RTI 0897 – Aged Care Direction documents

Purpose of contextual information

The purpose of this document to provide further context regarding Right to Information (RTI) application 0897.

Important Caveats

1. As part of the CHOs role, it is necessary to be appraised of the risks to the public of the spread of serious infections and the public health measures available to control or reduce that risk. For that purpose, the CHO has developed an extensive knowledge of the available public health responses to transmission of disease. The CHO has read extensively on the subject and kept abreast of published articles in peer reviewed journals dealing with responses to the spread of other infectious diseases, including SARS and Ebola. The CHO has available to her, extensive texts and other materials on public health related responses to infection. The CHO has attended numerous conferences and seminars over her period in the role directed to those issues. Since the outbreak of COVID – 19, the CHO has read extensively into public health responses by other countries, WHO publications, epidemiological reports, published papers, statistical and modelling reports and information, and has participated in meetings and discussions.
2. In particular, over the last 15 years, the CHO has had significant experience in setting Queensland policy to manage communicable diseases in communities. This has ranged from the spread of tuberculosis in the north of PNG, to controlling the impacts of swine flu, to the spread of Hendra virus from horses to humans.
3. The CHOs longstanding experience as Queensland's CHO, as well as the numerous executive and clinical roles she has held over the course of her career have significantly shaped her approach to decision making in an emergency, and permits her to express opinions and judgement.
4. The opinions the CHO expressed are wholly or substantially based upon her knowledge and experience in previous pandemics, as well as her own observations and other information that has come to her, including the number and rapidity of infections, the sources of the infections and the practical steps implemented to respond to the spread of the virus.

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

CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia version 3.0

Publishing history			
Version	**Date**	**Reason / Changes**	**Endorsed by**
1.0	13/03/20	Initial Release	CDNA
2.0	30/04/20	Revision Update clinical presentation in older people Update infection prevention and control guidance	CDNA
3.0	10/06/20	Revision Update outbreak identification and management guidance Update infection prevention and control guidance	CDNA

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

This guideline is provided to assist public health authorities, residential care services, health care workers and carers by providing best practice information for the prevention and management of COVID-19 outbreaks in RCF. This guideline captures the knowledge of experienced professionals and provides guidance on good practice based upon the available evidence at the time of completion. Readers should not rely solely on the information contained within this guideline. Guideline information is not intended to be a substitute for

advice from other relevant sources including, but not limited to, advice from a health professional. Clinical judgement and discretion may be required in the interpretation and application of these guidelines.

The membership of CDNA and AHPPC, and the Commonwealth of Australia as represented by the Commonwealth Department of Health (the Department), do not warrant or represent that the information contained in the guideline is accurate, current or complete. CDNA, AHPPC and the Department 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 contained in the guideline.

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1. Introduction

This guideline applies to all residential care facilities (RCF) in Australia. This refers to any public or private aged care, disability services or other congruent accommodation setting in Australia where residents are provided with personal care or health care by facility staff, and may also include long stay hospital wards and rehabilitation hospitals that care for older Australians where relevant. However, as older age is a risk factor for severe disease, these guidelines have a strong focus on residential aged care facilities.

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

Appendix 1 provides a summary of COVID-19 management in RCF in Australia.

While this guideline focuses on RCF, the principles are applicable to many settings including: residential facilities for people with physical and mental disabilities, other community based health facilities (e.g. drug and alcohol services, community mental health), detention and correctional centers, military barracks, boarding schools, hostels and any other setting where residents sleep, eat and live either temporarily or on an ongoing basis. Additional guidance for investigation and management of COVID-19 outbreaks in high-risk settings is available in the *CDNA COVID-19 National Guidelines for Public Health Units* (CDNA National Guideline).

COVID-19 Outbreaks

It can be difficult to tell the difference between COVID-19 and respiratory illness caused by other viruses based on symptoms alone. Suspected COVID-19 cases are referred to as a 'suspect case' until a causative pathogen is identified through diagnostic testing (e.g. nose and throat swab collection) or the criteria for classification as a 'probable case' are met, in the absence of diagnostic testing.[1]

If the virus that causes COVID-19 (SARS-CoV-2) is detected during an outbreak this is referred to as a COVID-19 outbreak (refer to section 4).

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

[1] Case definitions are outlined in the CDNA National Guideline

Legal Framework

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

COVID -19 is a notifiable condition under the Australian National Notifiable Diseases List (NNDL).[2] This means that in all Australian states and territories, either the medical officer requesting the test and/or the laboratory performing the test, are responsible for notifying the relevant jurisdictional public health authority of the case of COVID-19, as per local legislative requirements.

Roles and Responsibilities

Residential Care Facility

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

RCF are required to:

- detect and notify outbreaks to state health departments
- self-manage outbreaks in accordance with this guideline, the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (2019), and the *Australian Health Sector Emergency Response Plan for Novel Coronavirus* (2020)
- confirm and declare an outbreak (refer to section 5)
- follow advice on infection control measures and appropriate use of personal protective equipment (PPE), available on the Department of Health website
- confirm and declare when an outbreak is over (refer to section 5).

The State/Territory Department of Health and Human Services

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

- Assisting facilities in confirming outbreaks by applying the case definition correctly and providing advice on obtaining testing samples
- Providing guidance on outbreak management
- Monitoring for severity of illness (record deaths and hospitalisations)

[2] Australian National Notifiable Diseases List (NNDL) is available at: https://www.legislation.gov.au/Details/F2018L00450

- Informing relevant stakeholders of outbreaks
- Monitoring the number of COVID-19 outbreaks occurring as the epidemic progresses
- Contributing to national surveillance.

Australian Aged Care Quality and Safety Commission

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

- independently accredit, assess and monitor aged care services against the Aged Care Quality Standards, including the requirement to minimise infection-related risks through implementing standard and transmission based precautions to prevent and control infection;
- resolve complaints about the delivery aged care services; and
- educate providers, including with respect to best-practice infection prevention and control.

2. Understanding COVID-19

Recognising COVID-19

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

The most common signs and symptoms include:

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

Other symptoms can include:

- shortness of breath
- sputum production
- fatigue
- sore throat
- loss of taste
- loss of smell
- diarrhoea
- nausea or vomiting

Less common symptoms include:

- headache
- myalgia/arthralgia
- chills
- nasal congestion
- haemoptysis

- conjunctival congestion

Older people may also have the following symptoms:

- confusion or behavioural change
- worsening chronic conditions of the lungs
- loss of appetite

Staff should be cognisant of these symptoms and note that the majority of cases experience mild symptoms. If staff develop any symptoms, they must isolate and get tested to prevent transmitting the virus to other staff members or residents.

Elderly patients often have non-classic respiratory symptoms including behaviour change, and may not develop a fever. Ideally, staff should know residents well so that they can detect changes in behaviour. RCF should consider testing any resident with any new respiratory symptom, even if they are not typical of COVID-19. Asymptomatic COVID-19 infections are relatively common and may occur in residents in RCF. In RCF, public health units may consider testing asymptomatic contacts to inform management of the outbreak.[3]

Incubation Period

People with COVID-19 generally develop signs and symptoms, including mild respiratory symptoms and fever, on an average of 5-6 days after exposure to the virus (mean incubation period 5-6 days, range 1-14 days). In rare cases the incubation period may exceed 14 days.

Routes of Transmission

COVID-19 is transmitted via droplets and fomites, during unprotected contact with an infected person or contaminated objects. Airborne spread has not been reported for COVID-19; however, it may occur during aerosol-generating procedures[4] conducted in health care settings. As a result, nebuliser use should be avoided wherever possible and spacers should be used as an alternative. Faecal shedding of the virus has been demonstrated in some patients, and viable virus has been identified in some cases. Although the faecal-oral route does not appear to be a driver of COVID-19 transmission, it may become important in RCF; as such, cases with ongoing diarrhoea or uncontained faecal incontinence who may have limited capacity to maintain standards of personal hygiene should continue to be isolated until 48 hours after the resolution of these symptoms.

People at risk of complications from COVID-19

The following people are, or are likely to be, at higher risk of serious illness from COVID-19:

- People 70 years and older
- People 65 years and older with chronic medical conditions (see below)
- Aboriginal and Torres Strait Islander people 50 years and older with one or more chronic conditions (see below)
- People with a compromised immune system (see below).

[3] See case definition in the CDNA National Guideline

The Department of Health is regularly updating and refining a list of chronic medical conditions[4] associated with a higher risk of complications from COVID-19 based on emerging evidence, available here. To date this includes:

- Chronic renal failure
- Coronary heart disease or congestive cardiac failure
- Chronic lung disease (severe asthma (for which frequent medical consultations or the use of multiple medications is required), cystic fibrosis, bronchiectasis, suppurative lung disease, chronic obstructive pulmonary disease, chronic emphysema)
- Poorly controlled diabetes
- Poorly controlled hypertension
- BMI >40.

People at any age with significant immunosuppression are also at higher risk of serious illness. Significant immunosuppression is defined as:

- Haematological neoplasms: leukemias, lymphomas, myelodysplastic syndromes
- Post-transplant: solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months or on treatment for GVHD)
- Immunocompromised due to primary or acquired immunodeficiency (including HIV infection)
- Current chemotherapy or radiotherapy
- High-dose corticosteroids (≥20 mg of prednisone per day, or equivalent) for ≥14 days
- All biologics and most disease-modifying anti-rheumatic drugs (DMARDs) as defined as follows:
    - Azathioprine >3.0 mg/kg/day
    - 6-Mercaptopurine >1.5 mg/kg/day
    - Methotrexate >0.4 mg/kg/week
    - High-dose corticosteroids (20mg/day or more prednisone or equivalent). If <14 days treatment, can resume work when treatment ceased
    - Tacrolimus (any dose)
    - Cyclosporine (any dose)
    - Cyclophosphamide (any dose)
    - Mycophenolate (any dose)
    - Combination (multiple) DMARDs irrespective of dose.

Complications of COVID-19

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

Complications include:

- pneumonia (interstitial pneumonitis, secondary bacterial infection)
- respiratory failure
- septic shock

[4] See the Department of Health website for Advice for People at Risk of COVID-19

- multi-organ dysfunction/failure.

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

3. Preparedness and Prevention

Preparation

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

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

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

Prepare an Outbreak Management Plan

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

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

Planning Assumptions

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

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

- A COVID-19 pandemic will affect the entire health care system and the community. Hospitals, local public health units and other services may have limited capacity. RCF may not be able to rely on the same level of support they receive now from other

parts of the health care system or from other community services during an outbreak.

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

Education

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

Prompt and clear information needs to be provided to residents and families regarding the outbreak including respiratory hygiene and cough etiquette, hand hygiene and restrictions on visitation if they have any symptoms of COVID-19. A sample letter outlining the

preventative steps families and visitors can take to reduce the risk of bringing COVID-19 into the facility can be found at Appendix 3.

Staff should be informed, and supported (e.g. leave policies), to exclude themselves from work when they have acute respiratory symptoms, and to notify the facility if they become a confirmed or probable COVID-19 case. Casual staff should also notify their agency if they become unwell and be supported to exclude themselves from working with any elderly persons. Staff exclusion during an outbreak is discussed further in section 5.

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

Workforce Management

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

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

Staff Education and Training

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

Topics for staff education and training should include:

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

- Safe laundering of linen
- Food handling and cleaning of used food utensils
- Collection and handling of respiratory swabs, where appropriate and aligns with the staff's prior training and skillset.

Online training modules for Hand Hygiene and COVID-19 infection prevention and control are available. All staff should undergo regular refresher training on infection prevention and control measures.

Consumable Stocks

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

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

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

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

Prevention

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

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

Exposure Prevention

Exposure prevention actions include:

- Self-screening for staff, volunteers and visitors (including visiting workers)
  - RCF should instruct all staff to self-screen for symptoms, and to observe any exclusion and quarantine requirements related to returning from international or interstate travel.

  - Staff should be made aware of early signs and symptoms of COVID-19. **Staff must not come to work if symptomatic and must report their symptoms to the RCF.** Sick leave policies must enable employees to stay home if they have relevant symptoms.
  - RCF should use signage at entrances and reception to inform visitors to self-identify if they have relevant symptoms, travel history or exposure. Visitors must be instructed not to enter the RCF until any symptoms have completely resolved or they have been released from self-quarantine if identified as a close contact of a confirmed case.
- Monitor residents and employees for fever or acute respiratory symptoms
  - Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a face mask (if tolerated).
  - In general, for care of residents with undiagnosed respiratory infection use standard, contact, and droplet precautions[5] unless a procedure requires airborne precautions.
- Active screening for resident admissions or re-admissions/returning residents
  - Assess residents for symptoms of COVID-19 upon admission to the facility and implement appropriate infection prevention practices for incoming symptomatic residents.
- Implementation of other infection prevention and control measures, which include:
  - Hand hygiene and cough and sneeze etiquette
  - Use of appropriate PPE
  - Environmental cleaning measures
  - Isolation and cohorting
  - Social distancing
  - Ceasing use of nebulisers and using spacers as an alternative where possible.

Prevention of Introduction into the Facility

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

- RCF should comply with all Commonwealth, and State or Territory direction on restrictions to visitors to RCF when they are unwell or when there is significant community transmission occurring.
- RCF should advise all regular visitors to be vigilant with hygiene measures including social distancing, and to monitor for symptoms of COVID-19, specifically fever and acute respiratory illness. They should be instructed to stay away when unwell, for their own and residents' protection, and to observe any self-quarantine requirements.
- Signage and other forms of communication (i.e. information and factsheets) must be used to convey key messages including what actions the facility is taking to protect them, and explaining what they can do to protect themselves and residents.

[5] Even in the context of low active case numbers and limited community transmission of COVID-19 in Australia, droplet precautions are appropriate to prevent transmission of other respiratory infections, such as influenza.

- RCF must ensure that adequate hand washing facilities and alcohol based hand rub, as well as tissues and lined disposal receptacles, are available for visitors to use at the entrance of the facility and in each resident's room.
- Visitors should not be prevented from entering a RCF unless they are unwell, an outbreak is occurring, or relevant Commonwealth, and State or Territory advice does not allow entry of the visitor. Protracted restrictions on visitors is likely to have detrimental impacts for resident's wellbeing.

Prevention of Spread Within and Between Facilities

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

- Keep residents and staff informed through regular communication.
  - Support personal protection measures including respiratory hygiene, cough and sneeze etiquette, and hand washing.
- Monitor residents and employees for fever or acute respiratory symptoms
  - Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a surgical mask (if tolerated).
  - In general, for care of residents with undiagnosed respiratory infection use standard, contact, and droplet precautions unless a procedure requires airborne precautions.
- Health care personnel should monitor Commonwealth Department of Health and state public health information sources to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness. If there is transmission of COVID-19 in the community, in addition to implementing the precautions described above for residents with acute respiratory infection, facilities should also consult with public health authorities for additional guidance.
- Identify dedicated employees to care for patients with COVID-19 and provide infection control training.
  - Guidance on implementing recommended infection prevention practices is available in section 5.
- Identify suitable sites where individuals may be cohorted together into either: isolation of the sick OR quarantine of those exposed.
  - Staff working at a facility with an outbreak should only work within one of the cohorts and not move between those with the disease and those in quarantine.
- Arrange diagnostic testing for members (staff and residents) with symptoms consistent with COVID-19.
  - If other members of the setting are symptomatic, test these individuals for other respiratory pathogens such as influenza, as well as COVID-19.
- Provide the correct supplies to ensure easy and correct use of PPE.
  - Make PPE, including facemasks, eye protection, gowns, and gloves, available immediately outside of the resident room.
  - Position a disposal receptacle near the exit inside any resident room to make it easy for employees to discard PPE.

  - Post signs on the door or wall outside of the resident room clearly describing the type of precautions needed and required PPE.
- Notify facilities and transport service providers prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19; or transferring to a higher level of care.
- Notify any confirmed COVID-19 cases in residents and employees to the relevant jurisdictional public health authority.
- If an outbreak occurs in a facility, facility staff should not work at another facility until the outbreak is over.

4. Identifying COVID-19

Identification

Prevention and management of influenza outbreaks in RCF have been built around surveillance of influenza-like illness (ILI). Building on that model, RCF should establish systems to monitor staff and residents for COVID-19 with a high level of vigilance and have a low threshold for investigation. Surveillance for fever or acute respiratory infection,[6] rather than ILI, is very sensitive for detecting possible cases of COVID-19 in the context of confirmed local transmission of COVID-19. Effective surveillance will facilitate early recognition and management of cases.

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

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

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

[6] In the CDNA National Guideline, examples of acute respiratory infection (ARI) are cough, shortness of breath or sore throat.

Case Definition

The CDNA National Guideline provides the current case definition for COVID-19, to classify an individual as a confirmed, probable or suspect case. COVID-19 should be suspected in any resident who meets the criteria for a suspect case. Clinical and public health judgement should be used to determine if individuals with sudden and unexplained onset of other clinically compatible COVID-19 symptoms should be considered for testing.

Testing for COVID-19

The recommended tests and methods of sampling for COVID-19 are outlined in the CDNA National Guideline. Once requested by a medical officer, specimens should be collected by an appropriately trained health care professional or pathology collector using the appropriate transmission-based precautions. Residents do not need to be transferred to hospital for the purpose of testing for COVID-19. Guided by the clinical picture, the responsible medical officer should consider requesting testing for additional respiratory pathogens.

Procedures for obtaining nose and throat swabs are at Appendix 4.

Notification – State/Territory Department of Health

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

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

In addition to completing the report at Appendix 5, RCF must be prepared to provide the following information to the PHU:

- information on the setup of the facility
- total number of residents and/or staff with fever or ARI
- date of onset of illness of each person
- symptoms of each person
- number of people admitted to hospital with fever or ARI (if applicable)
- number of people with symptoms clinically compatible with COVID-19 who have died
- total number of staff that work in the facility and in the affected area
- total number of residents in the facility and in the affected area
- whether appropriate respiratory specimens have been collected
- results of any respiratory specimens already tested.

The PHU should advise and, where appropriate, assist the RCF with the following:

- defining the outbreak setting

- confirming and declaring a COVID-19 outbreak
- arranging diagnostic testing for COVID-19 for all staff and residents in the outbreak setting
- ensuring that the facility managers notify other staff, residents and visitors where relevant, that cases of COVID-19 have occurred
- advising your staff about enhanced implementation of infection control measures
- ensuring that staff who have worked at any other aged care facility or provided in home care in the last 14 days are identified by the facility
- collating information onto a line list
- ensuring staff form an outbreak management team (see below)
- identifying and informing relevant internal and external stakeholders
- isolating and treating people who test positive. Quarantining people who test negative and monitoring for illness
- where feasible, commencing a program of repeat tests for those who may be susceptible or incubating who are in quarantine
- identifying suitable sites where individuals may be cohorted together into either: isolation of the sick OR quarantine of the exposed.

Information for PHUs managing outbreaks in RCF and other high-risk settings is available in the CDNA National Guideline.

The PHU will provide the RCF with a preferred case list (also called a 'line list') template to use when an outbreak is notified. If any deaths occur during an outbreak, the local PHU and Commonwealth Department of Health must be notified as soon as possible within 24 hours. Hospitalisation of residents should be noted on the case list and sent to the department daily (see section 5).

State/territory Public Health Unit Contact details

State	Contact Details
Queensland	13 432 584 (13 HEALTH)
New South Wales	1300 066 055
Australian Capital Territory	Business Hours: 02 5124 9213 After Hours: 02 9962 4155
Victoria	1300 651 160
Tasmania	1800 671 738
South Australia	1300 232 272
Western Australia	08 9222 8588 or 08 6373 2222 (If confirmed COVID-19)
Northern Territory	08 8922 8044

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

Notification – Resident and Facility General Practitioners

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

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

5. COVID-19 Case and Outbreak Management

Response to symptoms of COVID-19 in a resident

Residents with symptoms consistent with COVID-19 require appropriate health care support, including access to their primary care provider for medical management.

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

- Immediately isolate ill residents and minimise interaction with other residents.[7]
- If COVID-19 is suspected, have a low threshold for requesting medical review and testing.
- Transfer residents to hospital ***only if their condition warrants***. If transfer is required, advise the transport service provider and hospital, in advance, that the resident is being transferred from a facility where there is potential or confirmed COVID-19. A sample transfer advice form is provided at Appendix 7.
- Notify the appropriate authorities as outlined in section 4.
- Due to the importance of undertaking early action to minimise transmission in RCF, the PHU may advise the facility to implement additional actions while awaiting a test result.

Response to symptoms of COVID-19 in a staff member

Health care, aged or residential care workers and other members of staff who develop symptoms of respiratory illness should immediately be excluded from the facility and remain isolated whilst a diagnosis is sought. If COVID-19 is excluded, the staff member may be able to return to work once cleared and asymptomatic. If a diagnosis of COVID-19 is

[7] Refer to Infection Control Expert Group *COVID-19 Guidelines for Infection Prevention and Control for Residential Care Facilities*

confirmed, the staff member must be excluded until they meet the criteria for release from isolation outlined in the CDNA National Guideline. The RCF must make appropriate notification to the relevant authorities as outlined in section 4. Due to the importance of undertaking early action to minimise transmission in RCF, the PHU may advise the facility to implement additional actions while awaiting a test result.

Response to an Outbreak of COVID-19

This section provides detailed information on the required actions to be implemented once an outbreak has been identified. An outbreak management checklist is provided at Appendix 8. Additional information for public health units responding to an outbreak in a high risk setting is available in the CDNA National Guideline.

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

Declaring an Outbreak

> A COVID-19 outbreak is defined as **a single confirmed case of COVID-19 in a resident, staff member or frequent attendee of a RCF.**

This definition does not include a single case in an infrequent visitor of the facility. A determination of whether someone is a frequent or infrequent visitor may be based on frequency of visits, time spent in the setting, and number of contacts within the setting.

While the definitions above provide guidance, the state/territory PHU will assist the RCF in deciding whether to declare an outbreak. Public health units may advise that the facility should take some actions where an outbreak is suspected, whilst awaiting laboratory confirmation.

Establishing an Outbreak Management Team

The RCF is responsible for managing the outbreak and should take a strong leadership role with support from the PHU staff. An internal outbreak management team (OMT) should be established to direct, monitor and oversee the outbreak, confirm roles and responsibilities and liaise with the state/territory Department of Health and Public Health Unit. The team should not be part of day to day facility management, and should meet within hours of the identification of a case. It considers the progress of the response, undertakes ongoing monitoring, deals with unexpected issues, and initiates changes, as required. When an OMT is formed, it is important to meet regularly, usually daily, at the height of the outbreak to monitor the outbreak, initiate changes to response measures and to discuss outbreak management roles and responsibilities. In reality, a small number of staff will perform multiple roles in an OMT.

For detailed information on forming and implementing an OMT, refer to Appendix 9.

Testing During an Outbreak

Once an outbreak is declared, the public health unit will assist in coordinating testing in the facility. If an index case of COVID-19 acquired their infection in the facility, there are likely to be other cases in the facility.

The public health unit will assist the RCF OMT to:

- test all members of the facility, including staff
- isolate positive cases, which may involve cohorting
- quarantine members of the community who test negative to prevent transmission
- screen individuals who test negative for symptoms and, where feasible, implement a program of repeat tests (e.g. 72 hourly)[8]
    - Repeat testing will identify those who are pre-symptomatic to enable rapid removal from the environment
- Staff should also be regularly screened for symptoms.

The PHU will help identify when cases can be released from isolation, according to the requirements outlined in the CDNA National Guideline.

Implementing Infection Prevention and Control Measures

RCF should adhere to the IPC guideline published by the Infection Control Expert Group (ICEG IPC guideline), available on the Department website - *COVID-19 Infection Prevention and Control in Residential Care Facilities*. The below provides a brief overview of the requirements.

Isolation and Cohorting

RCF should refer to the ICEG IPC guidelines for detailed information on the placement of residents within the RCF. A resident with relevant symptoms be placed in a single room with their own ensuite facilities, if possible, while a diagnosis is sought. Where possible, residents requiring droplet precautions should be restricted to their room. Residents may attend urgent medical or procedural appointments but should wear a mask, if tolerated.

Once resident isolation or cohorting measures are in place, to further reduce the risk of transmission, it is preferable to allocate specific RCF staff to the care of residents in isolation (i.e. staff cohorting). The RCF should ensure there are sufficient RNs at the facility to allow this, which may require surge staffing. A register of staff members caring for patients with COVID-19 should be maintained by the RCF. The RCF must ensure that staff members:

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

[8] See Section 11, Outbreak investigation and management in high-risk settings, in the CDNA National Guideline for additional information about repeat testing in the context of an outbreak.

- do not work in other facilities even if asymptomatic, until the outbreak is declared over.

Standard Precautions

Standard precautions are a group of infection prevention practices always used in healthcare settings, and must be used in RCF with a suspected or confirmed COVID-19 outbreak. Standard precautions include performing hand hygiene before and after every episode of resident contact (5 moments), the use of PPE (including gloves, gown, appropriate mask and eye protection) depending on the anticipated exposure, good respiratory hygiene and regular cleaning of the environment and equipment (see Figure 1 for more information).

Figure 1. Standard Precautions

Standard precautions consist of:

- hand hygiene, as consistent with the 5 moments for hand hygiene
- the use of appropriate personal protective equipment
- respiratory hygiene and cough etiquette
- the safe use and disposal of sharps
- regular cleaning of the environment and equipment
- reprocessing of reusable medical equipment and instruments
- aseptic technique
- waste management
- appropriate handling of linen.

Standard precautions should be used in the handling of: blood (including dried blood), all other body substances, secretions and excretions (excluding sweat), regardless of whether they contain visible blood; non-intact skin; and mucous membranes.

Source: adapted from *Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).*

Hand Hygiene

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

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

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

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

Personal Protective Equipment (PPE)

Staff must wear appropriate PPE when caring for infected residents requiring contact and droplet or airborne precautions. PPE requirements for care of patients with suspected, probable or confirmed COVID-19 are outlined in the guidelines from the ICEG, available on the Department of Health website.

RCF staff must be trained and deemed competent in the proper use of PPE, including donning and doffing procedures. Refresher training is recommended for all existing staff, including non-clinical support staff, and as required for new staff. PPE should be removed in a manner that prevents contamination of the HCW's clothing, hands and the environment. PPE should be immediately discarded into appropriate waste bins. Hand hygiene should always be performed before putting on PPE and immediately after removal of PPE, as well whilst wearing PPE. Useful educational and promotional material for the proper use of PPE can be found at Appendix 11.

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

Respiratory Etiquette

Respiratory etiquette relates to precautions taken to reduce the spread of virus via droplets produced during coughing and sneezing. Residents, staff and visitors should be encouraged to practice good respiratory etiquette, which includes coughing or sneezing into the elbow or a tissue, and disposing of the tissue then cleansing the hands. Useful educational and promotional material can be found at Appendix 12. Specific advice should be given to any resident with ARI as a reminder.

Transmission-based Precautions

Transmission based precautions are infection control precautions used in **addition** to standard precautions to prevent the spread of COVID-19. COVID-19 is most commonly

spread by contact and droplets. Less commonly, airborne spread may occur e.g. during aerosol generating procedures[9] or care of severely ill patients.

Contact and Droplet precautions are the additional infection control precautions required when caring for residents with suspected or confirmed COVID-19. **Contact and Airborne** precautions, including the use of P2/N95 mask which has been fit-checked, are required when conducting aerosol generating procedures.[10]

For further information about transmission-based precautions when caring for residents with suspected or confirmed COVID-19, see the guidelines on COVID-19 Infection Prevention and Control for Residential Care Facilities developed by the ICEG, available on the Department of Health website.

Environmental Cleaning and Disinfection

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

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

Detailed information on environmental cleaning and disinfection is available in the Commonwealth Department of Health factsheet – COVID-19 *Environmental cleaning and disinfection principles for Health and Residential Care Facilities*.

The following principles should be adhered to:

- Well resident's rooms and communal areas should be cleaned daily.
- Frequently touched surfaces should be cleaned more frequently. These include:
  - bedrails, bedside tables, light switches, remote controllers, commodes, doorknobs, sinks, surfaces and equipment close to the resident.
  - Walking frames, sticks
  - Handrails and table tops in facility communal areas, and nurses station counter tops
- Rooms of ill residents should be cleaned AND disinfected. This includes cleaning AND disinfecting:
  - frequently touched surfaces at least daily
  - equipment after each use
  - surfaces that have been in direct contact with, or exposed to, respiratory droplets

[9] Aerosol-generating procedures are outlined in the CDNA National Guideline and include manual ventilation before intubation, tracheal intubation, non-invasive ventilation, tracheostomy suctioning, cardiopulmonary resuscitation, bronchoscopy and high flow nasal oxygen.

- Rooms should undergo a 'terminal clean' when an ill resident is moved or discharged
- Cleaners should:
  - Wear appropriate PPE, including impermeable disposable gloves and a surgical mask plus eye protection or a face shield while cleaning. If there is visible contamination with respiratory secretions or other body fluid, the cleaners should wear a full length disposable gown
  - adhere to the cleaning product manufacturer's recommended dilution instructions and contact time
  - use a Therapeutic Goods Administration (TGA) listed disinfectant with virucidal claims (kills viruses). A chlorine-based product such as sodium hypochlorite is suitable for disinfection. The manufacturer's instructions for dilution should be followed.

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

Signage

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

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

Visitors and Communal Activities

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

Facilities should implement the following:

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

  - wear PPE as directed by staff
  - enter and leave the facility directly without spending time in communal areas
  - perform hand hygiene before entering and after leaving the resident's room and the RCF
  - the register should include the visitor being checked for symptoms on arrival
- Cease using nebulisers and use spacers as an alternative wherever possible.

The ICEG Guidelines on COVID-19 Infection Prevention and Control for Residential Care Facilities, provide detailed information on IPC precautions relating to visitors to RCF.

Management of Staff

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

During a confirmed COVID-19 outbreak staff should attend work only if they are asymptomatic. All staff members should self-monitor for signs and symptoms of COVID-19 and self-exclude if unwell, even if appropriate PPE has been used. Refer to section 5 for further guidance regarding the management of staff members with suspected or confirmed COVID-19. Facility staff, including casual and agency staff, should not work at another facility, until the outbreak is declared as over. All staff working on site should participate in any whole-of-facility testing and be regularly screened for symptoms (and tested, if necessary) during an outbreak. A register should be maintained for all staff with staff checked for symptoms (including fever) at the beginning of every shift.

Admissions and Transfers

The ICEG guidelines on COVID-19 Infection Prevention and Control for Residential Care Facilities provide detailed information on the management of admissions and transfers during an outbreak.

New admissions

Admissions of new residents into the facility should be restricted. Depending upon the extent of the outbreak and the physical layout of the building, restrictions may be applied to one floor, a wing or the entire facility. Where new admissions are unavoidable, new residents and their families must be informed about the current outbreak and adequate outbreak control measures must be in place for these new residents. Families may wish to make alternative arrangements until the outbreak is over.

Re-admissions of confirmed cases

The re-admission of residents who met the case definition and have been hospitalised for their illness is permitted, provided appropriate accommodation and infection prevention and control requirements can be met. Residents who have been transferred to hospital, for any reason, should be readmitted to the facility as soon as they are well enough to be discharged from hospital.

Re-admission of non-cases

If there is a current COVID-19 outbreak in the facility, residents who have been in hospital who are not suspected or confirmed cases of COVID-19, should re-admitted to the facility, as soon as they are well-enough for discharge, provided the facility has implemented adequate outbreak control measures and residents who are not affected can be accommodated safely. If non-cases are re-admitted, the resident and their family must be informed about the current outbreak. Families may wish to make alternative arrangements (e.g. family care) until the outbreak is over.

Transfers

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

Unaffected residents

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

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

Monitoring Outbreak Progress

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

Testing (including repeat testing) and ongoing actions for individuals in the defined setting should be undertaken in line with the CDNA National Guideline. This includes:

- isolating and treating individuals who test positive
- quarantining, as best as possible, and monitoring for symptoms, those individuals who test negative
- where feasible, commencing a program of repeat testing for those in quarantine.[11]

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

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

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

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

Specialised advice is available from the following sources:

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

Declaring the Outbreak Over

The time from the onset of symptoms of the last case until the outbreak is declared over can vary. Repeat PCR testing of the quarantined cohort allows for close observation of the outbreak and clarity regarding when it can be declared over. In most circumstances, A COVID-19 outbreak can be declared over if no new cases occur within 14 days (maximum incubation period) following the date of isolation of the last case. A decision to declare the outbreak over should be made by the OMT, in consultation with the PHU, who may recommend a longer period prior to declaring the outbreak over. Once the outbreak is over, it should be ensured that cluster reports are provided to relevant stakeholders and that data is summarised appropriately.

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

- To maintain general infection control measures.
- To monitor the status of ill residents, communicating with the public health authority if their status changes.

[11] Repeat testing should be undertaken in line with the CDNA National Guideline

- To notify any late, COVID-19-related deaths to the PHU.
- To alert the PHU to any new cases, signalling either re-introduction of infection or previously undetected ongoing transmission.
- To advise relevant state/territory/national agencies of the outbreak in a RCF, if applicable.

Reviewing Outbreak Management

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

Audits are commonly used in clinical medical and nursing practice as part of continuous quality improvement, and may be an appropriate method by which to review the management of the outbreak. Australian public health practitioners and researchers have developed an outbreak audit process, with a framework for deciding which outbreak investigations to audit, an approach for conducting a successful audit, and a template for trigger questions. This tool enables agencies such as RCF to assess their outbreak response against best practice and is available at https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-9-472

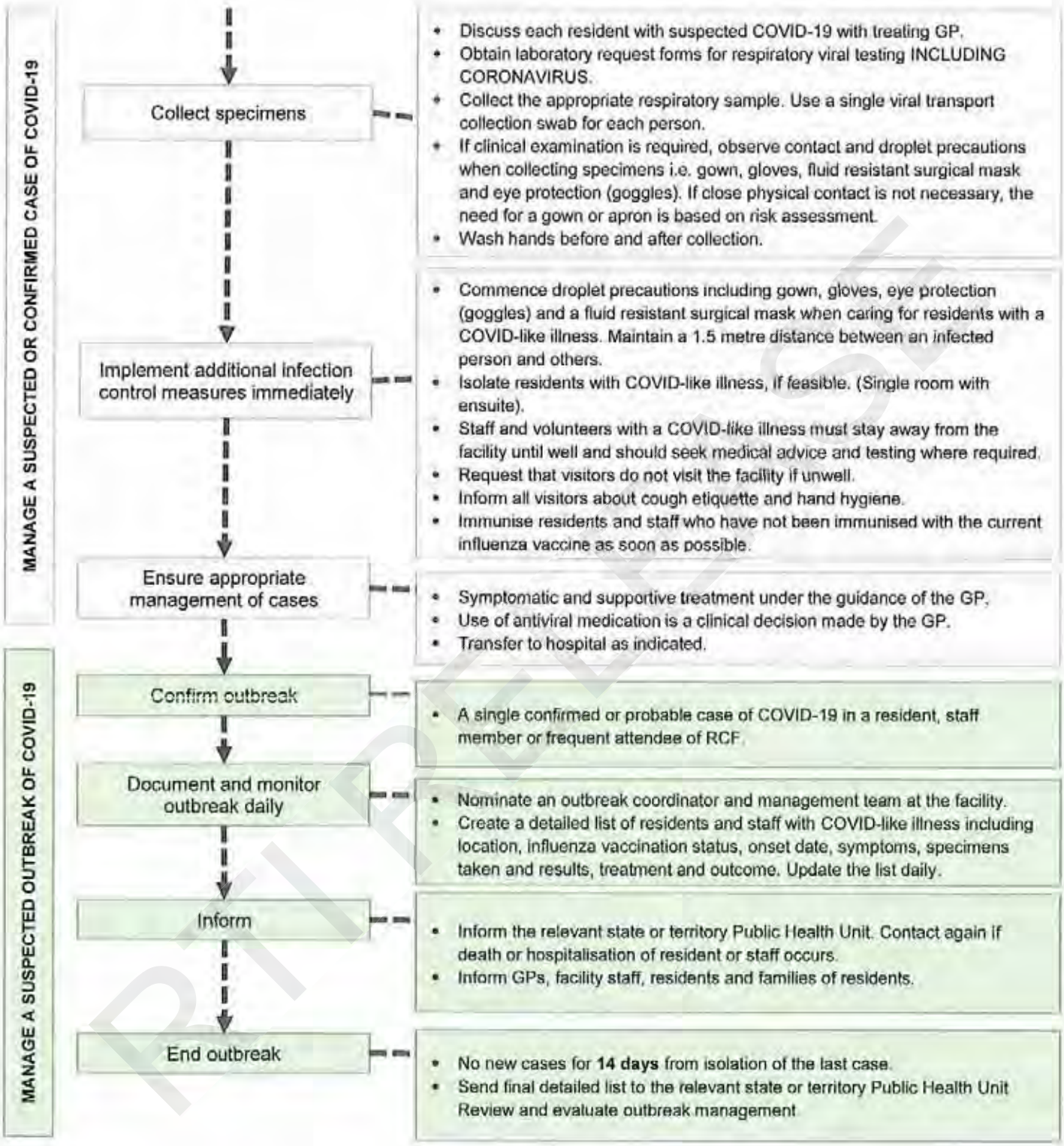
Appendix 1. Flow Chart for COVID-19 Management in RCF

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

This guideline is intended for use within residential care facilities in Australia and has been adapted from Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units.
https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm
Note: the case definition may change over time

RISK ASSESSMENT FOR COVID-19

TASK	ACTION / INFORMATION
Plan for cases	• Develop a facility management plan • Ensure all staff and general practitioners (GPs) are aware of this plan.
Vaccinate all residents and staff against influenza	• Ensure all staff, residents and volunteers are aware of the importance of annual influenza vaccination and pneumococcal vaccine where appropriate. • Ensure staff are aware of mandatory requirements for vaccination, and provide free and accessible vaccination at times that cater for all shifts. • Encourage GPs to vaccinate residents against influenza and pneumococcal. • Create a list of staff and residents by influenza vaccination status; ensure it is kept updated and accessible.
Infection control preparedness	• Provide refresher infection control training to all staff that includes information about COVID-19 • Ensure personal protective equipment (PPE), hand washing facilities and alcohol based hand rubs are available near point of care. • Encourage frequent and appropriate hand hygiene at all times (5 Moments). • Ensure infection control signage is available for use. • Consider how case isolation will be managed. • Develop contingency staffing plans in event of staff illness and isolation. • Ensure stocked respiratory hygiene stations are at each visitor entrance
Assess residents for signs & symptoms of COVID-19	**1. Risk Assessment for COVID-19:** • Staff and management should keep up to date with the latest guidelines on who should be tested for COVID-19, by reviewing their state or territory Health Department website. • Staff should be aware that they are working in a high risk environment and should not attend work if they feel unwell, to protect themselves and residents. • Staff should be vigilant in monitoring for COVID-19 and should strongly encourage good hygiene for both residents and staff.
	2. Identify signs/symptoms of COVID-19: **CLINICAL CRITERIA** Fever (≥37.5°C) or history of fever OR acute respiratory infection (e.g. cough, shortness of breath, sore throat). The treating clinician may consider investigating residents with atypical signs and symptoms of COVID-19.


MANAGE A SUSPECTED OR CONFIRMED CASE OF COVID-19
Collect specimens
• Discuss each resident with suspected COVID-19 with treating GP.
• Obtain laboratory request forms for respiratory viral testing INCLUDING CORONAVIRUS.
• Collect the appropriate respiratory sample. Use a single viral transport collection swab for each person.
• If clinical examination is required, observe contact and droplet precautions when collecting specimens i.e. gown, gloves, fluid resistant surgical mask and eye protection (goggles). If close physical contact is not necessary, the need for a gown or apron is based on risk assessment.
• Wash hands before and after collection.
Implement additional infection control measures immediately
• Commence droplet precautions including gown, gloves, eye protection (goggles) and a fluid resistant surgical mask when caring for residents with a COVID-like illness. Maintain a 1.5 metre distance between an infected person and others.
• Isolate residents with COVID-like illness, if feasible. (Single room with ensuite).
• Staff and volunteers with a COVID-like illness must stay away from the facility until well and should seek medical advice and testing where required.
• Request that visitors do not visit the facility if unwell.
• Inform all visitors about cough etiquette and hand hygiene.
• Immunise residents and staff who have not been immunised with the current influenza vaccine as soon as possible.
Ensure appropriate management of cases
• Symptomatic and supportive treatment under the guidance of the GP.
• Use of antiviral medication is a clinical decision made by the GP.
• Transfer to hospital as indicated.
MANAGE A SUSPECTED OUTBREAK OF COVID-19
Confirm outbreak
• A single confirmed or probable case of COVID-19 in a resident, staff member or frequent attendee of RCF.
Document and monitor outbreak daily
• Nominate an outbreak coordinator and management team at the facility.
• Create a detailed list of residents and staff with COVID-like illness including location, influenza vaccination status, onset date, symptoms, specimens taken and results, treatment and outcome. Update the list daily.
Inform
• Inform the relevant state or territory Public Health Unit. Contact again if death or hospitalisation of resident or staff occurs.
• Inform GPs, facility staff, residents and families of residents.
End outbreak
• No new cases for **14 days** from isolation of the last case.
• Send final detailed list to the relevant state or territory Public Health Unit Review and evaluate outbreak management

Appendix 2. COVID-19 Outbreak Preparedness Checklist

Planning actions	✓
Does your RCF have a respiratory outbreak plan that covers all the areas identified below?	
Has your RCF updated its respiratory outbreak plan this year?	
Have the relevant health care providers/organisations in the community (e.g. associated GPs, infection control consultants) been involved in the planning process?	
Are all RCF staff aware of the plan including their roles and responsibilities?	
Staff, resident and family education	
Has your RCF staff undergone education and training in all aspects of outbreak identification and management, particularly competency in infection control and appropriate PPE use?	
Has your RCF run one or more staff education sessions (see section 3 for suggested content)?	
Has your RCF provided resident families with information regarding prevention of transmission?	
Staffing actions	
Does your RCF have a staffing contingency plan in case 20% to 30% of staff fall ill and are excluded for 14 days? Are you cohorting staff to limit the number of close contacts if someone becomes unwell?	
Has your RCF developed a plan for cohorting staff in an outbreak (see section 5 for detail)?	
Stock levels	
Has your RCF acquired adequate stock of PPE, hand hygiene products, nose and throat swabs and cleaning supplies?	
Outbreak recognition actions	
Does your RCF routinely *assess* residents for respiratory illness, particularly for fever or cough (with or without fever)? Do you document changes in residents behaviour or health?	
Does your RCF *support and encourage* staff to report COVID-19 symptoms during the pandemic?	
Does a process exist to notify the facility manager and the state/territory Department of Health and Human Services as soon as practicable (and within 24 hours) of when a COVID-19 case is suspected?	
Communication actions	
Does your RCF have a contact list for the state/territory health department and other relevant stake holders (e.g. facility GPs and infection control consultants)?	
Does your RCF have a plan for communicating with staff, residents, volunteers, family members and other service providers (e.g. cleaners) during an outbreak?	
Does your RCF have a plan to restrict unwell visitors entering the facility as well as limitation of well visitors during an outbreak to reduce risk of transmission both within the facility and externally (e.g. security, signage, restricted access)?	
Cleaning	
Does the plan identify who is responsible for overseeing increased frequency of cleaning, liaison with contractors or hiring extra cleaners as necessary?	

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

[Facility Letterhead]

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

Dear family member

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

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

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

Avoid spreading illnesses
Washing your hands well with liquid soap and water or using alcohol-based hand rub before and after visiting and after coughing or sneezing will help reduce the spread of disease. Cover your mouth with a tissue or your elbow (not your bare hand) when coughing or sneezing and dispose of used tissues immediately and wash your hands.

Follow any restrictions the residential care facility has put in place
Facilities will post signs at entrances and within their units to inform you if an outbreak is occurring so look out for these warning signs when entering the facility.

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

Stay away if you're unwell
If you have recently been unwell, been in contact with someone who is unwell or you have symptoms of respiratory illness (e.g. fever, cough, shortness of breath, sore throat, muscle and joint pain, or tiredness/exhaustion) please do not visit the facility until your symptoms have resolved. If you have been in contact with a confirmed case of COVID-19 you must stay away until you are released from self-isolation.

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

unwell. Avoid spending time in communal areas of the facility if possible to reduce the risk of spreading infection.

Thank you for your assistance in adhering to these steps. These measures will greatly assist residential care facilities and protect the health of your relatives in the event of a COVID-19 outbreak.

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

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

Yours sincerely,

[Name]
[Position]
[Facility/Organisation]

Appendix 4. Swab Collection Procedure

Swab Collection Procedures

Guidance on the collection of upper respiratory specimens from the Public Health Laboratory Network (PHLN) is available on the Department of Health website.

Detailed guidance on laboratory testing for SARS-CoV-2 (the virus that causes COVID-19) from the PHLN is available on the Department of Health website.

1. Before performing swab

IMPORTANT NOTES:

- Contact your laboratory provider for current local advice about swabs.
- Do not use bacterial swabs for specimen collection. If in doubt, check!
- To conserve swabs, the same swab that has been used to sample the oropharynx should be utilised for nasopharynx/deep nasal sampling.

Obtain required materials:

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

2. Performing the swabs

IMPORTANT NOTES:

- *Choose an area for the procedure where the patient can rest their head against a wall or on a high-backed chair with room for you to stand beside (not in front of) the patient.*
- *Ensure the area is well lit, with hand washing and infectious waste disposal facilities.*
- *Remember to **WASH AND DRY HANDS** before and after the procedure!*
- *Gloves, surgical mask and eye protection **MUST** be worn when collecting nose and throat swabs. The need for a gown or apron is based on risk assessment.*[12]
- *Masks should **NOT** be touched during wear and should **NOT** be worn around the neck at any time. When removed, handle the mask by the ties of the mask only.*

Preparation:

1. Perform hand hygiene.
2. Don PPE in the order of gown, surgical mask, eye protection, and gloves.
3. Explain the procedure to the patient and obtain consent.
4. Place patient standing or sitting with head tilted at 70^0, supported against a bed, chair or wall.

[12] See the *ICEG guidance on use of PPE in non-inpatient health care settings during the COVID-19 outbreak* for additional information on PPE during specimen collection.

3. After performing the swab

Labelling and storage of specimen:

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

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

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

Date/time: _____ Public Health Officer: _____

Contact details:
Person notifying outbreak: _____ Position: _____

Telephone number: _____ Email: _____

Facility details:
Name of Facility _____

Address: _____

Facility Manager / Director: _____

Telephone number: _____ Fax number: _____

Email address: _____

Description of facility: _____

Total number of residents: _____ Total number of staff: _____

Age range of residents: _____

Number of units / wings / areas in facility: _____

Floorplan provided: Yes / No

Residents:

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

RCF Staff:

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

Appendix 6. Letter to GPs – COVID-19 Outbreak

[Facility Letterhead]

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

Respiratory outbreak at [Facility Name]

Dear Doctor,

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

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

We recommend that you:

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

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

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

- Isolation of symptomatic residents
- Use of appropriate PPE when providing care to ill residents
- Exclusion of symptomatic staff from the facility
- Restriction/limitation of visitors to the facility until the outbreak has resolved
- Promotion of thorough hand washing and cough and sneeze etiquette.

Should you require further information regarding COVID-19, please refer to the Commonwealth Department of Health website:
https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert

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

Yours sincerely,
[Name]
[Position]
[Facility/Organisation]

Appendix 7. Transfer Advice Form

[Facility Letterhead]

Date: ...../...../.....

To: [Admitting Officer, Facility Name]

Please be advised that: [Resident Name]

is being transferred from a facility where there is a cluster/outbreak of **COVID-19**. At this stage the outbreak is:

☐ suspected

☐ confirmed (date of specimen collection:.....)

Please ensure that **appropriate infection control precautions** are taken upon receipt of this resident.

At the time of transfer:

☐ The resident **does not have** an acute respiratory illness

☐ The resident **has** an acute respiratory illness

☐ The resident is a **suspected case of COVID-19**

☐ The resident is **confirmed case of COVID-19**

Resident details: _____ _____
Given name Surname

Date of birth:

Name of originating facility:

Name of contact person:

Phone number:

Appendix 8. COVID-19 Outbreak Management Checklist

	✓
Identify	
Identify if your facility has an outbreak using the definition in the guideline	
Screen staff for symptoms at the start of each shift	
Implement infection control measures	
Isolate / cohort ill residents	
Implement contact and droplet precautions	
Provide PPE outside room	
Display sign outside room	
Exclude ill staff until symptom free (or if confirmed cased of COVID-19, until they meet the release from isolation criteria)	
Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility	
Display outbreak signage at entrances to facility	
Increase frequency of environmental cleaning (minimum twice daily)	
Collect respiratory specimens	
Collect appropriate respiratory specimens from ill residents or staff, or from asymptomatic residents who are quarantined if undertaking repeat testing	
If it is likely that the case acquired infection in the facility, all members of the facility should be tested initially	
Notify	
The state/territory Health Department	
Contact the GPs of ill residents for review	
Provide the outbreak letter to all residents' GP's	
Inform families and all staff of outbreak	
Restrict	
Restrict movement of staff between areas of facility (e.g. to ensure staff caring for patients who are isolated and patients who are quarantined are kept separate) and between facilities	
Avoid resident transfers if possible	
Restrict ill visitors, unless absolutely necessary	
Cancel non-essential group activities during the outbreak period	

Monitor	
Monitor outbreak progress through increased observation of residents for fever and/or acute respiratory illness and undertake repeat testing, where feasible	
Update the case list daily at the facility and provide to the public health unit daily	
Add positive and negative test results to case list	
Declare	
If a repeat testing strategy has been employed, in most circumstances the outbreak can be declared over when there are no new cases 14 days from the date of isolation of the most recent case.	
Review	
Review and evaluate outbreak management – amend outbreak management plan if needed	

Appendix 9. Forming an Outbreak Management Team

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

The OMT should initially meet within hours of the identification of a case and daily thereafter to:

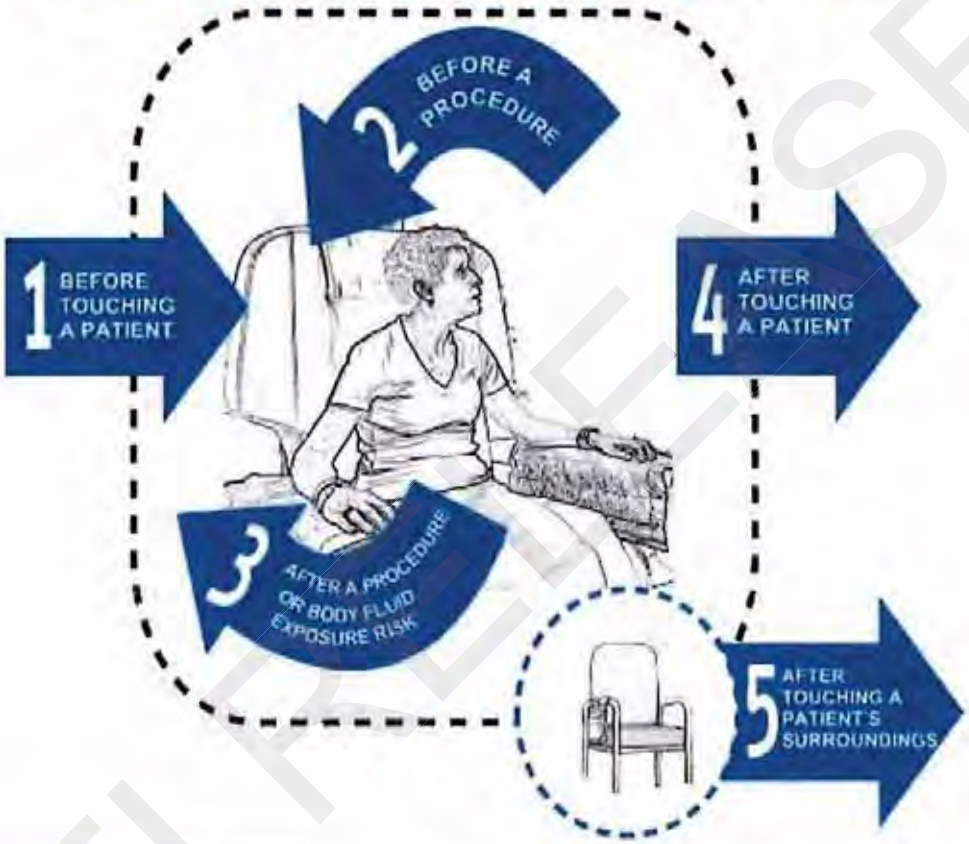
- direct and oversee the management of the outbreak
- monitor the outbreak progress and initiate changes in response, as required
- liaise with GPs and the state/territory Department of Health, as arranged.

The OMT should include the following roles and functions:

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

Appendix 10. Hand Hygiene

5 Moments for HAND HYGIENE



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

Hand Hygiene Australia
www.hha.org.au

Adapted from
World Health Organization

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a

1b

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

2

Rub hands palm to palm;

3

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

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

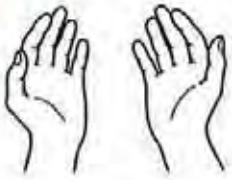
6

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

7

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

8



Once dry, your hands are safe.

World Health Organization | Patient Safety | SAVE LIVES Clean Your Hands

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

0

Wet hands with water;

1

Apply enough soap to cover all hand surfaces;

2

Rub hands palm to palm;

3

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

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

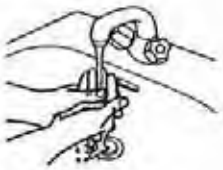
6

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

7

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

8

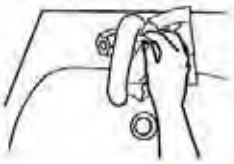


Rinse hands with water;

9

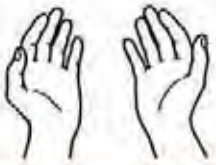
Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11



Your hands are now safe.

World Health Organization | Patient Safety | SAVE LIVES Clean Your Hands

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

Appendix 11. Proper Use of Personal Protective Equipment (PPE)

SPECIAL PRECAUTIONS FOR COVID-19 DESIGNATED ZONES

BEFORE entering the COVID-19 zone to see the FIRST PATIENT

Follow these steps

1.  Perform hand hygiene
2.  Put on a fluid-resistant long sleeved gown or apron
3.  Put on a fluid-resistant surgical mask
4.  Put on protective eyewear
5.  Perform hand hygiene
6.  Put on disposable, non-sterile gloves

When MOVING BETWEEN patients in the designated COVID-19 zone

Follow these steps

Gown and glove change is always required for a patient that has a Multi-Resistant Organism (MRO) or other infection.

1.  Dispose of gloves
2.  Perform hand hygiene
3. Check if PPE is contaminated or damaged in this order (gown, eyewear, mask)

⚠ If one or more items are contaminated or damaged go to 4

If no items are contaminated or damaged go to 6

4.  All contaminated equipment should be removed in this order (gown, eyewear, mask) with hand hygiene between steps
5.  Put on clean set of PPE (Repeat blue entry steps 1-4)
6.  Perform hand hygiene
7.  Put on disposable, non-sterile gloves

Outside of COVID-19 designated zones standard precautions apply.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Source: Special precautions for COVID-19 designated zones, Australian Commission on Safety and Quality in Health Care.

Appendix 12. Respiratory Etiquette

Cough and Sneeze Etiquette

- When coughing or sneezing, use a tissue to cover your nose and mouth
- Dispose of the tissue afterwards
- If you don't have a tissue, cough or sneeze into your elbow

- After coughing, sneezing or blowing your nose, wash your hands with soap and water
- Use an alcohol-based hand cleanser if you do not have access to soap and water

Remember:

Hand hygiene is the single most effective way to reduce the spread of germs that cause respiratory disease!

Anyone with signs and symptoms of respiratory infection:

- should be instructed to cover their nose/mouth when coughing or sneezing;
- use tissues to contain respiratory secretions;
- dispose of tissues in the nearest waste receptacle after use; and
- wash or cleanse their hands afterwards.

COVID-19.IMT

From: COVID-19.IMT
Sent: Friday, 3 April 2020 7:45 AM
To: SHECC
Subject: HPE CM: FW: Flu vaccine information and resources as discussed in CHO Teleconference 02/04/20
Attachments: coronavirus-covid-19-restrictions-on-entry-into-and-visitors-to-aged-care-facilities_1.pdf

Importance: High

Dear SHECC

Can you please forward to participants on the CHO teleconference as requested by Dr Alun Richards.

Please note the request was for the information to be forwarded yesterday.

Thank you for your help.

Kind regards
Meghan

Hi COVID and Candice,

Access to influenza vaccine was discussed at today's CHO teleconference. I have provided up to date information on what is currently occurring below. Could this be forwarded to all those participants on the CHO teleconference? Preferably today if possible as I won't be able to participate in tomorrow's teleconference due to a conflicting national teleconference.

Thanks

Alun

Dear Colleagues,

An update on the status of influenza vaccine distribution and the recent announcement about new mandatory influenza vaccination requirements for aged care facilities is detailed below.

Influenza distribution update
All Queensland immunisation providers eligible for National Immunisation Program (NIP) funded influenza vaccine have now received their first vaccine allocation.

In this initial allocation, providers received nearly 220,000 doses of *Fluad Quad®*. This vaccine is indicated for people aged 65 years and older. A second allocation of almost 370,000 doses of influenza vaccines (*Fluad Quad® Afluria Quad®* and *Fluarix Tetra®)* commenced yesterday (1 April 2020) and is anticipated to be completed by close-of-business 9 April 2020 (Easter Thursday).

From 14 April 2020, vaccine providers will be able to order the full range of NIP funded influenza vaccines via email on a weekly basis. These are to be emailed to QHIP-ADMIN@health.qld.gov.au The email only service is to maintain continuity as a result of COVID-19 so that staff can work remotely even and maintain the service in the event of individuals being sick or in quarantine.

Vaccine providers have been advised of and provided with resources to support these new arrangements which are at https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/immunisation/service-providers

Distribution of influenza vaccine for Queensland Health healthcare worker vaccination program commenced on Monday 30 March 2020 and will also be completed by mid–April.

New requirements for aged care facilities
On 18 March 2020, the Prime Minister announced a range of actions agreed by the National Cabinet, to protect the Australian community from the spread of coronavirus (COVID-19). These actions include restrictions on entry for all persons including visitors to residential aged care facilities to reduce the risk of resident spreading COVID-19.

Unless aged care workers meet the criteria for NIP funded vaccine they would usually be vaccinated using occupational supplies from the private market. That vaccine is mostly distributed as far as we are aware.

Queensland Health aged care staff and other Queensland Health staff are supplied with HHS funded vaccine for workplace programs, distribution of which is ongoing.

All states and territories have released directions under relevant state/territory legislation which set out specific requirements with regard to entry into and visitors to residential aged care facilities. The directions for Queensland are at Queensland

The Australian Government has developed some FAQs relating to influenza vaccination on the restriction on entry into and visitors to aged care facilities. These are attached.

I hope this is of assistance.

Thanks

Alun

Dr Alun Richards
Acting Executive Director
Communicable Diseases Branch

Phone: [redacted]
Address: Level 3, 15 Butterfield St, Herston QLD 4006
Email: [redacted]ealth.qld.gov.au

Australian Government
Department of Health

Coronavirus (COVID-19)

FAQs - Restrictions on entry into and visitors to aged care facilities

Influenza vaccinations

All states and territories have released directions that set out requirements with regard to entry into and visitors to residential aged care facilities. These directions give effect within each jurisdiction to the decisions made by National Cabinet that were **announced** by the Prime Minister on 18 March 2020.

The state and territory directions set out specific requirements in relation to influenza vaccinations.

The directions are published on state/territory government websites as follows:

- **New South Wales**
- **Victoria**
- **Queensland**
- **South Australia**
- **Western Australia**
- **Tasmania**
- **Australian Capital Territory**
- **Northern Territory**

What happens if staff are not able to be vaccinated due to cultural, religious or health reasons?

Tasmania and New South Wales do allow some exemptions to the influenza immunisation requirements.

Residential aged care providers may otherwise need to redeploy staff that are not able to be vaccinated.

Does everyone entering a residential aged care service need to be vaccinated?

Yes. This applies to **staff, visitors, health practitioners, volunteers and others** (for example, cleaners, tradesman, gardeners, maintenance staff).

Do residential aged care providers still need to provide free influenza vaccinations to staff and volunteers?

Yes. All Australian Government subsidised residential aged care providers continue to be required to have in place an influenza vaccination program offering staff and volunteers free access to annual influenza vaccinations at the provider's cost.

What are aged care providers' obligations regarding persons entering the service?

Under the state and territory directions, 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 set out in the relevant state and territory directions.

How will aged care providers know whether persons seeking to enter a service on an ad hoc basis (eg tradesmen) have been vaccinated?

Approved 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.

Will aged care providers need to substantiate that a visitor has been vaccinated and keep records?

Approved 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. Approved providers may also consider maintaining records to support effective administration and to substantiate their compliance with this requirement.

How will compliance with these requirements be assessed?

State and territory law enforcement agencies will enforce these directions. Persons who fail to comply with any of the directions could face penalties including fines for individuals and for bodies corporate.

Will residents still have the right to refuse vaccination?

While vaccination for all residents is important to protect themselves and others against influenza, residents have the right to refuse vaccinations.

Who can administer an influenza vaccination?

Influenza vaccinations prescribed by an authorised prescriber can be administered by the prescriber or a number of other health professionals including nurses, doctors or Aboriginal health professionals.

In some circumstances flu vaccinations can also be administered by pharmacists where they have undertaken the appropriate education and training and are authorised to do so. All health professionals are required to practice in accordance with state/territory legislation and relevant policy.

COVID-19.IMT

From: Scott Brown
Sent: Tuesday, 14 April 2020 6:08 PM
To: Heidi Grodecki
Cc: Alun Richards; Bronwyn Nardi; COVID-19.IMT
Subject: HPE CM: FW: FOR URGENT APPROVAL: [CHO] - [Standard Lines]: Flu Vaccine mandate emails - Due 14 April 2020

Categories: Compliance Ops

Hi Heidi,

Please find below the email trail from Bron Nardi to us re this matter.

We seek an amendment to clarify the 'strategic intent' of the Age Care Directive. We suggest the following wording for section 2(d): *the person does not have a 2020 seasonal influenza vaccine by 1 May 2020, if such a vaccine is available to the person; or*

The reasons are:

1. It provides clarity that a person needs to be vaccinated with the latest/current influenza vaccine and not the 2019 vaccine. It is important to note that the 2019 vaccine was available for the first two months of this year, but is no longer available and is not recognised as appropriate protection for the 2020 influenza season.
2. Influenza vaccine was not available on 18 March. Distribution of this year's vaccine commenced on 23 March and is ongoing.
3. It is understood that the strategic intent was that these requirements would be implemented from 1 May, which is consistent with the PM's announcement.
4. This change would align Queensland with the national position on this matter.

It would be appreciated if this could be urgently progressed with LPU.

Regards, Scott.

Scott Brown
A/Manager

Phone: [redacted]
Address: Level 3/15 Butterfield Street, Herston, QLD 4006
Email: Scott.Brown@health.qld.gov.au

Queensland Health
Immunisation Program, Communicable Diseases Branch

www.health.qld.gov.au

Queensland Government

From: Alun Richards <Alun.Richards@health.qld.gov.au>
Sent: Tuesday, 14 April 2020 5:56 PM
To: Scott Brown <Scott.Brown@health.qld.gov.au>
Subject: Fwd: FOR URGENT APPROVAL: [CHO] - [Standard Lines]: Flu Vaccine mandate emails - Due 14 April 2020

Get Outlook for iOS

From: Bronwyn Nardi <Bronwyn.Nardi@health.qld.gov.au>
Sent: Tuesday, April 14, 2020 5:28:30 PM
To: CHO CHO <CHO_CHO@health.qld.gov.au>; Alun Richards <Alun.Richards@health.qld.gov.au>
Subject: RE: FOR URGENT APPROVAL: [CHO] - [Standard Lines]: Flu Vaccine mandate emails - Due 14 April 2020

I was under the impression that the CHO intended for the flu vaccination aspect to apply from 1 May 2020, the reason being that the vaccine had not been distributed on 18 March and just now is in limited supply.
RACF are seeking people bring in their vaccination receipt from last year which is clearly not appropriate.
Could you have another look and perhaps check with JY. I think the current directive is unachievable until there is sufficient vaccine in the community for folk to comply with the directive.
bron

From: CHO CHO <CHO_CHO@health.qld.gov.au>
Sent: Tuesday, 14 April 2020 5:20 PM
To: Bronwyn Nardi <Bronwyn.Nardi@health.qld.gov.au>
Cc: CHO CHO <CHO_CHO@health.qld.gov.au>
Subject: FOR URGENT APPROVAL: [CHO] - [Standard Lines]: Flu Vaccine mandate emails - Due 14 April 2020

Good afternoon Bron,

Points below cleared by Dr Richards. This was also reviewed by the Public Health Incident Management Team (COVID-19). For your approval. Thanks.

Proposed standard response:

- On 18 March 2020, the Prime Minister announced a range of actions agreed by the National Cabinet, to protect the Australian community from the spread of coronavirus (COVID-19). These actions include restrictions on entry for all persons including visitors to residential aged care facilities to reduce the risk of resident spreading COVID-19.
- The Australian Government has developed some FAQs (attached) relating to influenza vaccination on the restriction on entry into and visitors to aged care facilities, which provide additional information on this requirement.
- All states and territories have released directions under relevant state/territory legislation which set out specific requirements with regard to entry into and visitors to residential aged care facilities.
- The public health direction issued by Queensland's Chief Health Officer on 21 March 2020 states that a current influenza vaccination is required for all persons working in or visiting a residential aged care facility in Queensland. The directions for Queensland in their entirety are here: Queensland.
- All persons either working in or attending a residential aged care facility from 21 March 2020 must have a current influenza vaccination, if the vaccination is available.

- Under the Aged Care Direction, a person must not enter a residential aged care facility in the State of Queensland from the time of publication until the end of the declared public health emergency, if the person does not have an up to date vaccination against influenza, if such a vaccination is available to them.
- The Queensland Government strongly supports this requirement and encourages annual influenza vaccination to prevent both the infection and the spread of influenza in the community.
- Vaccination is particularly important for elderly people as they are at high risk of complications from influenza and have the highest influenza-associated death rates each year.
- This year, influenza vaccination is even more important. It is important to reduce the influenza burden on our health care system while it responds to COVID-19 and while influenza vaccine does not offer protection against COVID-19, it can reduce the potential for more severe health outcomes if an individual becomes infected with both influenza and COVID-19.
- On 6 April 2020, the Australian Health Protection Principal Committee (AHPPC) of the Australian Health Ministers Advisory Committee (AHMAC) published a statement about COVID-19 in children and early childhood and learning centres (ECLC). The statement advises that ECLC should remain open during the COVID-19 pandemic as they are considered essential services.
- The statement recommends influenza vaccination for children, staff and parents attending these services. The statement does not mandate influenza vaccination for these services.
- That is, influenza vaccination for children, staff or parents attending ECEC is strongly recommended, but not mandatory.

Kind regards,
YJ

Prevention Division Correspondence Team
Madison Crofts – A/Briefings Officer – 3708 5194
YJ (Ying Juin) Yip – Correspondence Officer – 3708 5193
Jacqui Collard – Correspondence Officer (Tue, Wed & Thur) – 3708 5195
Tracey Dean – Correspondence Officer – 3708 5196

Address: Level 2, 33 Charlotte Street, Brisbane, QLD 4000
Email: cho_cho@health.qld.gov.au

Queensland Health
Office of the Chief Health Officer and Deputy Director-General, Prevention Division

www.health.qld.gov.au

Queensland Health
Office of the Chief Health Officer and Deputy Director-General, Prevention Division

www.health.qld.gov.au

Queensland Government

Queensland's Health Vision: By 2026 Queenslanders will be among the healthiest people in the world.

Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future

From: Cdu Cdu <CDU@health.qld.gov.au>
Sent: Tuesday, 14 April 2020 5:18 PM
To: CHO CHO <CHO_CHO@health.qld.gov.au>
Subject: CDB Response - DUE 3pm 14/04: [CHO] - [Standard Lines]: Flu Vaccine mandate emails - Due 14 April 2020

Hi CHOCHO

See points below cleared by Dr Richards. This was also reviewed by the Public Health Incident Management Team (COVID-19).

Proposed standard response:

- On 18 March 2020, the Prime Minister announced a range of actions agreed by the National Cabinet, to protect the Australian community from the spread of coronavirus (COVID-19). These actions include restrictions on entry for all persons including visitors to residential aged care facilities to reduce the risk of resident spreading COVID-19.
- The Australian Government has developed some FAQs (attached) relating to influenza vaccination on the restriction on entry into and visitors to aged care facilities, which provide additional information on this requirement.
- All states and territories have released directions under relevant state/territory legislation which set out specific requirements with regard to entry into and visitors to residential aged care facilities.
- The public health direction issued by Queensland's Chief Health Officer on 21 March 2020 states that a current influenza vaccination is required for all persons working in or visiting a residential aged care facility in Queensland. The directions for Queensland in their entirety are here: Queensland.
- All persons either working in or attending a residential aged care facility from 21 March 2020 must have a current influenza vaccination, if the vaccination is available.
- Under the Aged Care Direction, a person must not enter a residential aged care facility in the State of Queensland from the time of publication until the end of the declared public health emergency, if the person does not have an up to date vaccination against influenza, if such a vaccination is available to them.
- The Queensland Government strongly supports this requirement and encourages annual influenza vaccination to prevent both the infection and the spread of influenza in the community.
- Vaccination is particularly important for elderly people as they are at high risk of complications from influenza and have the highest influenza-associated death rates each year.
- This year, influenza vaccination is even more important. It is important to reduce the influenza burden on our health care system while it responds to COVID-19 and while influenza vaccine does not offer protection against COVID-19, it can reduce the potential for more severe health outcomes if an individual becomes infected with both influenza and COVID-19.
- On 6 April 2020, the Australian Health Protection Principal Committee (AHPPC) of the Australian Health Ministers Advisory Committee (AHMAC) published a statement about COVID-19 in children and early childhood and learning centres (ECLC). The statement advises that ECLC should remain open during the COVID-19 pandemic as they are considered essential services.
- The statement recommends influenza vaccination for children, staff and parents attending these services. The statement does not mandate influenza vaccination for these services.
- That is, influenza vaccination for children, staff or parents attending ECEC is strongly recommended, but not mandatory.

Thanks
Soph

From: CHO CHO <CHO_CHO@health.qld.gov.au>
Sent: Thursday, 9 April 2020 11:35 AM
To: Cdu Cdu <CDU@health.qld.gov.au>
Subject: DUE 3pm 14/04: [CHO] - [Standard Lines]: Flu Vaccine mandate emails - Due 14 April 2020

Good morning,

Please see email below for your action. Action taken/ Response due by 3pm 14/04. Thanks.

Kind regards,
YJ

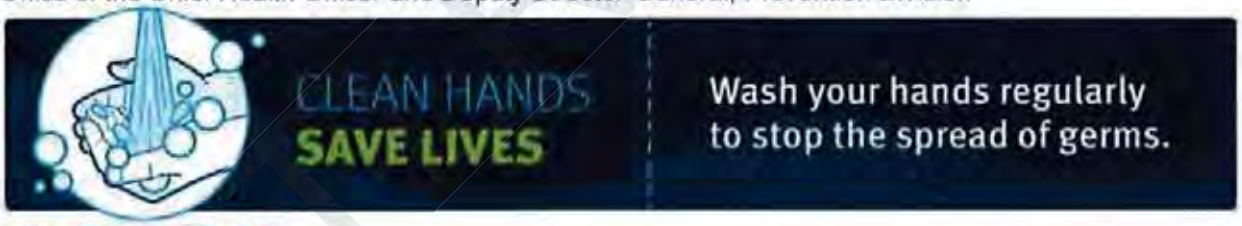
Prevention Division Correspondence Team
Madison Crofts – A/Briefings Officer – 3708 5194
YJ (Ying Juin) Yip – Correspondence Officer – 3708 5193
Jacqui Collard – Correspondence Officer (Tue, Wed & Thur) – 3708 5195
Tracey Dean – Correspondence Officer – 3708 5196

Address: Level 2, 33 Charlotte Street, Brisbane, QLD 4000
Email: cho_cho@health.qld.gov.au

Queensland Health
Office of the Chief Health Officer and Deputy Director-General, Prevention Division

www.health.qld.gov.au

Queensland Health
Office of the Chief Health Officer and Deputy Director-General, Prevention Division



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Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

From: SDLO <SDLO@health.qld.gov.au>
Sent: Thursday, 9 April 2020 10:43 AM

To: CHO CHO <CHO_CHO@health.qld.gov.au>
Cc: SHECC_Corro <SHECC_Corro@health.qld.gov.au>; DLO <DLO@health.qld.gov.au>; EXECSUPPORT <EXECSUPPORT@health.qld.gov.au>
Subject: [CHO] - [Standard Lines]: Flu Vaccine mandate emails - Due 14 April 2020

Good morning,

DLO has been receiving quite a lot of correspondence regarding the Commonwealth the Flu Vaccine Directive that starts on the 1 May 2020.
The correspondence has been addressed to the Minister of Health, Minister of Education and the Prime Minister.

While we can find information about mandated vaccination for aged care workers and visitors to aged care facilities, the correspondence is mostly in relation to mandated vaccines for child care workers, healthcare workers (in general), teachers and children. Does Immunisation Program have any knowledge of additional directives to come into place on 1 May 2020?

Additionally, in an effort to stem this correspondence from individually filtering down to the Immunisation Program, please provide dot point standard lines of reply and advice for when these would not be applicable.

Due back to SDLO by **COB Tuesday 14 April 2020**.

An example email is attached for your information and to inform the response.

Kind regards

Sarah Johnson
A/Briefing and Liaison Officer
Office of the Director-General

Phone:
Email: SDLO@health.qld.gov.au
Address: Level 37, 1 William Street, Brisbane QLD 4000

Queensland Health

www.health.qld.gov.au

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Public Health Directions –
Aged Care Direction

Title	*Aged Care Direction*
Date effective	21 March 2020

a. **nature of the right**

This Aged Care Direction (Effective on 21 March 2020) may engage the following rights:

- freedom of movement (section 19)
- peaceful assembly and freedom of association (section 22)
- protection of families (section 26)

Freedom of movement

Section 19 of the Human Rights Act provides that every person lawfully within Queensland has the right to move freely within Queensland, to enter and leave it and has the freedom to choose where to live. The right means that a person cannot be arbitrarily forced to remain in, or move to or from, a particular place. The right also includes the freedom to choose where to live, and freedom from physical and procedural barriers, like requiring permission before entering a public park or participating in a public demonstration in a public place. The right may be engaged where a public entity actively curtails a person's freedom of movement. The Direction may limit the right to freedom of movement by preventing loved ones from visiting their family at their preferred date and length of time (for example, this direction limits visits to two hours and once per day). Further, this direction does not allow a person to enter in circumstances where they:

- have returned from overseas in the last 14 days;
- had contact with a person with COVID-19 in the last 14 days
- visited a COVID-19 hotspot in the last 14 days
- have a fever (37.5 degrees or more)
- have a cough, runny nose, sore throat or breathing difficulties
- the person does not have an up to date vaccination against influenza, if such a vaccination is available to the person
- are under 16 years of age, unless you're visiting a resident to provide end of life support.

Freedom of association

Section 22 of the Human Rights Act upholds the rights of individuals to gather in order to exchange, give or receive information, to express views or conduct a protest or demonstration. The direction may limit the right to peaceful assembly as it restricts certain types of visitors from entering an aged care facility, which in turn may prevent groups gathering together for a common purpose/interest (e.g. sporting groups, clubs etc) (as outlined above).

Right to protection of families

The right to protection of families recognises that families are a fundamental unit of society and encompasses aspects of non-interference with family units and a guarantee of institutional protection of families. Internal limitations of lawfulness and arbitrariness apply to the right of the family. The direction may limit this right as it prevents family members and other personal visitors from visiting their loved ones. Specifically, the direction limits persons under 16 years of age from visiting a residential aged care facility, unless they are visiting a resident to provide end of life support.

b. **the nature of the purpose of the limitation, including whether it is consistent with a free and democratic society based on human dignity, equality and freedom**

The purpose of the Direction is to protect people who live in residential aged care facilities from novel coronavirus (COVID-19) and protect older Queenslanders. The purpose of the direction can only be

achieved by limiting the freedom of movement, right to peaceful assembly and freedom of association and the protection of families as it will prevent certain types of visitors from entering a residential aged care facility in Queensland. Containing and controlling the spread of COVID-19 provides a direct health benefit to the broader community and those most vulnerable living within aged care facilities.

Protecting the health, safety and wellbeing of people in the Queensland community, including those living in a residential aged care facility, from the risk posed by COVID-19 and its spread promotes the right to life (protected under section 16 of the Human Rights Act). The right to life places a positive obligation on the State to take steps to protect the lives of individuals e.g. from a unprecedented health emergency. This is a proper purpose consistent with a free and democratic society based on human dignity, equality and freedom.

c. **the relationship between the limitation to be imposed, and its purpose, including whether the limitation helps to achieve the purpose**

Reducing and containing the spread of COVID-19 within the community is achieved by the Direction. As COVID-19 is a communicable disease that may be easily transmitted between people and given the direct risk to the lives and health of others posed by a person who has been diagnosed with COVID-19, this purpose can only be achieved by limiting certain visitors to aged care facilities.

d. **whether there are any less restrictive (on human rights) and reasonably available ways to achieve the purpose of the Bill**

The purpose of the Direction cannot be achieved through any reasonably available and less restrictive means. COVID-19 is a communicable disease that may be easily transmitted between people. Social distancing has been proven to slow the transmission of COVID-19, particularly to vulnerable persons who may develop complications or otherwise require emergency or life-sustaining treatment. The amendments achieve the purpose by limiting certain visitors from entering residential aged care facilities.

e. **the balance between the importance of the purpose, which, if enacted, would impose a limitation on human rights and the importance of preserving the human rights, taking into account the nature and extent of the limitation**

The purpose of the Direction is to reduce the spread of COVID-19 within the community and protect the most vulnerable people within the community.

The limitation on the right to freedom of movement may be justified for the purpose of preventing the spread of COVID-19 within residential aged care facilities in Queensland. The limitation on the right of freedom of movement and freedom of association does not deny people living in residential aged care facilities or their visitors the ability to connect through other means of communication, for example, via telephone calls, emails, letters and video-conferencing.

The limitation on protection of families is justified as the direction is reasonably necessary for the protection of public health, including to deal with a serious threat to the health of the population or to prevent widespread disease within the community. This limitation is temporary and would not restrict other means of communication and engagement among family members. For example, family members can contact loved ones via phone calls, video conferencing, emails or letters. Ultimately, any limitation on the right to protection of families would be lawful and not arbitrary, as the action taken are necessary to prevent the spread of COVID-19.

Overall, the limitations on human rights are reasonable and demonstrably justifiable, as the Direction is only in force for a temporary period and will help contain the spread of COVID-19, thereby protecting the health and safety of the community. The health benefits to the broader community

by implementing the Direction outweighs any potential limitation on the person's right to freedom of movement, freedom of association and protection of families.

f. **Any other relevant factors**

Not applicable.

Public Health Directions –
Aged Care Direction

Title	*Aged Care Direction (No.2)*
Date effective	17 April 2020

The Aged Care Direction (No. 2) (Direction) amends the Aged Care Direction (now superseded). The Direction makes changes to:

- clarify persons entering the residential aged care facility must have an influenza vaccination from 1 May 2020;
- include an example that medical contra-indication to the flu vaccine is an example of a vaccination not being 'available to a person';
- provide a limited exemption from the vaccination requirement if a person is required to provide an emergency service (e.g. plumber required to fix a pipe); and
- clarify entry is permitted if a person's presence is required to exercise a power or function of a government agency under a law. This is the result of correspondence from the Aged Care Quality and Safety Commission.

These changes do not raise any further human rights implications, refer to Aged Care Direction (effective on 21 March 2020) for a full human rights assessment.

Public Health Directions –
Aged Care Direction

Title	*Aged Care Direction (No.3)*
Date effective	08 May 2020

The Aged Care Direction (No. 3) (Direction) amends the Aged Care Direction (No. 2). The Direction makes an amendment to clarify that the emergency service exception does not apply to health workers and they are required to have a flu vaccination to enter or remain on the premises of a residential aged care facility.
This change does not raise any further human rights implications, refer to Aged Care Direction (effective on 21 March 2020) for a full human rights assessment.

Public Health Directions –
Aged Care Direction

Title	*Aged Care Direction (No.4)*
Date effective	21 May 2020

The Aged Care Direction (No. 4) (Direction) amends the Aged Care Direction (No. 3). The Direction makes amendments to:

- allow a resident to leave a Registered Aged Care Facility (RACF) to attend a funeral;
- provide that the Chief Health Officer may grant a compassionate exemption to allow a resident to leave a RACF;
- allow a prospective resident's support person to enter a RACF; and
- reflect the extension to the public health emergency declaration to 17 August 2020.

These changes do not raise any further human rights implications, refer to *Aged Care Direction* (effective on 21 March 2020) for a full human rights assessment.