Australian Government

BE COVIDSAFE

Infection Control Expert Group

COVID-19 Infection Prevention and Control for Residential Care Facilities

Introduction

COVID-19 is an acute respiratory infection caused by SARS-CoV-2. Although community transmission in Australia is currently low, residential care facilities (RCFs) are vulnerable to outbreaks of respiratory infections. Older people are among those most at risk of severe disease and death from COVID-19.

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

Additional advice on managing COVID-19 outbreaks in RCFs has been published by the Communicable Diseases Network Australia.[1]

The COVID-19 outbreak globally, and in Australia, is evolving rapidly. Recommendations will be modified to deal with changing conditions.[2]

This document provides advice for IPC in RCFs in the context of COVID-19.

General principles of infection prevention and control in RCFs

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

Routine IPC measures relevant to any infectious disease risk

- **Hand hygiene** using soap and water or alcohol-based hand sanitiser (e.g. after going to the toilet, coughing, blowing the nose and before eating). Additional hand hygiene is required when caring for a resident with a respiratory infection.

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

[2] For the latest information about COVID-19, see the Department of Health website

- **Appropriate use of PPE**[3], especially when caring for a resident with a respiratory infection.
- **Cough etiquette and respiratory hygiene** for staff, residents (if possible) and visitors.
- **Frequent cleaning and disinfection** (at least daily) of floors and surfaces. More frequent cleaning of frequently touched or soiled surfaces.[4]
- **Isolating or cohorting** residents confirmed to have an infection caused by the same pathogen.
- **Annual influenza vaccination** of residents, staff and all visitors to RCFs.
- **Standard contact and droplet precautions** when caring for a resident with a respiratory infection.
- **Limiting unnecessary movement** of residents and staff within and between facilities.

Spread of COVID-19

The virus that causes COVID-19 most commonly spreads through:

- Direct contact with droplets from an infected person's cough or sneeze. This can be avoided by cough etiquette and physical distancing (see below).
- Close contact[5] with an infectious person.
- Touching objects or surfaces (e.g. bed rails, doorknobs or tables) that have been contaminated with respiratory droplets from an infected person and then touching the face, especially mouth, nose or eyes.

Collection of respiratory specimens

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

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

Placement of residents within the RCF

With appropriate IPC precautions, many RCF residents with COVID-19 and their contacts can be safely cared for within the facility.

Placement of residents with suspected or confirmed COVID-19

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

- Residents should be isolated while they are infectious (as determined by the Public Health Unit).
    - During this period, if they are ambulatory and well enough, they may leave the room for exercise. They must be supervised and avoid contact with other residents.

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[3] Supplies of personal protective equipment may be limited during a significant outbreak especially if it is prolonged. State and Commonwealth authorities endeavour to secure and distribute adequate supplies. It should be used only as recommended.
[4] See *Environmental cleaning and disinfection principles for health and residential care facilities*
[5] See the Communicable Diseases Network Australia *COVID-19 National Guidelines for Public Health Units*
[6] Refer to *Coronavirus (COVID-19) guidance on use of personal protective equipment (PPE) in non-inpatient health care settings, during the COVID-19 outbreak*

    - If residents must leave their room while infectious they should wear a surgical mask.
- Remind staff and residents of the need for cough etiquette and respiratory hygiene.
- Staff and visitors in contact with ill residents should follow contact and droplet precautions (see below).
- Supplies of PPE should be available immediately outside the room.
- Special arrangements may be needed for care of residents with dementia who need to be isolated.

If a single room is not available, the following principles can guide resident placement.

- Residents with the same pathogen[7] who are assessed by the RCF as suitable roommates, can share a room (i.e. be cohorted).
- Ill residents sharing a room should be more than 1.5 metre apart. There should be a privacy curtain between them to minimise the risk of droplet transmission.
- Staff in direct contact with ill residents should follow contact and droplet precautions (see below).
- Staff caring for residents who have COVID-19 should be cohorted as far as possible. This reduces the chance of the virus spreading to other staff and residents.

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

- Any resident who remains well but has been in close contact with a confirmed or probable case, in the period extending 48 hours before symptoms began in the confirmed or probable case, should be quarantined in a single room for 14 days.
- They should be monitored for symptoms of COVID-19 (at least daily).
- They may leave their room for exercise or activity, with supervision by a staff member, if necessary, to ensure that they avoid contact with other residents.
- If a single room is not available, residents in quarantine can share a room. The same precautions as for room-sharing by confirmed cases apply (see above). If COVID-19 is later confirmed in one of the residents, they should be separated. The resident who has COVID-19 should be isolated. The other resident should remain in quarantine.

Hospital transfer of residents with suspected or confirmed COVID-19

- The RCF may decide a resident's condition warrants transfer to hospital. The decision should be made in consultation with relatives and take account of their previous health status and advanced care directive.
- The ambulance service and hospital must be advised, in advance, that the resident is being transferred from a RCF where COVID-19 is suspected or confirmed.
- If the resident needs urgent medical attention, the RCF should call 000 and advise the operator of the COVID-19 risk.

[7] An acute respiratory illness may be due to COVID-19 or many other respiratory viruses. Laboratory tests are required to identify the cause. It is important that ill residents be separated until the causative pathogen for each ill resident is known. Only residents with the same respiratory pathogen may be cohorted together.

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

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

Key elements are:

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

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

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

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

A. Contact and droplet precautions

These precautions apply to:

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

Key elements are:

- **Standard precautions** (as above).
- **Use of PPE** including gown, surgical mask, protective eyewear, and gloves **when in contact with an ill resident.**
    - Protective eyewear can be in the form of safety glasses, eye shield, face shield, or goggles.
- **Isolation of ill residents** in a single room. If a single room is unavailable see: “Placement of residents with suspected or proven COVID-19” (above).

- **Enhanced cleaning and disinfection** of the ill resident's environment.[8]
- **Limit the number** of staff, health care workers, and visitors in contact with the ill resident.
- **Nebulisers** have been associated with a risk of transmission of respiratory viruses and their use **should be avoided**. A spacer or puffer should be used instead.

Note: When caring for an asymptomatic resident in quarantine, contact and droplet precautions should be followed (PPE includes a gown, surgical mask, protective eyewear, and gloves). Eye protection is optional. If the resident later develops symptoms or is confirmed to have COVID-19, staff who did not wear eye protection do not need to quarantine if they:

- Followed all other precautions
- Remain well
- Had no direct contact with respiratory secretions (i.e. a cough or sneeze directly into to the face).

B. Airborne precautions

Use of P2/N95 respirators, instead of surgical masks, are recommended, **in addition to all other precautions outlined above,** when performing certain high-risk (aerosol generating) procedures on patients with COVID-19. **Their use is unlikely to be needed in a RCF.**[9]

Note: P2/N95 respirators should only be used by staff who have been trained in their use. They should be fit checked with each use to ensure an adequate face seal.

Exclusion from work for RCF staff for COVID-19

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

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

Preparing for and responding to COVID-19 outbreaks in RCFs

The RCF should form an **Outbreak Management Team** to develop an Outbreak Management Plan[10]. The Plan should:

- Include easily accessible internal policies and procedures on routine, standard and transmission-based IPC precautions (as outlined above).
- Be informed by advice from an IPC professional.
- Ensure adequate supplies of PPE, alcohol-based hand rub and cleaning materials.
- Ensure RCF staff know the symptoms and signs of COVID-19.
- Ensure RCF staff are trained in IPC procedures (as above), including use of PPE.
- Consider the need to extend the use of PPE if the numbers of cases, contacts and/or resident areas or zones affected increase significantly. This may include using PPE beyond the situations recommended in this document.

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[8] See *Environmental cleaning and disinfection principles for health and residential care facilities*
[9] Refer to *Guidance on the use of personal protective equipment (PPE) in hospitals during the COVID-19 outbreak*
[10] Communicable Diseases Network Australia *COVID-19 National Guidelines for Public Health Units*

- Include a systematic strategy for detecting cases and managing residents or staff who develop symptoms consistent with COVID-19.
- Consider the need for a program of repeat tests for those in quarantine[11].
- Ensure daily hand-over for ARI monitoring and outbreak detection for staff performing this task.
- Ensure the local Public Health Unit is notified if the RCF suspects an ARI or COVID-19 case.
- Ensure residents have reviewed their Advanced Care Directives, in consultation with relevant family members or persons with medical power of attorney.

Resident movement during an outbreak

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

New admissions and readmissions during an outbreak

- RCFs should restrict admission of new residents into the facility. Depending upon the extent of the outbreak and the layout of the building, restrictions may be applied to a floor, a wing or the entire facility.
- Restrictions protect new residents and avoid extending the outbreak.
- Residents who are in hospital for any reason, including COVID-19, **should be readmitted to the RCF** as soon as they are well enough to be discharged from hospital.
- New or returning residents should be screened for relevant symptoms.

Visitor restriction and signage

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

- Follow, and stay up to date with, relevant advice on outbreak management in high-risk settings[11] and restrictions to visitors to RCFs.
- If appropriate IPC precautions can be implemented to protect staff and other residents, visiting restrictions may be relaxed in the context of end-of-life palliative care.
- Encourage and facilitate phone or video calls, or visits with physical barrier (e.g. window. balcony or ‘see-through’ fence) between residents and their friends and family members to maintain social contact while visiting restrictions are in place.
- Ensure all visitors, including essential external providers and visitors:
    - Visit only one resident (or staff member).
    - Go directly to the resident’s room or area designated by the RCF, and avoid shared areas.
    - Stay 1.5 metres from residents, if possible.

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

    - Use alcohol-based hand rub or wash their hands before entering and on leaving the RCF and the resident's room.
    - Practise cough etiquette and respiratory hygiene.
    - If visiting a resident who is in isolation or quarantine, follow contact and droplet precautions, as directed by RCF staff.
- Post signs or posters at the entrance and other strategic locations to remind visitors of the precautions including donning and doffing instructions at PPE stations.
- Screen visitors on entry to the facility for epidemiological (recent travel, contact with a COVID-19 case) and clinical risk factors (acute respiratory infection, fever/history of fever or loss of smell or taste).

Duration of isolation precautions for confirmed COVID-19 patients

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

Environmental cleaning

- During an outbreak, RCFs need to increase cleaning and disinfection of shared areas and residents' rooms.
- Frequently touched surfaces should be cleaned and disinfected frequently.
- Any resident care equipment should be cleaned and disinfected between each use or used exclusively for individual residents.[13]

Handling of Linen

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

Food service and utensils

- The principles of food hygiene should be followed in food preparation and service.
- Staff should perform hand hygiene before preparing or serving food to residents.
- Disposable crockery and cutlery are not required.
- Crockery and cutlery should be washed in a dishwasher, if available. Otherwise wash with hot water and detergent, rinse in hot water and leave to dry.

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

[13] See *Environmental cleaning and disinfection principles for health and residential care facilities*

- Cutlery and crockery from ill residents does not need to be washed separately. Hot water and detergent will inactivate any residual contamination.
- Staff should wash or sanitise their hands after collecting or handling used crockery and cutlery. Trays and utensils can be contaminated with saliva or respiratory droplets.
- Trays and trolleys used for delivery of food should be cleaned thoroughly with disinfectant wipes after use.

Waste Management

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

Management of Deceased Bodies

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

[14] See *Advice for funeral directors*

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

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

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

QUICK REFERENCE GUIDE

Activity	Detail
COVID-19 suspected or Acute Respiratory Illness	Even minor symptoms present (resident or staff member): • A cough • Shortness of breath • Fever • Sore throat • Loss of taste or smell Inform your senior nursing staff on duty; symptoms of COVID-19 in the elderly may be atypical
Implement precautions as soon as resident shows Acute Respiratory Illness symptoms	• Increase infection prevention and control measures • Contact resident's GP • Isolate resident if possible • Collect swabs as directed by medical officer • Warn visitors of risk
Nominate an infection control coordinator	Name: ……..….. Ph: …….. Pager: …….
Notify	• Your state/territory public health unit • Resident's GP and relatives or representative, all staff, all visiting GPs, allied health workers, volunteers, or anyone in contact with your facility
Document	• Details of resident(s) or staff member with symptoms • Onset date of acute respiratory illness symptoms for each resident • Types of symptoms • Their contacts – to identify 'at risk' groups
Manage residents who are ill	• Isolate from residents who are well • Dedicated staff where possible • Dedicated equipment: hand basin, single use towels, en suite bathroom, containers for safe disposal of gloves, tissues, masks, towels • Staff use personal protective equipment • Transfer to hospital if condition warrants
Restrict contact	• Symptomatic staff off work (and seek testing for COVID-19) • Limit staff movement into restricted area • Warn visitors and limit visit times • Suspend all group activities
Prevent spread	• Increase infection prevention and control measures • Personal hygiene – wear gloves, mask, ensure good hand hygiene • Environment – enhance cleaning measures • Medical – transfer to hospital if required

HAND HYGIENE BEFORE AND AFTER CONTACT WITH RESIDENTS

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