

# Coronavirus Disease 2019 (COVID-19) Outbreaks in Residential Care Facilities

## CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia

Revision history			
Version	Date	Reason / Changes	Endorsed by
1.0	13/03/20	Initial Release	CDNA

This guideline was developed by the Communicable Diseases Network Australia (CDNA), in consultation with the Aged Care sector, and noted by the Australian Health Protection Principal Committee (AHPPC). The document is adapted from previous work on Influenza Outbreaks in Residential Care Facilities (RCF) in Australia, Australian state and territory guidelines for respiratory illness outbreak management in RCF, documents and guidelines from the Australian Department of Health and other Australian health agencies, and documents and guidelines from various international health authorities including the World Health Organisation, Centres for Diseases Control and Prevention, and the Public Health Agency of Canada.

This guideline is provided to assist public health authorities, residential care services, healthcare workers and carers by providing best practice information for the prevention and management of COVID-19 outbreaks in RCF. This guideline captures the knowledge of experienced professionals and provides guidance on good practice based upon the available evidence at the time of completion. Readers should not rely solely on the information contained within this guideline. Guideline information is not intended to be a substitute for advice from other relevant sources including, but not limited to, advice from a health professional. Clinical judgement and discretion may be required in the interpretation and application of these guidelines.

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## 1. Introduction

This guideline applies to all residential care facilities (RCF) in Australia. This refers to any public or private aged care, disability services or other congruent accommodation setting in Australia where residents are provided with personal care or health care by facility staff. However, given individuals over the age of 65 are more susceptible to COVID-19 and are more likely to develop complications, the guidelines have a strong focus on residential aged care facilities.

Older people living in RCF are susceptible to outbreaks of respiratory illness, which commonly occur in winter. Respiratory illnesses due to COVID-19 is to be expected now, as there are outbreaks occurring globally and in Australia. Managing a COVID-19 outbreak (suspected or confirmed) effectively requires a number of required actions. These guidelines are designed to assist RCF to plan, prepare, detect and respond to COVID-19 outbreaks in their facility.

[Appendix 1](#) provides a summary of COVID-19 management in RCF in Australia.

While this guideline focuses on RCF, the principles are applicable to many settings including residential facilities for people with physical and mental disabilities, other community based health facilities (e.g. Drug and alcohol services, community mental health), detention and correctional centers, military barracks, boarding schools, hostels and any other setting where residents sleep, eat and live either temporarily or on an ongoing basis.

### 1.1. COVID-19 Outbreaks

It can be difficult to tell the difference between a respiratory illness such as COVID-19 and a respiratory illness caused by other viruses based on symptoms alone. Suspected COVID-19 cases are referred to as a 'suspect case' until a causative pathogen is identified through diagnostic testing (for example, nose and throat swab collection). If the COVID-19 virus (SARS-CoV-2) is detected during an outbreak this is referred to as a COVID-19 outbreak.

While all respiratory viruses can cause outbreaks and significant morbidity and mortality, COVID-19 is acknowledged as a significant health risk particularly for the elderly and individuals with co-morbidities or low immunity. These guidelines will assist RCF to manage all types of respiratory outbreaks, but the focus is predominantly on COVID-19.

### 1.2. Legal Framework

It is the responsibility of RCF to identify and comply with relevant legislation and regulations. RCF must fulfil their legal responsibilities in relation to infection control by adopting standard and transmission-based precautions as directed in the [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#) and by state/territory public health authorities. RCF are also required to operate under the [Aged Care Act 1997](#) to be accredited and be eligible for funding. Accreditation requires adherence to infection control standards. The Aged Care Quality and Safety Commission expects

organisations providing aged care services in Australia to comply with the [Aged Care Quality Standards](#).

COVID-19 is a notifiable condition under the Australian National Notifiable Diseases Surveillance System (NNDSS). This means that in all Australian states and territories, either the medical officer requesting the test and/or the laboratory performing the test, are responsible for notifying the relevant jurisdictional public health authority of the case of COVID-19, as per local legislative requirements.

### **1.3. Roles and Responsibilities**

#### **1.3.1. Residential Care Facility**

The primary responsibility of managing COVID-19 outbreaks lies with the RCF, within their responsibilities for resident care and infection control. All RCF should have in-house (or access to) infection control expertise, and outbreak management plans in place.

RCFs are required to:

- detect and notify outbreaks to state health departments.
- self-manage outbreaks in accordance with this guideline, the [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#), and the [Australian Health Sector Emergency Response Plan for Novel Coronavirus \(2020\)](#).
- Confirm and declare an outbreak.
- Provide advice on infection control measures and use of PPE.
- Confirm and declare when an outbreak is over.

#### **1.3.2. The State/Territory Department of Health and Human Services**

The relevant state/territory Department of Health will act in an advisory role to assist RCF to detect, characterise and manage COVID-19 outbreaks. This includes:

- Assisting facilities in confirming outbreaks by applying the case definition correctly and providing advice on obtaining testing samples
- Providing guidance on outbreak management
- Monitoring for severity of illness (record deaths and hospitalisations)
- Informing relevant stakeholders of outbreaks
- Monitoring the number of COVID-19 outbreaks occurring as the epidemic progresses
- Contributing to national surveillance.

#### **1.3.3. Australian Aged Care Quality and Safety Commission**

The Aged Care Quality and Safety Commission (the Commission) is the national regulator of aged care services. It takes a proportionate risk-based approach in responding to the COVID-19 situation. The role of the Commission is to:

- independently accredit, assess and monitor aged care services against the [Aged Care Quality Standards](#), including the requirement to minimise infection-related risks

through implementing standard and transmission based precautions to prevent and control infection;

- resolve complaints about the delivery aged care services; and
- provide education to providers, including with respect to best-practice infection prevention and control.

## 2. Understanding COVID-19

### 2.1. Recognising COVID-19

COVID-19 is a contagious viral infection that generally causes respiratory illness in humans. Presentation can range from no symptoms (asymptomatic) to severe illness with potentially life-threatening complications, including pneumonia. COVID-19 is spread by contact with respiratory secretions and fomites.

The most common signs and symptoms include:

- fever (though this may be absent in the elderly)
- dry cough

Other symptoms can include:

- shortness of breath
- sputum production
- fatigue

Less common symptoms include:

- sore throat
- headache
- myalgia/arthralgia
- chills
- nausea or vomiting
- nasal congestion
- diarrhoea
- haemoptysis
- conjunctival congestion

Older people may also have the following symptoms:

- increased confusion
- worsening chronic conditions of the lungs
- loss of appetite

Elderly patients often have non-classic respiratory symptoms; RCF should consider testing any resident with any new respiratory symptom.

## 2.2. Incubation Period

People with COVID-19 generally develop signs and symptoms, including mild respiratory symptoms and fever, on an average of 5-6 days after infection (mean incubation period 5-6 days, range 1-14 days).

## 2.3. Routes of Transmission

COVID-19 is transmitted via droplets and fomites during close unprotected contact with an infected person. Airborne spread has not been reported for COVID-19; however, it may occur during certain aerosol-generating procedures<sup>1</sup> conducted in health care settings. Faecal shedding of the virus has been demonstrated from some patients, and viable virus has been identified in some cases. Although the faecal-oral route does not appear to be a driver of COVID-19 outbreaks, it may become important in RCF, as such cases with ongoing diarrhoea or faecal incontinence who may have limited capacity to maintain standards of personal hygiene should continue to be isolated until 48 hours after the resolution of these symptoms.

## 2.4. People at risk of complications from COVID-19

People at risk of complications from COVID-19 include:

- people 65 years of age and over
- Aboriginal and Torres Strait Islander people
- people with chronic or other medical conditions
- people with a weakened immune system (due to a disease or medication)

## 2.5. Complications of COVID-19

Most people with COVID-19 have mild disease and will recover. Some people can develop complications which may be life-threatening and can result in death.

Complications include:

- pneumonia (secondary bacterial infection)
- respiratory failure
- septic shock
- multi-organ dysfunction/failure

Elderly residents may experience a worsening of chronic health problems such as congestive heart failure, asthma and diabetes.

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<sup>1</sup> Aerosol-generating procedures include manual ventilation before intubation, tracheal intubation, non-invasive ventilation, tracheostomy suctioning, cardiopulmonary resuscitation, bronchoscopy and high flow nasal oxygen



## 3. Preparedness and Prevention

### 3.1. Preparation

RCF must ensure that they are prepared for outbreaks of COVID-19 including for the occurrence for their first case of COVID-19. A well-functioning infection prevention control (IPC) program working in concert with a well-functioning occupational health (OH) program, is the basis for an effective IPC response during a COVID-19 pandemic.

Australian healthcare facilities will likely be impacted by a COVID-19 pandemic. It is therefore essential for RCF, in coordination with local and state/territory governments, to ensure that they can manage residents with COVID-19 while maintaining the level of care required for all other residents. This might include caring for residents who would usually be managed in the hospital setting.

The information provided in this guideline has been developed to provide RCF and their staff with the information they need to plan for and execute IPC and OH processes intended to prevent exposure to and transmission of COVID-19.

#### 3.1.1. Prepare an Outbreak Management Plan

Preparing an outbreak management plan will help staff identify, respond to and manage a potential COVID-19 outbreak; protect the health of staff and residents, and reduce the severity and duration of outbreaks if they occur. At a minimum, facilities must identify a dedicated staff member to plan, co-ordinate and manage logistics in an outbreak setting as well as communicate and liaise with the state/territory health department.

The prevention strategies outlined in this guideline should be included in the RCF outbreak management plan. A checklist to assist in outbreak preparedness can be found in [Appendix 2](#).

##### 3.1.1.1. *Planning Assumptions*

It is important to note that assumptions about the epidemiology and impact of COVID-19 may change as knowledge emerges.

The following public health assumptions are relevant to infection prevention control and outbreak management planning:

- A COVID-19 pandemic will affect the entire health care system and the community. Hospitals, local public health units and other services may have limited capacity. RCFs may not be able to rely on the same level of support they receive now from other parts of the health care system or from other community services during an outbreak.
- Pandemic COVID-19 plans developed by individual RCFs are:
  - coordinated with the plans of other organizations in their communities and local/regional pandemic plans; and

- consistent with the Australian Government Department of Health Australian Health Sector Emergency Response Plan for Novel Coronavirus (2020).
- The number of health care workers available to provide care may be reduced by up to one-third because of personal illness, concerns about transmission in the workplace, and family/caregiving responsibilities.
- Usual sources of supplies are disrupted or unavailable.
- A vaccine will not be available for at least twelve months. It will not be available in time for the first wave of illness but may be available in time to reduce the impact of the second wave. Once available, the vaccine will be in short supply and high demand.
- The efficacy of antivirals against COVID-19 is unknown but, if antivirals are shown to shorten the length of time people are ill, relieve symptoms and reduce hospitalizations; they may be introduced into standards of care. They will, however, be in short supply and high demand. Organisations will have to rely on traditional infection prevention and control practices (e.g., hand hygiene, appropriate personal protective equipment, and isolating sick individuals) as the main line of defence.
- Because Australia will not have a large enough supply of either antivirals or vaccine (when it is first developed) for the entire population, the government will have to set priorities for who receives them. RCFs must follow commonwealth and state/territory guidance for priority groups for immunisation and antiviral treatment and prophylaxis when available. During the course of the pandemic, priority groups may change based on the epidemiology of COVID-19 (i.e., the nature of the virus, the people most affected).
- To meet community needs during a pandemic, resources – including staff, supplies and equipment – may have to be reassigned or shifted.
- Care protocols may change and new practice may have to be adapted.
- RCF will need effective ways to communicate with residents' family and friends, in order to meet their needs for information but reduce the demands on staff.

### **3.1.2. Education**

Education for staff, residents and their families is vital to inform their behaviour and help manage the potential occurrence for ongoing transmission in an outbreak setting.

Prompt and clear information needs to be provided to residents and families regarding the outbreak including respiratory hygiene and cough etiquette, hand hygiene and restrictions on visitation if they have any symptoms of COVID-19. A sample letter outlining the preventative steps families and visitors can take to reduce the risk of bringing COVID-19 into the facility can be found at [Appendix 3](#).

Staff should be informed, and supported, to exclude themselves from work when they have any kind of respiratory illness and to notify the facility if they were confirmed to have COVID-19. Staff exclusion during an outbreak is discussed further in section [5.2.6](#).

The principle underlying staff and visitors staying away from the facility if they are unwell should be reinforced by placing signage at all entry points to the facility.

### **3.1.3. Workforce Management**

Facilities should have a staff contingency plan in the event of an outbreak where unwell staff members need to be excluded from work for a prolonged period until cleared to return to work. Health care workers may also require exclusion from the workplace if they have returned from travel to a country considered high risk for COVID-19, and such requirements will impact the workforce nationally. RCF should regularly review the [CDNA COVID-19 Interim National Guideline](#) for requirements relating to the exclusion of healthcare workers from clinical settings.

The workforce management plan should be able to cover a 20-30% staff absentee rate. Developing and maintaining a contact list for casual staff members or external nursing agencies is essential to timely activation of a surge workforce should an outbreak occur. Leave planning should also consider the nature of the pandemic and current outbreaks.

### **3.1.4. Staff Education and Training**

Each RCF is responsible for ensuring their staff are adequately trained and competent in all aspects of outbreak management prior to an outbreak. Staff should know the signs and symptoms of COVID-19 in order to identify and respond quickly to a potential outbreak. Additionally, all staff (including casual, domestic, hospitality and volunteer workers) need to understand the infection control guidelines and be competent in implementing these measures during an outbreak.

Topics for staff education and training should include:

- Symptoms and signs of COVID-19
- Exposure risk levels for COVID-19, including international travel
- Personal hygiene, particularly hand hygiene, sneeze and cough etiquette
- Appropriate use of PPE such as gloves, gowns, eye protection and masks, including how to don and doff PPE correctly
- Actions on experiencing symptoms of COVID-19 (do not work or visit an RCF)
- Handling and disposal of clinical waste
- Processing of reusable equipment
- Environmental cleaning
- Laundering of linen
- Food handling and cleaning of used food utensils

### **3.1.5. Consumable Stocks**

Facilities should ensure that they hold adequate stock levels of all consumable materials required during an outbreak, including:

- personal protective equipment (gloves, gowns, masks, eyewear)
- hand hygiene products (alcohol based hand rub, liquid soap, hand towel)
- diagnostic materials (swabs)
- cleaning supplies (detergent and disinfectant products)

Facilities should have an effective policy in place to obtain additional stock from suppliers as needed. In order to effectively monitor stock levels, facilities should:

- undertake regular stocktake (counting stock)
- use an outbreak kit / box

## 3.2. Prevention

There is currently no vaccination to prevent COVID-19. Avoidance of exposure is the single most important measure for preventing COVID-19 in RCF. RCF must have, and be vigilant in implementing, effective infection control procedures. RCFs are expected to use risk assessments to ensure the risks of a COVID-19 outbreak are as low as possible. This can involve examining the RCF's service environment, equipment, workforce training, systems, processes or practices that affect any aspect of how they deliver personal and clinical care.

The general strategies recommended to prevent the spread of COVID-19 in RCFs are the same infection prevention control strategies used every day to detect and prevent the spread of other respiratory viruses like influenza. During a COVID-19 pandemic, or when local community transmission of the disease is identified, RCF should focus on preventing introduction of the disease into the facility, or spread within or between facilities if infection has been identified within the RCF.

### 3.2.1. Exposure Prevention

Exposure prevention actions include:

- Self-screening for staff, volunteers and visitors (including visiting workers)
  - RCF should instruct all staff to self-screen for symptoms, and to observe any exclusion requirements related to returning from travel to a high-risk country.
  - Staff should be made aware of early signs and symptoms of COVID-19. Staff must not come to work if symptomatic and must report their symptoms to the RCF. Sick leave policies must enable employees to stay home if they have symptoms of respiratory infection.
  - RCF should use signage at entrances and reception to inform visitors to self-identify if they have relevant symptoms, travel history or exposure. Visitors must be instructed not to enter the RCF until any symptoms have completely resolved.
- Monitor residents and employees for fever or acute respiratory symptoms
  - Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).
  - In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless a procedure requires Airborne Precautions.
- Active screening for resident admissions or re-admissions/returning residents
  - Assess residents for symptoms of COVID-19 upon admission to the facility and implement appropriate infection prevention practices for incoming symptomatic residents.
- Implementation of non-pharmaceutical measures, which include:

- Hand hygiene and cough and sneeze etiquette
- Use of appropriate personal protective equipment
- Environmental cleaning measures
- Isolation and cohorting
- Social distancing

### **3.2.2.Prevention of Introduction into the Facility**

Family members of residents and other visitors (including visiting workers) can potentially transmit SARS-CoV-2 to residents. The following actions should be taken:

- RCF should advise all regular visitors to be vigilant with hygiene measures including social distancing, and to monitor for symptoms of COVID-19, specifically fever and acute respiratory illness. They should be instructed to stay away when unwell, for their own and residents' protection, and to observe any self-quarantine requirements.
- Signage and other forms of communication (i.e. information and factsheets) must be used to convey key messages including what actions the facility is taking to protect them, and explaining what they can do to protect themselves and residents.
- RCFs must ensure that adequate hand washing facilities and alcohol based hand rub, as well as tissues and lined disposal receptacles are available for visitors to use; at the entrance of the facility and in each resident's room.

### **3.2.3.Prevention of Spread Within and Between Facilities**

To prevent the spread of COVID-19, the following actions should be taken:

- Keep residents and staff informed through regular communication.
  - Support personal protection measures including respiratory hygiene, cough and sneeze etiquette, and hand washing.
- Monitor residents and employees for fever or acute respiratory symptoms
  - Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).
  - In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless a procedure requires Airborne Precautions.
- Healthcare personnel should monitor Commonwealth Department of Health and state public health information sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness. If there is transmission of COVID-19 in the community, in addition to implementing the precautions described above for residents with acute respiratory infection, facilities should also consult with public health authorities for additional guidance.
- Identify dedicated employees to care for patients with COVID-19 and provide infection control training.
  - Guidance on implementing recommended infection prevention practices is available in section [5.4](#).
- Provide the correct supplies to ensure easy and correct use of PPE.

- Make PPE, including facemasks, eye protection, gowns, and gloves, available immediately outside of the resident room.
- Position a disposal receptacle near the exit inside any resident room to make it easy for employees to discard PPE.
- Post signs on the door or wall outside of the resident room clearly describing the type of precautions needed and required PPE.
- Notify facilities and transport service providers prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19; or transferring to a higher level of care.
- Notify any possible COVID-19 illness in residents and employees to the relevant jurisdictional public health authority.

## 4. Identifying COVID-19

### 4.1. Identification

Prevention and management of influenza outbreaks in RCF have been built around surveillance of influenza-like illness (ILI). Building on that model, RCF should establish systems to monitor staff and residents for COVID-19 with a high level of vigilance and have a low threshold for investigation. Surveillance for fever or acute respiratory illness<sup>2</sup> (ARI, with or without fever), rather than ILI, is very sensitive for detecting possible cases of COVID-19 in the context of confirmed local transmission of COVID-19. Effective surveillance will facilitate early recognition and management of cases.

The aim of surveillance in RCFs is to ensure early identification of symptoms in residents and staff that may precede, or indicate early stages of, an outbreak. Identification of a resident or staff member with ARI should be followed by prompt testing for a causative agent. While confirmation of SARS-CoV-2 infection is pending, immediate and appropriate infection control management of the person with ARI may prevent further spread of the disease.

Facilities should have the capacity to count those with ARI and other severe respiratory illnesses each day and identify a potential COVID-19 outbreak. Prompt detection of outbreaks allows early implementation of control measures.

Healthcare personnel should monitor Commonwealth Department of Health and state/territory public health sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with undifferentiated respiratory illness. If there is confirmed local transmission of COVID-19 in the community, in addition to implementing the precautions described in this, facilities should consult with public health authorities for IPC guidance.

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<sup>2</sup> Acute Respiratory Illness (ARI) is defined in the [CDNA COVID-19 Interim National Guideline](#) as shortness of breath or cough.

## 4.2. Case Definition

The [CDNA COVID-19 Interim National Guideline](#) provides a case definition for COVID-19 suspect and confirmed cases. Case definitions provide the criteria that allows unambiguous classification of an ill person as a confirmed case, or a suspect case. COVID-19 should be suspected in any resident with fever or acute respiratory infection (with or without fever) in a setting where there is confirmed local transmission of COVID-19.

## 4.3. Testing for COVID-19

The recommended test and methods of sampling for COVID-19 is outlined in the [CDNA COVID-19 Interim National Guideline](#). Once requested by a medical officer, collection by an appropriately trained GP or pathology provider is the preferred option for obtaining appropriate respiratory samples. RCF staff who have received the applicable training in respiratory sample collection and the proper use of PPE may also collect the appropriate samples. Residents do not need to be transferred to hospital for the purpose of testing for COVID-19. Guided by the clinical picture, the responsible medical officer may request testing for additional respiratory pathogens.

Procedures for obtaining nose and throat swabs are at [Appendix 4](#).

## 4.4. Notification – State/Territory Department of Health

Laboratory confirmed COVID-19 is a notifiable disease in all Australian states and territories. The requesting medical officer and/or the testing laboratory is obligated to notify the infection to the jurisdictional communicable disease authority, depending on local legislative requirements; this notification is confidential.

If an outbreak is suspected, the local state/territory Department of Health must be notified immediately. A Public Health Unit (PHU) will assist with advice and guidance on appropriate follow on actions. A sample reporting template is available at [Appendix 5](#).

RCF must be prepared to provide the following information to the PHU:

- Information on the setup of the facility
- total number of residents and/or staff with fever and/or ARI
- date of onset of illness of each person
- symptoms of each person
- number of people admitted to hospital with fever and/or ARI (if applicable)
- number of people with influenza-like symptoms who have died
- total number of staff that work in the facility and in the affected area
- total number of residents in the facility and in the affected area
- whether appropriate respiratory specimens have been collected
- results of any respiratory specimens already tested

The PHU will advise and assist with the following:

- confirming the presence of an outbreak
- identifying the control measures that need to be in place

- testing of the initial respiratory specimens.

The PHU will provide the RCF with a preferred case list (also called a ‘line list’) template to use when an outbreak is notified. If any deaths occur during an outbreak, the department must be notified within 24 hours. Hospitalisation of residents should be noted on the case list and sent to the department daily (see section [5.5.1](#)).

#### 4.4.1.State/territory Public Health Unit Contact details

State	Contact Details
Queensland	13 432 584 (13 HEALTH)
New South Wales	1300 066 055
Australian Capital Territory	Business Hours: 02 5124 9213 After Hours: 02 9962 4155
Victoria	1800 675 398
Tasmania	1800 671 738
South Australia	1300 232 272
Western Australia	08 9222 4222 <a href="#">WA Health</a>
Northern Territory	08 8922 8044

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

#### 4.5. Notification – Resident and Facility General Practitioners

Unwell residents must be reviewed by their GP regardless of whether an outbreak is present or not. If a COVID-19 outbreak is present, all visiting GPs should be informed at the start of the outbreak. A sample letter for GPs can be found in [Appendix 6](#).

This will facilitate appropriate testing samples being obtained, early implementation of infection control procedures, and treatment for symptomatic. It is important to speak with the PHU to confirm the presence of an outbreak before issuing the outbreak letter to visiting GPs.



## 5. COVID-19 Case and Outbreak Management

### 5.1. Response to a Suspected Case of COVID-19 in a Resident

Residents with suspected or confirmed COVID-19 require appropriate healthcare support, including access to their primary care provider for medical management.

Special considerations in the management of residents with suspected or confirmed COVID-19 in an RCF include:

- Immediately isolate ill residents (or cohort) and minimise interaction with other residents.
- If COVID-19 is suspected, have a low threshold for requesting medical review and testing.
- Transfer residents to hospital **only if their condition warrants**. If transfer is required, advise the hospital in advance that the resident is being transferred from a facility where there is potential or confirmed COVID-19. A sample transfer advice form is provided at [Appendix 7](#).
- Notify the appropriate authorities as outlined in section [4.4](#) and [4.5](#).

In the instance of confirmed COVID-19, RCF management should consider this an opportunity to:

- Identify and implement enhanced infection control measures
- Implement surveillance for further cases
- Review outbreak plans and requirements for implementation.

### 5.2. Response to a Suspected Case of COVID-19 in a Staff Member

Health care workers and other members of staff who develop symptoms of respiratory illness should immediately be excluded from the facility and remain away whilst a diagnosis is sought. If COVID-19 is excluded, the staff member may be able to return to work once well and as guided by the infections period for their condition. If a diagnosis of COVID-19 is confirmed, the staff member must be excluded until they meet the criteria for release from isolation outlined in the [CDNA COVID-19 Interim National Guideline](#). The RCF must make appropriate notification to the relevant authorities as outlined in section [4.4](#) and [4.5](#).

As above, RCF management should consider this an opportunity to:

- Identify and implement enhanced infection control measures
- Implement surveillance for further cases
- Review outbreak plans and requirements for implementation.

### 5.3. Response to an Outbreak of COVID-19

This section provides detailed information on the required actions to be implemented once an outbreak has been identified. An outbreak management checklist is provided at [Appendix 8](#).

RCF should engage an infection control consultant or make contact with the residential in-reach service at their local health service should they require additional support in an outbreak. They may also be available to assist RCF to avoid the transfer of residents to hospital where possible.

### **5.3.1. Declaring an Outbreak**

A ***potential*** COVID-19 outbreak is defined as:

**Two or more cases of ARI in residents or staff of a RCF within 3 days (72 hrs).**

A ***confirmed*** COVID-19 outbreak is defined as:

**Two or more cases of ARI in residents or staff of a RCF within 3 days (72 hrs)**

**AND**

**At least one case of COVID-19 confirmed by laboratory testing.**

While the definitions provided above guidance, the state/territory PHU will assist the RCF in deciding whether to declare an outbreak.

### **5.3.2. Establishing an Outbreak Management Team**

The RCF is responsible for managing the outbreak. An internal outbreak management team (OMT) should be established to direct, monitor and oversee the outbreak, confirm roles and responsibilities and liaise with the state/territory Department of Health. It considers the progress of the response, undertakes ongoing monitoring, deals with unexpected issues, and initiates changes, as required. When an OMT is formed, it is important to meet regularly, usually daily, at the height of the outbreak to monitor the outbreak, initiate changes to response measures and to discuss outbreak management roles and responsibilities. In reality, a small number of staff will perform multiple roles in an OMT.

For detailed information on forming and implementing an OMT, refer to [Appendix 9](#).

## **5.4. Implementing Infection Prevention and Control Measures**

### **5.4.1. Isolation and Cohorting**

A resident with an ARI should be placed in a single room with their own ensuite facilities, if possible, while a diagnosis is sought. Where possible, residents requiring droplet precautions should be restricted to their room. Residents may attend urgent medical or procedural appointments but should wear a mask if tolerated.

If the resident requires transfer to another facility, including hospital, advise the hospital and transport provider in advance that the resident is being transferred from a facility where there is potential or confirmed COVID-19.

If a single room is not available, the following principles should be used to guide resident placement:

- Give highest priority to single room placement to residents with excessive cough and sputum production.
- Place residents together in the same room (cohort) with similar signs and symptoms or infected with the same pathogen (if known) and assessed as being suitable roommates.
- When a single room is not available, and cohorting of ill residents is not possible, a resident with a respiratory illness may be cared for in a room with a roommate(s) who does not have a respiratory illness. This is the least favourable option. In this case:
  - residents' beds should be separated by at least 1.5 metres
  - the curtain should be kept drawn between residents' beds
  - the roommate should be vaccinated against influenza with the current season's vaccine at least two weeks prior to being in the same room as the ill resident.
- In shared rooms (both cohorted with like illness, and residents with and without illness), staff must ensure they change their PPE and perform hand hygiene when moving between residents.

Once resident isolation or cohorting measures are in place, to further reduce the risk of transmission, it is preferable to allocate specific RCF staff to the care of residents in isolation. A register of staff members caring for patients with COVID-19 should be maintained by the RCF. The RCF must ensure that staff members:

- do not move between their allocated room/ section and other areas of the facility, or care for other residents.
- self-monitor for signs and symptoms of acute respiratory illness and self-exclude from work if unwell.

#### **5.4.2. Standard Precautions**

Standard precautions are a group of infection prevention practices always used in healthcare settings, and must be used in RCF with a suspected or confirmed COVID-19 outbreak. Standard precautions include performing hand hygiene before and after every episode of resident contact (5 moments), the use of PPE (including gloves, gown, appropriate mask and eye protection) depending on the anticipated exposure, good respiratory hygiene/cough etiquette and regular cleaning of the environment and equipment.

##### **5.4.2.1. Hand Hygiene**

COVID-19 can be spread by contaminated hands, hence frequent hand hygiene is important. Hand hygiene refers to any action of hand cleansing, such as hand washing with soap and water or hand rubbing with an alcohol based hand rub. Alcohol based hand rubs are the gold standard for hand hygiene practice in healthcare settings when hands are not visibly soiled. However, if hands are visibly soiled or have had direct contact with body fluids they should be washed with liquid soap and running water then dried thoroughly with disposable paper towel. Refer to [Appendix 10](#) for detailed information on hand hygiene.

Online hand hygiene courses are available and staff should be encouraged to do refresher training. There must be adequate access for staff, residents and visitors to hand hygiene stations (alcohol based hand rub or hand basins with liquid soap, water and paper towel) that should be adequately stocked and maintained. Hand basins for staff should, wherever possible, be hands-free (for example, elbow operated) to facilitate appropriate hand hygiene practices and prevent recontamination of hands when turning off taps. Staff should be made aware of the proper hand hygiene technique and rationale.

Encouraging hand hygiene among residents and visitors is another important measure to prevent the transmission of infectious organisms. Residents should wash their hands after toileting, after blowing their nose, before and after eating and when leaving their room. If the resident's cognitive state is impaired, staff caring for them must be responsible for helping residents with this activity. Visitors should be reminded to perform hand hygiene on entering and leaving the facility, and before and after visiting any resident.

The use of gloves should never be considered an alternative to hand hygiene. Hand hygiene is required before putting on gloves and immediately after they have been removed.

#### *5.4.2.2. Personal Protective Equipment (PPE)*

Staff must wear appropriate PPE when caring for infected residents requiring contact and droplet or airborne precautions. A gown, eye protection, mask and gloves may be required depending on the level of precaution required. PPE requirements for caring with patients with suspected or confirmed COVID-19 are outlined in [Appendix 11](#).

RCF staff must be trained and deemed competent in the proper use of PPE, including donning and doffing procedures. Refresher training is recommended for all existing staff, including non-clinical support staff, and as required for new staff. PPE should be removed in a manner that prevents contamination of the HCW's clothing, hands and the environment. PPE should be immediately discarded into appropriate waste bins. Hand hygiene should always be performed before putting on PPE and immediately after removal of PPE, as well whilst wearing PPE. Useful educational and promotional material for the proper use of PPE can be found at [Appendix 12](#).

RCF staff must change their PPE and perform hand hygiene after every contact with an ill resident, when moving from one room to another, or from one resident care area to another.

#### *5.4.2.3. Cough and Sneeze Etiquette*

Cough and sneeze etiquette relates to precautions taken to reduce the spread of virus via droplets produced during coughing and sneezing. Residents, staff and visitors should be encouraged to practice good cough and sneeze etiquette, which includes coughing or sneezing into the elbow or a tissue, and disposing of the tissue then cleansing the hands. Useful educational and promotional material can be found at [Appendix 13](#). Specific advice should be given to any resident with ARI as a reminder.

### 5.4.3. Transmission-based Precautions

Transmission based precautions are infection control precautions used in **addition** to standard precautions to prevent the spread of COVID-19. COVID-19 is most commonly spread by contact and droplets. Less commonly airborne spread may occur e.g. during aerosol generating procedures<sup>3</sup> or care of severely ill patients.

**Contact and Droplet precautions** are the additional infection control precautions required when caring for residents with suspected or confirmed COVID-19. **Contact and Airborne** precautions are required when conducting aerosol generating procedures<sup>4</sup> or caring for severely ill patients who are coughing excessively.

For further information about transmission-based precautions when caring for residents with suspected or confirmed COVID-19, see [Appendix 14](#).

### 5.4.4. Environmental Cleaning and Disinfection

Regular, scheduled **cleaning** of all resident care areas is essential during an outbreak. Frequently touched surfaces are those closest to the resident, and should be cleaned more often. During a suspected or confirmed COVID-19 outbreak, an increase in the frequency of cleaning with a neutral detergent is recommended.

**Cleaning AND disinfection** is recommended during COVID-19 outbreaks. Either a 2-step clean (using detergent first, then disinfectant) or 2-in-1 step clean (using a combined detergent/disinfectant) is required.

The following principles should be adhered to:

- Patient room/zone should be cleaned daily
- Frequently touched surfaces should be cleaned more frequently. These include:
  - bedrails, bedside tables, light switches, remote controllers, commodes, doorknobs, sinks, surfaces and equipment close to the resident.
  - Walking frames, sticks
  - Handrails and table tops in facility communal areas, and nurses station counter tops
- Cleaners should:
  - observe contact and droplet precautions
  - adhere to the cleaning product manufacturer's recommended dilution instructions and contact time
  - use a [Therapeutic Goods Administration \(TGA\) listed disinfectant with claims of efficacy against enveloped viruses](#) (as the easiest class of microorganisms to kill). If unsure, a chlorine-based product such as sodium hypochlorite is suitable for disinfection.

---

<sup>3, 3</sup> Aerosol-generating procedures include manual ventilation before intubation, tracheal intubation, non-invasive ventilation, tracheostomy suctioning, cardiopulmonary resuscitation, bronchoscopy and high flow nasal oxygen

- The room should be terminally cleaned when the ill resident is moved or discharged

Equipment and items in patient areas should be kept to a minimum. Ideally, reusable resident care equipment should be dedicated for the use of an individual resident. If it must be shared, it must be cleaned and disinfected between each resident use.

Linen should be washed and sanitised using hot water (>65 degrees for 10 minutes) and standard laundry detergent. Linen should be dried in a dryer on a hot setting. There is no need to separate the linen for use by ill residents from that of other residents. Appropriate PPE should be used when handling soiled linen.

Crockery and cutlery should be washed in a hot dishwasher or if not available, by hand using hot water and detergent, rinsed in hot water and dried. There is no need to separate the crockery and cutlery for use by ill residents from that of other residents.

More information on environmental cleaning and disinfection is available in the Commonwealth Department of Health factsheet – [Environmental cleaning and disinfection principles for COVID-19](#).

#### **5.4.5. Signage**

RCF should place signs at the entrances and other strategic locations within the facility to inform visitors of the infection prevention control requirements. A droplet precaution sign must be placed outside symptomatic residents' rooms to alert staff and visitors to the requirement for transmission-based precautions.

Standardised signs are available to all RCF to increase the awareness of healthcare workers, patients and visitors to the necessary precautions to be applied for all patients (Standard Precautions) and for those patients who require Transmission-based Precautions, due to COVID-19. These resources are available at the Australian Commission for Safety and Quality in Health Care website: <https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/infection-control-signage>

#### **5.4.6. Visitors and Communal Activities**

During a COVID-19 outbreak, where possible, the movement of visitors into and within the facility should be restricted.

Facilities should implement the following:

- Suspend all group activities, particularly those that involve visitors (e.g. musicians).
- Postpone visits from non-essential external providers (e.g. Hairdressers and allied health professionals).
- Inform regular visitors and families of residents of the COVID-19 outbreak, and request that they only undertake essential visits. Young children should not visit the facility as they are generally unable to comply with standard precautions and PPE requirements.
- Ensure visitors who do attend the RCF to visit an ill resident are recorded on a register of visitors and comply with the following guidance:

- Report to the reception desk on arrival
- visit only the ill resident
- wear PPE as directed by staff
- enter and leave the facility directly without spending time in communal areas
- perform hand hygiene before entering and after leaving the resident's room and the RCF.

#### **5.4.7. Staff**

For suspected or confirmed cases of COVID-19 it is preferable that only staff who have been designated to care for patients with COVID-19 provide care for these residents. During an outbreak of COVID-19, wherever possible, healthcare workers should not move between wings or units of the facility to provide care for other residents. This is particularly important if not all wings/units are affected by the outbreak. It is preferable to cohort staff to areas (in isolation or not in isolation) for the duration of the outbreak.

During a confirmed COVID-19 outbreak staff should attend work only if they are asymptomatic. All staff members should self-monitor for signs and symptoms of COVID-19 and self-exclude if unwell. Refer to section [5.2](#) for further guidance regarding the management of staff members with suspected or confirmed COVID-19.

#### **5.4.8. Admissions and Transfers**

##### *5.4.8.1. New admissions*

An ongoing outbreak does not mean the facility has to go into complete "lock down". It is preferable that admission of new residents to an affected unit during an outbreak does not take place. Where new admissions are unavoidable, new residents and their families must be informed about the current outbreak and adequate outbreak control measures must be in place for these new residents. Families may wish to make alternative arrangements until the outbreak is over.

##### *5.4.8.2. Re-admissions of confirmed cases*

The re-admission of residents who met the case definition and have been hospitalised for their illness is permitted, provided appropriate accommodation and infection prevention and control requirements can be met.

##### *5.4.8.3. Re-admission of non-cases*

The re-admission of residents that have not been on the COVID-19 outbreak case lists (i.e. they are not a known case) should be avoided during the outbreak period if possible. If non-cases are re-admitted, the resident and their family must be informed about the current outbreak and adequate outbreak control measures must be in place. Families may wish to make alternative arrangements (e.g. family care) until the outbreak is over.

#### 5.4.8.4. *Transfers*

If transfer to hospital is required, the ambulance service and receiving hospital must be notified of the outbreak/suspected outbreak verbally and through using a resident transfer advice form (see [Appendix 4](#)).

#### 5.4.8.5. *Unaffected residents*

In some circumstances, it may be feasible to transfer residents who are not symptomatic, to other settings (e.g. family care) for the duration of the outbreak. The family or receiving facility should be made aware that the resident may have been exposed and is at risk of developing disease. They should be provided with information regarding the symptoms of COVID-19 and the use of appropriate personal protective measures.

**Note:** In Residential Aged Care settings, security of tenure provisions of the *Aged Care Act 1997* will need to be considered.

### 5.5. Monitoring Outbreak Progress

Increased and active observation of all residents for the signs and symptoms of COVID-19 is essential in outbreak management to identify ongoing transmission and potential gaps in infection control measures. Facilities should have the capacity to monitor or count residents and staff displaying signs and symptoms of COVID-19 daily, to ensure swift infection control measures are implemented or strengthened to reduce transmission and the duration of the outbreak.

Updates to information in the line list should occur through daily meetings of the OMT, or more frequently if major changes occur. The line list should be provided to the PHU each day (or as arranged) until the outbreak is declared over.

Updated information will be reviewed by the PHU for evidence of ongoing transmission and effectiveness of control measures and prophylaxis. The PHU will discuss this with the RCF OMT and advise of any required changes to current outbreak control measures.

The OMT should review all control measures and consider seeking further advice from PHU if:

- The outbreak comprises more cases than can be managed.
- The rate of new cases is not decreasing.
- Three (3) or more residents are hospitalised related to COVID-19, OR
- A COVID-19-related death has occurred: telephone to notify the PHU of this.

Specialised advice is available from the following sources:

- A local state, territory or regional PHU.
- Infection control practitioners may be available for advice in local hospitals, state and territory health departments, or as private consultants.
- Geriatricians or Infectious Disease physicians may be approached for specialist management of complex infections.



## 5.6. Declaring the Outbreak Over

The time from the onset of symptoms of the last case until the outbreak is declared over can vary. Generally, A COVID-19 outbreak can be declared over if no new cases occur within 14 days (maximum incubation period) following the date of isolation of the case. A decision to declare the outbreak over should be made by the OMT, in consultation with the PHU.

The OMT may make decisions about ongoing RCF surveillance after declaring the outbreak over, considering the following needs:

- To maintain general infection control measures.
- To monitor the status of ill residents, communicating with the public health authority if their status changes.
- To notify any late, COVID-19-related deaths to the PHU.
- To alert the PHU to any new cases, signalling either re-introduction of infection or previously undetected ongoing transmission.
- To advise relevant state/territory/national agencies of the outbreak in a RCF, if applicable.

## 5.7. Reviewing Outbreak Management

Following a declaration that an outbreak is over, it is important for all parties to reflect on what worked well during the outbreak and which policies, practices or procedures need to be modified to improve responses for future outbreaks. Although a debrief may seem unnecessary for outbreaks of short duration involving a small number of cases, the OMT in collaboration with the local PHU should consider a debrief for any outbreak, a prolonged outbreak, or one with unusual features in relation to outbreak management. A debrief provides the opportunity to identify strengths and weaknesses in outbreak response and investigation processes, and provide information to help improve the management of similar outbreaks in the future. It should involve all members of the OMT and any others who participated in the response to the outbreak.

Audits are commonly used in clinical medical and nursing practice as part of continuous quality improvement, and may be an appropriate method by which to review the management of the outbreak. 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, and a template for trigger questions. This tool enables agencies such as RCFs to assess their outbreak response against best practice and is available at

<https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-9-472>

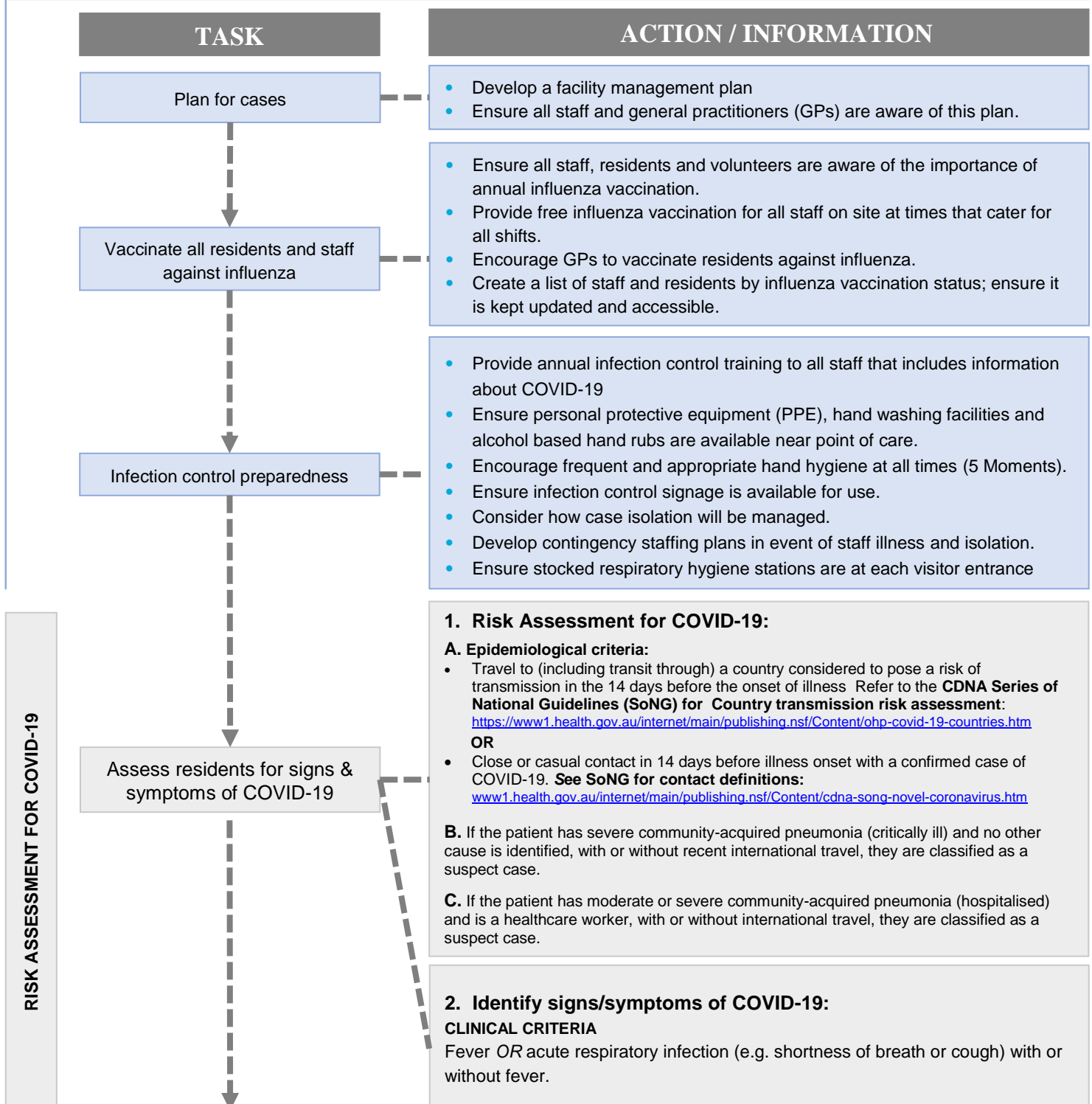
## Appendix 1. Flow Chart for COVID-19 Management in RCF

# Flowchart for COVID-19 Management in Residential Care Facilities in Australia

This guideline is intended for use within residential care facilities in Australia and has been adapted from Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units.

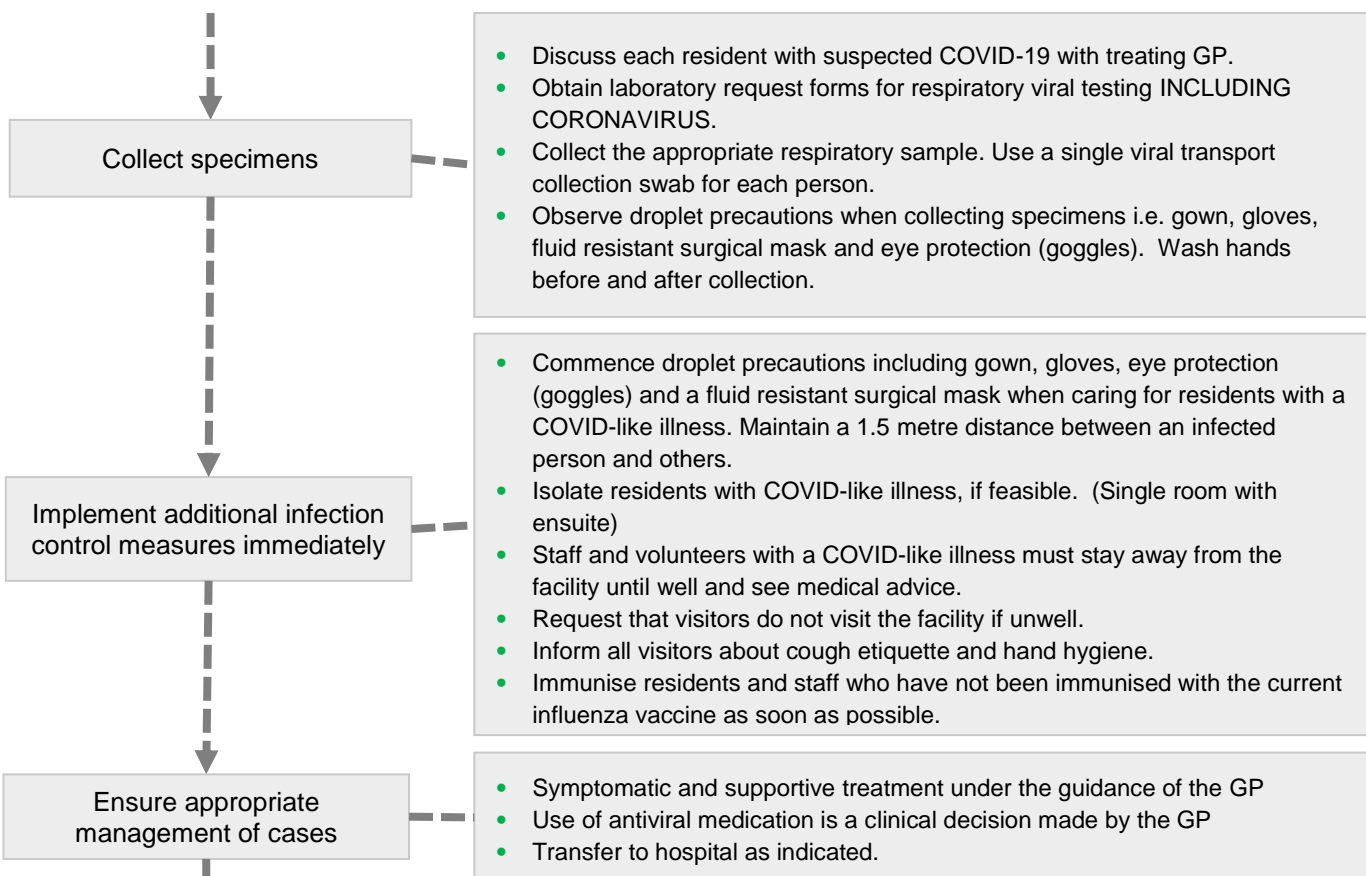
<https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm>

Note: the case definition may change over time

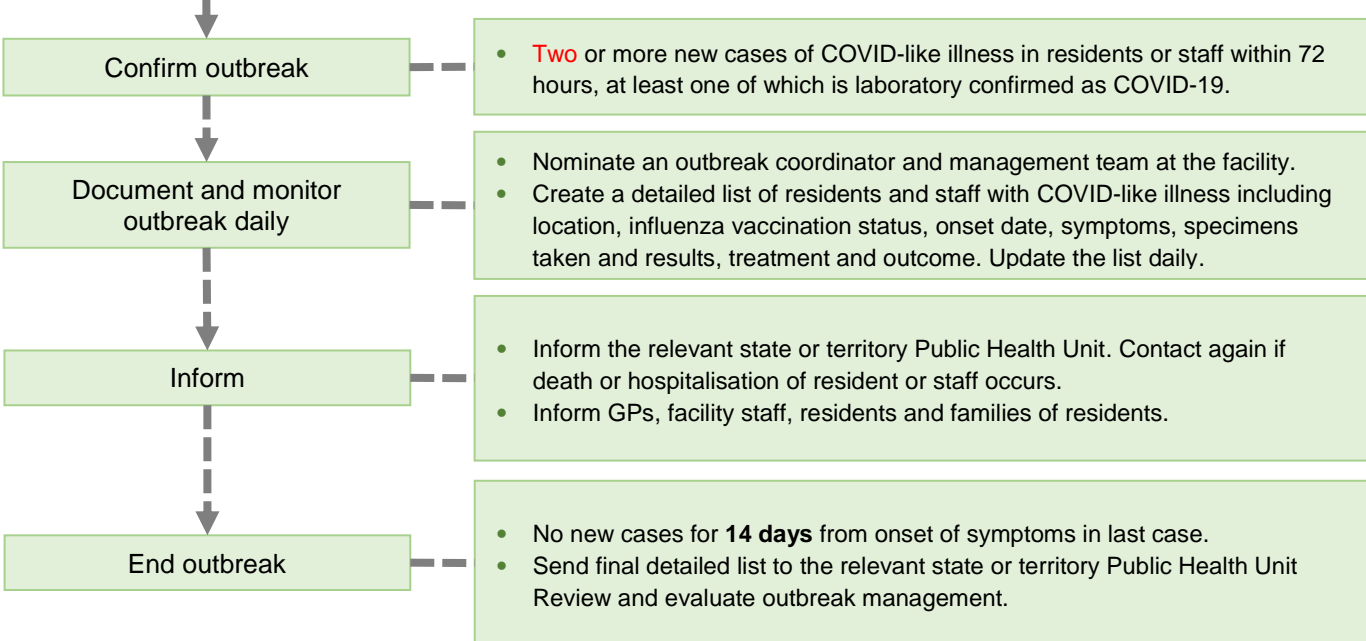


RISK ASSESSMENT FOR COVID-19


MANAGE A SUSPECTED OR CONFIRMED CASE OF COVID-19



MANAGE A SUSPECTED OUTBREAK OF COVID-19



## Appendix 2. COVID-19 Outbreak Preparedness Checklist

<b>Planning actions</b>	
Does your RCF have a respiratory outbreak plan that covers all the areas identified below?	
Has your RCF updated its respiratory outbreak plan this year?	
Have the relevant health care providers/organisations in the community (e.g. associated GPs, infection control consultants) been involved in the planning process?	
Are all RCF staff aware of the plan including their roles and responsibilities?	
<b>Staff, resident and family education</b>	
Has your RCF staff undergone education and training in all aspects of outbreak identification and management, particularly competency in infection control?	
Has your RCF run one or more staff education sessions?	
Has your RCF provided resident families with information regarding prevention of transmission?	
<b>Staffing actions</b>	
Does your RCF have a staffing contingency plan in case 20% to 30% of staff fall ill and are excluded for 14 days?	
Has your RCF developed a plan for cohorting staff in an outbreak?	
<b>Stock levels</b>	
Has your RCF acquired adequate stock of PPE, hand hygiene products, nose and throat swabs and cleaning supplies?	
<b>Outbreak recognition actions</b>	
Does your RCF routinely <i>assess</i> residents for respiratory illness, particularly for fever or cough (with or without fever)?	
Does your RCF <i>encourage</i> staff to report COVID-19 symptoms during the pandemic?	
Does a process exist to notify the facility manager and the state/territory Department of Health and Human Services as soon as practicable (and within 24 hours) of when a COVID-19 case is suspected?	
<b>Communication actions</b>	
Does your RCF have a contact list for the state/territory health department and other relevant stake holders (e.g. facility GPs and infection control consultants)?	
Does your RCF have a plan for communicating with staff, residents, volunteers, family members and other service providers (e.g. cleaners) during an outbreak?	
Does your RCF have a plan to restrict unwell visitors entering the facility as well as limitation of well visitors during an outbreak to reduce risk of transmission both within the facility and externally (e.g. security, signage, restricted access)?	
<b>Cleaning</b>	
Does the plan identify who is responsible for overseeing increased frequency of cleaning, liaison with contractors or hiring extra cleaners as necessary?	

## Appendix 3. Letter to Families – Preventing Spread of COVID-19

[Facility Letterhead]

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

Dear family member

There is local transmission of Coronavirus Disease 2019 (COVID-19) in the community. COVID-19 primarily causes respiratory illness in humans, and while all types of respiratory viruses can cause sickness in the elderly, COVID-19 is a particularly contagious infection that can cause severe illness and death for vulnerable people.

### **COVID-19 Pandemic**

COVID-19 has caused outbreaks of illness in the Australian community, and local transmission has occurred in some communities. Residential care facilities are particularly susceptible to COVID-19 outbreaks. Even when facilities actively try to prevent outbreaks occurring, many external may lead to residents or staff contracting the COVID-19 and outbreaks in residential care facilities.

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

### **Avoid spreading illnesses**

Washing your hands well with liquid soap and water or 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.

### **Follow any restrictions the residential care facility has put in place**

Facilities will post signs at entrances and within their units to inform you if an outbreak is occurring so look out for these warning signs when entering the facility.

**It is important to** follow the infection control guidelines as directed by the facility staff. This may include wearing a disposable face mask and/or other protective equipment (gloves, gowns) as instructed. Certain group activities may be postponed during an outbreak.

### **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 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 self-isolation.

### **Limit your visit**

If there is an outbreak in the residential care facility, we ask that you only visit the person you have come to see and keep children away if they or your resident family member is

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 residential care 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:

<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert>

Yours sincerely,

**[Name]**

[Position]

[Facility/Organisation]

## Appendix 4. Swab Collection Procedure

### Swab Collection Procedures

#### 1. Before performing swab

*Obtain required materials:*

- Personal protective equipment (PPE) for the health care worker taking the swab, including gown, gloves, eye protection (goggles or face shield), and surgical mask.
- One dry, sterile, flocked swab.
- One viral culture swab with viral culture medium.

#### **IMPORTANT NOTES:**

- Contact your laboratory provider for current local advice about swabs.
- Do not use bacterial swabs for specimen collection. If in doubt, check!

#### 2. Performing the swabs

*Preparation:*

1. Perform hand hygiene.
2. Don PPE in the order of gown, surgical mask, eye protection, and gloves.
3. Explain the procedure to the patient and obtain consent.
4. Place patient standing or sitting with head tilted at 70°, supported against a bed, chair or wall.

*Deep nasal swab procedure: (refer to figure 1)*

1. Stand at the side of the patient's head and place your non-dominant hand on the patient's forehead with your thumb at the tip of the nose.
2. With the other hand, insert the flocked end of a dry, sterile swab horizontally into the patient's nostril, approx. 2-3 cm (gently pushing the swab directly back rather than up).
3. Place lateral pressure on the swab to collect cells from the midline nasal septum.
4. Rotate the swab twice (2 x 360 degree turns) against the turbinate in the nostril to ensure the swab contains epithelial cells (not mucus) from the nostril.
5. Withdraw the swab from the nostril. Place the swab back in its labelled tube or bottle.

**Figure 1**



### Throat swab procedure: (refer to figure 2)

1. Stand at the side of the patient's head and ensure their head is resting against a wall or supporting surface.
2. Place your non-dominant hand on the patient's forehead.
3. Ask the patient to open his/her mouth widely and say "aaah".
4. Use a wooden spatula to press the tongue downward to the floor of the mouth. This will avoid contamination of the swab with saliva.
5. Using the viral culture swab, insert the swab into the mouth, avoiding any saliva.
6. Place lateral pressure on the swab to collect cells from the tonsillar fossa at the side of the pharynx.
7. Rotate the swab twice (2 x 360 degree turns) against the tonsillar fossa to ensure the swab contains epithelial cells (not mucus).
8. Remove the swab, and place directly into its labelled tube or bottle.

Figure 2



#### IMPORTANT NOTES:

- Choose an area for the procedure where the patient can rest their head against a wall or on a high-backed chair with room for you to stand beside (not in front of) the patient.
- Ensure the area is well lit, with hand washing and infectious waste disposal facilities.
- Remember to **WASH AND DRY HANDS** before and after the procedure!
- Gloves, gown, surgical mask and eye protection **MUST** be worn when collecting nose and throat swabs.
- Masks should **NOT** be touched during wear and should **NOT** be worn around the neck at any time. When removed, handle the mask by the ties of the mask only.

### 3. After performing the swab

#### 5.7.1.1. Labelling and storage of specimen:

1. Label the tube or bottle containing the swabs with the patient's full name, date of birth, specimen type and date of collection. The accompanying request form should include the RCF facility name.
2. Remove PPE safely (remove gloves, perform hand hygiene, remove goggles or face shield, gown and mask and perform hand hygiene again).
3. Specimens should be **sent on the day of collection**. Refrigerate the specimen until it is sent to the laboratory (do NOT freeze the specimen). Specimens should be packaged in a small insulated bag/box (with ice bricks) for transport to the pathology laboratory.

**IMPORTANT NOTE:** Dispose of gloves, gowns and masks in an infectious (biohazard) waste bag.



## Appendix 5. Initial RCF report to a PHU – COVID-19 Outbreak

Date/time: \_\_\_\_\_ Public Health Officer: \_\_\_\_\_

### Contact details:

Person notifying outbreak: \_\_\_\_\_ Position: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

### 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: \_\_\_\_\_

**Floorplan provided:** Yes / No

### Residents:

Unit name	Resident no.	Long term	Short term / Respite	High Care	Dementia / Secure	Other

### RCF Staff:

Staff type	No. of RCF staff	No. agency staff	No. Casual staff	No. volunteers
Management				
Administrator				
Cleaner				
Nurse				
Carer / Care Assistant				
Agency				
Other (specify)				

## Appendix 6. Letter to GPs – COVID-19 Outbreak

[Facility Letterhead]

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

### Respiratory outbreak at [Facility Name]

Dear Doctor,

There is an outbreak of acute respiratory illness affecting residents at the facility named above. The outbreak may involve some of your patients who may require review.

It is important to establish if the outbreak is caused by **SARS-CoV-2**. Coronavirus Disease 2019 (COVID-19), caused by SARS-CoV-2, is a notifiable condition.

We recommend that you:

- Establish if any of your patients are affected
- Help determine if the outbreak is caused by SARS-CoV-2:
  - Obtain/order appropriate respiratory samples from residents who meet the case definition, for respiratory PCR testing.
- Ensure that your patients are vaccinated against influenza, if there are no contraindications
- Ensure that you observe hand hygiene procedures and use appropriate PPE when visiting your patients.

**Limit the use of antibiotics** to patients with evidence of bacterial superinfection, which is uncommon. There is significant evidence that antibiotics are over-prescribed during the during institutional respiratory illness outbreaks.

Control measures that the facility has been directed to implement include:

- Isolation of symptomatic residents
- 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.

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

<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert>

If you require any further information or advice please contact [insert details].

.

Yours sincerely,

**[Name]**

[Position]

[Facility/Organisation]

## Appendix 7. 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

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 **confirmed case of COVID-19**

**Resident details:** \_\_\_\_\_  
Given name Surname


**Date of birth:**

**Name of originating facility:**

**Name of contact person:**

**Phone number:**

## Appendix 8. COVID-19 Outbreak Management Checklist

	
<b>Identify</b>	
Identify if your facility has an outbreak using the definition in the guideline	
<b>Implement infection control measures</b>	
Isolate / cohort ill residents	
Implement contact and droplet precautions	
Provide PPE outside room	
Display sign outside room	
Exclude ill staff until symptom free (or if confirmed cases of COVID-19, until they meet the release from isolation criteria)	
Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility	
Display outbreak signage at entrances to facility	
Increase frequency of environmental cleaning (minimum twice daily)	
<b>Collect respiratory specimens</b>	
Collect appropriate respiratory specimens from ill residents or staff	
<b>Notify</b>	
The state/territory Department of Health and Human Services	
Contact the GPs of ill residents for review	
Provide the outbreak letter to all residents' GP's	
Inform families and all staff of outbreak	
<b>Restrict</b>	
Restrict movement of staff between areas of facility	
Avoid resident transfers if possible	
Restrict ill visitors where practical	
Cancel non-essential group activities during the outbreak period	
<b>Monitor</b>	
Monitor outbreak progress through increased observation of residents for fever and/or acute respiratory illness	
Update the case list daily at the facility and provide to the public health unit daily	
Add positive and negative test results to case list	

<b>Declare</b>	
Declare the outbreak over when there are no new cases 14 days from the date of isolation of the most recent case.	
<b>Review</b>	
Review and evaluate outbreak management – amend outbreak management plan if needed	

## Appendix 9. Forming an Outbreak Management Team

Several functions are critical within the outbreak management team (OMT), and some roles may be performed by the same person.

The OMT should initially meet daily to:

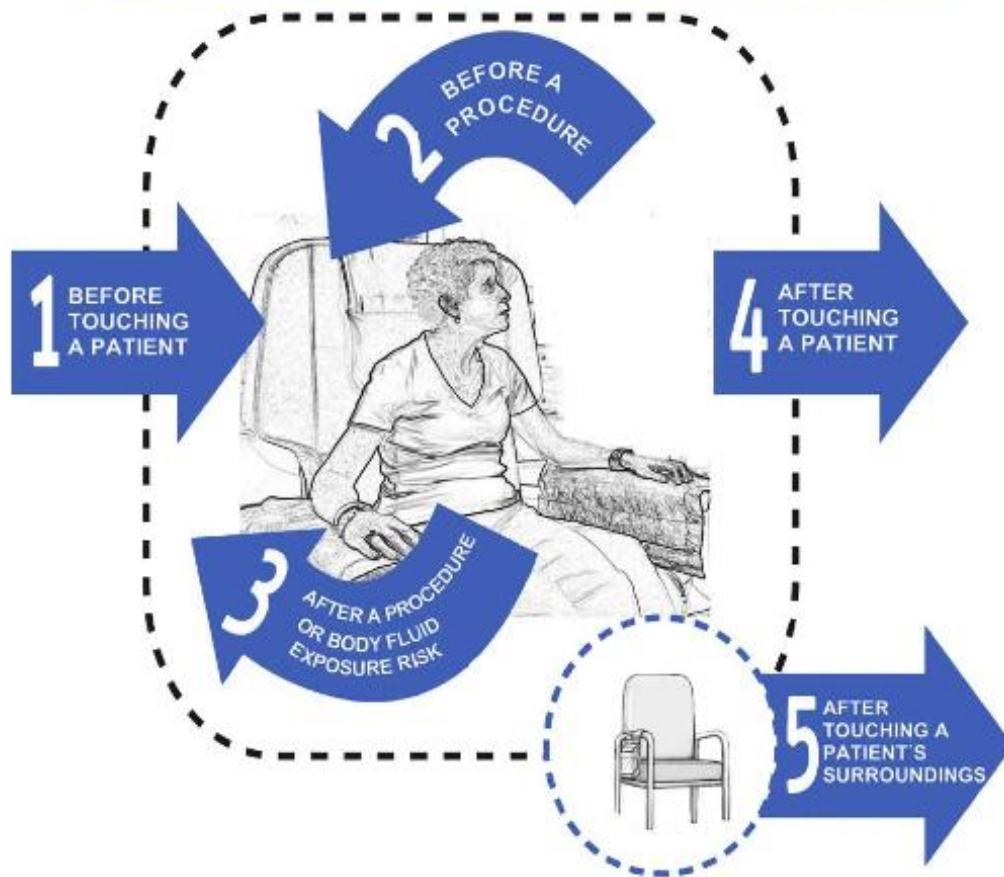
- direct and oversee the management of the outbreak
- monitor the outbreak progress and initiate changes in response, as required
- liaise with GPs and the state/territory Department of Health, as arranged.

The OMT should include the following roles and functions:

Role	Function
Chairperson (facility Director, Manager or Nursing Manager)	The chairperson is responsible for co-ordinating outbreak control meetings, setting meeting times, agenda and delegating tasks.
Secretary	The secretary organises OMT meetings, notifies team members of any changes, and records and distributes minutes of meetings.
Outbreak Coordinator (Nurse, Infection Control Practitioner or delegate)	The coordinator ensures that all infection control decisions of the OMT are carried out, and coordinates activities required to contain and investigate the outbreak. This role is often given to an Infection Control Practitioner (ICP) or delegate.
Media Spokesperson (facility Director, Manager or Nursing Manager)	Significant media interest in outbreaks in RCFs is common, especially if there are adverse outcomes. The department is available to assist facilities should media interest arise. It is recommended that facilities liaise with the department in this instance prior to making media statements.
Visiting General Practitioners	Some GPs may be available to participate in the OMT and their role should be identified during the planning process. It is valuable to identify a clinical lead amongst those GPs who attend a facility. In the management of an outbreak, the role of this person is important in facilitating assessment and management of ill residents, and in working with the RCF and the department to implement control strategies.
Public Health Officers	An understanding of what assistance can be provided by PHUs and role/responsibility clarification should be confirmed at the initial OMT meeting, although it is usually not necessary for PHUs to be part of the OMT.

## Appendix 10. Hand Hygiene

# 5 Moments for HAND HYGIENE



<b>1</b> BEFORE TOUCHING A PATIENT	When: Clean your hands before touching a patient and their immediate surroundings. Why: To protect the patient against acquiring harmful germs from the hands of the HCW.
<b>2</b> BEFORE A PROCEDURE	When: Clean your hands immediately before a procedure. Why: To protect the patient from harmful germs (including their own) from entering their body during a procedure.
<b>3</b> AFTER A PROCEDURE OR BODY FLUID EXPOSURE RISK	When: Clean your hands immediately after a procedure or body fluid exposure risk. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
<b>4</b> AFTER TOUCHING A PATIENT	When: Clean your hands after touching a patient and their immediate surroundings. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.
<b>5</b> AFTER TOUCHING A PATIENT'S SURROUNDINGS	When: Clean your hands after touching any objects in a patient's surroundings when the patient has not been touched. Why: To protect the HCW and the healthcare surroundings from harmful patient germs.

# How to Handrub?

**RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED**

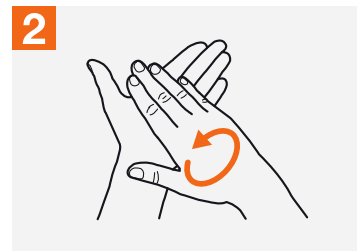
 **Duration of the entire procedure: 20-30 seconds**



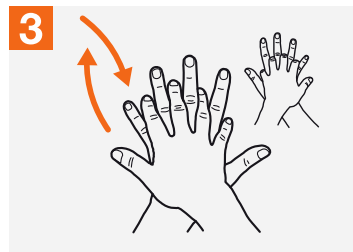
**1a** Apply a palmful of the product in a cupped hand, covering all surfaces;



**1b**



**2** Rub hands palm to palm;



**3** Right palm over left dorsum with interlaced fingers and vice versa;



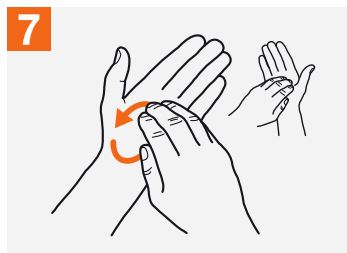
**4** Palm to palm with fingers interlaced;



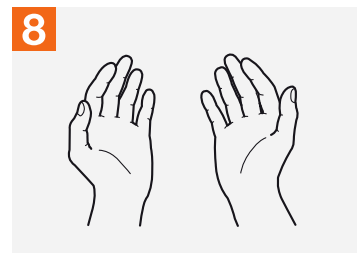
**5** Backs of fingers to opposing palms with fingers interlocked;



**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** Once dry, your hands are safe.



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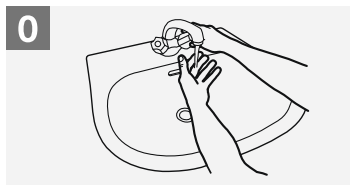
May 2009



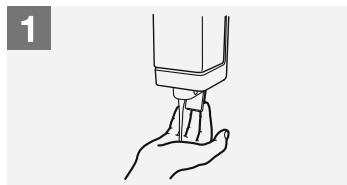
# How to Handwash?

**WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB**

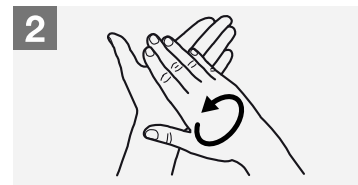
 **Duration of the entire procedure: 40-60 seconds**



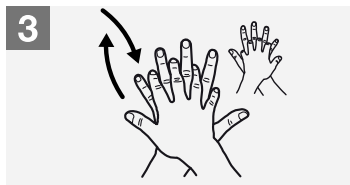
**0** Wet hands with water;



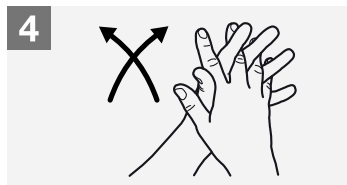
**1** Apply enough soap to cover all hand surfaces;



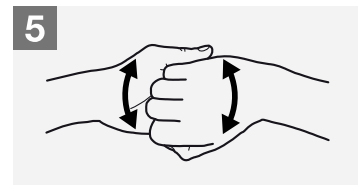
**2** Rub hands palm to palm;



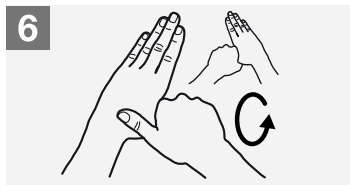
**3** Right palm over left dorsum with interlaced fingers and vice versa;



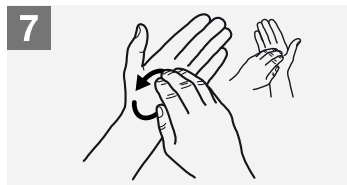
**4** Palm to palm with fingers interlaced;



**5** Backs of fingers to opposing palms with fingers interlocked;



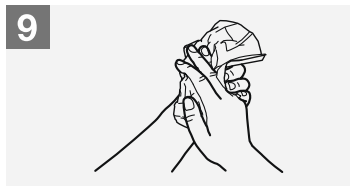
**6** Rotational rubbing of left thumb clasped in right palm and vice versa;



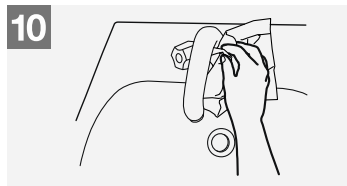
**7** Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



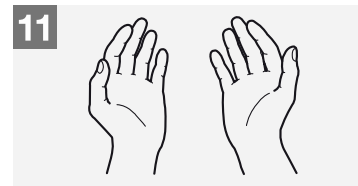
**8** Rinse hands with water;



**9** Dry hands thoroughly with a single use towel;



**10** Use towel to turn off faucet;



**11** Your hands are now safe.



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May 2009

Source: [Hand Hygiene Australia](#), adapted from '5 Moments for Hand Hygiene', 'How to Handwash', and 'How to Handrub' © World Health Organization 2009. All rights reserved.

## Appendix 11. Personal Protective Equipment Requirements

Personal Protective Equipment Requirements by Precaution			
Personal Protective Equipment	Precaution		
	Contact	Droplet	Airborne
<b>Gloves</b>	Yes	As per standard precautions	As per standard precautions
<b>Gown/Apron (impermeable)</b>	When healthcare worker's clothing is in substantial contact with the patient, items in contact with the patient, and their immediate environment	As per standard precautions	As per standard precautions
<b>Surgical Mask</b>	When in close contact (less than 1m)	Yes	No
<b>P2/N95 Respirator</b>	Not required	Not required	Yes
<b>Goggles/face shield</b>	Not required	As per standard precautions	As per standard precautions

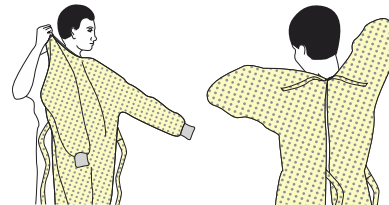
## Appendix 12. Proper Use of Personal Protective Equipment (PPE)

### SEQUENCE FOR **PUTTING ON** PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

#### 1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



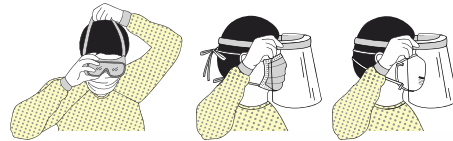
#### 2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator



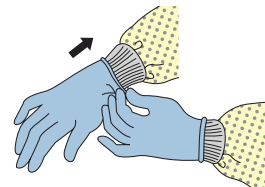
#### 3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit



#### 4. GLOVES

- Extend to cover wrist of isolation gown



### USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene



## HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

### 1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



### 2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container



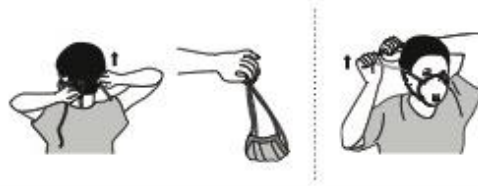
### 3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

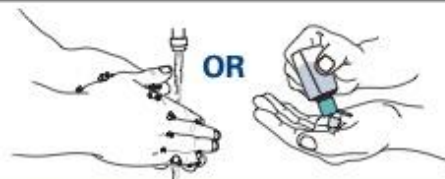


### 4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



### 5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS  
BECOME CONTAMINATED AND IMMEDIATELY AFTER  
REMOVING ALL PPE**



## HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

### 1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



### 2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

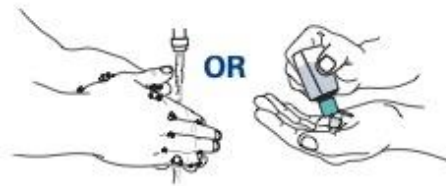


### 3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — **DO NOT TOUCH!**
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



### 4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE**



CS25872-E

Source: Centres for Disease Control and Prevention <https://www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf>

## Appendix 13. Respiratory Etiquette

### 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 the single most effective way 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; and
- wash or cleanse their hands afterwards.

## Appendix 14. Transmission-Based Precautions

Transmission-Based Precautions			
Infection Control Measure	Route of transmission		
	Contact	Droplet	Airborne
<b>Gloves</b>	For all manual contact with patient, associated devices and immediate environmental surfaces	As per Standard precautions	As per Standard precautions
<b>Gown</b>	When healthcare worker's clothing is in substantial contact with the patient, items in contact with the patient, and their immediate environment	As per Standard precautions	As per Standard precautions
<b>Surgical Mask</b>	As per Standard precautions	Yes	No
<b>P2/N95 Respirator</b>	Not required	Not required	Yes
<b>Goggles/face shield</b>	As per Standard precautions	As per Standard precautions	As per Standard precautions
<b>Standard single room with own ensuite</b>	Yes <i>OR</i> Cohort patients with door closed	Yes <i>OR</i> Cohort patients with door closed	No
<b>Negative pressure ventilation room</b>	Not required	Not required	Yes
<b>Special handling of equipment</b>	Single use or if reusable, reprocess according to IFU before reuse.	Standard Precautions Avoid contaminating environmental surfaces and	Standard Precautions Avoid contaminating environmental surfaces and

	Avoid contaminating environmental surfaces and equipment with used gloves.	equipment with used gloves.	equipment with used gloves.
<b>Transport of patients</b>	Surgical mask if coughing/sneezing and other signs and symptoms COVID-19. Notify the facility receiving patient. Advise transport staff of level of precautions to be maintained.	Surgical mask if coughing/sneezing and other signs and symptoms COVID-19. Notify the facility receiving patient. Advise transport staff of level of precautions to be maintained. Patients on oxygen therapy must be changed to nasal prongs and have a surgical mask over the top of the nasal prongs for transport (if medical condition allows).	Surgical mask if coughing/sneezing and other signs and symptoms COVID-19. Notify the facility receiving patient. Advise transport staff of level of precautions to be maintained. Patients on oxygen therapy must be changed to nasal prongs and have a surgical mask over the top of the nasal prongs for transport (if medical condition allows).
<b>Alerts</b>	Remove gloves and gown/apron and perform hand hygiene on leaving the room. Patient Medical Records must not be taken into the room. Signage of room.	Visitors to patient room must also wear surgical mask and perform hand hygiene. Patient Medical Records must not be taken into the room. Signage of room.	Visitors to patient room must also wear P2/N95 mask and perform hand hygiene. Patient Medical Records must not be taken into the room. Signage of room.
<b>Room cleaning</b>	Standard cleaning protocol.	Cleaning and Disinfection - Consult with infection prevention and control professional.	Cleaning and Disinfection - Consult with infection prevention and control professional.