Respiratory Illness Outbreaks in Residential Aged Care Facilities

2020 Interim Toolkit

Including COVID-19 and Influenza

Version 1.0; 9 April 2020
This document has been developed for the Tasmanian context using the following resources:

**COVID-19 Plan for the Victorian Aged Care Sector**

**Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia**

**Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities**

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

CDPU  Communicable Diseases Prevention Unit
GP    General Practice/General Practitioner
ILI   Influenza-like illness
NAT   nucleic acid test
OMT   Outbreak Management Team
PPE   personal protective equipment
RCF   residential care facility
RACF  residential aged care facility
VTM   Viral transport medium
Introduction

Scope and purpose
This toolkit was developed by Public Health Services Tasmania to assist aged care providers with managing the prevention, control and public health management of influenza and COVID-19 outbreaks in Residential Care Facilities (RCF) in Tasmania. It has been adapted to the Tasmanian context from the following national guidelines:

COVID-19:

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

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

Influenza:

- Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia

The knowledge and understanding of COVID-19 and the public health impact is rapidly evolving. The information pertaining to COVID-19 contained in this toolkit is purposely concise with links to key documents. It is highly recommended that these links are visited regularly to keep pace with the rapidly evolving environment.

This toolkit applies primarily to residential aged care facilities (RACF) but can also be applied to other RCF settings e.g. military barracks, correctional facilities and boarding schools.

Background
Older people living in RACF are susceptible to outbreaks of respiratory illness, which commonly occur in winter. While all respiratory viruses can cause outbreaks and significant morbidity and mortality, influenza and COVID-19 are currently acknowledged as a significant health risk particularly for the elderly and individuals 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 management of respiratory outbreaks, including those due to influenza. The first line of defence against COVID-19 are standard infection prevention and control measures, especially hand hygiene, which applies for all staff (clinical and non-clinical), residents and visitors.

Annual influenza planning should be integrated into planning for COVID-19, as influenza and COVID-19 might occur together. Influenza immunization 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 response in RACF for COVID-19.

The management approach to COVID-19 and influenza are similar, however there are key differences, as detailed in the Table 1 below. Unlike influenza, there are no definitive treatments for COVID-19 and the outcomes of concurrent infection (influenza and COVID-19) are unknown at this time.

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

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

<table>
<thead>
<tr>
<th></th>
<th>COVID-19</th>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever and acute respiratory symptoms</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Vaccine available</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Antiviral use</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Notification process</td>
<td>ASAP for suspected and confirmed cases for RACF, RACF residents and RACF workers</td>
<td>Applies when there is an outbreak</td>
</tr>
<tr>
<td>Precautions</td>
<td>Contact &amp; droplet</td>
<td>Contact &amp; droplet</td>
</tr>
<tr>
<td>Isolation of cases</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Incubation period</td>
<td>Average 5-6 days, range 1-14 days</td>
<td>Average 2 days, range 1-4 days</td>
</tr>
</tbody>
</table>

In the current environment, when residents develop respiratory illness, you will not know whether it is due to influenza or COVID-19 or another pathogen. The threshold for testing and notification to Public Health is lower for COVID-19 than for influenza. In 2020 you will be referring to the COVID-19 guidelines for the early management of respiratory illness with an unknown pathogen and then only need to refer to the influenza guidelines if you have a confirmed influenza outbreak.
Preparedness and Prevention

Steps to help prepare for a respiratory illness outbreak

- Have a **Respiratory Illness Outbreak Management Plan** - update this year to include new COVID-19 guidelines
- Encourage all residents to receive **influenza vaccine as soon as it is available**, unless contraindicated.
- Encourage all staff and visitors to receive **influenza vaccine by 1 May 2020**
- Establish or update an **immunisation register** to record the influenza immunisation status of all residents, staff, and visitors. Transfer vaccine records if residents move.
- Implement new **visitor restrictions and guidelines**
- Implement appropriate strategy for screening and recording influenza vaccine status and health status of staff and visitors entering the facility.
- Talk with your visiting **General Practitioners (GP)** about your outbreak management plan and involve them in the planning process.
- Talk with your GPs about how **antiviral medications** will be used in an influenza outbreak for both treatment and prevention. Document your agreed antiviral strategy in your influenza management plan. Ask your GPs about **standing orders** to use antiviral medications promptly to treat and/or prevent influenza when you have an outbreak.
- **Train staff** to correctly use Personal Protective Equipment (PPE) and Infection Control Practices, particularly Standard Precautions and transmission-based Droplet and Contact Precautions.
- Ensure you have **adequate available stocks of PPE**, cleaning materials and signage for visitors and residents. Ensure you have enough stock if there is a surge in demand and a predictable wait for replacement stock. Aged care providers that require Personal Protective Equipment (PPE) must now email agedcarecovidppe@health.gov.au for all requests. (Emails previously sent to the National Stockpile address don’t need to be resent, and have been captured in this new, dedicated aged care process).
- **Provide information** to residents’ and their families to raise their awareness of your infection control policies (including isolation protocols), and to ensure they are aware of visitor restrictions and guidelines. Facilitate social connection as much as possible within these guidelines and ensure residents’ and staff mental health is supported e.g. facilitate video calls and meetings, encourage writing letters and postcards, or share artwork.
- Prepare **staffing contingency plans** in case 20-30% of staff fall ill and are excluded for 14 days
- Consider how you can reduce risk of **transmission of respiratory illnesses between facilities** e.g. assess all transfers for respiratory symptoms before accepting transfer and assess
again on arrival, if staff work between more than one facility facilitate prompt communications when a suspected/confirmed case is identified and exclude staff if necessary,

- Ensure appropriate processes and practices are in place for **rapid identification of respiratory illness** in residents and staff.

- Prepare a **communication plan** for communicating with staff, residents, volunteers, family members and other service providers (e.g. cleaners) during an outbreak, including appropriate signage

- Prepare for additional **cleaning** requirements e.g. liaise with contractors or hire extra cleaners as required

- Ensure that you have discussed residents’ wishes with themselves and their families as well as their primary care provider. Have **advance care directives** in place for appropriate clinical management in the event of severe respiratory illness.

Case and outbreak management

Assessment of residents who have fever or respiratory illness

Ensure that the GP is informed immediately that a resident has a fever or respiratory illness and may be a suspected case of COVID-19. Inform the GP if there is an outbreak or suspected outbreak within the facility. If it is afterhours, contact the afterhours or locum service as per standard processes. Provide them with a comprehensive clinical history, current clinical observations and facility details. Isolate the resident if possible and use standard and droplet precautions.

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, continues to be the responsibility of the RACF.

Definition of suspected or confirmed cases of COVID-19

The definitions of cases are changing frequently. 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 or influenza outbreak

Outbreaks defined by the Communicable Diseases Network Australia as potential or confirmed are described in Table 2 below:

Table 2. Influenza and COVID-19 outbreak definitions

<table>
<thead>
<tr>
<th></th>
<th>COVID-19</th>
<th>INFLUENZA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Potential outbreak</strong></td>
<td>Two or more cases of illness consistent with COVID-19* in residents or staff within 3 days (72 hours)</td>
<td>Three or more cases of influenza-like illness (ILI)** in residents or staff of a facility within 3 days (72 hours)</td>
</tr>
<tr>
<td><strong>Confirmed outbreak</strong></td>
<td>Two or more new cases of illness clinically consistent with COVID-19* in residents or staff within 3 days (72 hours), PLUS</td>
<td>Three or more epidemiologically linked cases of ILI in residents or staff within 3 days (72 hours), PLUS</td>
</tr>
<tr>
<td></td>
<td>at least one case being laboratory confirmed as COVID-19</td>
<td>At least one case having a positive laboratory test, OR At least two cases having a positive point-of-care test.</td>
</tr>
</tbody>
</table>

* The Series of National Guidelines for COVID-19 defines the clinical criteria as:

Fever (≥38˚C) or history of fever (e.g. night sweats, chills)

OR

Acute respiratory infection (e.g. cough, shortness of breath, sore throat)

** The Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia defines Influenza-like illness (ILI) as:

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

Likely scenarios in RACF that require COVID-19 testing

In an aged care facility setting, the most likely scenarios that you will encounter where a staff member or resident is a suspect COVID-19 case and requires testing is as follows:

1. **A suspected COVID-19 case in a residential aged care worker:**
   Fever or respiratory symptoms in a residential care worker. The staff member should notify management, self-isolate and contact their GP or the Public Health Hotline for testing.

2. **A potential COVID-19 outbreak**
   Fever or respiratory symptoms in two or more residents or staff within 72 hours. Patients should be isolated and Public Health Services contacted.

3. **A suspected case in a resident**
   If a resident has been identified as a close contact of a confirmed case and is in quarantine, if they develop symptoms then they become a suspect case and require testing. In this scenario, Public Health will be monitoring the quarantine and in contact with you daily. You can discuss the development of symptoms with the COVID response team.

For checklists for specific scenarios, please see Appendix 1.

Testing for viral respiratory pathogens in residential aged care facilities

Nucleic acid test (NAT) testing for viral respiratory pathogens (including influenza and COVID-19) is performed by taking a combined throat and nasopharyngeal swab with a flocked swab, placed into viral transport medium (VTM).

In residents, if you believe that COVID-19 is unlikely on clinical grounds you do not need to contact Public Health.

Testing in aged care residents

If you have residents who meet suspect case definition or two residents and/or staff within the facility who meet the clinical criteria for COVID-19, please call the Public Health Hotline and access the dedicated healthcare professional hotline. If you are unable to get through and have a clear indication for testing, please email cdpu.outbreaks@health.tas.gov.au.
If Public Health recommends testing for COVID-19, a pack containing the correct swab, form, and collection instructions can be obtained from Hobart Pathology, Launceston Pathology, or North West Pathology (Table 3)

Follow instructions for specimen collection in suspected COVID-19 cases using appropriate PPE (see Appendix 2)

Complete the form with request for “COVID-19 and other respiratory viruses”. Please indicate on the form that the patient meets testing criteria for COVID-19 and that you have discussed with public health. Also include treating GPs details.

Table 3. Pathology provider contact details for specimen collection kits for residential aged care

<table>
<thead>
<tr>
<th>Location</th>
<th>Provider</th>
<th>Contacts</th>
</tr>
</thead>
</table>
| Hobart     | **HOBART PATHOLOGY**   | Sandy Burton  
Phone: 62231955  
Fax: 62241509  
Corrine McCallum  
Phone: 62231955  
Fax: 62241509 |
| Burnie     | **NORTH WEST PATHOLOGY**| Bernie McPherson  
Phone: 6432 8866  
Fax: 6432 8885  
Sharon Howe  
Phone: 6432 8870  
Fax: 6432 8885 |
| Launceston | **LAUNCESTON PATHOLOGY**| Mike Wise  
Phone: 63343636  
Fax: 63342273  
Kellie Ollington  
Phone: 63343636  
Fax: 63342273 |

CDPU will contact you to collect some further information about potential cases and give further advice. In the meantime, please ensure that you are following the infection prevention and control measures outlined in the national guidelines (provided in the introduction section).

For testing in residential care facilities other than aged care, please call Public Health to discuss.

**Testing in residential aged care workers**

If any residential care worker has a fever (≥ 38˚C) OR an acute respiratory infection (e.g. shortness of breath, cough, sore throat), they are classified as a suspect case.

They should notify management, isolate themselves, seek appropriate medical attention and must be tested for COVID-19. It is recommended that medical practitioners do not test or treat themselves and seek medical care from another medical practitioner.
To arrange testing, they may call the Public Health Hotline or contact their GP to arrange testing. They can then attend a testing centre close to them. A suspect case must not attend work and must stay in self isolation until they receive their test results.

**Notification to Public Health Services**

The following must be notified immediately to the Communicable Diseases Prevention Unit (CDPU) Public Health Services:

- A suspect case of COVID-19 e.g. a healthcare worker or a close contact of a confirmed case who has fever or respiratory symptoms
- A confirmed case of COVID-19
- A potential or confirmed outbreak of COVID-19 (e.g. two or more cases)
- A potential or confirmed outbreak of influenza

Please call the Public health hotline on 1800 671 738 and select the correct menu number to access the dedicated healthcare professional hotline. Additionally, notify the treating medical practitioners.

You can email CDPU outbreaks team on cdpu.outbreaks@health.tas.gov.au

Please do not contact the CDPU outbreaks team unless you have gone through the Public health hotline and been advised that testing is indicated, or if you have a clear indication for testing but have been unable to get through on the hotline.

**Information sharing with CDPU in the event of an outbreak**

When an outbreak is suspected or confirmed and notified to CDPU, they may request the following information from the RACF:

- resident or staff details
- description of RACF in terms of size, buildings, layout, infrastructure and staffing
- total number of residents/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
- total number of residents in the facility and in the affected area
- capacity to isolate/cohorte 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.

If an outbreak is present, all visiting GPs should be informed at the start of the outbreak. All GPs and healthcare providers (including transport / ambulance staff) must be informed before attending the RACF. If any deaths occur during the outbreak, CDPU must be notified within 24 hours.

**Line lists**

CDPU will email you a line list in the form of an Excel spreadsheet to collect key information about cases (Example in Appendix 4). This should be updated and sent to CDPU daily via email to cdpu.outbreaks@health.tas.gov.au

**Notification to the Australian Government Department of Health**

In the event of a confirmed outbreak, CDPU may notify the Australian Government Department of Health and/or the Aged Care Quality and Safety Commission so that additional support can be offered.
Information and policy guidance on specific topics

Staff members returning from overseas or interstate

In Tasmania, any person who has returned from anywhere overseas, interstate, or has been in close contact with a confirmed case of COVID-19 is required to be in self-quarantine for 14 days. RACF staff members who are in self-quarantine cannot go to work and should alert their employer. Depending on the type of work, and provided the employee is well, they may want to discuss alternative arrangements such as working from home. See the ‘Isolation guidance’ information sheets at www.health.gov.au/covid19-resources.

These staff members do not require clearance testing to return to work after completing their quarantine period.

Staff members returning from sick leave

Staff members who are sick should not return to work until they are well (depending on the condition).

If they have suspected COVID-19 they should not return until testing has excluded the infection or until they have been advised they can return by CDPU. If they have confirmed COVID-19 they should not return to work until they have been cleared by their healthcare provider and CDPU.

Influenza vaccination and exemptions

From 1 May, you must have your influenza vaccination to work in or visit an aged care facility. In Tasmania, if you have a letter from a specialist health practitioner (not a GP) stating that you have a medical contra-indication to influenza vaccine, then your employer can give you an exemption. Refusal on religious grounds is not an acceptable reason to allow entry into an aged care facility.

Aged Care providers should consider the suitability and possible alternate duties for those staff who cannot be vaccinated.

Aged care providers are required to 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.

Aged care providers should seek appropriate evidence of immunisation status from individuals seeking to enter the service. Appropriate evidence may be a statement or record from a health practitioner; or an immunisation history statement available from Medicare online or the Express Plus Medicare mobile app.

**Transfers into the RACF**

Residents who are being transferred into the RACF, even from an acute care facility, do not need to be “cleared” for COVID-19 and do **not** require testing if they are asymptomatic.

If you are concerned that the resident has come from an acute care facility where there have been confirmed COVID-19 cases, as a precaution you can admit the resident into a single room with ensuite if available and limit movement within the facility for 14 days. We would not recommend droplet and contact precautions or use of PPE unless they develop symptoms, or have been defined as a close contact with a confirmed COVID-19 case, in which case Public Health Services will be in contact with the RACF.

For transfers out of the facility, Ambulance Tasmania have protocols for appropriate infection prevention and control including the necessary measures for transporting a confirmed COVID-19 case.
Key Resources

Influenza outbreaks in residential aged care

The following documents describe best practice for managing influenza outbreaks, include many practical resources, and are available from Australian Government websites:

- **Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia**

- **Influ-Info Influenza kit for Aged Care**

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 cdpu.surveillancecnc@health.tas.gov.au

Infection prevention and control

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

- **Signage for infection control precautions**
• **Hand hygiene**
  

• **Online COVID-19 infection control training**
  

• **Tasmanian Infection Prevention and Control Unit**
  

• Aged care providers that require Personal Protective Equipment (PPE) must now email [agedcarecovidppe@health.gov.au](mailto:agedcarecovidppe@health.gov.au) for all requests. (Emails previously sent to the National Stockpile address don’t need to be resent, and have been captured in this new, dedicated aged care process).

**Additional resources from the Australian Government Department of Health**

• A number of new resources including posters and factsheets:
  
  o **COVID-19 Resources for Aged Care Providers and Health Care Workers**
    

  o **COVID-19 Resources for Aged Care Residents and Families**
    

• The Australian Government Department of Health Coronavirus app

• A suite of [education videos](#):
  
  o [Coronavirus video – Older Australians](#)
  o [Coronavirus video – Social distancing](#)
  o [Coronavirus video - Help Stop The Spread](#)
  o [Coronavirus video - Recent Traveller](#)
  o [Coronavirus video - Good Hygiene Starts Here](#)
  o [Coronavirus video - Stay Informed](#)
• Subscribe to aged care sector announcements and newsletters
  

**Tasmanian Government**

• Tasmanian coronavirus website
  

• CDPU Aged Care Respiratory Illness Preparedness Webinar (link to recording)
  
  www.dropbox.com/sh/kez9evk103fs1xs/AABtCgEL584Gk8WMCGVcCa-Ga?dl=0

**Australian Government Aged Care Quality and Safety Commission**

• A number of resources and updates are available at:
  

• 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 Department of Health Information:
  

• Australian government Department of Health FAQs
  

**Dementia**

• A number of COVID-19 resources are available from 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
www.advancecareplanning.org.au/footer-menu/faqs#

**Palliative care**

Practice tips for care workers in aged care from palliAged

**Grief and bereavement resources**

Australian centre for grief and bereavement
www.grief.org.au
Appendices

Appendix 1. Responses to specific scenarios

The following are specific scenarios which an RACF could face during the COVID-19 epidemic and for which the facility should be fully prepared to deal with. Checklists for actions required for each scenario are outlined below.

- A suspect case in a resident or a potential outbreak in a facility
- A confirmed case in a resident
- A confirmed case in a staff member
- A confirmed case in a visitor
- A confirmed outbreak in a facility

Checklist - Response to a suspect case in a resident or a potential outbreak in a facility

☐ Immediately implement droplet and contact infection control protocols as per outbreak management plan. Where possible isolate the resident in a single room with the door closed. Avoid unnecessary interactions on behalf of staff with resident. If the resident cannot be isolated, avoid interactions with other residents and place a face mask, if tolerated, on the suspected case. If isolation not possible, consider cohorting.

☐ Continue to maintain routine care provision of resident(s). Consider how to maintain proactive approaches to support residents with complex behaviours including dementia and mental health diagnosis.

☐ Increase frequency of clinical observations and monitoring of 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.

☐ Any person entering the room should use droplet and contact precautions PPE (single-use surgical mask, eye protection, gown and gloves).

☐ Ensure the doctor or staff interacting with the resident use PPE correctly, and that there is adequate PPE, waste disposal and hand sanitiser / hand washing facilities available at the room.

☐ Contact 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 them that this is a suspected case of COVID-19.

☐ As this is a sensitive setting, testing and transport of the test to the laboratory should be prioritised and carried out urgently.

☐ Arrange for transfer of the resident to hospital only if clinically indicated, in consultation with the healthcare provider. If transfer is required, inform the hospital and transport staff that the resident has a suspected case of COVID-19.
☐ Notify CDPU as soon as is practicable and as per current guidelines to facilitate prioritised testing.

☐ Assist CDPU in collecting critical information about the case and contacts / exposures.

☐ Consider enhanced infection and control measures and enhanced surveillance for further cases. Review outbreak plans and prepare for further cases.

**Checklist - Response to a confirmed case in a resident**

☐ Immediately implement droplet and contact infection control protocols as per outbreak management plan. Where possible isolate the resident in a single room with the door closed. Avoid unnecessary staff interactions with resident. If the resident cannot be isolated, avoid interactions with other residents and place a face mask, if tolerated, on the confirmed case. If isolation is not possible, consider cohorting.

☐ Continue to maintain routine care provision for resident. Consider how to maintain proactive approaches to support residents with complex behaviours including dementia and mental health diagnosis.

☐ Increase frequency of clinical observations and monitoring of resident.

☐ 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, and that there is adequate PPE, waste disposal and hand sanitiser / hand washing facilities available at the room.

☐ Assist the CDPU with collection of critical information and contact tracing.

☐ Implement enhanced surveillance for early detection of further cases (daily symptom screening and observations).

☐ Complete daily line list and email to CDPU. Inform department promptly if case deteriorates / if transfer is required.

☐ The resident should not be removed from isolation until agreement by CDPU and treating general practitioner.

☐ Limit movement of staff across facilities or to other workplaces if possible.

☐ Limit non-essential access to facility as per guidelines and Public Health directives.

☐ 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 and families / visitors.

**Checklist - Response to a confirmed case in a staff member**

☐ Any member of staff (healthcare or non-healthcare) who develops symptoms compatible with coronavirus infection should immediately be excluded from the facility and should remain away whilst a diagnosis is determined.

☐ 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 discharge from isolation as per the national guidelines.

The RACF must notify CDPU as soon as practicable unless contact has already been made

Assist CDPU with collecting critical information (contact tracing).

Perform environmental risk assessment to identify any breaches to infection control policies, identify and implement enhanced infection control measures and cleaning / disinfection procedures.

Implement enhanced surveillance for further cases within the facility and amongst staff.

Review outbreak plans and requirements for implementation.

Assess staffing issues. Inform staff, residents and families / visitors.

**Checklist - Response to a confirmed case in a visitor**

- Notify CDPU and assist in collecting critical information – determining if there are any close and casual contacts of the case and the timeframe of exposure.

- Determine whether isolation of individual residents or staff, cohorting or quarantine of a section of the facility is required, in consultation with the department.

- Consider restricting visitors and movement in and out (and within) the facility.

- Inform staff, residents, and families / visitors.

- Implement increased infection and control policies, and cleaning / disinfection procedures.

- Limit non-essential access to facility as per guidelines and Public Health directives.

**Checklist - Response to an outbreak in the facility**

- An outbreak in this scenario refers to one confirmed case in a resident or staff member plus two or more cases of acute respiratory infection in staff or residents within 3 days

- Continue to maintain routine care provision for residents. Consider how to maintain proactive approaches to support residents with complex behaviours including dementia and mental health diagnosis.

- Implement enhanced surveillance for early detection of further cases early (daily symptom screening)

- Increase frequency of clinical observations and monitoring of affected residents.

- Establish an Outbreak Management Team (OMT) and activate the outbreak response plan. It is the facility’s responsibility to manage the outbreak. This will include limiting movement of staff across facilities or to other workplaces if possible.

- Arrange for isolation or cohorting of residents in rooms or units as necessary.

- Arrange for designated staff to look after isolated or cohorted patients to reduce the risk of transmission to other residents.

- The outbreak lead should keep a log of the entire outbreak, meet daily with the OMT, and liaise with the department. Agree method for daily status updates with the department and provide a clinical daily status update to the department. Inform the department promptly if a
case deteriorates / if transfer is required. The facility should engage an infection control consultant or make contact with the residential in-reach service at their local health service if they require additional support in an outbreak.

☐ Avoid all unnecessary transfers of residents to hospital, new admissions or readmissions unless absolutely necessary.

☐ Restrict visitors.

☐ Inform staff, residents and families / visitors.

☐ Telehealth appointments should be facilitated where possible to avoid unnecessary movements.

☐ Residents should not be removed from isolation until agreement by CDPU and treating general practitioner.
Appendix 2. COVID-19 swab collection information

COVID-19 Throat and Nasopharyngeal Swab Collection Information Sheet

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 patients head back slightly and immobilise by holding the chin.
2. Gently insert the swab into a nostril until a slight resistance is felt.
   • Insert the swab directly back, not upwards.
   • The distance of insertion should equal the length of the patient’s index finger. Mark this distance on the swab prior to insertion.
3. Once in place, rotate the swab gently for 10-15 seconds.

4. Slowly remove the swab and REPEAT on the OTHER SIDE.
5. Place the swab into the vial of liquid transport
6. Break the shaft of the swab at the scored point and discard the proximal end, leaving the swab itself in the liquid media.

Please double bag the specimen as per collection instructions.
SPECIMEN COLLECTION IN SUSPECTED COVID-19 CASES

PATIENT: When patients present they should wear a SURGICAL MASK and perform hand hygiene with alcohol hand rub.

COLLECTORS AND ANY OTHER PERSON’S PRESENT AT TIME COLLECTION ARE TO WEAR FULL PPE for CONTACT AND DROPLET PRECAUTIONS

Please be familiar with the Donning and Doffing Procedure.

Please see additional illustrated guide.

DONNING PROCEDURE SUMMARY:
1. Perform hand hygiene and gown.
2. Perform hand hygiene and mask.
3. Perform hand hygiene and fit single use eye protection (or safety glasses-decontaminated after every use).
4. Perform hand hygiene and glove.

BLOOD SAMPLES

If blood samples are required, only take in tubes and equipment required and collect blood samples first, before the patient removes their mask.

1. DON PPE AS PER THE DONNING PROCEDURE.
2. Take samples, label with patient name & DOB, date and time, labels check by patient, before placing into specimen bag. Please use a separate REQUEST FORM for these specimens.
3. Remove gloves, perform hand hygiene and don new gloves.
4. Place blood specimens and blood taking equipment placed OUTSIDE ROOM prior to taking COVID-19 specimens to avoid contamination. (Tourniquets- single use or decontaminated after each use).
5. Remove gloves, perform hand hygiene and don new gloves.

Proceed to COVID specimen collection in the same PPE.
Appendix 3. Summary of COVID-19 testing process in RACF

RACF identifies potential COVID-19 (or influenza) outbreak

RACF calls Public Health Hotline on 1800 671 738 and selects healthcare professional hotline. If unable to get through, and there is a clear indication for testing against current criteria, the RACF can email cdpu.outbreaks@health.nsw.gov.au


Current guidelines (Not mandatory):
- Suspect case in one resident as per guidelines (e.g., close contact of a confirmed case)
- OR
- Two cases of illness consistent with COVID-19* within an aged care facility or other residential care facility; military barracks; boarding school; correctional facility; detention centre

In the absence of any other high-risk factors e.g., contact with a confirmed case, recent overseas or interstate travel.

*Clinical criteria: Fever (≥38°C) OR history of fever (e.g., night sweats, chills) OR acute respiratory infection (e.g., cough, shortness of breath, sore throat)

Testing approved

1. RACF contacts pathology provider and they will supply COVID-19 collection pack with the correct swab, form, and collection instructions.
2. RACF completes form with request for “COVID AND RESPIRATORY VIRUS PCR: Patient meets current testing criteria and has been discussed with Public Health.” Ensure treating GP details are on request.
3. RACF collects swab and sends to lab for testing.

Testing not approved

RACF:
- Implements droplet and contact precautions
- Places possible isolate in a single room
- Continues clinical care as per primary care provider
- Monitors for further cases and call back if needed

CDPU contacts RACF to collect further information and sends them a line list to complete.
## Appendix 4. Example line list from CDPU

**Respiratory Illness Outbreak Investigation - Illness Register (Line Listing) in Residents**

<table>
<thead>
<tr>
<th>Date</th>
<th>Facility Name</th>
</tr>
</thead>
</table>

### 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 chills, Headache, Myalgias, Diaphoresis

*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
- **Name**
- **Resident**
- **Date of Birth**
- **Gender**

### Symptoms (Y/N)
- **Date of symptom onset**
- **Symptoms**
  - Cough
  - Sore Throat
  - Headache
  - Diaphoresis

### Testing
- **Date of NAAT Result**
- **Results of NAAT**
- **Date of NAAT Test**

### Treatment
- **Date of Treatment**
- **Medication**
- **Other Treatment**
- **Discharge date**
- **Resident Outcome**

### Appendix 4. Example line list from CDPU

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*Respiratory Illness in Aged Care Toolkit*  
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