known as partners-in-care in RCF) who regularly provide additional day-to-day care and support to residents, as well as provision of opportunities for residents who are not cases or contacts to safely participate in communal activities within the RCF if they so choose.

RCFs must ensure they are prepared for outbreaks of COVID-19. To prepare for COVID-19 outbreaks, RCFs should:

1. Provide staff with ongoing education, training and assessment, including in IPC and outbreak management and ensure sufficient staff with expertise in IPC are available.
2. Ensure staff and visitors adhere to current guidelines for standard precautions at all times.
3. Ensure adequate supplies (e.g. PPE, RAT and other consumable materials).
4. Prepare an outbreak management plan that includes surge plan for workforce, PPE and testing, and regularly review it to ensure it aligns with current advice, public health directions and guidelines.
5. Consider where and how residents can be cohorted according to risk.
6. Ensure consultation with residents and those that care for them regarding their wishes after an exposure has occurred in the facility. Consideration should be given to their preference for strict isolation to prevent exposure and possible infection or their desire to socialise with others of similar exposures.
7. Support residents and staff to be fully vaccinated against COVID-19.
8. Support safe visitation to reduce the effects of social isolation and promote resident wellbeing.
9. Develop a systematic method for detecting and recording residents in the facility who develop COVID-19 like symptoms, such as fever or cough. This can be the same method used for detecting influenza-like symptoms, as outlined in the CDNA Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia.
Staff education

Each RCF must undertake regular staff training in all aspects of outbreak management before an outbreak. See Appendix 1 for topics to include in staff education in addition to IPC.

Infection prevention and control (IPC) program

For a sustainable IPC program, RCFs should ensure:

- appropriate physical and administrative controls
- adequate financial resources
- professional support
- continuing staff education and training.

The Commonwealth now requires Commonwealth subsidised residential aged care facilities (RACF) to have at least one IPC lead who is a member of the nursing staff and has completed an identified IPC course. For more information see Infection prevention and control lead/s.

All staff (including casual, domestic, hospitality and volunteer workers) need to understand the advice outlined in the Infection Control Expert Group (ICEG) COVID-19 guidelines for infection prevention and control in residential care facilities. They need to be competent in implementing these measures during an outbreak. Staff should also be aware of and follow any extra jurisdictional requirements.

Understanding standard precautions

Standard precautions are IPC practices routinely implemented in healthcare and RCF to reduce the likelihood of transmission of infection. They apply to all staff, residents and visitors. For more information, see the Australian Guidelines for the Prevention and Control of Infection in Healthcare.
Ensuring supplies

Facilities should stock adequate levels of all consumable materials required during an outbreak and have an effective process in place to monitor stock levels (including regularly counting stock and reviewing usage) and obtain stock from suppliers in advance as needed.

Supplies include:

- PPE (gloves, long sleeve, fluid resistant gowns, eye protection (face shield, goggles or safety glasses), masks and Particulate Filter Respirators (PFR) (with the classification of P2/N95 in various types and sizes). Note: normal prescription glasses do not provide adequate protection and are not suitable for use as eye protection
- hand hygiene products (alcohol-based hand rub, liquid soap, paper hand towel)
- diagnostic materials (swabs) or arrangements for immediate access to in-reach PCR testing
- rapid antigen tests (RAT) for testing of residents and screening of staff and visitors in accordance with jurisdictional and/or Commonwealth guidance
- cleaning supplies (detergent and disinfectant products):
  - a disinfectant on the TGA list of disinfectants for use against COVID-19; or
  - a chlorine-based product such as sodium hypochlorite
- clinical waste bags and linen bags (ensure jurisdictional guidance is followed regarding PPE disposal)
- medical supplies such as oxygen and equipment such as IV stands and syringe drivers for subcutaneous medication delivery
- an imprest pharmacy system to allow rapid access to restricted medications, where required.

The required amount of PPE will differ for each facility. RCFs should ensure they have enough supplies stored onsite for an immediate facility-wide commencement of care in full PPE. Additional supplies should be ordered if a case occurs in the facility. If cases occur, and the RCF cannot access PPE from commercial suppliers, they can request PPE from the National Medical Stockpile (NMS). For RCFs, state offices of the Commonwealth will coordinate access to PPE when cases are reported to the Commonwealth. For urgent issues, escalate applications through the relevant case management team.

Note that the ICEG does not recommend vinyl gloves for the clinical care of patients or residents in the context of COVID-19. Powder-free latex or nitrile gloves are superior in clinical care and are less likely to result in breaches compared with vinyl gloves. Gloves should be selected and worn in line with the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021).

Rough guide to estimate required PPE:

- Count the number of times staff members (including cleaners) access a resident’s room (for example, 20 times per day)
- Add in the number of times this access needs to be by 2 carers (for example, +3 times per day)
- Multiply this total by the number of residents in the facility.

A 100 resident facility would need to have onsite 2,300, (20+3) multiplied by 100, sets of PPE (mask or PFR, gloves and gowns) for one day.
Exposure and outbreak definitions

An RCF COVID-19 exposure is defined as:
- any case of COVID-19 in staff, residents or a visitor at the facility during their infectious period that does not meet the definition of an outbreak.

An RCF COVID-19 outbreak is defined as either:
- Two or more residents of a residential care facility who have been diagnosed with COVID-19 via RAT or PCR test within 5 days and has been onsite at the residential care facility at any time during their infectious period; or
- Five or more staff, visitors and/or residents of the residential care facility diagnosed with COVID-19 through RAT or PCR test within past 7 days who worked/visited during their infectious period.

Jurisdictional public health guidance may vary. It is important to ensure your approach is based on local guidance.
Considerations for exposure management and assessment

It is important to ensure the RCF approach is based on local guidance. In many jurisdictions, exposures within an RCF can be managed by the provider in line with the Updated COVID-19 Test and Isolate National Protocols without involvement of the PHU.

Following an exposure, RCFs should undertake exposure assessment to determine if any staff or residents have been exposed to the person with COVID-19 and develop an agreed management plan based on the degree of assessed risk. RCFs should refer to jurisdictional advice for guidance.

A management plan will support workforce planning, provide additional control to prevent outbreaks and inform outbreak management planning. Where exposure management plans are required they should be developed by the individual RCF in collaboration and consultation with staff, health professionals, residents and families. Plans should consider:

- mapping staff, visitor and resident movements to assess risk
- testing protocols for those exposed in line with jurisdictional testing guidance
- use of appropriate controls according to assessed risk
- defining roles and responsibilities within the RCF for assessing the risk from an exposure
- consider site specific factors that will impact the response required
- consider when advice of PHU may be required
- describe and define events that would require moving to outbreak management.
Considerations for outbreak management plans

Outbreak management plans developed by individual RCF need to be:

- site specific, tested and practised to ensure they are fit for purpose
- consistent with local jurisdictional public health guidance
- coordinated with the plans of other organisations in their communities and local/regional pandemic plans
- developed in collaboration / consultation with
  - staff
  - health professionals including primary care/general practice
  - service providers
  - other community organisations
  - residents and their representatives
- reviewed and updated regularly.

Plan to minimise exposure risk

Facilities should understand guidance and develop mitigation strategies to minimise exposure risk. For example, the use of eye protection and enhanced respiratory protection (P2/N95 rather than surgical mask) during the provision of resident care and whilst in prolonged contact will minimise the risk of exposure and transmission.

Plan to assess exposure

Understanding the exposure is important in assessing the likely risk related to an interaction. Management, in terms of quarantine (furlough) of staff after exposure to a case should consider degree of contact with the case and the use of PPE, this will help determine the likely exposure and the degree of risk. See the matrices in the Interim Guidance on managing workforce in regards to COVID-19 in aged care for details. It is also important to review local guidelines for advice around return to work for staff who have had an exposure particularly where there are workforce shortages.

Plan for an outbreak management team

RCF should activate their facility outbreak management team (OMT) to coordinate and manage the outbreak. The team members, roles, responsibilities and contact details of the facility team should be defined in the outbreak management plan.

An interagency OMT may also help provide an efficient, coordinated and rational investigation and management of the outbreak, including monitoring the outbreak, initiating changes to response measures, discussing outbreak management roles and responsibilities and ensuring timely and effective communication with all relevant stakeholders. The outbreak management plan also needs to clearly outline:

- in what circumstances an interagency OMT is required (i.e. a defined outbreak but not discrete exposures), this should be guided by jurisdictional advice
- team members
- roles and responsibilities
- up to date contact details of the team members
- alternate contacts or agreed processes in place in case a staff member needs to quarantine
- agreed policy and procedures (i.e. frequency of meetings, communications, function, documentation).

An outbreak should be managed as a command and response system. The leader/s of the response should be senior facility/provider staff with the authority to make decisions and delegate responsibilities. Consideration of alternative leader/s will be needed. As well as leading the facility OMT and chairing the OMT meeting if convened, OMT leader/s need to be present on site, visible, identifiable and accountable. The leader and others with specific roles in the outbreak need to be clearly identifiable (e.g. using different coloured masks or tape on the outside of PPE or hat).
The OMT should meet and communicate regularly. In the absence of a meeting, a streamlined process for communication with all agencies (that captures relevant data including case numbers, line lists, issues and risks) needs to be considered. Decisions should be documented. At each meeting they should update:

- new cases
- testing numbers, including staff who are not onsite
- resident vaccination status
- resident deaths / vaccination status
- IPC and PPE compliance
- clinical and welfare concerns
- workforce
- communication
- supplies – PPE, food services, laundry, waste management.
- This data can then be used for reporting to local, state and Commonwealth health authorities as required or requested.

See Appendix 4 for an example of OMT membership and roles.

**Plan staffing**

**Additional staff**

Additional staff are likely to be needed if there is an outbreak to compensate for those lost to quarantine/furlough and also for additional workforce required to manage the required mitigations for outbreak management. Replacement of staff (such as those who work repeated shifts due to worker furlough or shortage) should also be included in planning.

Staff policies for sick leave need to ensure staff, who at stay home because they have COVID-19 like symptoms, are not disadvantaged.

To manage staff absences the RCF should:

- have a staff contingency plan for surge capacity during an outbreak
- consider the current nature of the pandemic and ongoing outbreaks when planning leave
- develop and maintain a contact list for casual staff members or external nursing agencies
- educate and orientate surge workforce staff to the function of the unit before commencing work.

**Plan for work roles during an outbreak**

Structure the workforce management plan to minimise the movement of staff across multiple areas. Staff caring for residents with COVID-19 should not be caring for other residents who are not showing signs of the illness. RCF may consider site wide cohorting of staff to reduce the impact of an exposure on their workforce. All work should be in accordance with IPC plan and/or IPC lead guidance.

**Resident care and safety**

If the exposure assessment identifies that a significant proportion, or all, of the staff need to quarantine or furlough, arrangements must properly ensure resident care and safety.

The outbreak management plan must include arrangements for handover to replacement staff. The facility must make available current residents’ care/clinical records and operational information required to ensure that the safety of residents and staff is not compromised.

In an outbreak, consider ID wrist bands to assist new staff to identify residents. Picture boards of residents and facility site plans may also help staff who are unfamiliar with the facility to assist during outbreaks.

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3 The term ‘furloughing’ is used in some jurisdictions to describe staff being quarantined according to relevant legislation.
Plan for provision of healthcare

The outbreak management plan needs to consider and plan for the ongoing clinical care for residents during the outbreak. RCF may need onsite GP and allied health services support. RCF need to:

- understand in advance which GPs will attend onsite during an outbreak
- be aware of local clinical care options for COVID-19 including virtual support
- contact the local PHN who may be able to assist with identifying alternate GPs who can attend see your local Primary Health Network
- plan for the provision of routine health services during the outbreak including allied health, pathology and pharmaceutical services.

In an outbreak, the RCF may have staff, GPs and other health professionals who have not worked at the facility before. The outbreak management plan should include consideration of how new staff will correctly identify residents and access and use electronic management and resident care systems. This includes remote access to case notes including medication requirements and vaccination status.

The outbreak management plan needs to identify who will provide back-up IT services. The RCF Business Continuity Plan should already address access to electronic systems and reference to this may be sufficient. Keep resident care plans updated in electronic systems so that new staff have access to records and include up-to-date resident photographs.

Plan to cohort residents

A clear priority in managing an outbreak is to proactively limit spread to unaffected staff and residents, while taking a risk-based least-restrictive approach to requiring isolation and quarantine so as to minimise the impact of restrictions on residents. The principles are to:

- avoid proximity to and contact with COVID-19 cases
- avoid contact with potentially contaminated areas and equipment
- optimise ventilation.

To avoid contact with cases, cohorting is used to group individuals with the same clinical status in the same location. Consider re-arrangement of rooms and re-purposing of other areas. Plan how to cohort residents together into rooms, dedicated areas or a separate wing or building, where feasible. It may be helpful to let families know in advance about any temporary moves in the case of an outbreak.

Outbreak management plans should include floor-maps which have been colour coded and labelled with instructions for how to cohort in response to infection patterns.

Ideally, there should be five areas for:

- **Cases in isolation.** These are residents who have confirmed COVID-19 and have not yet met the criteria for release from isolation. Isolation in rooms should be limited to the shortest time possible to reduce risk of transmission. They may mix with other confirmed cases in isolation.
- **Contacts in quarantine.** Individuals who have met the close contact/household-like contact definition. Facilities should have policy support and plans to assist in the isolation of residents who choose to isolate and to manage those who are willing to risk exposure by continuing to mingle post exposure.
- **Released contacts.** This includes those who have completed quarantine. Groups with similar exposure or assessed risk can be considered for management in a shared space.
- **Recovered cases** who have been released from isolation. If cleared they may re-join other residents.
- **Buffer areas between potentially contaminated and non-contaminated cohorts.** For example, nurses station, corridors, staff lunchrooms, meeting rooms, drug rooms. This also includes transition points between areas where staff must put on or take off PPE.

Staff who are higher risk contacts and are returning to work during their quarantine period due to critical workforce shortages should only care for residents who are in the higher risk exposure group or who are cases.

If feasible and an entire wing or whole facility is impacted, asymptomatic residents may be given the choice to leave their rooms, eat in shared dining rooms (separate to or staggered from, exposed residents) and participate in social activities (for exposed residents). These residents should not enter
other parts of the facility and should participate in any required risk mitigations such as daily rapid antigen testing prior to leaving their rooms. Exposed and non-exposed residents should not mix within the facility.

### Linen and waste
- The outbreak plan should include the ability to increase clinical and general waste storage and removal as well as an ability to increase linen supply.

### Develop a communications plan
RCF should develop a proactive communication plan ready for immediate activation in the event of an outbreak. This will support:
- the provision of clear, consistent and timely information to all stakeholders
- reducing the demands on staff by proactively meeting stakeholders need for information
- accommodating an increased number of enquiries and contacts.

A communication plan is key to meeting the needs of families and staff who are likely to experience high levels of anxiety and uncertainty about how they will be impacted and how risks will be managed. Regular and effective communication is essential, especially if family and friends are unable to visit their loved ones. Specific staff will be required to be appointed solely for communication. There may be opportunity for staff who are quarantining at home due to COVID-19 exposure to take on this role.

For RACF, the [National COVID-19 Residential Aged Care Emergency Communication Guide](#) provides guidance on communication in advance of, and during, a COVID-19 outbreak. It covers roles and responsibilities, and communication protocols and processes for the Australian Government, State and Territory Governments, the Aged Care Quality and Safety Commission (ACQSC) and residential aged care facility (RACF) providers.

More information about how to prepare a communications plan is in Appendix 1.

### Plan for resident transfers

#### When there are COVID-19 cases in the community, but not in the facility
RCF should work with families and carers to plan in advance for resident care. If there is an outbreak in the local community, families may elect to take a resident home. If residents are going to be moved to a family member’s home from the RCF, they should be moved early if possible. Residents and families need to be aware that, if the resident returns when there is community transmission, they may be required to undergo temporary quarantine and testing.

#### When there are COVID-19 cases in the facility
Moving residents may help reduce exposure to the virus and prevent prolonged periods in isolation by limiting the extent and duration of the outbreak. RCF should be aware of jurisdictional guidance around management of residents in an outbreak situation (i.e. moving residents who have COVID-19 to hospital residents who are not infected to reduce transmission risk). Currently, many jurisdictions only transfer an infected resident to hospital if there is a specific clinical requirement.

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.

Any decision to transfer a resident within or external to the facility needs to be made in consultation with the resident, and any alternate decision makers for the resident. Residents wishes must be accommodated where possible – some residents who were absent from the facility when the outbreak commenced may choose to return to their home regardless of the risk of contracting COVID-19.

Residents and families need to be kept informed of any plans or decisions to move residents.

### 4. Prevention
RCF should apply controls to reduce the risk of COVID-19 entering the facility. Staff, family members of residents, and other visitors (including visiting workers) can transmit SARS-CoV-2 (the virus that causes COVID-19) to residents.
High density living, frequent close personal care contact, complex centralised systems and frequently used surfaces and areas all contribute to RCF being at particularly high risk. Therefore, RCF need to ensure they have appropriate screening measures in place on entry to a facility, including to guide management of residents returning to facilities. Advice for screening those entering facilities is provided by the Aged Care Quality and Safety Commission. When there is high, ongoing community transmission and there is sufficient rapid antigen testing (RAT) available, RCFs could consider introducing a testing program as part of their risk management measures. This may include RAT prior to staff entry, for residents after return from absences, or for visitors on entry. Where RAT supply is limited, focus may be on rural or remote facilities given the significant difficulties in finding alternative workforce and the potential need to transfer unwell residents significant distances from their home.

Protracted limitations on visitor entry has detrimental impacts on the wellbeing of residents. Family and friends support resident wellbeing and welfare, physical and mental health and improve quality of life. External service providers such as allied health and personal care are an essential component of person-centred residential care. RCFs should ensure that each resident can be visited by one essential visitor at all times, including during management of an outbreak or exposure (see below). The risk related to the entry of essential visitors needs to be assessed and mitigations applied to appropriately manage any risk associated with visitation.

All people who enter a facility need to consider their likelihood of introducing infection. The principles are that:

- **staff and visitors should not enter** if they have respiratory symptoms, irrespective of their vaccination status
- **people should stay home** if they have been required to quarantine
- **people should comply with any state or territory requirements**, including for COVID-19 and influenza vaccination
- **people can spread COVID-19** even if they do not have symptoms and as such, they:
  - must comply with RCF requirements, this includes wearing masks and undertaking a test if required
  - need to be more careful when there is high local community transmission
  - need to understand that outdoor visits are less risky for transmission than indoor
  - should minimise social contacts to reduce risk
  - should always use COVID safe behaviours including hand and respiratory hygiene and physical distancing where possible.
Use signs

RCF should use signs in multiple sites in the facility, in graphics and text to remind all people to maintain COVID safe behaviours and to designate specific zones where required.
Provide hygiene resources

Facilities must ensure that adequate masks, hand hygiene supplies, liquid soap, alcohol-based hand rub, paper towel, tissues and lined disposal bins are available for visitors to use. At a minimum these should be at the entrance of the RCF, in the visitor area and the entrance to each resident room.
Vaccination

Being fully vaccinated for COVID-19 reduces the risk of severe disease and vaccination of staff working in facilities is required in Australia. Completing a COVID-19 course of vaccination is strongly recommended for every resident and staff member. New residents should be encouraged to be vaccinated.

Unvaccinated people are not as well protected against severe disease. Unvaccinated people should be advised that if an outbreak occurs, different controls may be required to protect them from infection, such as a requirement to stay in their rooms for the duration of the outbreak.

**Facilities need to maintain records of vaccination history and status for each resident.**

Vaccinated people can still acquire COVID-19 but usually have a milder illness. Severe disease can still occur in a small proportion of vaccinated people particularly older people and those with certain comorbidities.

Vaccinated people can still spread the disease. Current evidence suggests that the initial amount of virus in a vaccinated person who acquired the disease is similar to those who are unvaccinated. However, vaccinated people may have a more rapid decline in their ability to infect others in subsequent days.

Please refer to local jurisdictional guidance for detail on the recommended quarantine period.
Establish a COVID Safe workplace

Outbreaks in RCF have shown that transmission can occur between staff. To reduce this risk, the RCF should ensure:

- ongoing education, training and communication about the risk of transmission
- measures to limit contact between staff working different shifts:
  - conduct handovers by phone instead of in person
  - minimise staff contact across a facility by cohorting staff to working in certain areas/wings
  - minimise staff mixing across shifts by rostering the same staff on together where possible
  - limit social contact between staff working different shifts
  - hold meetings virtually
  - ensure staff working change over shifts are not using the same locker room or shared facilities at shift change over
  - have strategies in place to avoid staff spending time together unmasked e.g. in tea rooms or in permitted smoking areas – this may require rostering of meal breaks and/or staff eating outside if weather permits.
- staff are encouraged to consider how and where they come together in the facility (e.g. offices, staff bathrooms and break rooms, encourage meal breaks to be taken outside if feasible) and to follow COVID Safe practices
- all rooms are labelled with how many people can be in the room at one time. The number needs to meet the state or territory density restrictions, such as 2 or 4 square metres per person.

5. Detecting a Case
Monitor staff, residents and visitors

A high level of vigilance and low threshold for investigation is needed particularly when there is widespread community transmission. Effective surveillance for fever or acute respiratory illness (ARI), and for atypical presentations in older people, can facilitate early detection and management of COVID-19 cases.

It is recommended that facilities:

- use a [screening tool](#) to assist identify cases in residents including by looking for signs of change
- have a policy and process to initiate testing residents and staff (either using RAT or PCR) for COVID-19 as soon as any respiratory symptoms or fever occur.

When disease in the community is high, periodic and comprehensive screening and testing of staff and focused testing of residents may be considered as one mitigation to reduce transmission.4

If staff develop symptoms, they should don a surgical mask, inform their supervisor, immediately leave the facility, have a test, stay home until they receive the test result and notify their supervisor of the result.

Staff and visitors may avoid testing when they have symptoms because of fear of isolation requirements. Regular, clear messaging around the need for timely testing and strict adherence to isolation/quarantine should be undertaken to mitigate this risk, particularly if there is community transmission. Messaging should be accompanied by other supports where possible.

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4 Modelling studies estimated that weekly PCR testing to screen health care workers and other high-risk groups irrespective of symptoms, would reduce their contribution to SARS-CoV-2 transmission by 23%. Imperial College COVID-19 Response Team *Comparison of Molecular Testing Strategies for COVID-19 Control: a mathematical modelling study* Lancet Volume 20, Issue 12, December 2020
Test for COVID-19 and other respiratory diseases

Testing programs can be effective at reducing entry and in controlling transmission of SARS-CoV-2. Testing programs should be developed in consultation with stakeholders, informed by jurisdictional guidance and supported by a formal policy approach.

Rapid Antigen Tests

Rapid antigen testing for SARS-CoV-2 may be used to diagnose COVID-19 in some jurisdictions and may be used in specific settings to screen for the disease. Rapid antigen tests are less sensitive than PCR tests resulting in a higher rate of false negative results. For more information see PHLN and CDNA joint statement on SARS-CoV-2 rapid antigen tests. RCFs should follow jurisdictional guidance on the use of rapid antigen tests. RCFs must be aware of the jurisdictional requirements for reporting/registering positive rapid antigen test results and should assist residents in this process.

Polymerase chain reaction (PCR) tests

PCR testing is used for diagnostic testing for COVID-19 in Australia. This usually involves taking a swab deep in the nose and back of the throat.

It can be difficult to tell whether a respiratory illness is caused by SARS-CoV-2 (the virus that causes COVID-19) or a different virus based on symptoms alone. In order to determine whether a respiratory illness is COVID-19, RCF should:

- facilitate testing for COVID-19 and influenza if residents have any new symptoms of respiratory infection and both illnesses are circulating locally
- consider testing for COVID-19 if residents have any other new symptoms and there have been COVID-19 cases in the community
- while awaiting test results, isolate the person in a room with a private bathroom wherever possible (in limited circumstances use of commode toilets may assist)
- ensure staff who care for the tested resident wear appropriate PPE.

If advised by a medical practitioner, the RCF should facilitate testing for other respiratory pathogens.

Specimen collection

The recommended tests and methods of sampling for COVID-19 are outlined in the CDNA COVID-19 National Guidelines for Public Health Units. Specimens should be collected by an appropriately trained health care professional or pathology collector using appropriate PPE. Depending on the location, saliva as a sample for testing may, or may not be, appropriate. Refer to PHLN statement on use of saliva as an alternative specimen. For the use of rapid antigen detection devices, users must follow the instructions for use provided by the manufacturer or sponsor. Using the incorrect specimen will invalidate the result. Staff should be trained in specimen collection prior to an outbreak occurring in an RCF. This may expedite the ability to have results available sooner. Devices designed for self-collection of a specimen and testing, must be used according to the manufacturer’s instructions.

Difficulties collecting a sample for testing

Testing can be difficult in some circumstances, for example:

- cognitive resistance or impairment – inability for resident to understand the process
- sensory deficit or dysphasia – inability to understand the explanation of the process or the rationale for testing
- communication barrier – people from non-English speaking backgrounds who may require a translator to understand the testing process or rationale and people with hearing deficits
- objection resistance – claimed right to refuse test expressed by resident (or advocate) or staff member
- behavioural resistance due to other issues or a combination of those described above.

All options to facilitate testing of residents should be explored, while considering mitigating risk for staff and resident, for example:
• leaving a swab for familiar staff members to use at a later time (this may not be possible if the specimen is critical to diagnosis)
• supervised self-testing
• alternative modes of testing such as saliva testing if verified in the RCF’s jurisdiction.

If no test can be undertaken due to lack of consent, resistance or distress the resident should be treated as though they had tested positive if they have had either symptoms or epidemiological links to suggest they may be. Whilst in isolation, the resident should have care provided with appropriate standard and transmission-based precautions until a test can be undertaken or an appropriate period of isolation has been completed. If the test was undertaken for screening purposes only (i.e. the resident is not a contact or symptomatic) isolation is not required.

Actions while awaiting a test result for symptomatic resident or a high-risk contact:
• isolate the resident and minimise interaction between other residents
• provide PPE supplies to staff and check practical skills in use of PPE for each staff member
• place PPE, including surgical masks, particulate filter respirators (PFRs), eye protection, gowns and gloves and a disposal receptable immediately outside the resident’s room
• place alcohol-based hand rub near the entry/exit of the resident’s room
• place signage outside symptomatic residents’ rooms to alert staff and visitors to the level of precautions required for the resident(s) and for how long. Signs are available at the Australian Commission for Safety and Quality in Health Care website.
• avoid using nebulisers, continuous positive airway pressure (CPAP) and suction if possible
• review all residents and staff for symptoms and document the results of this review
• continue to monitor all residents
• arrange testing for anyone else with symptoms compatible with COVID-19.

Provide notification of positive test results
Immediately notify state/territory health departments of positive test results, and the Commonwealth, where required.

RCF should notify the PHU of the case as soon as possible. See a sample reporting template at Appendix 5.

In residential aged care facilities, also report the case (within 24 hours) to the Commonwealth. For further information see the First-24 hours – managing COVID-19 in a residential aged care facility.

Disability residential services operated by registered NDIS providers are also required to report the case to the NDIS Quality and Safeguards Commission. For further information see the Notification of event form – COVID-19 (registered providers).

RCF must be aware of jurisdictional requirements for reporting positive rapid antigen test results and should assist residents in this process.

Determine whether the case/s constitutes an exposure or an outbreak

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

An RCF COVID-19 exposure is defined as:
• any case of COVID-19 in staff, residents or a visitor at the facility during their infectious period that does not meet the definition of an outbreak.

An RCF COVID-19 outbreak is defined as either:

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5 Refer to Infection Control Expert Group COVID-19 Infection Prevention and Control for Residential Care Facilities
6 Refer to the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021)
• Two or more residents of a residential care facility who have been diagnosed with COVID-19 via RAT or PCR test within 5 days and has been onsite at the residential care facility at any time during their infectious period; or
• Five or more staff, visitors and/or residents of the residential care facility diagnosed with COVID-19 through RAT or PCR test within past 7 days who worked/visited during their infectious period.

**A symptomatic case** is considered infectious from 48 hours prior to symptom onset to 7 days after the date on which the first positive specimen was collected.

**An asymptomatic case** is considered infectious, from 48 hours prior to the collection date of the first positive specimen to 7 days after the date on which the first positive specimen was collected.

A risk assessment should occur for staff members who have worked while infectious with consideration of the type/length of exposure and controls in place (such type of mask and eye protection).

If the diagnosis is not confirmed, clear and wide communication of these decisions will be important. For information on interpreting tests results see [PHLN guidance on nucleic acid test result interpretation here](#).

**State and territory public health unit contact details**

Table 1. State and territory public health unit contact details and links to jurisdictional guidance

<table>
<thead>
<tr>
<th>State</th>
<th>Contact Details</th>
<th>RCF outbreak guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>Business Hours: 02 5124 9213 After Hours: 02 6207 7244</td>
<td>Managing COVID-19 exposures and outbreaks in residential aged care facilities - COVID-19 (act.gov.au)</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>08 8922 8044</td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>13 432 584 (13 HEALTH) Coronavirus hotline: 134 268</td>
<td>Aged care sector</td>
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<td></td>
<td></td>
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<tr>
<td>South Australia</td>
<td>1300 232 272 Coronavirus hotline: 1800 253 787</td>
<td>Aged Care - COVID-19</td>
</tr>
<tr>
<td>Tasmania</td>
<td>General enquiries: 1300 135 513 Coronavirus hotline: 1800 671 738</td>
<td>Coronavirus (COVID-19)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>General enquiries: 08 9222 0221 Coronavirus hotline: 13COVID (13 26 843)</td>
<td>COVID-19 information for aged care and community care providers</td>
</tr>
</tbody>
</table>

Current contact details at the time of publication of these guidelines. Up to date local state and territory health department contact details are available on the [Commonwealth Department of Health website](#).
6. **Activate the Outbreak Management Plan**

Different jurisdictions have different approaches to managing outbreaks. It is essential that RCF staff and lead/s are aware of and follow current guidance around management of COVID-19 outbreaks in RCFs for their jurisdiction.

Supports can be provided through both jurisdictional public health units and the Commonwealth Department of Health. Support may range from active management to limited support through provision of advice and may include:

- provision of advice or directions on outbreak management in consultation with facility lead/s
- provision of advice or directions on required IPC measures for cases and outbreaks in line with jurisdictional requirements in consultation with facility IPC lead/s
- provision of advice or directions on testing requirements such as scope and frequency
- assistance with arranging tests and development of testing plans to support alignment with jurisdictional testing protocols
- assistance with monitoring, recording and reporting outcomes (case numbers, deaths and hospitalisations)
- assistance and support in defining the likely risk related to specific exposures and the required quarantine and testing requirements
- informing relevant clinical care providers in the relevant state and territory health departments of outbreaks
- declaring an outbreak over and/or endorsing the definition of an outbreak closure by appropriate authorities and determining when public health actions can be stood down.
Approach in exposure/outbreak investigation and management in RCF

It is important to refer to local guidelines and manage the RCF approach to exposures and outbreaks in accordance with jurisdictional guidelines. RCF should nuance their approach based on their risk assessment of the potential exposure and/or outbreak and available guidance. Jurisdictional public health units provide guidance to inform risk assessment and management.

Residents who are positive for COVID-19: Isolate in their room, if clinically indicated arrange transfer to a clinical care facility

People who acquire the disease after vaccination are still able to transmit the virus to others. If the disease is mild, residents can be cared for in the facility with appropriate attention to IPC. Residents should be assessed regularly and appropriate clinical care provided.

Consider a ‘least restrictive’ risk-based approach for managing isolation within an RCF to 7 days in accordance with the Updated COVID-19 Test and Isolate National Protocols.

Consider ‘cohorting’ residents in an RCF (where practical, and building layout allows) to ensure the smallest number of residents are impacted by isolation restrictions

Staff positive for COVID-19

If a diagnosis of COVID-19 is confirmed in a staff member, the staff member must isolate away from the facility. Isolation must continue until they meet the criteria for release from isolation outlined in the CDNA COVID-19 National Guidelines for Public Health Units (see Release from isolation). The RCF must make appropriate notification to the relevant authorities.

RCF undertakes a risk assessment to determine if there is an exposure or an outbreak and activates their Outbreak Management Plan if necessary

Actions will depend on the outcome of the risk assessment of the exposures or outbreak. In the case of an outbreak RCF may be required to:

Notify the state or territory health department

Notify the Commonwealth

Actions for identified exposures should be guided by local jurisdictional advice.

More information on early actions for Commonwealth subsidised aged care facilities is in the First 24 hours – managing COVID-19 in a residential aged care facility fact sheet. Information is also available through each jurisdiction’s health department website.

Activate the facility outbreak management team

The RCF provider is responsible for quality of care, safety and well-being of residents and should take a strong leadership role.

- Where an exposure is declared, this can be managed by the facility / provider and an outbreak management team (OMT) may not be required.

If an outbreak has been declared, the RCF should activate the facility OMT to direct, monitor and oversee the outbreak. The OMT will determine frequency of communication / meetings (in person or by teleconference / electronic) at the height of the outbreak to:

- monitor the outbreak
- identify problems
- initiate changes to response measures
- discuss outbreak management roles, responsibilities and priorities
- escalate concerns to the appropriate authorities.

Activate the interagency OMT if necessary

- The RCF should also consider whether activation of the interagency OMT is required. Refer to jurisdictional guidance.
Contact Assessment and Management

Conduct a risk assessment of each person’s potential exposure and activate testing regime

Within 24-48 hours, identify all people in close contact with the case/s (including visitors and staff).

For further information also see the First-24 hours – managing COVID-19 in a residential aged care facility.

For staff

Review affected staff to assess the risk of exposure. It is important to refer to jurisdictional guidance on return-to-work arrangements. You may also refer to the Commonwealth Permissions and Restrictions for Workers in Aged Care – Interim Guidance. This advice will help you determine quarantine requirements for staff. Staff who are low-risk exposures, or who are high-risk exposures but who work in areas where there is a high impact on services and are asymptomatic, will be able to continue attending work with specific controls in place (for example a negative RAT prior to each shift for the first 7 days following exposure). Staff identified as close contacts may not be required to quarantine when in the community but other mitigations may be required.

Refer to jurisdictional advice for guidance.

For residents

Review residents who may have had contact with the case. Movement restriction may be required for the affected group while risk is assessed. Residents who have shared a defined area (e.g. a wing of a facility) and/or who have had a household like exposure with a case during their infectious period, are considered close contacts. Residents who do not fulfill this definition are not. Contacts in defined area may be managed as group.

Access vaccination status and prioritise administration of booster immunisation

If an exposure has been declared, the single case is isolated to prevent further spread in the facility. Where an outbreak is declared, cases should be isolated with other cases, not with unexposed residents.

It is important that RCF 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 and deconditioning through application of the least restrictive controls appropriate.

Activate a focused testing regime as described below or as per defined jurisdictional guidance.

For visitors

Where an exposure has been declared

- A risk-based approach should be used to facilitate, where possible, essential visitors to impacted residents. Visitors who are usual partners in care, who are willing to comply with RCF required risk mitigations (such as vaccination, wearing appropriate PPE, taking a RAT, following directions from facility IPC lead/s etc) should be allowed to visit affected residents in their rooms.

- Other visitors should be discouraged or offered contactless visits. Residents who are not impacted should be allowed visitors as usual if affected areas can be appropriately separated to ensure safe visitation.

Where an outbreak has been declared

- A risk-based approach should be used to facilitate, where possible, essential visitors to impacted residents. Visitors who are usual partners in care, who are willing to comply with RCF required risk mitigations (such as vaccination, willingness to wear appropriate PPE, take a RAT test, follow directions from facility IPC lead/s etc) may be allowed to visit affected residents in their rooms. They should not move between an affected area and an unaffected area.

- Visitors who are not essential visitors may not attend residents who have had a high-risk exposure or who are cases. This group may be permitted as visitors through contactless visits. Where possible these visits should occur outdoors or in an area with significant natural ventilation.
• Visitors to unaffected parts of the facility can enter if they are willing to comply with the RCF required risk mitigations. They must be advised not to enter the affected parts of the facility.

• Establish separate areas for cohorting following the facility plan and arrange cohorting based on results from tests, exposures and choice of the resident.

In most circumstances, only cases require restriction to their rooms. Cohorting enables other residents with similar exposure or risk level, including residents with COVID-19, to be grouped together in an area of the facility away from other residents. The RCF should discuss with residents and their families action during an outbreak. This should include discussion of:

• desire to be isolated to prevent infection – some residents may choose to be isolated if there is a concern regarding a potential outbreak, others may choose to be able to leave their rooms where this is considered appropriate and proportionate to the risk

• desire to be visited and willingness of those visitors to adhere to any guidance put in place by the facility

• the acceptability of additional precautions applied to prevent infection in those residents who are higher risk e.g. unvaccinated or immunocompromised or not fully vaccinated

• risks and concerns if families wish to take care of a resident by removing them from the facility.

Use the facility plan to establish cohort areas in collaboration with the state or territory health department. See Plan for cohorting residents for more information.

Areas with residents who have confirmed or suspected COVID-19 should be geographically separated. Residents in quarantine can be managed with people with similar risk and management should be based on a risk assessment. Facilities have found it useful to have staff who can act as runners to fetch items for staff who are wearing PPE.

• Ensure the areas:
  • are clearly designated with clear signage in place
  • have a hygiene and PPE station and waste disposal at entry if appropriate
  • are decluttered as much as possible to make cleaning and decontamination easier
  • have limited entry/access to each cohort
  • have separate (and spacious if possible) break areas for staff
  • have single rooms. If individuals in quarantine need to be placed in shared rooms, consideration should be given to transferring residents where possible, to allow single occupancy in a room. If individuals must be placed in shared rooms, they should be separated by at least 2 metres. Wherever possible, privacy screens or barriers that can be wiped clean should be used to physically separate individuals.
  • have dedicated areas where staff can change before leaving work.

Enhance infection prevention and control

Increase the number of sites for hand sanitiser, one should be available at each bed space.

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).

Detailed information on environmental cleaning and disinfection is in the COVID-19 Environmental cleaning and disinfection principles for health and residential care facilities factsheet. Disinfectants registered with the TGA as effective against the virus (SARS-CoV-2) are listed at TGA disinfectants use against COVID-19.
Additional requirements for cleaning will be:

- a system to clean and disinfect reusable PPE and shared equipment
- an increase in the number of cleaning staff to:
  - support enhanced cleaning schedules
  - provide daily cleaning and disinfection of individuals' rooms and communal areas.

Use appropriate PPE

For detailed information on risk assessment for appropriate PPE use and IPC for RCF, see the ICEG guidelines for IPC in residential care facilities and refer to local public health advice.

RCF should undertake a local risk assessment to inform the appropriate level of PPE for staff providing direct care or working within the resident zone.7

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.

Precautionary approach

Early in an outbreak, before a risk assessment is able to be undertaken, P2/N95 respirators should be used for early responders to facilities reporting a case/s of COVID-19 while the extent of the outbreak remains unknown.

Risk based approach

If supported by local guidance, once cohorts/individuals at low risk have been established staff may use a surgical mask in place of the P2/N95 along with other appropriate PPE including gloves, gown, and eye protection.

Usage

Staff need to undergo regular training in PPE use and need to be monitored to ensure correct use (donning, doffing and fit checking) across all shifts, as strict techniques and processes can be hard to maintain. Staff spotters should be used to observe and support donning and doffing of PPE, particularly in the early stages of an outbreak. See Personal protective equipment training for information on fit testing and fit checking.

Activate the RCF Communications Plan

For exposures and outbreaks a dedicated staff member should be directed to activate the communication plan and be responsible for communication with staff, residents and families. Communication should be frequent and clear and all communication with should be documented.

Collate information into a line list

The minimal information required in the list of cases is provided below. This table is called a line list where one line is for each case. RCFs should appropriately record this information and provide to local public in accordance with local guidance.

<table>
<thead>
<tr>
<th>Case Name</th>
<th>Staff or resident</th>
<th>DOB</th>
<th>Location in facility or place of care</th>
<th>Date test positive</th>
<th>Symptoms Yes/No</th>
<th>Number of doses of vaccine</th>
<th>Date of last vaccine</th>
</tr>
</thead>
</table>

7 Includes being in the same room as a resident and in corridors, communal areas and other areas of a facility where residents may enter.
Activate your screening/testing program

Lessons from outbreaks in Australia have shown that it is useful to have defined testing programs to manage outbreaks and exposures in facilities.

It is important to note that jurisdictional guidance around testing regimens may differ and it is important to refer to local guidance. Some testing regimes are described in Table 2.

Table 2 Possible testing regimes during an outbreak in a facility (RCF should be aware of jurisdictional testing protocols)

<table>
<thead>
<tr>
<th>Situation</th>
<th>Testing population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First positive case, resident or staff member (care provider or other) who worked while infectious</td>
<td>Focus testing on the identified exposure group. This might include staff (clinical, administrative, cleaning, catering etc.) and residents. Visitors who attended and were exposed while the case was infectious (usually 48 hours prior to symptoms or 48 hours prior to the positive test if asymptomatic) should be contacted and referred for testing in the community.</td>
</tr>
<tr>
<td>Positive case in a staff member who had not worked during their infectious period</td>
<td>No additional testing required (except in accordance with public health advice). If concern is that RCF was source of infection, appropriate testing of possible sources.</td>
</tr>
<tr>
<td>Ongoing outbreak</td>
<td>May be focused (symptomatic or exposed residents and staff) or include all residents and staff at a regular interval (refer to jurisdictional public health advice) but NOT those who have been cleared from isolation for COVID-19 in the past 4 weeks. Refer to jurisdictional advice.</td>
</tr>
<tr>
<td>Quarantined or furloughed staff or residents</td>
<td>An early test (approximately day 2) and a later test on day 6 or as mandated by the PHU. At any time with symptoms.</td>
</tr>
<tr>
<td>Stable outbreaks near the end with no ongoing spread evident (as advised by PHU)</td>
<td>Cease regular testing regime when no new cases identified or as directed by the PHU. Test all previously negative staff and residents before exit from quarantine/furlough or as guided by the PHU.</td>
</tr>
</tbody>
</table>

Note: Where there is likely to be a delay in testing due to resources (e.g. in rural/remote areas) the RCF must notify the Commonwealth and seek advice from the state/territory health department.

Declare an outbreak over

Any of the following may result in declaring the outbreak over:

- Source of infection and transmission understood within the facility, and there is no further risk of transmission.
- No further resident cases identified within past 7 days from when the last case was effectively isolated.
- Where residents identified as a case or close contact are able to effectively isolate and there is no ongoing risk, the RCF can consider a staged return to business as usual.

An outbreak may be declared over when any of the above are met. For more sensitive areas such as Dementia or Memory Units a period of up to 14 days may be considered, review jurisdictional advice for guidance.

The outbreak may be declared over by the RCF lead/s or with consultation with the PHU. Please refer to jurisdictional guidance for details.

Additional precautions for the period from 7-14 days may be required. Review jurisdictional advice for further guidance. This may include screening, movement restrictions or other protections.
7. Other considerations during an outbreak
Ensure ongoing clinical care for all residents

All residents should receive their usual ongoing medical care, including essential allied health and mental health care, during the outbreak and the outbreak recovery period. Services that maintain the physical and emotional wellbeing of residents should continue to be provided as much as possible.

Some services may be provided through remote monitoring and telehealth and RCF need to ensure that they have the technology available to support this. Good IPC practices are needed for the safe use of remote monitoring and telehealth equipment, including tablet devices.

All visiting GPs should be informed at the start of the outbreak and provided with the contact details of the clinical oversight manager. A sample letter for GPs can be found in Appendix 7.

In addition to a letter to GPs, Commonwealth funded aged care facilities and disability residential services may also contact the Primary Health Network. The Primary Health Network may liaise with those providing primary medical and allied health care in the local area. They can assist in sourcing practitioners willing to attend facilities. This will ensure ongoing continuity of care where usual GPs and allied health professionals are unable to do so.

GPs may not be aware of the role they can play during an outbreak and may be more willing to be involved once they are given information about what they can do.

Local virtual COVID-19 care pathways may be available to residents. Facilities should be aware of local resources.
Provide care for residents with mild disease / symptoms

Cases of mild disease are likely to occur especially in vaccinated residents. These residents are able to be cared for in the facility using appropriate infection prevention and control to prevent spread to others. Assign staff to provide care only to those with COVID-19 and not care for other residents during the outbreak.

A useful resource for providing care for people in the community with COVID-19 is the RACGP home care guidelines.

A showering risk assessment should consider:

- the residents’ fitness level and ability to cooperate
- ventilation
- layout of the shower room
- whether appropriate distance from other residents can be maintained
- the degree of support needed
- time spent in close proximity to the resident.

To assist a resident who has COVID-19 in the shower

- wear appropriate PPE, including a P2/N95, face shield, fluid resistant gown, gloves and water-resistant boots or shoe covers
- turn on extractor fans while showering and leave the door open, if possible
- avoid getting the Particulate Filter Respirators wet, as much as possible
- doff and dispose of PPE safely and don new PPE.
Enable resident bathing

It is important that residents who have COVID-19 are able to shower or have bed baths to maintain personal hygiene. Independent showering should be facilitated if supported by a risk assessment. If not supported alternatives, such as a bed bath, should be provided if the risk of a shower is unacceptably high.
Visitors

- During a COVID-19 outbreak when vaccination rates are high, visitor access into and within the facility may be limited. However, visitor access should continue to be facilitated by RCFs, to mitigate the adverse effects of social isolation on residents. Visitation arrangements must comply with state and territory directions. Measures that RCFs can consider during an outbreak include:
  - Only allow visits by people likely to comply with RCF mitigations and jurisdictional directions
  - Visitors should comply with local public health and RCF requirements this may include:
    - a state approved check in app
    - complete a screening questionnaire on entry to ensure they are asymptomatic, and have not been identified as a close contact or directed to quarantine wear PPE as directed by staff (young children may not be able to comply)
    - avoidance of specific areas (such as communal areas or other resident areas)
    - consider visiting outdoors
    - good hand hygiene before entering and after leaving the facility, and the resident’s room
    - have a negative rapid antigen test prior to entry
    - review of vaccination status.

RCFs may also consider the advice in the Industry Code for Visiting RAC Homes during COVID-19

Essential visitors to exposure or outbreak affected areas of an RCF

RCFs should enable each resident to be visited by an essential visitor at all times, even during an outbreak.

- **Essential visitors**: are people who provide one or more of physical, social and emotional support to a resident. This may include people who provide personal care, people who support residents with mental health concerns, dementia or cognitive impairment or other support. Essential visitors can also be known as ‘partners-in-care’.

- **Risk based approach**: should be used to facilitate, where possible, essential visitors to impacted residents. Visitors who are usual partners-in-care, who are willing to comply with RCF required risk mitigations (such as are fully vaccinated, are willing to wear appropriate PPE, take a RAT, follow directions from facility IPC lead/s) should be allowed to visit affected residents in their rooms. However, if an essential visitor is not fully vaccinated, other measures may be considered to allow that person to continue visiting and supporting the resident. A factsheet prepared by the ACQSC provides more information on the partners-in-care model.

- **Visitor Mitigations**: should be based on RCF specific risk assessment but generally, essential visitors should not move between an affected area and an unaffected area. RCFs should offer essential visitors the opportunity to undertake basic IPC training, including use of PPE.

- **Non-essential visitors**: those who are not usual partners-in-care or who are unvaccinated may not attend residents who have had a high-risk exposure or who are cases. This group may be permitted as visitors through contactless visits. Where possible these visits should occur outdoors or in an area with significant natural ventilation.

- **Volunteers**: Access to volunteers should continue during outbreaks to ensure social engagement and resident wellbeing. In these cases, volunteers should meet the same requirements as essential visitors, including undertaking basic IPC training, completing pre-entry screening and being authorised by the RCF.

- **Visitors to unaffected parts of the RCF**: these visitors can enter if they comply with public health and RCF requirements (which may include being fully vaccinated, completing pre-entry screening procedure, RAT testing, PPE and following instructions). They must be advised to avoid the affected parts of the facility.

Visiting residents who have COVID-19

Visits to residents with COVID-19 should also be managed using a risk-based approach. It is particularly important in compassionate circumstances such as end of life care. RCF should consult with the PHU to determine appropriate mitigations to support families, carers, and pastoral supports (emotional and spiritual support) to visit cases. Mitigations may include measures such as assessment of vaccination status, use appropriate IPC and PPE and no contact with other residents.
Manage staff

- Once resident cohorting measures are in place, application of specific measures may help reduce the risk of transmission, mitigation measures should be applied based on the individual RCF risk assessment. Measures include:

  - **Allocate specific RCF staff to the care of residents in isolation.** Staff should not share common areas with staff from other sections or move to other areas of the facility.

  - **Support staff caring for residents with COVID-19.** Staff may need to be supported to be accommodated out of their own homes (e.g. onsite, nearby hotels) if they live with other vulnerable people.

  - **Limit roles.** For example, dedicated kitchen staff should not undertake cleaning roles and not enter areas where there are confirmed or suspected cases of COVID-19 or individuals in isolation.

  - **Screening.** Staff working should participate in focused or whole-of-facility testing following internal policy or jurisdictional or Commonwealth Department of Health guidance, and be regularly screened for symptoms (and tested, if necessary) during an outbreak. Focus should be on staff caring for cases. Record staff testing details in a register.

  - **Maintain a register.** The RCF should maintain a register of staff members caring for residents with COVID-19 or working in an area with COVID-19 cases (e.g. cleaners). It is also important to maintain a record staff who are away because of COVID-19 exposure or illness and the date cleared to return to work.

Take a risk-based approach to manage risk related to admissions and transfers

The ICEG guidelines for IPC in residential care facilities provide detailed information on the management of admissions and transfers during an outbreak.

Residents may attend medical or procedural appointments. The RCF should:

- consult the service provider to determine if the appointment is essential and alert them to the status of the resident
- ensure the resident wears a surgical mask when attending the appointment, if tolerated
- ensure staff escorting residents wear appropriate PPE, which may include a surgical mask or PFR, gown, eye protection and gloves, and observe hand hygiene
- make transport arrangements in consultation with transport providers including carers/family.

**New admissions**

Admissions of new residents into the affected area of the facility during an outbreak should be avoided, where possible. Depending upon the extent and stage of the outbreak and the physical layout of the building, restrictions may be applied to one floor, a wing or the entire facility.

**Re-admission of residents confirmed to have COVID-19**

The return of residents who have been admitted to hospital needs to be considered on a case-by-case basis but should be facilitated by the RCF if possible. This also applies for those residents who are still infectious and require isolation from others. A decision to return a resident needs to take into account:

- the best care for the resident
- the potential for ongoing transmission from the case
- the ability of the RCF to continue to safely isolate the case
- the level of community transmission
- hospital capacity.

If the isolation period can be completed successfully in the facility, it may be appropriate to return the resident to the RCF for care. This will require consultation between the PHU, treating clinicians, RCF as well as the resident and family. Refer to Release from isolation below for further details.

**Re-admission of residents/people without COVID-19**

The re-admission of residents who are not a known COVID-19 case should be considered if the resident can be cohorted away from other residents who have COVID-19, or are in quarantine, if consent has been obtained from the resident and their family and the risk is understood. Re-admission to an affected area of the facility should be avoided if possible where an outbreak is uncontrolled and ongoing cases are being detected.

If non-cases are re-admitted, the resident and their family must be informed about the current outbreak and risk to the resident. Adequate outbreak control measures must be in place. Residents and families may wish to make alternative arrangements (e.g. family care) until the outbreak is over. If the resident returns from the community when there is community transmission, they may be required to undergo temporary quarantine and testing.

**Moving unaffected residents out of the facility**

In some circumstances, it may be feasible to transfer residents who have not been exposed to COVID-19 to other settings (e.g. to family care) for the duration of the outbreak. A risk assessment should be done to understand the family circumstances and health status prior to transferring residents. The PHU may provide advice. Considerations will include the vaccination status of the resident and of every member in the receiving household. If there is a requirement to quarantine, details will be needed for how this will be done and who will co-quarantine while providing care. The clinical needs of the resident and plans for if the resident develops COVID-19 will also need to be considered. Decisions to move residents should be made quickly to minimise ongoing risk of exposure.
Unless there is a Public Health Direction or Order preventing movement of a resident, the final decision rests with the resident or, if they are unable to make the decision, the resident’s representative.

Note: In residential aged care settings, residents who take emergency leave do not use any of their social leave entitlements. This means they can move in with their family during the emergency without losing their aged care place. More information is at Coronavirus (COVID-19) Information for Permanent Aged Care Residents – Emergency Leave.

Transfers to hospital

Admission to hospital should generally be undertaken only if required for clinical care. It is noted that other considerations such as the outbreak situation, the state/territory policies, the needs of the individual resident, and the ability to manage the case on site without placing other residents at risk must be assessed. If transfer to hospital is required, the ambulance service and receiving hospital must be notified of the outbreak/suspected outbreak verbally. A resident transfer advice form (see Appendix 11) must be completed. Ensure the Advanced Care Directive accompanies the resident to hospital if one has been prepared.

When there is widespread community transmission transfer to hospital of unexposed residents may not prevent exposure (e.g., from visitors to the hospital, or nosocomial transmission).

Releasing residents from isolation in RCF

Jurisdictions provide guidance regarding when COVID-19 cases can be released from isolation. These criteria are outlined in the CDNA COVID-19 National Guidelines for Public Health Units and the COVID-19 Test and Isolate National Protocols. If a person has met the appropriate criteria it is not necessary for them to:

- undergo isolation or quarantine in another ward, the facility they are returning to, or any other location, or
- have evidence of any negative test results for SARS-CoV-2 prior to returning to residential aged care or any other setting.
Declare the outbreak over

Outbreaks can generally be declared over at 7 days after the date of isolation of the last case. The outbreak may be declared over by the RCF lead/s or with consultation with the PHU. Please refer to jurisdictional guidance.

More sensitive areas such as Dementia or Memory Units a period up to 14 days may be considered. Additional precautions for the period from 7-14 days may also be required. This may include screening, movement restrictions or other protections. Refer to jurisdictional guidelines.

Review the Outbreak

After declaring an outbreak over, the facility lead/OMT should reflect on:

- strengths and weaknesses in the response and investigation
- which policies, practices, or procedures to improve responses for future outbreaks.

It is useful to complete an audit. Audits are used in practice as part of continuous quality improvement. They can be useful for healthcare workers to review how the outbreak was managed. Australian public health practitioners and researchers have developed an outbreak audit process, with:

- a framework for deciding which outbreak investigations to audit
- an approach for conducting a successful audit
- a template for trigger questions.

Please see Outbreak Investigation Audits to access an auditing tool. This tool helps agencies like RCF to assess their outbreak response against best practice. RCF should provide a document outlining lessons learned to the PHU and Commonwealth. This will help enable ongoing quality improvement in the management of outbreaks.
## 8. Glossary

<table>
<thead>
<tr>
<th>Terms</th>
<th>Glossary</th>
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</thead>
<tbody>
<tr>
<td>AHPPC</td>
<td>Australian Health Protection Principal Committee</td>
</tr>
<tr>
<td>ARI</td>
<td>acute respiratory illness</td>
</tr>
<tr>
<td>CDNA</td>
<td>Communicable Diseases Network Australia</td>
</tr>
<tr>
<td>CPAP</td>
<td>continuous positive airway pressure</td>
</tr>
<tr>
<td>DRS</td>
<td>disability residential services</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
</tr>
<tr>
<td>ICEG</td>
<td>Infection Control Expert Group</td>
</tr>
<tr>
<td>ILI</td>
<td>influenza-like illness</td>
</tr>
<tr>
<td>IPC</td>
<td>infection prevention and control</td>
</tr>
<tr>
<td>NACAP</td>
<td>National Aged Care Advocacy Program</td>
</tr>
<tr>
<td>NDIA</td>
<td>National Disability Insurance Agency</td>
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<tr>
<td>NNDL</td>
<td>National Notifiable Disease List</td>
</tr>
<tr>
<td>OMT</td>
<td>Outbreak management team</td>
</tr>
<tr>
<td>OPAN</td>
<td>Older Persons Advocacy Network</td>
</tr>
<tr>
<td>PCR</td>
<td>polymerase chain reaction</td>
</tr>
<tr>
<td>PFR</td>
<td>particulate filter respirator</td>
</tr>
<tr>
<td>PHN</td>
<td>Primary Health Network</td>
</tr>
<tr>
<td>PHU</td>
<td>Public health unit</td>
</tr>
<tr>
<td>PPE</td>
<td>personal protective equipment</td>
</tr>
<tr>
<td>RAT</td>
<td>rapid antigen test</td>
</tr>
<tr>
<td>RCF</td>
<td>residential care facilities</td>
</tr>
</tbody>
</table>
9. Appendices
APPENDIX 1. Processes, plans and training needed to prevent and prepare

Processes

- Establish processes to screen all staff and visitors for symptoms or identify whether they have been at risk of exposure.
- Ensure there is access to infection control expertise, preferably in-house. Note: there are specific requirements regarding IPC staff at residential aged care facilities, see the Department of Health website for more information.
- Training program for all aspects of outbreak management, including:
  - IPC, PPE use including fit testing and checking of PFRs. This should include face to face training on:
    - hands-on practical experience on the hierarchy of actions that provide IPC. For more information see COVID-19 hierarchy of controls.
    - correct use of PPE, donning and doffing see Section 3.3 Table 14 in Australian Guidelines for the Prevention and Control of Infection in Healthcare.
    - observing other workers for safe donning and doffing
    - regular refresher training on IPC measures. Training is not ‘once only’ but a continuous process for maintaining competency in IPC, including PPE use in routine drills to practise the training.
  - what to expect if case/s occur in a facility
  - COVID-19 vaccination
  - where to access individual state or territory directions and exposure sites
  - what to do if experiencing even mild symptoms of COVID-19 (get tested and stay home while awaiting test results)
  - what to do after contact with a known or suspected case (quarantine if a close contact)
  - requirement to notify cases to PHUs.
- Regular program of re-training in place to review and refresh IPC and PPE skills.
- Standard IPC precautions in place.
- Adequate supply of TGA approved PPE available and a reliable source for further supplies.
- Established systems to monitor residents and staff for symptoms of COVID-19.
- Developed outbreak management plan, which is tested and regularly updated including:
  - membership
  - surge workforce plan
  - communications plan (see below)
  - established linkages and integrated with the applicable state and territory preparedness arrangements
  - processes for laboratory tests.
- Prepared, practised and operationalised COVID Safe plans in keeping with state public health orders.
- Conducted a WHS risk assessment and addressed identified gaps.
- Established clinical models of care for all residents during facility lockdowns and outbreaks.

Note: smaller facilities such as disability residential services may not have access to in-house services, such as a regular training program for IPC and PPE or an existing supply of PPE. Facilities in these circumstances should consider seeking support from local health providers to assist in preparation for COVID-19 outbreaks.

Communications Plan

The communications plan should have established systems to manage communications and engagement with families of residents and community that support the RCF. This should include consideration of materials in languages other than English and images.
RCF will need to develop a list of contact details for people and organisations who will need to be contacted if there is an outbreak. These include:

- the local PHU
- for residential aged care facilities - the Commonwealth email address (agedcareCOVIDcases@health.gov.au)
- resident’s family and friends. These contacts need to be more extensive than the usual primary contact(s) to avoid the risk that family and friends find out information through the media first
- attending general practitioners and allied health professionals
- the Primary Health Network
- the local health department
- geriatric in-reach services
- usual contractors such as cleaners.

The communication plan should identify the following:

- dedicated staff to manage communications. A very high volume of inbound and outbound calls should be expected during an outbreak. RCF need to consider if they will have the capacity to handle this volume. Where a facility does not have capacity, an external call centre can be pre-arranged to undertake communication activities on behalf of the facility.
- a dedicated registered nurse or appropriately qualified individual (e.g., social worker) to provide updates and liaison with frontline carers who are behind the quarantine line
- staff who have been trained in IPC precautions and PPE use to facilitate phone and video calls with the resident, family, and aged care advocates during the outbreak.
- The plan should also include strategies for providing information to residents, families, staff, and other visitors (e.g., government and non-government external providers) during the outbreak period. This may include:
  - identification of communication channels such as phone, email, webinars, website and social media, as well as telecommunication facilities for teleconferences with multiple agencies
  - establishment of Facebook groups, videoconference groups and email lists in the preparation phase to pre-communicate with residents and families. This will ensure they can be utilised during an outbreak, noting that usual communication channels may not be available.
  - development of email templates and talking points, including in languages other than English where appropriate, including messaging on:
    - the initial announcement of the outbreak and what residents, families and staff should expect during the outbreak (e.g. how families will be updated on the status and welfare of individual residents)
    - options for connecting residents with families during extended periods of isolation, such as window visits, video calls and phone calls
    - how infection risks will be managed and support for staff who are identified as infected or as close contacts
    - identifying methods for communicating with residents or family members who are not computer literate. Providing a link to a letter or other communication may not be useful. A phone number they can ring and/or other form of communication should also be provided
    - pre-preparing informative signs including for designated cohort areas and for donning and doffing PPE stations.
  - RCF also need to consider protocols for managing media enquiries in liaison with the state health media advisers.
  - For RACF, the National COVID-19 Residential Aged Care Emergency Communication Guide provides guidance on communication in advance of, and during, a COVID-19 outbreak. It covers roles and responsibilities, and communication protocols and processes for the Australian Government, state and territory governments, the Aged Care Quality and Safety Commission (ACQSC) and RACF providers.

For aged care facilities, the Older Persons Advocacy Network (OPAN) can assist with communications with residents and families. The OPAN COVID-19 Communications Toolkit provides resources to assist facilities plan and implement their COVID-19 outbreak communications. These include a video aimed at informing residents about what will need to happen in an outbreak.
• OPAN organisations support consumers and their families and representatives to effectively access and interact with Commonwealth funded aged care services and have their rights protected. They provide advocacy support under the National Aged Care Advocacy Program (NACAP). Information about OPAN and how to contact the organisation should be provided to all residents and their families as part of the preparation for an outbreak and during the outbreak. Residents and families may be asked if their details can be shared with OPAN if there is an emergency.

The Commonwealth case lead will ensure that aged care facility residents are provided with Commission resources on what they can expect during an outbreak.

**Resident wellbeing**

Outbreaks can be distressing for residents. Restrictions on visitors and communal activities and reduced contact with residents and staff can lead to residents feeling isolated. The mental health and wellbeing of residents is vital.

To support resident wellbeing the RCF should:

- support residents to stay connected with family, friends and the community
- encourage residents and families to interact regularly through phone calls and social media. There are short courses available on Be Connected that may help older Australians learn new technologies such as Skype and FaceTime
- help residents maintain a structured day with activities to fight boredom. For example, read, engage in crafts and puzzles, watch TV, or listen to music and audiobooks
- have a process to monitor resident engagement and look for signs of acute changes to mental status
- have a program to ensure that entertainment resources and equipment are decontaminated between residents.

Resources for aged care facilities are available on the Older Persons Advocacy Network. Aged care facilities should also make residents aware of the Older Australians COVID-19 Support Line.

Resources for disability care facilities are available on the Disability Advocacy Network Australia | Disability Advocacy Network Australia (dana.org.au).
APPENDIX 2. Staff Testing in Residential Care Facilities

Screening (no symptoms)
- Keep working

Close contact
- Quarantine as directed by jurisdictional guidelines

COVID-19 symptoms
- Isolate at home as directed by jurisdictional guidelines

Keep working (unless advised not to by PHU*)
### APPENDIX 3. COVID-19 Outbreak Preparedness Checklist

<table>
<thead>
<tr>
<th>Planning actions</th>
<th>✔️</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your RCF have a COVID-19 Outbreak Management Plan that has been updated this year?</td>
<td></td>
</tr>
<tr>
<td>Are RCF staff aware of the plan including their roles and responsibilities, including those on the Outbreak Management Team?</td>
<td></td>
</tr>
<tr>
<td><strong>Staff, resident and family education</strong></td>
<td></td>
</tr>
<tr>
<td>Has your RCF staff undergone education and training in all aspects of outbreak identification and management?</td>
<td></td>
</tr>
<tr>
<td>Has your RCF run staff education sessions on IPC, including PPE use?</td>
<td></td>
</tr>
<tr>
<td>Has your RCF provided residents’ families with information regarding strategies to minimise the risk of introduction and transmission of COVID-19?</td>
<td></td>
</tr>
<tr>
<td>Do you know which residents may wish to live with their family during an outbreak?</td>
<td></td>
</tr>
<tr>
<td><strong>Staffing actions</strong></td>
<td></td>
</tr>
<tr>
<td>Does your RCF have a staffing contingency plan in case 20% to 50% of staff fall ill or are excluded for 14 days?</td>
<td></td>
</tr>
<tr>
<td>Has your RCF developed a plan for assigning staff to cohorts in an outbreak?</td>
<td></td>
</tr>
<tr>
<td><strong>Stock levels</strong></td>
<td></td>
</tr>
<tr>
<td>Has your RCF adequate stock of PPE, hand hygiene products, nose and throat swabs and cleaning supplies for the duration of an outbreak?</td>
<td></td>
</tr>
<tr>
<td>Are fit tested PFRs available for all staff who may enter the resident zone?</td>
<td></td>
</tr>
<tr>
<td><strong>Outbreak recognition actions</strong></td>
<td></td>
</tr>
<tr>
<td>Does your RCF routinely assess residents for COVID-19 symptoms, particularly for fever or cough (with or without fever)? Do you document changes in resident’s behaviour or health?</td>
<td></td>
</tr>
<tr>
<td>Does your RCF support and encourage staff to report COVID-19 symptoms during the pandemic?</td>
<td></td>
</tr>
<tr>
<td>Does a process exist to notify the facility manager and the state/territory health department as soon as practicable (and within 24 hours) when a COVID-19 case is suspected or laboratory confirmed?</td>
<td></td>
</tr>
<tr>
<td><strong>Communication actions</strong></td>
<td></td>
</tr>
<tr>
<td>Does your RCF have a contact list for the state/territory health department and other relevant stakeholders (for example, facility GPs and infection control consultants)?</td>
<td></td>
</tr>
<tr>
<td>Does your RCF have a communications plan for an outbreak?</td>
<td></td>
</tr>
<tr>
<td>Does your RCF have a plan to restrict unwell visitors entering the facility and limit well visitors during an outbreak to reduce risk of transmission both within the facility and externally (e.g., security, signage, restricted access)?</td>
<td></td>
</tr>
<tr>
<td><strong>Environmental management</strong></td>
<td></td>
</tr>
</tbody>
</table>

51
<table>
<thead>
<tr>
<th>Planning actions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the plan identify who is responsible for overseeing increased frequency of cleaning, liaison with contractors or hiring extra cleaners as necessary?</td>
<td></td>
</tr>
<tr>
<td>Does the plan identify options to increase the collection and disposal of waste?</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 4. Example outbreak management team structure

#### Outbreak management team – Example of membership and roles

<table>
<thead>
<tr>
<th>OMT Role</th>
<th>OMT Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>The first 24 hours</td>
<td></td>
</tr>
<tr>
<td>Chair Senior RCF leader/e</td>
<td>A senior person from the facility/provider with authority to make decisions and delegate responsibilities. Otherwise, the public health unit should lead.</td>
</tr>
<tr>
<td>Co-chair such as public health unit lead or other appropriate alternative&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Assigned by the public health unit or local health district to provide advice if required in complex outbreaks to assist with understanding testing requirements and provide additional guidance around isolation and cohorting of patients.</td>
</tr>
<tr>
<td>Secretary</td>
<td>The RCF allocates a secretary who organises OMT meetings, records and distributes action items and minutes.</td>
</tr>
<tr>
<td>RCF IPC Practitioner(s) (onsite)</td>
<td>Ensures that all infection control decisions of the OMT are carried out, and coordinates activities required to contain the outbreak. This includes IPC strategy; PPE usage; staff training and compliance; and service processes and systems. Facilities should ensure they have their own access to more than one person with this skillset. In certain circumstances the person could be an employee skilled in IPC, an IPC Practitioner organised by the PHU / local health district or a clinical first responder organised by the Commonwealth Department of Health.</td>
</tr>
<tr>
<td>Communications officer from RCF</td>
<td>Follows the communication plan to inform staff, families and others as required.</td>
</tr>
<tr>
<td>Commonwealth Department of Health case manager (if an aged care facility), if necessary</td>
<td>May activate a clinical first responder. The case officer will liaise with the clinical manager to assist access to primary health care and allied health through the PHN. Provides access to resources to assist in the response including PPE, workforce and supplementary testing.</td>
</tr>
<tr>
<td>Clinical oversight manager – this may be from the RCF or from the Commonwealth, as required</td>
<td>A person from the facility who ensures ongoing clinical management of all residents, based on the advice of the OMT and on known clinical risks and needs of individual residents. For the COVID-19 patient/s, this includes ensuring clinical monitoring and management occurs. Care considerations include hospitalisation, geriatric in-reach services, GPs or other locally available models of care. For all residents this means ensuring usual clinical care and managing the rapid deconditioning, nutritional and mental health risks associated with isolation. The clinical manager will notify the PHN, liaison with the state/territory coordinator for local district health services and the Commonwealth Department of Health case officer to ensure</td>
</tr>
</tbody>
</table>

---

<sup>8</sup> Requirement is dependent on jurisdictional guidance.

<sup>9</sup> Contact details for the PHN can be obtained from the PHU or the [Department of Health website](https://www.gov.au).
<table>
<thead>
<tr>
<th>OMT Role</th>
<th>OMT Function</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>appropriate medical and allied health services are available to residents.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional members over time if required</td>
<td></td>
</tr>
<tr>
<td>PHU Contact Tracer (if available)</td>
<td>Provides feedback on progress with contact tracing, testing and isolation of healthcare workers, external visitors, contractors, volunteers, allied health professionals, doctors, agency staff etc.</td>
</tr>
<tr>
<td>PHU Epidemiologist (if available)</td>
<td>Provides expert opinion on containment plans, epidemiological links to other RCF and epidemiological links to the community. Integrates multiple lines of information including data on hospitalisation, deaths etc. with existing state databases, prepare reports and advise state health officials on the progress of outbreak.</td>
</tr>
<tr>
<td>Aged Care Quality and Safety Commission Case officer (if an aged care facility), if necessary</td>
<td>Provides primary point of contact for providers and consumers in relation to quality of care. Monitors compliance with the Aged Care Quality Standards. Provides access to the Chief Clinical Advisor for the ACQSC and supports protection, care and wellbeing for all residents impacted in RCF</td>
</tr>
<tr>
<td>Geriatrician or general practitioner</td>
<td>A person with specialist training and expertise in caring for the health of older people who can advise on the management of all residents during the outbreak. A person with an existing relationship with the facility and the local GPs can provide advice on clinical management and can also liaise with the local infectious disease teams if needed.</td>
</tr>
<tr>
<td>Infectious disease physician (if available)</td>
<td>A person with specialist infectious diseases expertise who may attend or advise the attending clinicians on clinical assessment and management of the person with COVID-19.</td>
</tr>
<tr>
<td>Local health district coordinator for health care in the home (state/territory government)</td>
<td>A person from the Local Health District who coordinates the provision of state based in-reach services such as Hospital in the Home and Virtual Aged Care teams. This person has a role to source specialist in-reach capacity to back up primary clinical care where necessary.</td>
</tr>
</tbody>
</table>
## APPENDIX 5. COVID-19 Outbreak Management Checklist for the RCF

<table>
<thead>
<tr>
<th>Task</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declare an outbreak</td>
<td>✔️</td>
</tr>
<tr>
<td>Have an RCF Outbreak Management Team meeting within hours of diagnosis</td>
<td></td>
</tr>
<tr>
<td>Identify other cases</td>
<td></td>
</tr>
<tr>
<td>Arrange testing for all exposed residents and staff</td>
<td></td>
</tr>
<tr>
<td>Increase observation of residents to detect symptoms and signs of COVID-19</td>
<td></td>
</tr>
<tr>
<td>Establish a screening system for symptoms in staff at the start of each shift</td>
<td></td>
</tr>
<tr>
<td>Implement infection control measures – for those affected</td>
<td></td>
</tr>
<tr>
<td>Isolate / cohort ill residents in their room</td>
<td></td>
</tr>
<tr>
<td>Place hand sanitiser, PPE, signage and appropriate waste bins outside resident/s’ room</td>
<td></td>
</tr>
<tr>
<td>Ensure fit tested PFRs are available for all staff who may work within the resident zone</td>
<td></td>
</tr>
<tr>
<td>Implement infection control measures – for the entire facility</td>
<td></td>
</tr>
<tr>
<td>Display outbreak signage at entrances to facility</td>
<td></td>
</tr>
<tr>
<td>Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility. Increase access to hand sanitiser</td>
<td></td>
</tr>
<tr>
<td>On advice from public health unit – require all staff to wear surgical masks or P2/N95 PFRs (until risk assessment is complete) along with other PPE</td>
<td></td>
</tr>
<tr>
<td>Increase frequency of environmental cleaning (minimum twice daily) and add focus of frequently touched surfaces such as bedrails</td>
<td></td>
</tr>
<tr>
<td>Ensure all staff monitor for symptoms and stay away if unwell</td>
<td></td>
</tr>
<tr>
<td>Inform</td>
<td></td>
</tr>
<tr>
<td>Activate the communications plan</td>
<td></td>
</tr>
<tr>
<td>Inform the local Public Health Unit and all residents’ GPs</td>
<td></td>
</tr>
<tr>
<td>If a Commonwealth supported aged care facility - inform the Commonwealth</td>
<td></td>
</tr>
<tr>
<td>If a NDIS-funded residential disability facility – notify the NDIS Quality and Safeguards Commission</td>
<td></td>
</tr>
<tr>
<td>Restrict</td>
<td></td>
</tr>
<tr>
<td>Restrict movement of staff between areas of facility</td>
<td></td>
</tr>
<tr>
<td>Avoid resident transfers</td>
<td></td>
</tr>
<tr>
<td>Restrict visitors with the exception of those on compassionate grounds</td>
<td></td>
</tr>
<tr>
<td>Cancel non-essential group activities during the outbreak period</td>
<td></td>
</tr>
<tr>
<td>Monitor</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>Status</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Declare an outbreak</td>
<td>✓</td>
</tr>
<tr>
<td>Continue observation of residents for fever and/or acute respiratory illness and undertake repeat testing</td>
<td></td>
</tr>
<tr>
<td>Update the case list daily at the facility and provide to the interagency OMT where convened and public health unit daily</td>
<td></td>
</tr>
<tr>
<td>Add positive and negative test results to case list</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 6. Initial Facility Report to a PHU – COVID-19 Outbreak

Date/time: ___________________ Public Health Officer: ___________________

Contact details:
RCF registered name: ___________________ Trading name (if different): ________________
RAC ID number (if relevant): ___________________
Person notifying outbreak: _______________ Position: ___________________
Telephone number: ____________________ Email: _________________________

Case details:
Name _______________ Age ___ Sex ___ Current location of the case _________________

Facility details:
Name of Facility:_______________________________________________________
Address: _____________________________________________________________
Facility Manager / Director: ______________________________________________
Telephone number: _____________________ Fax number: ___________________
Email address: _________________________
Description of facility: _________________________________________________
Total number of residents: _______________ Total number of staff: _______________
Age range of residents: _________________________________________________
Number of units / wings / areas in facility: __________________________________
Attached floorplan with location of case marked: Yes / No

Residents:

<table>
<thead>
<tr>
<th>Unit name</th>
<th>Resident no.</th>
<th>Long term</th>
<th>Short term / Respite</th>
<th>High Care</th>
<th>Dementia / Secure</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RCF Staff:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>No. of RCF staff</th>
<th>No. agency staff</th>
<th>No. Causal staff</th>
<th>No. volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catering staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Assistant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 7. Letter to Families

[Facility Letterhead]

....../....../......

Dear family member

Local transmission of Coronavirus Disease 2019 (COVID-19) has been reported in the community around our facility. COVID-19 primarily causes respiratory illness in humans. While all types of respiratory viruses can cause sickness in the elderly, COVID-19 is a very contagious infection that can cause severe illness and death for vulnerable people.

Residential care facilities are particularly susceptible to COVID-19 outbreaks. Many external cases may lead to residents or staff contracting the COVID-19 and enabling outbreaks in residential care facilities to become established.

Families play an important role in protecting their relatives from community viruses. Practical steps you can take to prevent COVID-19 from being introduced into residential care facilities are outlined below.

**Be fully vaccinated**

The best way to protect your family member is to be fully vaccinated against COVID-19. If you are eligible for a vaccine, get vaccinated.

**Avoid spreading illnesses**

Washing your hands well with liquid soap and water or using alcohol-based hand rub before and after visiting and after coughing or sneezing will help reduce the spread of disease. Cover your mouth with a tissue or your elbow (not your bare hand) when coughing or sneezing and dispose of used tissues immediately and wash your hands.

**Stay away if you’re unwell**

If you have recently been unwell, been in contact with someone who is unwell or you have symptoms of respiratory illness (e.g. fever, cough, shortness of breath, sore throat, muscle and joint pain, or tiredness/exhaustion) please get yourself tested for COVID-19. Do not visit the facility until your symptoms have resolved. If you have been in contact with a confirmed case of COVID-19 you must stay away until you are released from quarantine.

**Limit your visit**

We ask that you only visit the person you have come to see and keep children away if they or your resident family member are unwell. Avoid spending time in communal areas of the facility if possible, to reduce the risk of spreading infection.

Thank you for your assistance in adhering to these steps. These measures will greatly assist our facilities and protect the health of your relatives in the event of a COVID-19 outbreak.

Should you require further information regarding COVID-19, please refer to the Commonwealth Department of Health website:


Yours sincerely,

[Name]

[Position]

[Facility/Organisation]
APPENDIX 8. Letter to GPs – COVID-19 Outbreak

[Facility Letterhead]

……/……/……

Respiratory outbreak at [Facility Name]

Dear Doctor,

There is an outbreak of COVID-19 at the facility. The outbreak may involve some of your patients who may require review. Ongoing routine clinical care is important and you are welcome to attend the facility if you are fully vaccinated and use appropriate PPE.

In keeping with national and jurisdictional guidelines and in consultation with the local PHU, the facility has implemented the following control measures:

- Testing of all staff and residents
- Audit of vaccination status of all residents
- Isolation of symptomatic residents and residents who test positive for COVID-19 in consultation with the Public Health Unit
- Use of appropriate PPE when providing care to ill residents
- Exclusion of symptomatic staff from the facility
- Restriction/limitation of visitors to the facility until the outbreak has resolved
- Promotion of thorough hand washing and cough and sneeze etiquette
- Postponement of all non-urgent appointments for people in isolation.

If you require any further information or advice please contact the clinical oversight manager [insert name and contact details].

Yours sincerely,

[Name]
[Position]
[Facility/Organisation]
APPENDIX 9. Use of PPE in RCF for staff who work in the resident zone

Use of PPE in residential care facilities

Putting on (donning) PPE*: Entering the resident zone

* Required PPE depends on the circumstances and should be informed by risk assessment. PPE should be used in accord with the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021). Refer to jurisdictional guidance for more information.
Use of PPE in residential care facilities

Taking off (doffing) PPE*:
Leaving the resident zone

Remove gloves
Remove gown
Remove eye protection (face shield/goggles)
Remove surgical mask or particulate filter respirator

Hand hygiene
Hand hygiene
Hand hygiene
Hand hygiene

* Required PPE depends on the circumstances and should be informed by risk assessment. PPE should be used in accord with the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021). Refer to jurisdictional guidance for more information.
Use of PPE in residential care facilities

Changing PPE between residents:

Finish resident care → Remove gloves → Remove gown → Don new gown → Don new gloves → Move to next resident

Hand hygiene → Hand hygiene

When moving between residents with confirmed COVID-19 in a dedicated area, mask/PFR, eye protection and gown can be worn for up to 4 hours unless visibly soiled, likely contaminated, wet or damaged.

If you need to replace your eye protection or mask/PFR you should do so at a safe distance from residents.
APPENDIX 10. Hand hygiene and cough etiquette posters

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a. Apply a palmful of the product in a cupped hand, covering all surfaces;

1b. Rub hands palm to palm;

2. Right palm over left dorsum with interlaced fingers and vice versa;

3. Palm to palm with fingers interlaced;

4. Backs of fingers to opposing palms with fingers interlocked;

5. Rotational rubbing of left thumb clasped in right palm and vice versa;

6. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

7. Once dry, your hands are safe.
How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

1. Apply enough soap to cover all hand surfaces;
2. Rub hands palm to palm;
3. Right palm over left dorsum with interlaced fingers and vice versa;
4. Palm to palm with fingers interlaced;
5. Backs of fingers to opposing palms with fingers interlocked;
6. Rotational rubbing of left thumb clasped in right palm and vice versa;
7. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;
8. Rinse hands with water;
9. Dry hands thoroughly with a single-use towel;
10. Use towel to turn off faucet;
11. Your hands are now safe.

World Health Organization
Patient Safety
SAVE LIVES
Clean Your Hands

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UNHCR acknowledges the Highways Unlimited on Social (HUS) in particular the members of the Training Center Programme, for their active participation in developing this material.
Cough and Sneeze Etiquette

- When coughing or sneezing, use a tissue to cover your nose and mouth
- Dispose of the tissue afterwards
- If you don’t have a tissue, cough or sneeze into your elbow.

- After coughing, sneezing or blowing your nose, wash your hands with soap and water
- Use an alcohol-based hand cleanser if you do not have access to soap and water.

Remember:
Hand hygiene is one of the most effective ways to reduce the spread of germs that cause respiratory disease!

Anyone with signs and symptoms of respiratory infection:
- should be instructed to cover their nose/mouth when coughing or sneezing
- use tissues to contain respiratory secretions
- dispose of tissues in the nearest waste receptacle after use
- wash or cleanse their hands afterwards.
APPENDIX 11. Transfer Advice Form

[Facility Letterhead]

Date: ……/……/……

To: [Admitting Officer, Facility Name]

Please be advised that: [Resident Name]

is being transferred from a facility where there is a cluster/outbreak of COVID-19. At this stage the outbreak is:

☐ suspected

☐ confirmed (date of specimen collection:……………………………………..)

Please ensure that appropriate infection control precautions are taken upon receipt of this resident.

At the time of transfer:

☐ The resident does not have an acute respiratory illness

☐ The resident has an acute respiratory illness

☐ The resident is a suspected case of COVID-19

☐ The resident is a confirmed case of COVID-19

<table>
<thead>
<tr>
<th>Resident details: Click or tap here to enter text.</th>
<th>Click or tap here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given name Click or tap here to enter text.</td>
<td>Surname</td>
</tr>
</tbody>
</table>

Date of birth: Click or tap to enter a date.

Name of originating facility: Click or tap here to enter text.

Name of contact person: Click or tap here to enter text.

Phone number: Click or tap here to enter text.