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Australian Centre for Disease Control

Communicable Diseases network AUSTRALIA

Communicable Diseases Network Australia

National Outbreak Management Guideline for Acute Respiratory Infection (including COVID-19, influenza and RSV) in Residential Aged Care Homes

Version 2.0
June 2024

Disclaimer

The Communicable Diseases Network Australia (CDNA) has developed this guideline in consultation with jurisdictions and the aged care sector. The Australian Health Protection Principal Committee (AHPPC) endorsed the first iteration of this guidance on 23 September 2022. Where guidance differs from state and territory policies, residential aged care homes (RACH) should follow local state or territory recommendations.

This update recognises the need for RACH to employ a risk-based approach for the early identification of acute respiratory infection and management of outbreaks, supported by specific resources and tools provided by jurisdictions, and guidance from their local public health unit. This guidance supports RACHs to take a more proportionate approach in managing the risk of respiratory infection with consideration of resident's wellbeing, recognising the detrimental effects on residents of social isolation and inactivity.

This document captures the knowledge of experienced professionals and the sector. It provides guidance on good practice, based on evidence available at the time of completion. It is intended to provide nationally consistent risk and principles-based guidance.

This guideline incorporates information adapted from:

- Australian state and territory guidelines for outbreak management in RACHs
- documents and guidelines from the Australian Government Department of Health and Aged Care (herein called the Commonwealth) and other Australian health agencies.

CDNA acknowledges NSW Health for the provision of their jurisdictional guidance to direct the revision and update of this work.

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

RACHs should read these guidelines in conjunction with the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021) and its supplementary resource 'The Aged Care Infection Prevention and Control Guide' (note that this was not released at time of publication). This guidance is not meant to be exhaustive but instead aims to supplement more detailed guidance available at a state, territory, and institutional level. This guidance does not override or change any obligation an employer may have under occupational health and safety laws.

While every effort has been made to ensure the accuracy and completeness of the contents of the guideline at the time of publication, members of CDNA and AHPPC, and the Commonwealth do not warrant or represent that the information in the guideline is accurate, current, or complete. CDNA, AHPPC and the Commonwealth do not accept any legal liability or responsibility for any loss, damages, costs, or expenses incurred by the use of, reliance on, or interpretation of, the information in the guideline.

Revision history			
Version	Date	Reason / Changes	Endorsed by
1.0	23/09/22	Initial Release	AHPPC
2.0	07/06/24	Changes to improve structure. Inclusion of combination RATs for testing. Changes to days in isolation following COVID-19 diagnosis. Inclusion and reference to Aged Care Infection Prevention and Control Guide. Removal of Appendix 2 – Treatment and prophylaxis.	CDNA

Contents

Purpose

To assist Residential Aged Care Homes (RACHs) in Australia with planning, preparing, detecting and managing cases, contacts, and outbreaks of acute respiratory infections (ARI).

Overview

- In this guideline, the term ARI comprises infections caused by respiratory pathogens including but not limited to SARS-CoV-2 (COVID-19), influenza virus and respiratory syncytial virus (RSV).
- ARI transmission is primarily via droplet and aerosol spread when infected individuals cough, sneeze, talk, shout or during interventions that increase aerosolisation of respiratory particles.
- Many ARI can be spread before symptoms appear in an infected person. Early identification of cases and prompt initiation of infection control procedures, testing and treatment are essential to contain spread and minimise the chance of serious illness or death.
- Outbreaks in RACHs can be caused by the spread of more than one respiratory pathogen. A resident or staff member can be simultaneously infected with more than one respiratory pathogen. This may require use of more than one of the management pathways outlined in this guideline.
- Symptoms of ARI are often similar, regardless of the pathogen causing illness. Testing symptomatic residents and staff members is essential to confirm the diagnosis and guide management.

ARI definition

Recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion, with or without other symptoms.

Other symptoms may include:

- headache, muscle aches (myalgia), fatigue, loss of appetite, nausea or vomiting and diarrhoea. Loss of smell and taste can also occur with COVID-19
- fever (≥37.5°C) can occur, however is less common in elderly individuals
- in the elderly, other symptoms to consider are new onset or increase in confusion, change in baseline behaviour, falling, or exacerbation of underlying chronic illness (e.g., increasing shortness of breath in someone with congestive heart failure).

- Respiratory viral infections can vary from no symptoms to severe disease and death. As antiviral treatments are available for COVID-19 and influenza, early recognition, testing and diagnosis are important for individual management as well as for preventing spread to others.
- The RACH should ensure staff, family and residents are aware of ARI symptoms and the need to report them when observed in residents. Clinical processes should be in place to identify clinical changes, and screening of uninfected residents should be escalated when there are cases in the RACH. Ideally, staff should know residents well so they can detect subtle changes in condition or behaviour.

Preparedness

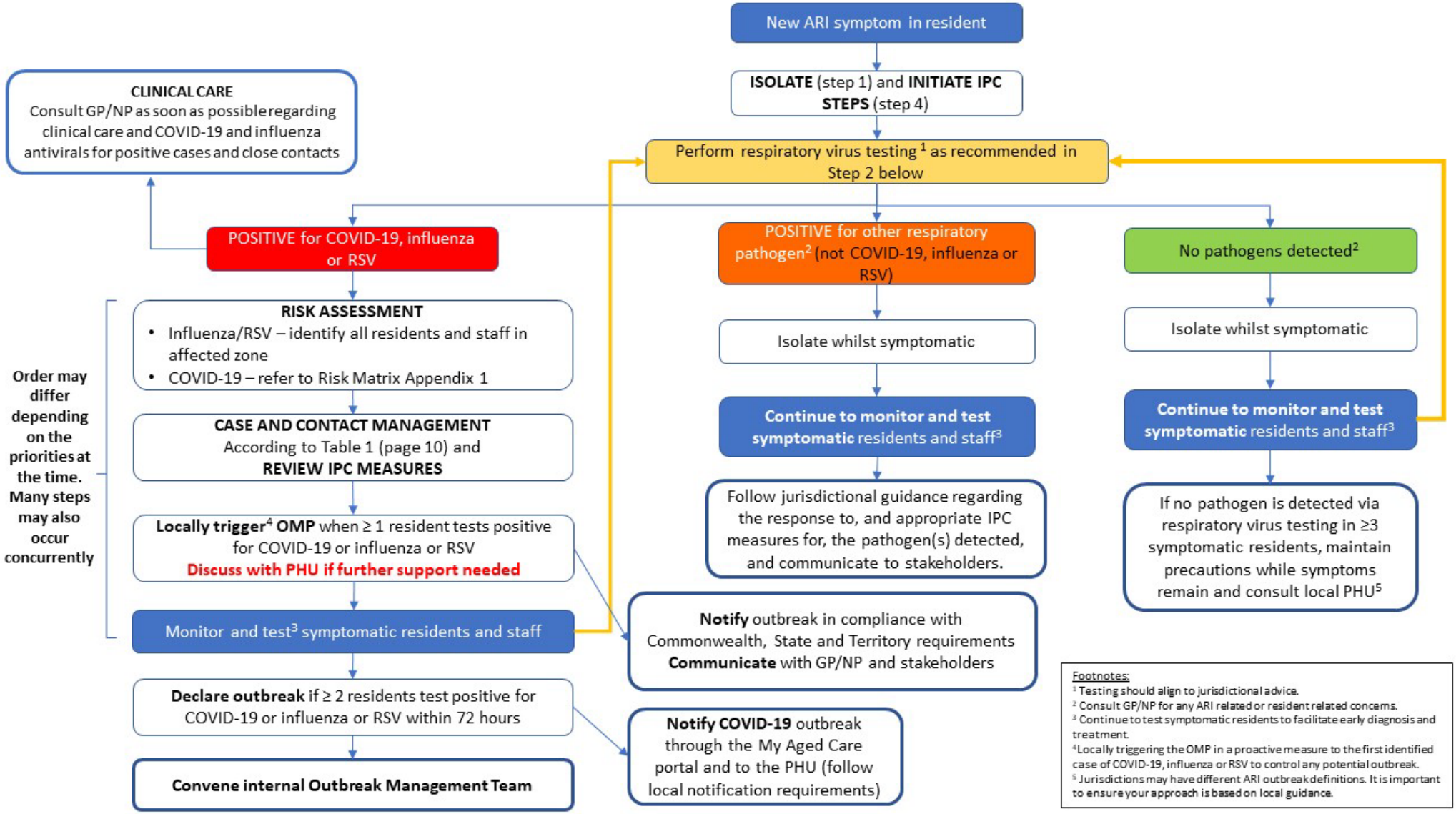
All RACHs must have appropriate preparedness plans in place to ensure a prompt response to an ARI outbreak. Outbreak management plans (OMP) and workforce surge capacity plans should be regularly reviewed to ensure they are consistent with current jurisdictional and national guidelines, and industry codes. A preparedness plan should cover the following:

- Vaccination
  - Promote and facilitate COVID-19 and influenza vaccination among residents, staff, visitors and contractors as per Australian Technical Advisory Group on Immunisation (ATAGI) advice.
  - Have workplace vaccination policies to encourage staff to be up to date with vaccinations.
    - Residential aged care providers are required to offer an influenza vaccination program for all service staff and volunteers.
  - Monitor and record vaccination status (including date of vaccinations) for residents, staff and visitors for COVID-19, influenza and RSV.
  - Encourage residents to discuss vaccination (including COVID-19, influenza, and RSV), with their general practitioner (GP).
    - RSV vaccination is available for people aged 60 years and older, at a cost (see ATAGI statement).
- Infection prevention and control (IPC) activities
  - All RACHs are required to implement IPC practices in line with the Aged Care Quality Standards.
  - All RACHs must have an IPC lead nurse, who is supported by management and has adequate time, training and resources to oversee IPC capability across the service.
  - Aged care providers should regularly undertake IPC risk assessments and stay up to date with national and jurisdictional IPC guidance.
  - All aged care workers should have suitable qualifications, experience and training to perform IPC practices relevant to their role. RACHs should conduct regular staff training in IPC practices and outbreak response activities, including recognition of ARI symptoms.
  - Ensure standard precautions are implemented at all times to minimise the risk and impact of an outbreak.
  - Ensure adequate procurement of IPC supplies (including hand hygiene products, personal protective equipment [PPE], waste and cleaning supplies). Have arrangements in place to replace or increase resource supply, if needed.
  - Consider where and how residents and staff can be feasibly cohorted according to risk.
  - Optimise methods to improve indoor air quality and reduce transmission of COVID-19, influenza or RSV through mechanical or natural ventilation.
  - Develop strategies for waste management (increased waste during an outbreak).
- Planning for clinical care (including antiviral medications)
  - Engage with GP or nurse practitioners (NP) to develop a plan for each resident and ensure it supports the overall OMP, including:
    - Obtain consent for testing and consider how to promptly organise pathology forms for respiratory PCR testing, if required

        - Assess suitability and consent for antiviral treatment (for COVID-19 and influenza)
        - Consider if pathology testing is required for recent (generally within 6 months) kidney function results to be available
        - Clinical management and referral pathways if ARI symptoms are identified, including arranging alternate clinician engagement (e.g. onsite or telehealth support from local acute healthcare) as required in an outbreak situation.
        - Establish a system to rapidly access antiviral medications from a community pharmacy.
- Testing
    - Maintain supplies and monitor expiry dates of Rapid Antigen Tests ([RATS]; combination COVID-19, influenza A/B and RSV, where possible), and have methods in place to replace or increase supply.
    - Establish laboratory testing arrangements, pathology request processes, and a timely method of receiving and recording results.
    - Ensure staff are trained in the collection of appropriate specimens for testing and use of RATs.
    - Develop a systematic method for detecting and recording residents in the RACH who develop ARI symptoms, and their accompanying testing date/s and results.
    - Emphasise the importance of early testing among residents, staff and visitors at the RACH who have ARI symptoms to limit onward transmission and facilitate access to antiviral treatments.
- Workforce planning
    - Establish workforce surge capacity and contingency planning for staff absenteeism.
- Maintaining resident wellbeing
    - Engage residents and their representatives in key decisions prior to an outbreak, including resident choices regarding isolation, and if temporary relocation during an outbreak is appropriate and consented to.
    - Receiving visitors is an important contributor to a resident's wellbeing. Work with residents and their support network to identify nominated essential visitors in the event of an outbreak
        - Essential visitors will require basic IPC training facilitated by the aged care provider. See 'Supporting visitors and partners in care with IPC' for more information.
    - Consider how to support ongoing visitation during outbreaks, including engaging residents and their representatives to help develop plans for alternate arrangements for leisure and lifestyle maintenance to be implemented.
    - Develop a communication plan to ensure regular communication with staff, residents, family and visitors during an outbreak, including strategies to support residents to stay connected with their families and friends to reduce the sense of isolation.
    - Considerations should be made for residents receiving palliative care or at end of life.
    - When planning, RACHs should consider jurisdictional advice and the sector code for visiting in aged care homes regarding entry restrictions (including screening) for visitors and staff, and use of PPE during an outbreak.

Responding to new ARI symptoms in a resident

Figure 1. Overview of initial actions – New Acute Respiratory Infection (ARI) Symptoms



Initial actions – New ARI symptoms in a resident

The steps outlined below are a guide only and the step-by-step order may differ depending on the priorities at the time. **Note: Steps are likely to occur concurrently**.

Step 1: Isolate the symptomatic resident

- Isolate the symptomatic resident immediately in their own room, with designated bathroom, if possible, until testing is complete, and a diagnosis is known (**Step 2**).
- Implement enhanced IPC measures (**Step 4**) for staff caring for affected resident.
- Allocate staff to affected and unaffected residents and areas/zones (**Step 4**).
- Implement individual resident isolation, communication and leisure and lifestyle plan.

NOTE: Isolation arrangements should only be implemented after consideration of the resident's dignity, choice and continuity of care, and only after an individual risk assessment has been completed.

Step 2: Test

Test symptomatic residents as soon as possible to enable earlier treatment and outbreak control. Testing should align to jurisdictional advice, such as the need for confirmatory PCR testing for initial symptomatic residents.

- Work with a GP or NP to enable prompt clinical review and respiratory virus testing of residents with ARI symptoms.
- Test symptomatic residents in a RACH with a COVID-19 RAT (or combination RAT, if available) and if a pathogen is not detected, a respiratory panel PCR. Ensure pathology request forms identify the name of the RACH and the requesting clinician's details for follow up and notification.
    - If a false positive RAT is suspected, the RACH should consult with the resident's GP/NP for consideration of further testing.
- Ensure all symptomatic residents remain isolated until initial testing is complete, and pathogen is known.
    - If no pathogen is detected on respiratory virus testing for three or more symptomatic residents, precautions should be maintained while residents are symptomatic, and the PHU contacted for further advice.

Step 3: Risk assessment and risk management

Following receipt of test results, assess and manage risk to RACH:

- Activate the OMP (**Step 7**) with the first resident who tests positive for COVID-19, influenza or RSV while awaiting test results of other residents.
- Risk assess for potential exposures that may have occurred and identify contacts (e.g. residents within the same room, residents who have shared a tearoom whilst symptomatic).
- Isolate (**Step 1**) and test (**Step 2**) any other symptomatic residents.
- Symptomatic staff should be tested (RAT or PCR), directed to their GP and excluded from the workplace until they are well, and the recommended exclusion period has lapsed as per table 1.
- Establish affected and unaffected zones. Review IPC measures implemented, identify and address any gaps (**Step 4**).
- Once the diagnosis is known, refer to **Step 5** for specific management of cases and contacts.

Step 4: Infection prevention and control measures

- Vaccination
  - Review COVID-19, influenza and RSV vaccination status of residents and staff.
  - During an outbreak, encourage and support vaccination, in accordance with ATAGI recommendations.
    - Vaccination can proceed during an outbreak with appropriate IPC.
- Cohort, zone and relocate
  - Identify the areas of the RACH that are at risk.
  - Take whole-of-RACH action where the whole home is impacted. Where only a wing or floor of the RACH is impacted, manage that area as an outbreak site. Identify crossover areas at risk of transmission, such as shared staff rooms, meal breaks, lifts, and car-pooling between staff.
  - If practical, cohort residents together where more than one resident case is positive with the same pathogen. Residents who are identified as contacts with similar exposures may also be cohorted together.
  - Cohort cases with different respiratory pathogens separately. For example, influenza cases should be cohorted away from COVID-19 cases, contacts should not be cohorted with confirmed cases.
  - Based upon the risk assessment and test results, identify the RACH areas that:
    - are completely unaffected and can be staffed with non-exposed staff and managed separately (unaffected zone).
    - are affected due to exposures (exposure zone).
    - have cases (affected zone).
  - Set up donning/doffing areas as per outbreak management plan.
  - Ensure all zones:
    - are clearly designated with clear signage in place.
    - have an adequate number of sites for alcohol-based hand rub, ideally at each bed space or point of care.
    - hand hygiene, PPE station and waste disposal at the entry, exit and at appropriate locations within the zone.
    - are decluttered as much as possible to make cleaning and disinfection easier.
    - have limited entry/access to each zone.
    - have separate, dedicated (spacious if possible or multiple areas if not) break areas for staff.
  - Dedicate staff to specific zones and areas for the duration of the outbreak, in line with IPC principles. For more information, refer to the:
    - Australian Guidelines for the Prevention and Control of Infection in Healthcare; and
    - Aged Care Infection Prevention and Control Guide (when published)
- PPE
  - The RACH should undertake a local risk assessment to inform the appropriate level of PPE for staff providing direct care or working within zones.
  - Align with the Australian Guidelines for the Prevention and Control of Infection in Healthcare and supplementary resource the Aged Care Infection Prevention and Control Guide (when published), and refer to local public health advice.
    - Staff should consult with the IPC lead or the person/s responsible for IPC if uncertain about the appropriate level of PPE required.
  - If required to leave their room, isolating residents should wear surgical masks where possible, able and willing.

- Environmental cleaning and disinfection
  - Environmental cleaning and disinfection of the affected areas should be completed by allocated staff who have the training and skill to perform thorough cleaning using:
    - a physical clean using an Australian Register of Therapeutic Goods (ARTG) listed combined detergent and disinfectant product that makes specific claims for use (2-in-1 clean)
      OR
    - a physical clean using detergent followed by a an ARTG listed chemical disinfectant that makes specific claims for use (2-step clean).
  - Further guidance for cleaning can be found in Coronavirus cleaning and disinfection for health and residential aged care homes. These cleaning principles are also applicable to RSV and influenza.

For more information see the Australian Guidelines for the Prevention and Control of Infection in Healthcare and the Aged Care Infection Prevention and Control Guide (when published).

Step 5: Case and contact management

Inform resident and/or substitute health care decision-maker / relative of positive results or exposure.

Table 1 – Case and contact management for COVID-19, influenza, and other confirmed respiratory pathogens (including RSV).

			COVID-19 (RAT or PCR)	Influenza (RAT or PCR)	Other respiratory pathogen (inc. RSV)
CASES	**Resident**	Release from isolation	• After 5 days since symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved and COVID-19 RAT is negative **OR** • After day 7 if acute symptoms resolved and no fever for 24 hours. No testing required.[1] Note: During isolation, case can cohort with COVID-19 positive residents.	• After 5 days from symptom onset, or until acute symptoms resolved, whichever is longer. **OR** • 72 hours after antivirals commenced regardless of symptoms. No testing required. Note: During isolation, case can cohort with influenza positive residents.	Once acute symptoms resolved. No testing required. Note: During isolation, case can cohort with residents with same confirmed pathogen.
		Antiviral treatment	COVID-19 antivirals (via treating clinician).	Influenza antivirals (via treating clinician).	Seek guidance from treating clinician.
	Staff	Return to work[2]	• After 5 days since symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved and COVID-19 RAT is negative **OR** • After 7 days if acute symptoms resolved for 24 hours, no testing required. If symptoms continue, return when acute symptoms resolved and no fever for 24 hrs.[1]	• 5 days from symptom onset, or until acute symptoms resolved, whichever is longer. **OR** • 72 hours after antivirals commenced. No testing required.	Once acute symptoms resolved. No testing required.
	Visitors[3]	Visitors to RACH	After day 7 if acute symptoms resolved and no fever for 24 hours. No testing required.[1]	• After 5 days from symptom onset or until symptoms resolved, whichever is longer. **OR** • 72 hours after antivirals commenced.	Exclude if symptomatic.

			COVID-19 (RAT or PCR)	Influenza (RAT or PCR)	Other respiratory pathogen (inc. RSV)
CONTACTS	**Resident**[4]	Contact testing	All residents in the affected zones and other contacts. See Appendix 1.	Symptomatic residents in the same zone (likely wing).	Symptomatic residents in the same zone (likely wing).
		Contact isolation	Limit movement of affected resident within the facility until test results return and risk assessment completed. See Appendix 1.	Residents who are in same zone(s) should avoid moving between different zones.	Nil.
		Post-exposure prophylaxis	Nil.	Influenza antivirals to be considered in outbreak (via treating clinician). See 'Antiviral prophylaxis considerations during an influenza outbreak' for more information.	Nil.
	Staff	Return to work	See Appendix 1.	Exclusion not needed if no symptoms. Wear a surgical mask when at work for 7 days from last exposure.	Immediately if no symptoms.
		Post-exposure prophylaxis	Nil	Consider influenza antivirals for unvaccinated staff and staff with comorbidities or pregnancy at higher risk of more serious disease (via treating clinician). See 'Antiviral prophylaxis considerations during an influenza outbreak' for more information.	Nil
	Visitors[3]	Return to RACH	Can visit after Day 7 of last contact with COVID-19 case if symptom-free.	Immediately if no symptoms. A mask should be worn for 7 days from last exposure if visiting the RACH.	Immediately if no symptoms.

Note: RACHs should ensure management is aligned with jurisdictional guidance. Jurisdictions and/or individual RACHs may have additional recommendations, including different isolation and quarantine periods. Where there is a mixed outbreak, follow the more restrictive quarantine and isolation guidance.

[1] This minimum standard aims to balance this risk with the impact of prolonged isolation on individuals and communities. A small proportion of cases may still be infectious when released from isolation.
[2] If there are critical staff shortages, staff may return to work earlier with additional precautions, in accordance with local workplace policies and guidance. RACHs may also liaise with their local PHU.
[3] Note that in an outbreak, RACHs may implement visitor restrictions. In exceptional circumstances (including visiting persons undergoing end-of-life care), it may be appropriate for persons who are cases or contacts to enter a RACH. This should occur on a case-by-case basis in discussion with the RACH, with additional mitigations in place to minimise the risk of transmission to staff and residents.
[4] Testing and isolation is not required for residents if it has been less than 4 weeks since recovery from their previous COVID-19 infection unless they become symptomatic. If symptomatic, they should isolate, even if they receive a negative result.

Cases

- Residents
  - Ensure residents isolate away from other residents.
  - On diagnosis, homes are obliged to promptly contact the resident's GP/NP regarding clinical assessment, care, and treatment (including antiviral medications if infected with COVID-19 or influenza – see Table 1.
  - Encourage and facilitate GP/NP to continue to provide residents their routine primary care as needed either onsite and/or virtually.
    - Seek alternative support if the usual health practitioner is unavailable.
  - Continue residents' ongoing daily care onsite (e.g., mobilisation, allied health services, time sensitive pathology tests, routine catheter changes, wound reviews etc).
  - Continue essential off-site appointments (e.g., dialysis), with negotiation with the receiving service provider and transport service if the resident has been infected with COVID-19, influenza or RSV. RACHs should ensure that residents and transport providers are provided with a mask and appropriate advice on mask wearing and IPC if they leave the RACH.
- Staff
  - Staff members who are a positive case should be excluded from the workplace until their acute symptoms have resolved and the recommended exclusion period has lapsed as per Table 1.
  - In the event of critical staff shortages, liaise with local PHU / Commonwealth if serious concerns regarding continuity of care or resident welfare.

Contacts

- General
  - In assessing contacts of a positive case, identify all staff and residents in the affected area who have been potentially exposed, ensure they monitor for symptoms, limit movement in the RACH, and are managed as per Table 1.
  - It is important that RACH use a risk-based approach to contact assessment and management. The risk of transmission should be managed whilst balancing the risk related to social isolation and deconditioning by using the least restrictive controls appropriate.
  - Where residents cannot be effectively isolated, more frequent testing of contacts may be recommended. Refer to jurisdictional advice.
- Residents
  - If symptoms develop, immediately isolate (after an individual risk assessment) (**Step 1**) and test (**Step 2**) the resident, with management determined by pathogen (as per Table 1).
  - Continue off-site appointments (e.g., dialysis). RACHs should ensure that residents and transport providers are provided with a mask and appropriate advice on mask wearing and IPC if they leave the RACH.
- Staff
  - Staff returning to work following a RACH exposure to COVID-19, influenza or RSV should not move between their section and other areas of the RACH, where possible.

Identifying contacts during a COVID-19 outbreak

- For information about how to identify contacts, see Appendix 1 (Table 2). In general:
  - If a resident is diagnosed with COVID-19 and the source is unknown or unclear:
    - Test all residents in the affected area by RAT or PCR (depending on availability) to find cases, irrespective of whether they are symptomatic. Consider all residents in the affected area as contacts.
    - See Appendix 1 to identify other resident and staff contacts.

- In outbreaks from a known source or in the case of an exposure from a known source, use Appendix 1 to identify contacts.

Antiviral prophylaxis considerations during an influenza outbreak

- Residents:
  - Consider the use of influenza antiviral medication during influenza outbreaks as post exposure prophylaxis for residents in the affected zone, in consultation with the prescribing clinician, outbreak management team and state/territory public health unit.
  - Consent for antiviral prophylaxis must be obtained. Ideally, this would be established and documented by the GP or NP in each resident's individual plan as part of preparedness activities.
- Staff:
  - During a confirmed influenza outbreak, staff who have not received an influenza vaccination are at higher risk of acquiring influenza. Unvaccinated staff should work only if asymptomatic and wearing a mask.
  - If antiviral prophylaxis is used during the outbreak, consenting unvaccinated staff should receive antiviral medication at the same time as asymptomatic residents. Any antiviral use by staff should be documented.

Other movement restriction considerations during an outbreak

- Residents in unaffected areas can continue to attend external appointments.
- Consider relocating residents who are on a palliative care pathway and require additional supports (e.g., compassionate care / visiting, symptom control) to an area where they are at less risk of further exposure (or if cases, plan for how residents can be supported with visits).
- Any transfers (other than for clinical need) should be planned and coordinated with receiving services and in consultation with the resident, their family or alternative decision-makers. Inform the receiving service about the outbreak at the RACH/wing, regardless of whether the resident being transferred is a case or not.
- New and returning RACH residents from the community, hospital or emergency department can be admitted/return to a RACH with appropriate IPC measures in place.
  - Ensure decision making is based on the advice of the local outbreak management team (OMT – see **Step 7**) and in consultation with residents and their representatives.

Step 6: Notification and reporting

- Notify positive COVID-19 cases in a RACH to the Commonwealth via the My Aged Care provider portal.
- Notification requirements for ARI outbreaks may differ between jurisdictions, and local requirements should be followed.
- Notify other care providers, RACHs, and hospitals where residents have had an exposure and have subsequently been transferred or require immediate transfer for care.
- Record and report details of each resident and staff case.
  - If relevant, confirm with the local PHU on preferred data format and template. RACHs should complete required information for all affected residents and staff, this will include vaccination status, symptoms, symptom onset, test results, any treatment to date and other identifying information.

Step 7: Activate outbreak management plan (OMP)

- Activate the RACH OMP with the first resident who tests positive for COVID-19, influenza or RSV while awaiting test results for other residents.
- Note that cases of COVID-19, influenza or RSV in staff members do not trigger an outbreak response but go to **Step 3 Risk Assess** if they were in contact with residents while infectious.

Declare an outbreak if 2 or more residents test positive within a 72-hour period for:

- COVID-19 or
- Influenza or
- RSV

Note: Jurisdictions may have different ARI outbreak definitions. It is important to ensure your approach is based on local guidance.

- Once an outbreak has been declared, convene an internal outbreak management team (OMT) meeting, and confirm the RACH staff members who will lead and manage the outbreak.
- Ensure the OMT meets and communicates regularly, with decisions documented.
- The OMT should contact the local PHU if additional advice is needed, particularly in the event of sustained, unexplained transmission.

Resident choice regarding isolation

- For aged care, consumer dignity and choice is Standard 1 in The Aged Care Quality Standards.
- Residents have the choice to quarantine during an outbreak or to mix with people with similar exposure. Unaffected residents have the right to choose their level of engagement with exposed residents and cases. Their preferences should be recorded in their care plans and regularly reviewed. Ensure residents are made aware that if they choose to not isolate during an outbreak, they may increase their risk of catching or transmitting the infection.
- Where it is practical, the RACH can manage this risk by considering:
  - Enabling residents with the same ARI to engage in social activities together if they are well enough to do so and if they can be kept separated from residents who are exposed or unaffected.
  - Residents exposed to the same pathogen may choose to leave their rooms to eat in shared dining rooms and participate in social activities with other residents from the exposed area[2].
  - Exposed residents should be supported to not socialise with positive cases or residents from unaffected areas.
  - Ensuring unaffected residents can leave their rooms to participate in shared activities and dining with other unaffected residents (e.g., with dedicated staff, dining room, social room).
- Where possible, ensure visits to affected and exposed residents occur in an area with good ventilation. The *Aged Care Act 1997*, the Charter of Aged Care Rights and the Aged Care Quality Standards include specific responsibilities that provide a legislative basis to this requirement for RACHs.
- Communicate with residents, families and visitors to inform them of the situation as soon as the OMP is activated. Additionally, inform residents, families and visitors entering the RACH during an outbreak of the current situation, as well as any associated restrictions or recommendations.

[2] Jurisdictions may recommend the testing of exposed residents prior to leaving their room. Follow local guidance.

Step 8: Communicate

- Establish systems to manage regular communications and engagement with residents, families, workers, visitors and community that support the RACH. Consider an agreed process to rapidly communicate changes in the situation to all staff throughout their shift.
- Ensure all affected residents are aware of their diagnosis, exposure status, testing and isolation recommendations and choices. Individual communications strategies need to be considered for residents who may have difficulty following instructions due to cognitive impairment or language barrier and documented in advance of any outbreak.
- Ensure residents' family and carers are aware of the exposure/outbreak at the RACH. Maintain confidentiality of the identity of positive residents, as far as possible.
- Ensure staff are aware of the exposure/outbreak at the RACH and remain on high alert monitoring themselves and residents for ARI symptoms. Ensure they know what to do if they or a resident develops symptoms.
- Ensure visitors are aware of the exposure/outbreak at the RACH and that nominated essential visitors and volunteers[3] are permitted to continue to visit affected and exposed residents, including those in designated affected zones. Visitors should comply with entry restrictions, as outlined by the RACH.
- The RACH may arrange virtual visits (e.g., via tablet) or contactless visits for visitors (e.g., window visits).
- Put up notices of the outbreak at all entrances including information to ensure awareness of the outbreak and minimise unnecessary visits that may lead to inadvertent transmission. Display signage, including PPE recommendations or other precautions, outside the room of affected residents. See the Australian Commission on Safety and Quality in Health Care for resources.

Step 9: Declaring an outbreak over

- A decision to declare the outbreak over should be made by the OMT and can be in consultation with the PHU. Generally, this is 7 days after the last case tests positive or the date of isolation of the last case in a resident, whichever is longer.
- Outbreak closure should not occur if there are pending PCR test results for contacts or symptomatic residents.
- Additional testing or measures may be recommended by the PHU in the 7 days following an outbreak being considered "over". This is more likely where there is extensive or poorly understood transmission, where there are significant numbers of residents not up to date with vaccination, or transmission is within a memory support unit.
- Once an outbreak is declared over, RACHs should remain on high alert and:
  - test appropriately anyone with new symptoms, no matter how mild;
  - carefully monitor contacts for behavioural changes, lack of appetite, and lethargy; and
  - ensure visitors (who may be at higher risk themselves) are aware that there has been a recent outbreak.
- Individual cases should remain in isolation for the required period (as per **Step 5**) even if the outbreak has been declared over for the RACH.
- Once an outbreak is over, RACHs should evaluate the response to and management of the outbreak to identify strengths and weaknesses. Consider conducting a debrief with all employees and contractors involved with the outbreak. This evaluation should lead to identifying areas for improvement and implementing appropriate actions to enhance quality control.

[3] As per 'Ensuring safe visitor access to residential aged care'. Aged Care Quality and Safety Commission.

Appendices

Appendix 1: COVID-19 exposure and outbreak management

Appendix 2: Key documents and resources

Appendix 1: COVID-19 exposure and outbreak management

Table 2. Suggested actions based on COVID-19 exposure[1]

STAFF	RESIDENTS[2]
Definition Where a worker has been exposed to a COVID-19 case within or outside the RACH with: • no effective PPE (N95/P2 masks, eye protection) during aerosol generating behaviours or procedures • at least 15 minutes face to face contact where both mask and protective eyewear were not worn by exposed person and the case was without a mask, or • greater than 2 hours in the same room as a case with inadequate PPE.	**Definition** Where a resident has been exposed to a COVID-19 case: • in a shared defined area (e.g., prolonged contact during activity or shared living space) and/or • outbreak-related contact (e.g., co-located in the same ward / wing / shared area with unknown exposure).

Management
• Review affected staff to assess exposure and risk.
• If staff have been exposed to a COVID-19 case and are returning to work, implement the following risk mitigation strategies:[3]
  ○ Test (RAT initially, if negative proceed to PCR if available), followed by daily RATs (until day 7)
  ○ Isolate immediately if symptoms develop at any time or upon testing positive (even if asymptomatic)
  ○ Work in P2/N95 masks for the first 7 days following exposure
  ○ Avoid staff redeployment to unaffected areas to minimise risk of potential spread
  ○ Avoid shared spaces or meal rooms.
	Management
	<u>Choose to quarantine</u>
	• Residents can choose to remain in room, away from others) for up to 7 days
	• Test (PCR if available, or RAT) day 2 and day 6.
	OR
	<u>Choose to not quarantine</u>
	• If RAT negative, enable socialisation by choice of resident with others who have similar exposure level
	• RAT at least every second day up to day 7.
	• Release from quarantine:
	  ○ After day 7 with a day 6 negative result and asymptomatic.

[1] Jurisdictions may recommend, and RACHs may implement additional mitigations for recent cases or current contacts, particularly during periods where the risk of transmission is high. These may include testing, mask-wearing (i.e., surgical or PFR), and avoiding common areas.

[2] Testing and isolation is not required for residents if it has been less than 4 weeks since recovery from their previous COVID-19 infection unless they become symptomatic. If symptomatic, they should isolate, even if they receive a negative result.

[3] Staff should talk to their employer about their return to work and take additional precautions in accordance with local workplace policies and guidance.

Appendix 2. Key documents and resources

Australian Government Department of Health and Aged Care

- Prevent and prepare for COVID-19 in residential aged care. COVID-19 advice and resources for aged care providers.
- Managing a COVID-19 outbreak in residential aged care. Information on COVID-19 outbreaks in residential aged care, responding to an outbreak and resources.
- Infection prevention and control lead/s. Further information on the role of an IPC lead in residential aged care.

Aged Care Quality and Safety Commission

- Aged Care Quality Standards. The Commission expects organisations providing aged care services in Australia to comply with the Quality Standards.
- Dealing with infectious outbreaks. Advice on managing the health, safety and wellbeing of older persons during infectious outbreaks.
- Supporting visitors and partners in care with IPC. Advice and resources on supporting RACH visitors in IPC and the Partnerships in care program.
- Infection prevention and control in aged care - Cognitive decline and dementia. Advice on creating an environment with strong IPC practices while continuing to provide a positive experience for people with cognitive decline and dementia.
- Infection prevention and control. IPC tools, resources and location-based guidance for aged care.

Australian Commission on Safety and Quality in Healthcare

- Infection prevention and control in aged care. A series of IPC resources on for aged care service providers and staff.

CDNA Series of National Guidelines (SoNGs) for Public Health Units

- CDNA National Guidelines for Public Health Units. Coronavirus Disease 2019 (COVID-19).
- CDNA National Guidelines for Public Health Units. Seasonal Influenza Infection.

Infection prevention and control

- Australian Guidelines for the Prevention and Control of Infection in Healthcare. Detailed national guidance on standard and transmission-based precautions
- TGA disinfectants use against COVID-19. Disinfectants registered with the TGA as effective against the virus (SARS-CoV-2).

Treatment and prophylaxis

- Pharmaceutical Benefits Scheme Factsheet. Lagevrio.
- Pharmaceutical Benefits Scheme Factsheet. Paxlovid.
- Australian Department of Health and Aged Care. Information on Oral treatments for COVID-19, including links to an Information sheet for residents in residential aged care facilities and their families – COVID-19 oral medicines and a COVID-19 medicines – Easy read document.
- Australian Government Department of Health and Aged Care. Use of Tamiflu in residential aged care.
- Health Direct. Tamiflu.
- Therapeutic Guidelines.
    - Influenza

    - COVID-19
- Health Direct. Respiratory syncytial virus (RSV).

Vaccination

- The Australian Technical Advisory Group on Immunisation (ATAGI). Advice on the National Immunisation Program and immunisation.
- Australian Immunisation Handbook. Clinical advice on the safe and effective use of vaccines in practice.
- Australian Government Department of Health and Aged Care. Information for aged care providers, workers and residents about COVID-19 vaccines.
- Australian Government Department of Health and Aged Care. Influenza (flu) vaccine. Information about the influenza vaccine, who it is recommended for, how and where to get vaccinated.