COVID-19 Outbreaks in Residential Aged Care Facilities

Toolkit to support planning, preparedness and response

Department of Health

Tasmanian Government

We acknowledge and respect Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we work and live, and pay respect to Elders past and present. For around 40 000 years, Aboriginal people have lived on lutruwita/Tasmania, within strong and resilient communities. We acknowledge that as we work to strengthen resilience against COVID-19 across Tasmania.

Version 6.0, January, 2021

Contents

Abbreviations

CDNA	Communicable Diseases Network of Australia
CDPU	Communicable Diseases Prevention Unit (Public Health Services, Department of Health)
DoH	Department of Health
GP	General practitioner
OMCT	Outbreak management coordination team (multi-agency, led by Public Health Services)
OMT	Outbreak management team (internal to the facility)
PHS	Public Health Services
PPE	Personal protective equipment
RACF	Residential aged care facility

Updates since earlier versions of this document

Content that has been changed since Version 5.0 of the Respiratory Illness in Residential Aged Care Toolkit is highlighted in yellow. Where a whole section is new or modified, only the heading is highlighted.

Resources updated

Contact

Please contact aceoc@health.tas.gov.au

Introduction

Scope and purpose of this document

This toolkit was developed by Public Health Services (PHS), Department of Health (DoH) Tasmania to assist aged care providers with the prevention, control and public health management of COVID-19 outbreaks in residential aged care facilities (RACFs) in Tasmania. It has been adapted to the Tasmanian context from the following national guidelines:

- Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities
- Coronavirus (COVID-19) guidelines for infection prevention and control in residential care facilities

The knowledge and understanding of COVID-19 and the public health impact is rapidly evolving. The information about COVID-19 in this toolkit is purposely concise with links to key documents. It is highly recommended that staff involved in planning, preparing and responding to COVID-19 outbreaks in residential aged care facilities (RACFs) review the linked documents above regularly to stay up-to-date with the evolving situation.

This toolkit is primarily for RACFs but can also be used for other residential settings e.g. military barracks, correctional facilities and boarding schools.

Earlier versions of this toolkit included information on influenza outbreaks. That information has been removed and this document is focused solely on COVID-19. Please refer to the **Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia** for information on management of influenza in RACFs.

Background

While all respiratory viruses can cause outbreaks and significant morbidity and mortality for people living in RACFs, COVID-19 is a particularly significant health risk for people aged over 70 years and people with co-morbidities or low immunity.

COVID-19 vs influenza in residential aged care settings

COVID-19 is a new challenge, but health services and RACF have knowledge and skills to respond to this challenge based on experience with managing other respiratory outbreaks, including influenza. The first line of defence against COVID-19 is standard infection prevention and control measures, especially hand hygiene, for all staff (clinical and non-clinical), residents and visitors.

Annual seasonal influenza planning should be integrated into planning for COVID-19, as influenza and COVID-19 might occur together. Influenza immunisation for all staff and residents and strict risk reduction measures are essential to protecting residents, workforces and the wider community. As COVID-19 might present in a similar way to influenza, robust systems for preventing, detecting and managing outbreaks of viral respiratory illnesses safely are a key feature of the COVID-19 response in RACFs.

The management approach to COVID-19 and influenza are similar, however there are key differences, as detailed in Table 1. Unlike influenza, there are no definitive treatments for COVID-19 and the outcomes of concurrent infection (influenza and COVID-19) are not yet known.

Influenza and COVID-19 cases must be isolated separately and not cohorted together.

Table 1. Similarities and differences – COVID-19 and seasonal influenza

	COVID-19	Influenza
Fever and acute respiratory symptoms	Yes	Yes
Vaccine available	No	Yes
Antiviral use	No	Yes
Notification process	As soon as possible for **suspected** and **confirmed** cases in RACF residents and staff	Yes, when there is an outbreak
Infection prevention and control precautions	Contact and droplet	Contact and droplet
Isolation of cases	Yes	Yes
Incubation period	Average 5–6 days, range 1–14 days	Average 2 days, range 1–4 days

When residents develop respiratory illness, it is not possible to know whether it is due to influenza, COVID-19 or another pathogen prior to testing. Use the COVID-19 guidelines for the early management of respiratory illness with an unknown pathogen. Only use the influenza guidelines if you have a confirmed influenza outbreak.

When acute respiratory illness is undiagnosed, use the COVID-19 Guidelines.

Signs and symptoms of COVID-19

The most common symptoms of COVID-19 are (in the absence of an alternative diagnosis that explains the clinical presentation):

- fever (or symptoms of fever, e.g. chills, night sweats)
- acute respiratory infection (sore throat, shortness of breath, cough, runny nose with or without a fever)
- loss of smell or loss of taste
- tiredness or fatigue.

Fever may be absent in older people.

Test for COVID-19 in any resident of a RACF with any new respiratory symptom, however mild.

Less common symptoms include headache, myalgia/arthralgia, stuffy nose, nausea, vomiting and diarrhoea.

Older people may have non-classic respiratory symptoms, mild or atypical presentations, such as:

- increased confusion
- worsening chronic lung disease
- nasal or conjunctival congestion, haemoptysis, anosmia, sore throat or sputum production
- loss of appetite.

Most people with COVID-19 experience a mild illness and recover. Some people develop potentially life-threatening complications, and some may die. People aged over 70 years are at greater risk of complications and may also experience worsening of chronic health problems such as congestive heart failure, asthma and diabetes, as a complication of COVID-19.

Older people at highest risk are those with other chronic illnesses and/or weakened immune systems.

Transmission

The virus that causes COVID-19 spreads through:

- close contact with an infectious person
- contact with particles or droplets from an infected person (such as from singing, shouting, uncovered coughs or sneezes)
- certain aerosol-generating procedures in clinical settings (e.g. intubation)
- touching objects or surfaces (like doorknobs, sink taps and tables) that have cough or sneeze droplets from an infected person, and then touching your mouth, nose or eyes.

Definition of Suspected, Probable, or Confirmed Cases of COVID-19

The definitions of suspect, probable and confirmed cases are subject to change as the situation develops and more becomes known about COVID-19.

For current definitions of suspected and confirmed cases see: Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units

Definition of a COVID-19 Outbreak in a RACF

A COVID-19 outbreak is defined as a single (or more) confirmed case/s of COVID-19 in a resident, staff member or frequent attendee of a residential care facility.

Preparedness

RACFs must ensure they are well prepared for COVID-19 cases and outbreaks. The following steps are key in ensuring preparedness. Please refer to Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities for further details.

Outbreak management plan	• It is each service's responsibility to have an up to date **COVID-19 outbreak management plan**. Key things to consider are: ○ How will you activate your internal outbreak response team? ○ Who will lead the outback response and be the key liaison to PHS, as the outbreak management coordinator? ○ How will you isolate, and cohort confirmed COVID-19 cases? ○ How will you quarantine residents who are close contacts of confirmed cases? ○ How will communication with staff, residents, and families be managed (in co-ordination with PHS)? ○ Ensure you include in your plan what will happen if a positive case is confirmed out-of-hours. What are your arrangements for primary care cover out-of-hours and what are your contingency plans if your usual GPs are unavailable? • **Talk with your visiting GPs** and involve them in the planning process. • Run through **scenarios** to test and update your plan.
PPE	• Ensure you have **appropriate and sufficient PPE available for an outbreak** (to last at least 72 hours but one week's supply is recommended**)** • Identify how PPE will be sourced, stored and disposed of during an outbreak • Ensure staff have been trained in how to use different types of PPE, donning and doffing • Identify where donning and doffing stations are to be located within the facility • Prepare signage to guide staff in donning and doffing PPE and develop a strategy for monitoring appropriate use of PPE • Aged care providers that require additional PPE should email all requests to agedcarecovidppe@health.gov.au
Communication plan and resources	• **Provide information** to residents and their families about your infection control policies (including isolation protocols), and ensure they are aware of visitor restrictions and guidelines. • Prepare a **communication plan** for communicating with staff, residents, volunteers, family members, GPs and other service providers (e.g. cleaners) during an outbreak. • Ensure you have appropriate **signage** readily available. • Confirm you have the latest contact details for each residents' nominated representative • Ensure you have an **up-to-date list of your GPs** (with contact email and phone numbers) and develop an engagement process to support communication before, during and after an outbreak. • Prepare **communication resources** that you may need in an outbreak (e.g. a template letter to staff, residents and families; signage/posters) ahead of time. • Prepare how you will facilitate communication and **social connection** between residents and their families in the event of an outbreak e.g. using phone and video-conference, encouraging letter/postcard writing, sharing artwork.
Staff education and training	• Train staff in recognising the symptoms of COVID-19 and management of suspect cases. • Train staff in the safe **collection of throat and deep nasal swabs** using appropriate personal protective equipment (PPE). (Support may be available to assist with face-to-face training if required – see below.)

	• Train staff in **activation** of your outbreak management plan. • Train staff to correctly use **PPE and in infection control practices**, particularly Standard Precautions, transmission-based Droplet and Contact Precautions and safe donning and doffing
Workforce planning	• Prepare **staffing contingency plans** in case 30–40 per cent of staff are unwell or quarantined and excluded for 14 days. • Plan for a **dedicated staffing model** to be implemented, in which staff (clinical and non-clinical) do not work across units or sites. • pandemic **signage** to manage a surge in demand and a predictable delay for replacement stock.

Cleaning and waste management	• Prepare for additional **cleaning** requirements:
	  ○ Ensure you have adequate cleaning supplies
	  ○ Liaise with contractors or hire extra cleaners as required.
	• Consider waste management strategies for dealing with an increase in volume of contaminated items including the safe storage and removal of waste

Care plans for residents	• Discuss with residents and their families their preferences for treatment including transfers to hospital in the event of a COVID-19 diagnosis. Ensure preferences and choices are clearly documented. • Have **advance care directives** and **goals of care** in place for appropriate clinical management in the event of severe respiratory illness.
Information for PHS	• Prepare a **map/plan** of your facility. • Ensure your **resident and staff details** are current and collated in an Excel spreadsheet, including correct names (ie not nicknames), date of birth and contact details.
Stay up to date	• Monitor changes to COVID-19 guidelines in Tasmania including Directions under the *Public Health Act 1997*, testing protocols and resources available. See www.coronavirus.tas.gov.au/ • Subscribe to the Australian Government DoH *Protecting Older Australians: Daily COVID-19 update*. Subscribe at agedcare.health.gov.au/AgedCareUpdates • Ensure you receive emailed updates (eg Toolkit updates) from PHS. Email aceoc@health.tas.gov.au with the correct email address for your facility if you are not receiving these.

Engaging with your visiting GPs

It is important to talk with your visiting GP about your COVID-19 outbreak management plan. Some areas for engagement include:

- ensuring you have a current list of visiting GPs and their contact details, including out of hours arrangements
- ensure you involve GPs in discussions about goals of care and advance care directives for your residents
- involve GPs in planning and preparedness activities; ensure they are aware of your outbreak management plan
- discuss what your GPs' roles may be in an outbreak
- consider contingency plans for delivering primary care to residents if your usual GPs are unable to attend in person during an outbreak; consider the arrangements for telehealth and GP cover.

Prevention

Key strategies for preventing introduction of COVID-19 into the facility are outlined below. Please see Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities for further details.

Implement hygiene measures

The following measures can help prevent introduction and transmission of COVID-19 within the facility:

- support and encourage hand and respiratory hygiene by residents, staff and visitors
  - provide hand washing stations and alcohol-gel stations throughout the facility
  - provide tissues and rubbish bins throughout the facility
  - provide signage and education to staff, residents and visitors
- support and encourage physical distancing.

Use of PPE is not generally recommended unless the resident has symptoms or is identified as a close contact of a confirmed COVID-19 case.

Remember the five moments of hand hygiene

Restrict entry to your facility

Managing transfers into the RACF

Residents being admitted to RACFs from other health facilities should be assessed by appropriate medical staff before admission to the facility.

All residents being transferred into the RACF should be screened for symptoms of COVID-19. If any symptoms are identified, organise testing and manage the resident with droplet and contact infection control precautions in line with the national guidelines.

Asymptomatic residents being transferred into an RACF from an acute care facility are NOT recommended to be tested for COVID-19. This may change based on COVID-19 epidemiology in Tasmania. For the latest testing recommendations in Tasmania, see: www.coronavirus.tas.gov.au/keeping-yourself-safe/testing-for-covid19

For transfers out of the facility, Ambulance Tasmania has protocols for appropriate infection prevention and control including for transporting confirmed COVID-19 cases.

If you are concerned that a resident is transferring from an acute care facility where there have been recent *confirmed* COVID-19 cases, as a precaution, consider:

- admitting the resident to a single room with an ensuite, if available
- limit the resident's movement within the facility for 14 days
- monitoring the resident for symptoms of COVID-19 for 14 days.

Droplet and contact precautions and use of PPE is not recommended unless the resident has symptoms or is identified as a close contact of a confirmed COVID-19 case, in which case PHS will advise the RACF as quickly as possible.

Restricting visitors

In Tasmania, visits to residential aged care facilities are restricted under the Direction for Residential Aged Care Facilities

Current information on visitor restrictions can be found here www.coronavirus.tas.gov.au/families-community

Since 26 October 2020, visits are permitted for people providing care and support, with the following restrictions:

1. No more than two people can visit each resident at any time.
2. Visits must take place in the resident's room, outdoors or in a non-communal area as designated by the facility.
3. Visitors must not have any symptoms of acute respiratory infection, including fever (higher than 37.5 degrees Celsius), symptoms of fever (e.g. chills, night sweats), cough, sore throat, runny nose, shortness of breath; or loss of taste or smell.
4. Unless an exemption has been granted, visitors must not be in quarantine. That means they must not have:
    a. Been in an area identified as medium or high-risk for COVID-19 in the previous 14 days
    b. Had contact with anyone known to have COVID-19, or reasonably suspected of having COVID-19, within the previous 14 days (except as part of their employment while wearing effective PPE)
5. All visitors must have had the 2020 influenza vaccine (see below).

For information about exemptions to these requirements, please see pages 13 and 14 of this document and www.coronavirus.tas.gov.au/families-community/aged-care-facility-visits

Screening staff and visitors

Under the current Directions under the *Public Health Act 1997*, all staff and visitors entering aged care facilities must be screened to identify people at higher risk of having COVID-19 and restrict their entry to the facility. People at higher risk of having COVID-19 include:

- people with fever (≥37.5 degrees Celsius) or history of fever (e.g. night sweats, chills); or acute respiratory infection symptoms (e.g. cough, shortness of breath, sore throat), or loss of taste or smell
- people who should be in quarantine because they have been in contact with a confirmed COVID-19 case or spent time in a COVID-19 medium or high-risk area in the previous 14 days.

In addition, people who have not been vaccinated against influenza in 2020 are restricted from entry to a RACF unless they have a letter from a medical practitioner stating they cannot safely have the vaccine.

A screening tool and supporting procedures have been developed to support RACFs:

- Health and Residential Care Service – Standard operating procedure for Entry Screening
- Staff/Visitor Screening Tool for Residential Care Services

Staff members who have been in quarantine

In Tasmania, any person who has arrived from a medium or high risk area for COVID-19 or been in close contact with a confirmed case of COVID-19 is required to be in quarantine for 14 days from their arrival or close contact. RACF staff members who are in quarantine cannot go to work and should alert their employer. Depending on the type of work they do and provided they are well, quarantining staff may want to discuss alternative arrangements such as working from home.

If staff remain well during quarantine and do not develop any symptoms of COVID-19 (even mild), they do not need clearance testing to return to work after completing quarantine, unless specifically

Staff members returning from sick leave

Staff members who are sick should not return to work until they no longer have symptoms (depending on the condition).
If staff have been tested for COVID-19 they must remain isolated and not return to work until testing has excluded the infection.
If staff have confirmed COVID-19, they must not return to work until they have been released from isolation by their healthcare provider and PHS.

Confirmed cases must remain isolated until they receive a letter from PHS confirming they can leave isolation and return to work.

Influenza vaccination and exemptions

As of 1 May 2020, anyone seeking to visit or work in a RACF must have had the 2020 influenza vaccination. In Tasmania, people with a letter or certificate from a medical practitioner stating they have a medical contra-indication to influenza vaccine can be exempted from this requirement by their employer. Refusal to vaccinate on religious grounds is not an acceptable reason to allow entry into an RACF.
Emergency responders (including GPs responding to emergency situations, Ambulance Tasmania and Tasmania Fire Service staff) and law enforcers are exempt from needing to provide evidence of influenza vaccination to enter the premises to provide emergency or law enforcement services.
RACFs must take all reasonable steps to ensure that a person does not enter or remain on the premises if they do not meet the influenza vaccination (and other) requirements. This includes seeking appropriate evidence of immunisation status from individuals seeking to enter the service. Appropriate evidence is a statement or record from a health practitioner; or an immunisation history statement available from Medicare online or the Express Plus Medicare mobile app.
More information is here: www.health.gov.au/resources/publications/coronavirus-covid-19-restrictions-on-entry-into-and-visitors-to-aged-care-facilities
Further information specific to Tasmania is here: www.coronavirus.tas.gov.au/families-community/aged-care-facility-visits/influenza-vaccines-in-residential-aged-care-settings-faqs

Exemptions to RACF visitor restrictions

The Director of Public Health or their delegate can provide exemptions to aged care visit restrictions for people in quarantine (i.e. people who have arrived from medium or high-risk areas and close contacts of confirmed cases) on a case-by-case ***if*** the person seeking to visit the facility:

- is well (no fever or symptoms of acute respiratory infection); ***and***
- is a significant person to a resident; ***and***
- seeks to provide end-of-life support to that resident.

For people arriving from medium or high risk COVID-19 areas, an application for exemption to visit an aged care facility is ***in addition to*** a G2G PASS and any exemption the person receives to travel to Tasmania and to leave quarantine. I.e., it is a two-step process with two different Tasmanian Government agencies.

Process to apply for exemption to aged care visitor restrictions

1. Applicant discusses the visit with the manager of the RACF
2. If the facility manager is supportive of visit, they issue a letter of support naming the visitor
3. The applicant obtains a letter from the resident's treating doctor, certifying that the resident is nearing end-of-life
4. The applicant applies for exemption to visit the RACF through the G2G website at www.coronavirus.tas.gov.au/travellers-and-visitors/g2g-pass select the category 'leaving isolation to enter an aged care facility' and uploads supporting information, including the letter of support from the RACF and letter from the resident's doctor.

Applications are assessed by PHS from Monday to Friday in business hours. Applications must be received at least three business days, but no more than 14 days, before the applicant intends to enter Tasmania. In extraordinary circumstances, urgent applications will be considered.

If exemption is granted, the applicant will receive a letter of exemption by email to the email address provided in the G2G application. If exemption is not approved, they will be notified by email.

For people traveling to Tasmania, exemption from PHS to leave quarantine to visit an aged care facility is the first step. After PHS has assessed the request to visit the facility, the application for a G2G pass is assessed. If approved, the applicant will receive a G2G pass.

If the applicant receives exemption to visit the RACF, they should take their G2G pass and the letter from PHS with them, as evidence that exemptions have been provided. Please do not permit entry to the RACF for people who do not have evidence that exemptions have been provided.

People given exemption to visit the RACF must still complete the entry screening form on arrival and ***declare that they are in quarantine***. They must also comply with any directions given by PHS or RACF staff, such as wearing facemasks.

For more information, call 1800 671 738 or email covid.response@health.tas.gov.au

Identification of COVID-19 in an RACF

Early identification of cases and rapid response is key to minimising transmission of COVID-19 within an RACF.

Assessment of residents with fever or respiratory illness

Unwell residents should be assessed and clinically managed by their GP. Maintaining the health and wellbeing of residents and ensuring their care needs are met is the responsibility of the RACF.

If a resident has a fever or respiratory illness and may be a suspected case of COVID-19:

1. Isolate the resident if possible and use standard and droplet precautions.
2. Inform the GP as soon as possible. Provide a comprehensive clinical history, current clinical observations and facility details.

   Tell the GP if there is an outbreak or suspected outbreak within the facility.

   If it is after hours, contact the after-hours or locum service as per standard processes.

When to test residents for COVID-19

Any resident of an RACF who meets clinical criteria for COVID-19 is considered a suspect case and should be tested. Clinical criteria include ANY of the following:

- fever (≥37.5°C) or symptoms of fever (e.g. night sweats, chills)
- acute respiratory infection symptoms (e.g. cough, shortness of breath, sore or itchy throat)
- loss of smell or taste.

Manage all suspect cases with contact and droplet precautions as per the national guidelines.

What to test for and how to arrange testing

Testing for influenza, COVID-19 and other respiratory viruses is recommended unless testing is being undertaken in a known COVID-19 outbreak, in which case testing for COVID-19 may be sufficient.

All facilities in Tasmania should have specimen collection packs available for urgent testing. Contact Sonic Healthcare (also known as Hobart, Launceston and North West pathology) to arrange delivery of specimen collection packs if required.

Specimens can be collected by an appropriately trained RACF staff member or GP.

For testing in residential care facilities other than aged care, please follow site-specific protocols or call PHS to discuss.

1. If you have an RACF resident/s who meets the clinical criteria for COVID-19 (as above), liaise with the treating GP, collect the specimen and call the **Sonic Healthcare ACF COVID-19 hotline** on **1800 570 573** (8:00am to 6:00pm) to arrange a courier to collect the specimen. *After hours, please initiate appropriate precautions (including isolation of the suspect case) and call the following morning.*

   The Sonic Collection Coordinator can also arrange urgent delivery of the required number of specimen collection kits, which include detailed specimen collection instructions, swabs and specimen transport bags if required.

   For facilities remote from the major centres (Hobart, Launceston and Burnie) a number of specimen collection packs (depending on the size of the facility) will be provided to be on-hand to facilitate urgent testing if required.

2. Don the appropriate PPE and **collect the sample,** using the instructions for specimen collection provided in Appendix 2.

   Providing samples for nucleic acid testing requires a combined throat and nasopharyngeal swab with a flocked swab, placed into viral transport medium.

   A specimen that is just for COVID-19 testing can be collected by a nasopharyngeal or combined throat and deep nasal swab

It is the responsibility of the RACF to provide appropriate PPE for

3. Complete the request form with a request for **'COVID-19, Influenza and other respiratory viruses'.** Write on the form that the patient meets testing criteria for COVID-19 and include the treating GP's details. If the GP has been consulted by telehealth, an unsigned request form will be accepted by Sonic Healthcare, ***if*** the requesting GP's details are included on the form.

Transport of specimens to the laboratory will be arranged by Sonic Health Care.

The results will be phoned to the referring doctor and RACF RN. In the event of a positive test, the Communicable Diseases Prevention Unit (CDPU) within PHS will be in contact with further advice and a team will be sent to the RACF to collect specimens from all residents and staff. See Appendix 3 for a summary flowchart of this process.

While awaiting test results, please follow the infection prevention and control measures outlined in the national guidelines.

Assessment of staff with fever or respiratory illness

Any residential care worker with a fever (≥37.5°C) or symptoms of fever (e.g. night sweats, chills) **OR** acute respiratory infection (e.g. cough, shortness of breath, sore throat) **OR** loss of smell or loss of taste, are classified as a ***suspect case***.

They should notify management, isolate themselves, seek appropriate medical attention and be tested for COVID-19. It is recommended that medical practitioners do not test or treat themselves but seek medical care from another medical practitioner.

Staff being tested for COVID-19 should tell their GP or the testing centre that they work in an RACF.

To arrange testing, staff may call the Public Health Hotline or contact their GP. Please instruct staff to tell their GP or the testing centre that they work in an RACF. Any staff with any symptoms, even mild, must not attend work and must self-isolate until they receive their test results, as per national and state guidelines.

More information on COVID-19 testing in Tasmania is here: www.coronavirus.tas.gov.au/keeping-yourself-safe/testing-for-covid19

For checklists for specific scenarios, please see Appendix 1

Assessment of other influenza-like illnesses in RACF

In addition to monitoring and testing for cases of COVID-19, RACFs should have systems in place for detection of outbreaks of other respiratory illnesses, such as influenza.

The national case definition for ILI includes:

- Sudden onset of symptoms AND at least one respiratory symptom (cough, sore throat or shortness of breath) AND at least one systemic symptom (fever, malaise, headache or myalgia)

Three or more people (including residents, staff and frequent visitors) with ILI within a 72-hour period indicates a potential influenza outbreak and CDPU should be notified by calling the Public Health Hotline on 1800 671 738.

Case and Outbreak Management

Information sharing

Notification to Public Health Services

Laboratory confirmed COVID-19 is a notifiable disease in Australia. CDPU (PHS) is notified by the laboratory of all positive tests and will undertake a case interview and contact tracing upon notification. There is a chance CDPU will not be informed that the case is linked to a RACF. For this reason, the **RACF must notify CDPU immediately of any confirmed or probable case of COVID-19 in a resident, staff member or frequent attendee of RACF.**

Please email the following information to cdpu.outbreaks@health.tas.gov.au:

- name, address and type of facility
- contact details and role/position of person notifying
- number of residents and staff in facility
- number of residents and number of staff unwell
- names and date of birth of all residents and staff tested
- date of specimen collection.

Alternatively, call the Public Health Hotline on 1800 671 738 and select the option to access the dedicated healthcare professional hotline.

Notification to treating GPs and other healthcare workers

In addition to notifying PHS, the RACF must notify all visiting GPs at the start of the outbreak. A template letter can be found in the appendices of Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities

The RACF must also inform other healthcare providers (including transport/ambulance staff) before they attend the RACF.

Please liaise with PHS before activating your communications plan.

Information sharing with CDPU

When an outbreak is suspected or confirmed and notified to CDPU, they will be in contact with the facility daily. CDPU staff may request the following additional information from the RACF:

- resident and staff details, including total number of residents in the facility and in the affected area
- description of the RACF in terms of size, buildings, layout, infrastructure and staffing
- total number of residents and staff with symptoms
- date of onset and details of symptoms of each person
- total number of staff that work in the facility and the affected area
- capacity to isolate/cohort cases
- whether respiratory specimens (nose and throat swabs) have been collected
- number of people admitted to hospital with an acute respiratory illness
- number of people with an acute respiratory illness who have died.

Line lists

CDPU will provide the RACF with a line list (in the form of an Excel spreadsheet) to record key information about cases (see example in Appendix 7). The RACF should update the line list and send it to CDPU daily by email to cdpu.outbreaks@health.tas.gov.au

Notification to the Australian Government Department of Health

In the event of an outbreak of COVID-19, the RACF should also notify the Australian Government DoH by email to agedcareCOVIDcases@health.gov.au The Department will work with the RACF to ensure they have the resources and support required during the outbreak.

CDPU may also liaise with the Australian Government DoH and/or the Aged Care Quality and Safety Commission so that additional support can be offered.

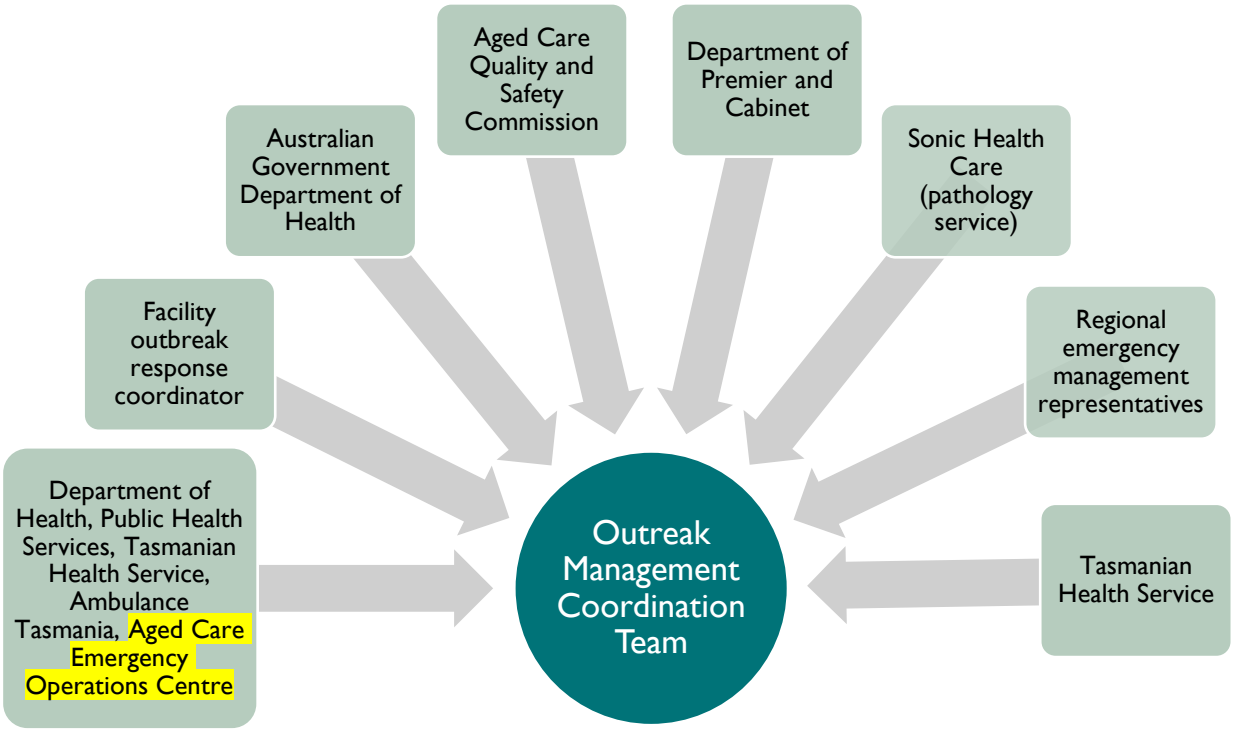
Roles and responsibilities in an outbreak

There are many stakeholders involved in outbreak management. The following table outlines the key responsibilities of the main organisations involved.

Stakeholder	Key role and responsibilities
The organisation responsible for the affected service/ facility	• Has main responsibility for managing COVID-19 outbreaks in that setting • Activates an internal outbreak response team • Implements its outbreak management plan and manages the outbreak in accordance with guidelines • Isolates confirmed case(s) • Supports PHS with contact tracing • Continues to provide high quality care to residents • Liaises with GPs and other clinical care providers • Communicates with residents, staff and families, in liaison with PHS • Manages staffing • Monitors and support health and well-being of residents.
Visiting GPs	• Provides clinical care for residents • Liaises with secondary and tertiary care providers.
PHS (CDPU)	• Assists the organisation responsible for the facility with communications about the outbreak • Provides outbreak management advice and support • Leads and coordinates contact tracing and management of close contacts • Advises health practitioners on management of confirmed cases • Monitors and reports on the outbreak • Coordinates communication activities • Coordinates on-site investigations, if needed.
The Australian Government DoH	• Appoints state-based 24/7 case manager to connect RACF to Australian Government support • Provides access to a First Nurse Responder who can assess infection prevention and control and provide ongoing oversight and training • Supports surge workforce supply • Supports PPE supply • Supports testing (via Sonic Healthcare and in coordination with PHS).
Aged Care Quality and Safety Commission	• Continues to act as regulator • Resolves complaints about the delivery of aged care services • Provides support as required.

The Outbreak Management Coordination Team

In the event of an outbreak, PHS will activate a multi-agency Outbreak Management Coordination Team (OMCT), whose key role is to coordinate support across the various agencies. The OMCT reports to the Director of Public Health. The membership of the OMCT will vary depending on the specific outbreak, but may include representation from the organisations shown below:



Key actions for the RACF in an outbreak

The following actions are key in outbreak management. Please see Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities for further details.

Action	Details
Isolate the case	• Isolate and manage with contact and droplet precautions. • Allocate specific staff to care for the confirmed case/s.
Notify	• Notify PHS (details as above). • Notify the Australian Government DoH (details as above).
Activate outbreak management team	• Activate the internal RACF outbreak management team. • Appoint outbreak management coordinator. • Meet and assign roles and responsibilities.
Ensure appropriate clinical management of case	• Liaise with the treating GP and provide appropriate clinical care • Transfer if appropriate (see sections on transfer of COVID-19 cases below).

Activate communication plan	• Liaise with PHS before activating your communication plan. • Allocate staff to manage communications.
Support contact tracing	• Support PHS with identification of contacts of the case and facilitate quarantine of those contacts. This may involve providing staff rosters and other information to PHS.
Enhance infection prevention and control	• Enhance hand hygiene, respiratory hygiene and physical distancing. • Enhance environmental cleaning and disinfection. • Use contact and droplet precautions for all cases, potential cases and quarantined residents.
Limit visitors and movement of persons into and within the facility	• Ensure non-essential people are excluded from the facility. • Ask residents to remain in their rooms; suspend communal activities. • Do not accept new admissions.
Surveillance for additional cases	• Monitor for symptoms in staff and residents and record in a line list. • Arrange testing for symptomatic staff and residents. • Share line list daily with PHS. • Support testing of asymptomatic staff and residents by Sonic Health Care *Testing of all staff and residents (including asymptomatic) may be organised and managed by Sonic Health Care*
Manage staff	• Allocate specific staff to care for residents in isolation. • Actively screen staff for symptoms. • Restrict staff working in other facilities, until the outbreak is over. • Plan for staffing shortages in case staff need to be quarantined. Liaise with the Australian Government Case Manager about workforce support if required.
Monitor and support health and wellbeing of residents and staff	• Maintain primary and routine care. • Support social connection e.g. using phone and video technology. • Support wellbeing of residents, including nutrition, physical activity, boredom, loneliness and fear. • Support morale and mental wellbeing of staff.
Declare the outbreak over	• Liaise with PHS about announcing the outbreak is over. • Return to routine activities gradually. • Review and debrief on outbreak response. • Review and revise the outbreak management plan as required.

The following document from the Australian Government DoH outlines the actions required in the first 24 hours: www.health.gov.au/resources/publications/first-24-hours-managing-covid-19-in-a-residential-aged-care-facility

Models of care, including place of care

In the event of an outbreak of COVID-19 in a RACF, decisions about models of care, including whether the resident/s should be managed in their home RACF or transferred to hospital, will be made on a **case-by-case basis**. The needs of the resident/s will be considered in consultation with the resident, their family, the facility, clinicians and PHS.

The model of care will be determined on a case-by-case basis guided by the following principles:

- care should be inclusive of all and focused on protecting vulnerable older Tasmanians, including those with underlying health conditions and compromised immune systems
- residents should be supported to receive appropriate, person-centred, holistic care in the environment that best suits their needs and respects their advance care directives
- the needs of residents who test positive to COVID-19 should be balanced with the needs and wellbeing of other residents in the facility, and the infection control risks
- the provision of care should be flexible, proportionate and able to be scaled up or down as required
- the capacity of the health sector, including potential impact for transfer services and their ability to manage residents/cases, should be considered
- the model of care should integrate the efforts of the Australian Government and Tasmanian Government and relevant public agencies and sectors to make best use of resources, systems, plans and processes.

Considerations for whether to provide care in a RACF or to transfer to hospital

Clinical and environmental factors should be considered before deciding the appropriate setting for care of a confirmed case/s.

Clinical factors include:

- clinical status of the patient e.g. if asymptomatic, mild or severe symptoms
- presence of comorbid conditions and particular clinical care needs
- goals of care and advance care directives for the resident and
- competency of the patient and their wishes or the wishes of their family/guardian
- the potential detrimental impact on the patient (e.g. delirium or functional decline) of transfer to hospital from their home.

Decisions on the most appropriate setting in which to provide healthcare for confirmed cases must consider clinical and environmental factors.

Environmental factors include:

- capacity of the RACF to appropriately isolate the patient in a single room with an ensuite, and manage with contact and droplet precautions
- capacity of the RACF to deliver appropriate clinical care and adequately monitor the patient; this may be adversely affected by quarantining of staff who are close contacts and absenteeism due to illness, staff anxiety and stress
- access to appropriate medical care should the patient deteriorate eg workforce capacity of the RACF and availability/capacity of visiting GPs or other clinical in-reach services
- the extent of the outbreak, including numbers of residents affected and if the acquisition source is known
- confidence in the RACF's ability to maintain adequate infection prevention and control and prevent transmission
- access to adequate PPE supplies.

Release from isolation

Residents (and staff) who are confirmed cases will be released from isolation by PHS in liaison with the treating clinician, when their symptoms have resolved and they are no longer considered infectious, as per the national guidelines.

PHS will provide instructions and a letter confirming that the resident can be released from isolation.

Key Resources

COVID-19 outbreaks in residential aged care

- Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities
- Coronavirus (COVID-19) outbreak management in residential care facilities Factsheet

For advice about specific aspects of outbreak management please contact CDPU on 1800 671 738 or email cdpu.outbreaks@health.tas.gov.au

Infection prevention and control

- Tasmanian Infection Prevention and Control Unit
  - Personal protective equipment for contact and droplet precautions (See Appendix 4)
  - Personal Protective Equipment Demonstration Videos
- Infection Control Expert Group (ICEG)
  - Coronavirus (COVID-19) guidelines for infection prevention and control in residential care facilities
  - Coronavirus (COVID-19) – Recommended minimum requirements for the use of masks or respirators by health and residential care workers in areas with significant community transmission
  - Guidance on use of personal protective equipment (PPE) in non-inpatient health care settings during the COVID-19 outbreak
  - Coronavirus (COVID-19) Environmental cleaning and disinfection principles for health and residential care facilities
- Australian Commission on Safety and Quality in Health Care
  - Infection Prevention and Control Signage
- Online COVID-19 Infection Control Training

Tasmanian Government

- Tasmanian coronavirus website
- CDPU Aged Care Respiratory Illness Preparedness Webinars – for a link to the recordings please email: cdpu.outbreaks@health.tas.gov.au

Primary Health Tasmania

- Tasmanian HealthPathways COVID-19 Assessment and Management in Aged Residential Care
- COVID-19: What to do in the first 30 minutes poster
- Coronavirus (COVID-19) response: information for health professionals

Australian Government Department of Health

- COVID-19 Resources for Aged Care Providers and Health Care Workers
- COVID-19 Resources for Aged Care Residents and Families
- COVID-19 Escalation Tiers and Aged Care Provider Responses
- Coronavirus Australia app
- COVIDSafe app

Education videos

- Coronavirus video – Older Australians
- Coronavirus video – Social distancing
- Coronavirus video – Help Stop the Spread
- Coronavirus video – Good Hygiene Starts Here
- Coronavirus video – Stay Informed

Subscribe to aged care sector announcements and newsletters

Australian Government Aged Care Quality and Safety Commission

- COVID-19 (coronavirus) information
- COVID-19 Consumer Resources
- COVID-19 flowchart posters

Restrictions on entry into and visitors to aged care facilities

- Tasmanian Government Restrictions on entry to residential aged care facilities information

Australian Government DoH information:

- Fact sheet Families and residents on restricted visits to residential aged care facilities
- Supporting safe, quality care for aged care consumers during visitor restrictions

Dementia

Dementia Australia:

- Tips for people living with dementia
- Tips for Carers, Families and Friends of People Living with Dementia
- Coronavirus (COVID-19) – Tips for residential care providers
- Coronavirus (COVID-19) – Tips for home care providers
- National Dementia Helpline 1800 100 500 (Monday-Friday 9-5pm).

Information for home care providers

- Coronavirus (COVID-19) Guide for Home Care Providers

Information for retirement communities

- Coronavirus (COVID-19) advice for retirement villages

Advance care directives

- Advice from Advance Care Planning Australia

Palliative care

- Practice tips for care workers in aged care from palliAged
- Palliative Care Australia

Grief and bereavement

Australian centre for grief and bereavement

Appendices

Appendix 1: Responses to specific scenarios

The following are scenarios that an RACF could face during the COVID-19 epidemic and for which the facility should be fully prepared:

- a suspect case (resident)
- a suspect case (staff member)
- a suspect case (visitor)
- a confirmed outbreak (ie a confirmed case in a resident, staff member or frequent attendee).

Checklists for actions required for each scenario are provided below.

Checklist: Response to a suspect case (resident)

- ☐ Immediately implement droplet and contact infection control protocols as per your outbreak management plan.
- ☐ If possible, isolate the resident in a single room with the door closed and avoid unnecessary interactions between staff and the resident. If the resident cannot be isolated:
  - avoid interactions between the suspect case and other residents
  - place a face mask, if tolerated, on the suspected case
  - consider cohorting confirmed cases of COVID-19.

Cohorting residents confirmed to have COVID-19 is OK. Do not cohort *suspected* cases until laboratory confirmation of COVID-19 is received.

- ☐ Continue to provide routine care to the suspect case/s. Consider how to proactively support residents with complex behaviours including dementia and mental health diagnoses.
- ☐ Increase frequency of clinical observations and monitoring of the resident(s).
- ☐ Identify if the resident has an advance care plan and ensure staff and family are familiar with the resident's preferences and values.
- ☐ Ensure any person entering the resident's room uses droplet and contact precautions including PPE (single-use surgical mask, eye protection, gown and gloves); and follows safe donning and doffing procedures.
- ☐ Ensure there is adequate PPE, waste disposal and hand sanitiser/hand washing facilities available in and outside the resident's room.
- ☐ Contact the resident's healthcare provider (if not already involved) to arrange for clinical assessment and testing. Unwell residents must be reviewed by their GP regardless of whether an outbreak is present or not. Inform the GP that this is a suspected case of COVID-19.
- ☐ Call Sonic Healthcare ACF COVID-19 hotline on **1800 570 573** to arrange testing.
- ☐ Arrange for transfer of the resident to hospital **only if clinically indicated**, in consultation with the resident, the resident's healthcare provider, PHS, the resident's family and the Tasmanian Health Service. If transfer is required, inform the hospital and transport staff that the resident is suspected to have COVID-19.
- ☐ Consider enhanced infection and control measures and enhanced surveillance for additional cases. Review the RACF outbreak management plan and prepare for further cases.
- ☐ If the case is confirmed, refer to the checklist for a confirmed outbreak.

Checklist: Response to a suspect case (staff member)

Any member of staff (clinical or non-clinical) who develops symptoms consistent with COVID-19 (even mild) should immediately be excluded from the facility and remain away while a diagnosis is determined.

- ☐ Isolate the staff member immediately. Give them a facemask to wear while leaving the facility and another in a Ziplock bag (eg specimen bag) to wear when traveling to be tested.
- ☐ Provide alcohol-based hand rub for the staff member to use before leaving the RACF.
- ☐ Instruct the staff member to seek testing as soon as possible, and to advise their GP or testing clinic that they work in a RACF.
- ☐ Instruct the staff member to stay away and to self-isolate while they wait to be tested and wait for their test result.
- ☐ Exclude the staff member from the facility

If COVID-19 is ruled out, the staff member can return to work once they are well, depending on their condition and guidance from their GP.

If a diagnosis of COVID-19 is confirmed, the staff member must not return to work and must remain in isolation until they meet the criteria for release from isolation as per the national guidelines and receive a letter from PHS advising them they are released from isolation. Refer to the checklist for a confirmed outbreak below.

Checklist: Response to a suspect case (visitor)

Any visitor who develops symptoms consistent with COVID-19 should immediately be excluded from the facility and remain away whilst a diagnosis is determined.

- ☐ Isolate the visitor immediately. Give them a facemask to wear while leaving the facility and another in a Ziplock bag (eg specimen bag) to wear when traveling to be tested.
- ☐ Provide alcohol-based hand rub for the visitor to use before leaving the RACF.
- ☐ Instruct the visitor to seek testing as soon as possible, and to advise their GP or testing clinic that they have visited an RACF.
- ☐ Instruct the visitor to stay away and to self-isolate while they wait to be tested and wait for their test result.

If COVID-19 is ruled out, the visitor may return once they are well, depending on their condition and guidance from their GP.

If a diagnosis of COVID-19 is confirmed, the visitor will be instructed by PHS to remain in isolation until they meet the criteria for release from isolation as per the national guidelines *and* receive a letter from PHS advising them they are released from isolation. Refer to the 'checklist for an outbreak', below.

Checklist: Response to a confirmed case (outbreak) in a RACF

- ☐ Immediately implement droplet and contact infection control protocols as per your RACF outbreak management plan. If possible, isolate the resident in a single room with the door closed. Avoid unnecessary staff interactions with the resident. If the resident cannot be isolated, avoid interactions with other residents and place a face mask, if tolerated, on the confirmed case. *Note, these measures will already be in place unless the confirmed case was asymptomatic when tested.*
- ☐ If isolation of confirmed cases is not possible, consider cohorting confirmed cases. **Do not cohort suspect cases or influenza cases with COVID-19 cases.**
- ☐ Notify CDPU via CDPU.outbreaks@health.tas.gov.au or phone 1800 671 738 and select the option for health professionals.
- ☐ Notify the Australian Government DoH; email: agedcareCOVIDcases@health.gov.au
- ☐ Continue to provide routine care to the resident. Consider how to proactively support residents with complex behaviours including dementia and mental health diagnosis.
- ☐ Increase the frequency of clinical observations and monitoring of residents.
- ☐ Identify if the resident has an advance care plan and ensure staff and family are familiar with the resident's preferences and values.
- ☐ Ensure the doctor or staff interacting with the resident use PPE correctly (including correct donning and doffing) and that there is adequate PPE, waste disposal and hand sanitiser/hand washing facilities available in and outside the room.
- ☐ Establish an internal outbreak management team and activate the RACF's outbreak management response plan. **It is the facility's responsibility to manage the outbreak.**
- ☐ Assist CDPU with collection of vital information and contact tracing.
- ☐ Limit the movement of staff within the facility, across facilities and to other workplaces.
- ☐ Arrange for designated staff to look after isolated or cohorted residents to reduce the risk of transmission to other residents.
- ☐ Enhance surveillance for early detection of additional cases (daily symptom screening and observations).
- ☐ Complete the daily line list and email it to CDPU. Inform PHS promptly if the case deteriorates or transfer to hospital is required.
- ☐ Limit non-essential access to the facility as per guidelines and Directions under the *Public Health Act 1997*.
- ☐ Avoid unnecessary transfers of residents to hospital, new admissions and readmissions.
- ☐ Facilitate telehealth appointments where possible.
- ☐ Perform risk assessment to identify any environmental/infection control shortcomings. Identify and implement enhanced infection control measures.
- ☐ Prepare for scale up of response (review outbreak plans and requirements for implementation).
- ☐ Inform staff, residents, families/visitors, and visiting GPs, in liaison with PHS.
- ☐ Do not remove confirmed cases from isolation until agreed by PHS and the treating GP.

Appendix 2: COVID-19 respiratory virus specimen collection in RACFs

Source: Hobart Pathology, Launceston Pathology and North West Pathology

Remember, when not wearing PPE, keep at least 1.5 metres

Training for collection of COVID-19 swabs in residents

- It is important that RACFs have staff trained and capable of collecting specimens to test for COVID-19 in residents. This is similar to taking swabs to test for influenza and other respiratory viruses.
- Collection instructions are shown in Appendix 2 and are supplied with the specimen collection packs. The video: Combination Nasal/Throat Swab is also useful.
- Contact and droplet precautions must be used when taking COVID-19 swabs. Use the Public Health Services (Tasmania) video demonstrating correct donning and doffing of PPE for contact and droplet precautions, based on the Australian Guidelines for the Prevention and Control of Infection in Healthcare
- If face-to-face training is required in addition to the provided information, please contact Sonic Health Care. They will try to facilitate training in Hobart Pathology, Launceston Pathology and North-west Pathology Collection Centres. You will be expected to travel to one of these centres and provide a volunteer to the have the procedure demonstrated on. Please discuss with the specimen collection supervisor in your region:
  - Hobart – phone 6223 1955
  - Launceston – phone 6334 3636
  - Burnie – phone 6432 8800.

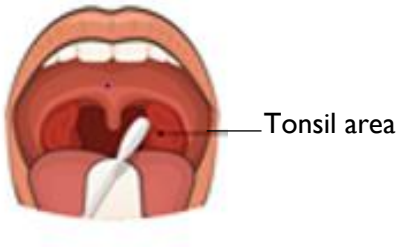
1. Remove the request form from the specimen bag and label with full patient details including the name of patient's requesting doctor, the resident's full name and date of birth etc.
2. Place the request form in the **outside pocket** of the specimen transport bag with the **patient details facing outwards**, to ensure the patient information details on the request form are clearly visible to laboratory staff.
3. Remove the swab from the specimen bag. Hand label the accompanying vial of liquid media with the full name, date of birth and site (Site = '**NTS**'), ensuring that the patient's name as written on the vial matches the name written on the request form.
4. Move the specimen bag at least 1.5 metres away from the patient to avoid contamination.
5. Don **PPE as per the correct donning procedure** (see Appendix 4).
6. Stand to the side of the patient to reduce exposure and proceed with collection (see Appendix 3).
7. Swab the patient's throat first **then** nose (perform both right and left deep nasal swabs) using one swab. Further details on swab collection are available in Appendix 3 or from the Public Health Laboratory Network (PHLN) COVID-19 swab collection and PHLN guidance on laboratory testing for SARS-CoV-2
8. Open the specimen collection bag and put the vial of liquid transport media into the inner pocket of the specimen collection bag, then seal.
9. Remove gloves, perform hand hygiene and don new gloves.
10. Clean the outside of the specimen collection bag and all touched surfaces with detergent/disinfectant.
11. Remove **PPE as per doffing procedure** (see Appendix 4).

Appendix 3: COVID-19 throat and deep nasal swab collection information sheet

Source: Hobart Pathology Launceston Pathology and North West Pathology

Take the **throat swab** first:

1. Do not touch any part of the swab other than the top of the swab.
2. Ask the patient to tilt their head back slightly and stick their tongue out.
3. If necessary, use a tongue depressor to push down the back of the tongue and expose the tonsil area.
4. Without touching the sides of the mouth, swab the back of the throat and tonsil area on both sides.
5. Withdraw the swab carefully, taking care not to touch any part of the mouth.



Using the **same swab**, collect the **nasopharyngeal specimens**:

1. Tilt the patient's head back slightly and immobilise by holding the chin.
2. Gently insert the swab directly back, not upwards, into a nostril 2-3 cm (or until resistance is met)
3. **Once in place, rotate the swab several times against the nasal wall**
4. **Slowly remove the swab and repeat on the other side.**
5. Places the swab into the transport medium.

6. Break shaft of the swab at the scored point and discard the proximal end, leaving the swab itself in the liquid media.
7. Place the specimen and request form in the specimen bag as per collection instructions.

Appendix 4: Personal protective equipment for contact and droplet precautions.

Personal Protective Equipment for **Contact and Droplet** Precautions

Contact and droplet precautions must be used for routine care of patients with suspected, probable and confirmed COVID-19. Use 'Contact and *Airborne* Precautions' for aerosol-generating procedures including intubation and bronchoscopy and for care of critically ill patients with suspected, probable or confirmed COVID-19.

Use the following personal protective equipment (PPE):

- gown – long sleeve
- gloves – non-sterile
- surgical mask (replace the surgical mask with a P2/N95 mask for Contact and Airborne Precautions
- protective eye wear.

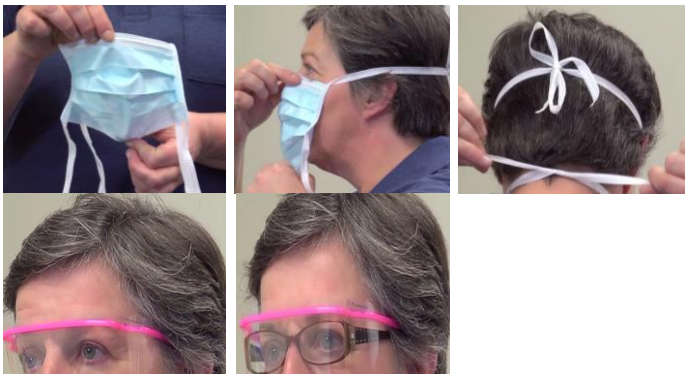
Sequence for putting on PPE

1. Gown

- **Perform hand hygiene.**
- Unfold the gown and slide your arms into the arm holes and through the cuffs.
- Secure the top of the gown at the back of the neck and tie the waist ties.

2. Mask and protective eyewear

- Put on the surgical mask. Press the nosepiece to conform with the bridge of your nose and cheekbones.
- Place eyewear over your eyes (and prescription glasses if worn) and adjust to fit.



3. Gloves

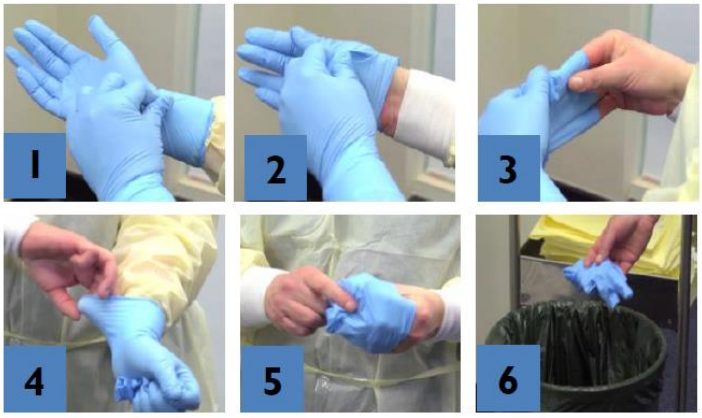
- **Perform hand hygiene**
- Put on the gloves.
- Extend the gloves to cover the wrist/cuff of your gown.

Sequence for removing PPE for Contact and Droplet Precautions

There are two approved sequences for removing PPE; steps 2 and 3 can be reversed with hand hygiene between. (ie remove gown, hand hygiene, remove eyewear, hand hygiene).

1. Remove Gloves

- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in the gloved hand.
- Slide the fingers of your un-gloved hand under the remaining glove at the wrist.
- Peel the second glove off over the first glove.
- Discard gloves in waste container.
- **Perform hand hygiene.**



2. Remove protective eyewear or face shield

- Handle the eyewear or face shield by the headband or earpieces.
- Place in designated receptacle for reprocessing or in waste container.
- **Perform hand hygiene.**

3. Remove gown

- Unfasten ties.
- Touching the inside of the gown only, pull the gown away from your neck and shoulders.
- Turn the gown inside out.
- Roll the gown down away from your body, continuing until the gown is in a ball.
- Discard in waste container.
- **Perform hand hygiene.**

4. Remove mask

- Unfasten the bottom tie and then the top tie.
- Lean forward and pull the mask away from your face by using the tie or bands.
- Hold the ties or band and discard directly into the waste container.
- **Perform hand hygiene.**

Appendix 5: PPE Indications for use and purchasing guidance

Personal protective equipment for COVID-19

Indications for use and purchasing guidance

Personal Protective Equipment (PPE) is used to protect mucous membranes, airways, skin and clothing from infectious agents.

This document describes the minimum requirements for PPE for health workers during the COVID-19 response and indications for use. These guidelines are based on the *Coronavirus Disease 2019 CDNA National Guidelines for Public Health Units*, available at www.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm

PPE required for COVID-19 includes:

- gown – long sleeve
- gloves – non-sterile
- protective eyewear/ face shield
- surgical mask **OR** P2/N95 respirator (see: 'Indications for use').

Indications for use of PPE for COVID-19

Contact and droplet precautions are used for:

- routine care of patients in quarantine or with confirmed, probable, or suspected COVID-19
- collecting respiratory specimens regardless of whether respiratory symptoms are present (excluding patients with severe symptoms, see contact and airborne precautions).

PPE for contact and droplet precautions requires the above PPE and a **surgical mask**.

Contact and airborne precautions are used for:

- performing aerosol-generating procedures including tracheal intubation, non-invasive ventilation, tracheotomy, cardiopulmonary resuscitation, manual ventilation before intubation, bronchoscopy and use of high flow nasal oxygen (note, nebulisers should be avoided)
- care of critically ill patients in ICU
- collecting respiratory specimens where the patient has **severe symptoms** suggestive of pneumonia, eg fever and breathing difficulty or frequent, severe or productive coughing episodes; these patients should be **managed in hospital** and sample collection conducted in a **negative pressure room**, if available.

Contact and airborne precautions should also be considered for prolonged or very close contact by medical or nursing staff.

PPE for contact and airborne precautions requires the above PPE and a **P2 or N95 respirator.**

See our 'Personal Protective Equipment for contact and airborne precautions' factsheet for more information.

Estimating the quantity of PPE required

The following formula is a guide to estimate the amount of PPE that may be required

Total number of Staff per shift (assume all wearing full PPE) x number of care episodes (i.e., 20) x 7 (for calculating for 7 days on hand). *double the total for gloves and specify the sizes required

Aged care providers can request PPE from the Australian Government Department of Health by emailing agedcarecovidppe@health.gov.au. Further information is available here: Advice for the aged care sector during COVID-19

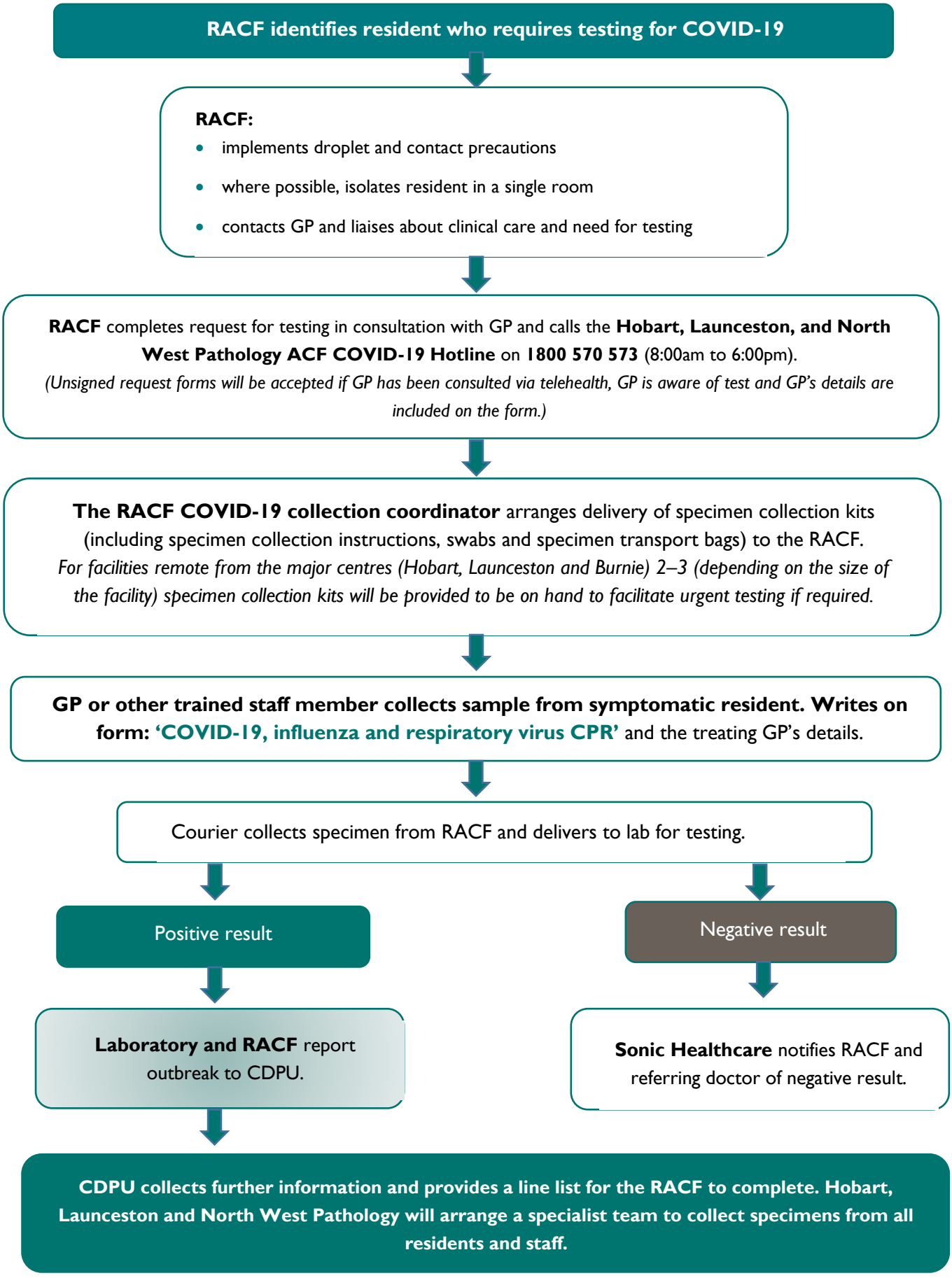
PPE purchasing guidance for COVID-19

In Australia, all PPE used to provide healthcare, must meet:

- Therapeutic Goods Administration criteria for listing on the Australian Register of Therapeutic Goods (ARTG) as a Medical Device Included Class 1* (i.e. lowest level of potential harm); **or**
- equivalent and relevant Australian Standards or ISO Standards.

Item	Characteristics	Australian Standard/ ISO Standard
Gown	Fluid impervious, long sleeved; single use. Barrier performance levels 1–4 may be used depending on task being undertaken.	• *A/NZS 4501.1:2008 Occupational protective clothing – Guidelines on selection, use, care and maintenance of protective clothing* • *AS/NZS 4501.2:2006 Occupational protective clothing – General requirements* • *ISO 22610: 2018 Surgical drapes, gowns and clean air suits, used as medical devices, for patients, clinical staff and equipment – Test method to determine the resistance to wet bacterial penetration* • *ASTM F1670M – Standard Test Method for Resistance of Materials Used in Protective Clothing to Penetration by Synthetic Blood.*
Gloves	Single use; non-sterile; natural rubber latex (NRL) or synthetic (eg nitrile).	• *AS/NZS 4011.1:2014 Single-use medical examination gloves, Part 1: Specification for gloves made from rubber latex or rubber solution* (ISO11193-1:2008) • *AS/NZS 4011.2:2014 Single-use medical examination gloves, Part 2: Specification for gloves made from poly (vinyl chloride)* (ISO11193-2:2006).
Protective eyewear/face shield	Single use or reusable when cleaned according to manufacturer instructions; anti fog; eyewear provides eye protection from multiple angles; face shield provides chin to crown protection.	• *AS1337.12010 Personal eye protection, Part 1 Eye and face protectors for occupational applications* • *ISO12311:2013 Personal protective equipment – Test methods for sunglasses and related eyewear* • *ISO 12312:2015 Eye and face protection – Sunglasses and related eyewear.*
Surgical mask	Fluid impervious; covering nose and mouth. ***Level 1 masks*** for use on people where there is a risk of droplet transmission to others e.g. patients under droplet precautions. ***Level 2 masks*** *protect from droplet exposure to microorganisms and minimal blood exposure. For COVID-19, masks must be a minimum of level 2 and may be worn with a face shield for additional fluid spray protection.* ***Level 3 masks*** *required in perioperative setting.*	• *AS4381:2015 Single-use face masks for use in healthcare.*
P2/N95 respirators	Raised dome or duckbill; facial fit covering nose and mouth. ***Standard*** *– suitable where a fluid spray beyond a cough or sneeze is unlikely. Worn with a face shield provides fluid spray protection not provided by the mask.* ***Surgical*** *– where there is a risk of exposure to high velocity splashes or sprays.*	**P2 masks:** • *AS/NZS 1715 Selection, use and maintenance of respiratory protective equipment* • *AS/NZS 1716:2012 Respiratory protective devices* **N95 masks** meet a US NIOSH classification (not the Australian Standard) so must be listed on the ARTG.

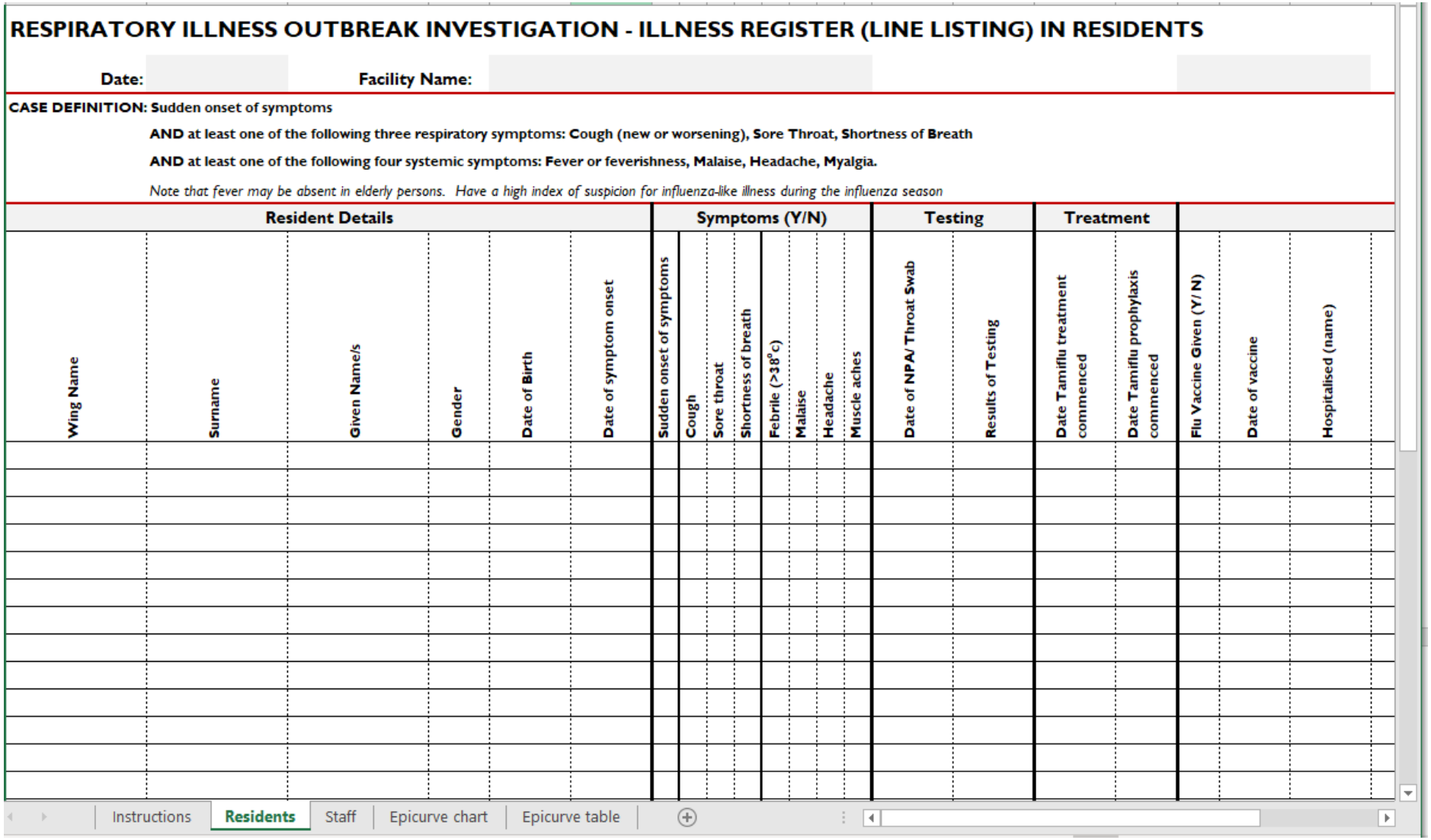
Appendix 6: Summary of COVID-19 testing process in RACFs



Appendix 6: Sonic Healthcare Aged Care Facility Checklist for testing of staff and residents in a COVID-19 outbreak

- Name and mobile number of primary contact
- Facility layout and information:
    - Number of wings
    - Map of facility
- Total number of residents
- Total number of staff
- Does your carpark have space for a drive-thru collection for staff (Y/N)?
- Donning and doffing area nominated
- Waste disposal area nominated
- Staff member nominated to assist with patient identification (1 facility staff member per 2 collectors)

Appendix 7: Example Line List from CDPU



RESPIRATORY ILLNESS OUTBREAK INVESTIGATION - ILLNESS REGISTER (LINE LISTING) IN RESIDENTS

Date: **Facility Name:**

CASE DEFINITION: **Sudden onset of symptoms**

AND at least one of the following three respiratory symptoms: Cough (new or worsening), Sore Throat, Shortness of Breath

AND at least one of the following four systemic symptoms: Fever or feverishness, Malaise, Headache, Myalgia.

Note that fever may be absent in elderly persons. Have a high index of suspicion for influenza-like illness during the influenza season

Resident Details						Symptoms (Y/N)								Testing		Treatment				
Wing Name	Surname	Given Name/s	Gender	Date of Birth	Date of symptom onset	Sudden onset of symptoms	Cough	Sore throat	Shortness of breath	Febrile (>38°c)	Malaise	Headache	Muscle aches	Date of NPA/ Throat Swab	Results of Testing	Date Tamiflu treatment commenced	Date Tamiflu prophylaxis commenced	Flu Vaccine Given (Y/N)	Date of vaccine	Hospitalised (name)

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