Acute Respiratory Infection

Exposure and Outbreak Management Plan

Version 10 8/4/23

Services must take all possible steps to prepare for and manage a COVID-19 outbreak. RACFs should be prepared to manage a COVID-19 outbreak independently as much as possible.

PLEASE REVIEW THE "IMPORTANT INFORMATION SECTION" OF THIS PLAN WITH ALL STAFF AS EDUCATIONAL TOOLS IN PREPARATION FOR OUTBREAK AND WHEN ACTIVATING THIS PLAN

THE ACUTE RESPIRATORY INFECTION PREPAREDNESS PLANNING CHECKLIST (APPENDIX 1) SHOULD BE REVIEWED MONTHLY TO SUPPORT EFFECTIVE OUTCOMES FROM THE EXPOSURE/OUTBREAK MANAGEMENT RESPONSE.

Your Outbreak Management Plan should be up to date and well-rehearsed for immediate activation.

The information within does not replace advice from other relevant sources including more detailed guidance from state jurisdictions, Public Health Unit and/or advice from a health professional.

Early Identification of Symptoms

Acute Respiratory Infections (ARI) include but not limited to, COVID-19, influenza, and respiratory syncytial virus (RSV).

Many ARI can be spread before symptoms appear in an infected person, therefore early identification of cases and early institution of infection control procedures, testing and treatment are essential to contain spread and minimise the chance of serious illness or death.

ARI definition = Recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion with or without other symptoms (see box below).

Other symptoms:
Headache, muscle aches (myalgia), fatigue, nausea or vomiting and diarrhoea, loss of smell and taste and loss of appetite can also occur with COVID-19.

Fever (≥37.5°C) can occur, however is less common in elderly individuals.

In the elderly, other symptoms to consider are new onset or increase in confusion, change in baseline behaviour, falling, or exacerbation of underlying chronic illness (e.g., increasing shortness of breath in someone with congestive heart failure).

Services should ensure staff, family and residents are aware of these symptoms and the need to report them when observed. Note that cases may experience mild symptoms, particularly in a vaccinated population. Have signs around the facility to remind people about COVID-19 safe behaviours. Signs are available on the intranet COVID-19 tile.

Anti-viral treatments are available for COVID-19 and influenza and therefore early recognition, testing and diagnosis are important for individual resident management as well as for preventing spread to others.

Reference: Outbreaks of Acute Respiratory Infection in Residential Care Facilities Communicable Diseases Network Australia

EXPOSURE AND OUTBREAK MANAGEMENT PLAN

Exposure

It is called a COVID-19 Exposure when someone with COVID-19 was infectious at the facility, but when the outbreak criteria is not met.

Outbreak

An Outbreak exists if there are Two or more residents diagnosed with COVID-19 or Influenza via RAT or PCR test within 72hrs (3 days) of each other, and who have been onsite at the RACF at any time during their infectious period.

The first 24 hours in managing an ARI case (EXPOSURE) in a residential aged care facility (RACF) is critical. The following key steps must be immediately undertaken when first case exposure is identified:

1. Identify Exposure
2. Isolate Case
3. Support the residents care needs
4. Stand up an Outbreak Control Team
5. Identify, test and implement infection restrictions for close contacts
6. Staff and Visitor Management
7. Communicate
8. Enhance Environmental Hygiene
9. Stock Check
10. Report
11. Maintain enhanced monitoring for any new case presentation

This plan also supports management of any further confirmed COVID 19 cases (OUTBREAK) in a RACF including Key Practice Points and Links for Further Information:

1. Report
2. Testing
3. Restriction Management
4. Convene Daily Meetings
5. Workforce Management
6. Ongoing Clinical Care
7. Communicate
8. Declare Outbreak Over and Debrief

EXPOSURE MANAGEMENT

EXPOSURE RESPONSE			Service Specific Requirements/Delegation	Date Completed
First 30min-2hrs				
1. IDENTIFY EXPOSURE	If there is any **symptomatic or confirmed ARI case** in a staff member, resident, or visitor at the facility during their infectious period immediately escalate to the RACF Service Manager, and enact this Exposure Management Plan			
2. ISOLATE CASE	Immediately isolate the Symptomatic/ARI case(s)			
	VISITOR	• If onsite, apply a surgical mask (if not already in place) • Leave the premises and follow Government recommendations for visiting high risk settings. • Check when the visitor was previously on-site and where relevant, what areas were accessed during their infectious period.		
	STAFF	• If onsite, apply a surgical mask (if not already in place), leave the premises and follow Organisational recommendations for working in high risk settings.		
	RESIDENT	• Inform the resident of isolation requirements, testing requirement or positive result with sensitivity. • Where possible guide the resident to isolate in a single room with an unshared bathroom and minimise interaction with others. Where isolation is not achievable (memory support or shared rooms) support separation by curtains and physical distancing where possible, identify high risk contacts and zone these areas accordingly. • Staff to apply appropriate increased level of personal protective equipment (PPE) – N95/PFR, eye protection, gown and gloves. • Donning and Doffing areas to be designated. • Where possible, encourage isolating residents to wear surgical mask particularly when staff members or essential visitors are in their room.		

EXPOSURE MANAGEMENT

<table>
<tr><th colspan="3">EXPOSURE RESPONSE</th><th>Service Specific Requirements/Delegation</th><th>Date Completed</th></tr>
<tr><td rowspan="2">3. SUPPORT RESIDENT CARE NEEDS</td><td>SYMPTOMATIC CASE</td><td>Discuss clinical management and treatment options with appropriate in-reach services, GPs, as required. All symptomatic resident must be clinically reviewed throughout every shift and documented in notes and assessments.
<u>TESTING</u>
Initial symptomatic residents should be tested by both RAT and PCR.
Respiratory virus PCR should include Influenza A, B and COVID-19 and other respiratory pathogens. Ensure all symptomatic residents remain isolated until initial testing is complete, and pathogen is known.</td><td></td><td></td></tr>
<tr><td>POSITIVE CASE</td><td>Clinical staff should perform a clinical assessment and refer to the COVID-19 Care Pathway or Acute Respiratory Illness Pathway. Further ensure there is strong ongoing clinical governance of routine care and there is access to GP to support treatment.
Clinical staff should familiarise themselves with any COVID-19 positive residents’ advance care directives, and make sure clinical decisions consider these plans and involve residents, families and representatives.
<u>ANTIVIRAL TREATMENT OPTIONS</u>
Notify the resident’s GP for discussion of treatment options. Perform clinical assessment to determine suitability for antiviral treatments. If appropriate, revisit conversations with residents, their families and representatives about the use of antiviral treatments.
<u>CONFIRM RESIDENTS VACCINATION STATUS</u>
Confirm resident’s vaccination status and health history to support assessment of level of risk and discussion with GP.
<u>UPDATE RESIDENT CARE ROUTINE</u>
Update care routines and notify relevant care stakeholders with required contingency cares. Review for example:
Use of nebuliser
Showering Routine considering Risk Assessment
Assess whether any non-essential services e.g. hairdresser requires suspension</td><td></td><td></td></tr>
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EXPOSURE MANAGEMENT

EXPOSURE RESPONSE		Service Specific Requirements/Delegation	Date Completed
Within 2hrs-4hrs			
4. STAND UP AN OUTBREAK CONTROL TEAM	Call a team meeting with key personnel identified in your OMP including Senior Management, IPC Lead, Laundry Kitchen Hospitality Supervisors, Allied Health, Maintenance Team where relevant to implement their roles and to coordinate on-site leadership at all times. Documents minutes including allocated tasks and actions taken on this plan.		
5. **IDENTIFY, TEST and IMPLEMENT INFECTION RESTRICTIONS FOR CLOSE CONTACTS**	Determine if any staff or residents have been exposed to the case and develop an agreed management plan based on the degree of assessed risk. Rapid Antigen Test close contact residents at baseline, then day 2 and day 6. If there are no further cases there is no need for more testing. However, remain alert for residents with new symptoms and test promptly. Confirm vaccination status/recency of infection of all residents to assess who is at greatest risk. Further, consult with a General Practitioner (GP) or Nurse Practitioner (NP) regarding clinical review and respiratory virus testing (PCR) of all residents who are close contacts. The identified area or wing in which close contacts are identified should be declared a Red Zone or Amber Zone based on level of assessed risk (See Close Contact and Zoning Information to help guide actions taken). Consult with residents and their representatives regarding the exposure, cohorting requirements, any visitor restrictions or additional PPE, testing requirement and symptom monitoring with sensitivity. Residential Exposure Q&A template is available on the COVID Tile to support this conversation if required. Nominated representatives may also be able to assist with heightened awareness of symptom monitoring. **Identify any high-risk exposure (close contacts) among Staff** Rapid Antigen Test close contact staff at baseline. If possible, staff who are close contacts should not come to work until day 7 after exposure. Before asking a close contact to come to work, managers should do everything they can to delay work or use other staff. If the absence has a large impact on services they can return to work following the Close Contact Risk Assessment Process to support associated actions required.		

EXPOSURE MANAGEMENT

EXPOSURE RESPONSE		Service Specific Requirements/Delegation	Date Completed
6. STAFF AND VISITOR MANAGEMENT	**Staff Cohorting** Nominate key staff to care for infected residents. Where possible cohort staff to identified zones. If this is not achievable staff who work across zones should follow the additional precautions: Staff working across zones during the same shift should wear full PPE undertaking donning and doffing in a neutral area (blue zone) between zones. Staff working subsequent shifts in a lower risk zone, should wear a P2 mask (including in green zone). Restrictions should also be placed on use of shared areas for staff working in effected areas e.g. tearooms, toilets. Avoid large group meetings and introduce short regular education sessions on IPC principles to prevent transmission. Communicate zones, PPE Requirements, donning and doffing stations, and identified spaces at each hand over using visual cues/posters available in the appendix of this plan/ COVID-19 Tile.		
	Communicate Area Status and Visitor Restrictions to families accordingly: **Residents who are symptomatic or identified cases (Isolating in room/Red Zone)** Maintain regular update on resident status. A risk-based approach should be used to facilitate, where possible, **essential visitors** to impacted residents Guidelines for Implementing the Essential Visitor Process are available on the COVID Tile. Visitors who are not essential visitors may not attend residents who are cases. This group may be permitted as visitors through contactless visits. **Residents who are identified high risk exposure** **(Amber Zone)** may continue to have visitors who are willing to comply with the RACF-required risk mitigations (such as wearing P2 Mask, taking a RAT, outside visits) – PPE is to be made available and education provided re donning and doffing. All such visitors must be informed of the requirements via group email/text. Advise visitors to not move between an affected area and an unaffected area of the facility. Where possible, these visits should occur outdoors or in an area with significant natural ventilation. Generic text, script and Q&A templates are available on the Organisational COVID Tile. **Residents who are not affected and reside in unaffected parts of the facility (Green Zones)** may continue to have visitors (including those who are not essential visitors) where visitors are willing to comply with the RACF required risk mitigations.		

EXPOSURE MANAGEMENT

<table>
<tr><th colspan="2">EXPOSURE RESPONSE</th><th>Service Specific Requirements/Delegation</th><th>Date Completed</th></tr>
<tr><td>7. COMMUNICATE</td><td>Print out this plan in colour; display appropriate poster and commence line listing

Inform all staff on current shift and provide thorough handovers for new staff for every shift including:
- the onsite facility manager and clinical lead
- everyone’s roles and responsibilities
- what to do if there is a problem
- what the escalation processes are
- Identified zones (Reinforce orientation with Poster on entry and/coloured maps)
- Restrictions related to a positive/symptomatic case
- Increased PPE for positive/symptomatic case
- Location of Donning and Doffing Station
- Nominated PPE Spotter
- Adjustment to Screening protocols
- Vigilance with Identifying Early Symptoms of COVID 19 for staff and residents
- Reinforce to ALL STAFF IPC protocols, including use of personal protective equipment (PPE), hand hygiene, cough etiquette and social distancing.

Identify staff to support contingent orientation for emergency workforce. Ensure familiarisation with Contingent Staff Checklists: COVID-19 Contingent Staff Orientation Checklist – Registered Nurse
COVID-19 Contingent Staff Orientation Checklist – Personal Carer

Ensure Email Notification to all relevant teams/units including:
Regional COVID Lead, General Manager and ACCS Infection Control Lead.
Customer Service Centre to advise of any site entry restrictions and support requirements.
All families and or representatives using the communications approved scripts.
Waste removal suppliers to inform them of the anticipated increase in clinical waste.
Site Contractors.</td><td></td><td></td></tr>
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EXPOSURE MANAGEMENT

<table>
<tr><th colspan="2">EXPOSURE RESPONSE</th><th>Service Specific Requirements/Delegation</th><th>Date Completed</th></tr>
<tr><td>8. ENHANCE ENVIRONMENTAL HYGIENE</td><td>Enhance IPC
- The IPC lead should check that outbreak IPC processes and practices are implemented.
- IPC Lead to review training and awareness of increased cleaning requirements during outbreak.
- Determine the on-the-ground infection control lead for each shift.
- Use of Hydrogen 2 in 1 chemical or a 2-step cleaning process with detergent and disinfectant.
- increase staffing to support twice a day touch point cleaning in common areas of infected lodges.
- Daily touch point cleaning schedules remains the same, infected quarantine rooms use 2 in1 chemical or 2 step clean.
- Refer to Blue Care Cleaning Manual and Cleaning Guideline on infection control process to clean.

Implement enhanced environmental cleaning and disinfection of the resident's environment and all shared equipment (for example monitors, BP cuffs, thermometers, glucometers) - clean frequently with a neutral detergent followed by a disinfection solution or use detergent and disinfectant impregnated wipes.

Waste management
Waste that is visibly soiled with blood and other bodily fluids, generated during clinical care of confirmed or suspected COVID-19 cases should be managed and disposed of as clinical waste
• Unsoiled PPE can be discarded into general waste if this is acceptable within local council regulation and local facility waste management procedures
• Further advice on waste management processes may be found here COVID 19 Waste Management Guide.

Soiled Linen
Soiled linen should always be treated as infectious.
• Routine procedures are sufficient for handling linen from residents in a RACF with a COVID-19 outbreak. This includes the linen of residents in quarantine or isolation.
• Relatives should not take linen home for washing.
• Place grossly contaminated / soiled linen in a soluble plastic bag and then in the linen skip. Alternatively, line the linen skip with a plastic bag for soiled linen.</td><td></td><td></td></tr>
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EXPOSURE MANAGEMENT

EXPOSURE RESPONSE		Service Specific Requirements/Delegation	Date Completed
9. STOCK CHECK	Ensure adequate supplies of handwashing consumables, PPE and Rapid Antigen Testing (RAT) kit supplies. Review N95 supplies ensuring stock supports all fit tested models. Place orders of additional PPE considering 5000 sets of PPE will support 7 days of an outbreak (18 positive residents) If you need additional PPE, RAT kits, hand hygiene or cleaning products, and cannot source this through your usual supplier, please escalate this to procurement. If extended delay despite this escalation you can order from the National Medical Stockpile via Stockpile.Ops@health.gov.au		
10. REPORT	**RISKMAN:** Resident ARI positive cases are entered via the Incident Module (Note: For COVID 19 if the resident passes away within 28 days of a positive COVID 19 Result the incident is to be upgraded to a catastrophic and comprehensive analysis completed). **Additional reporting for COVID 19 Cases:** Staff COVID-19 positive cases are entered via the COVID Register **MY AGED CARE PROVIDER PORTAL:** Residential aged care providers are required to immediately report **all** staff or resident COVID-19 cases to the Australian Government Department of Health through the COVID-19 Support Portal. This Portal can be accessed via the My Aged Care provider portal. In-home and community aged care services are no longer required to report COVID-19 cases to the Australian Government Department of Health. This Portal can be accessed via the Aged Care Provider Portal. For more information on this process, please see the Fact Sheet, User Guide and FAQs. NB: PHU escalation is only required for two or more residents however if advice is sought will support as required.		
11. MONITOR	Maintain enhanced Monitoring and Screening for any new case presentation – progress to Outbreak Management if any additional case identified.		

OUTBREAK MANAGEMENT

<table>
<tr><th colspan="2">OUTBREAK IDENTIFIED:
Two or more residents diagnosed with COVID-19 or Influenza via RAT or PCR test within 72hrs of each other, and who have been onsite at the RACF at any time during their infectious period</th><th>Service Specific Requirements/Delegation</th><th>Date Completed</th></tr>
<tr><td colspan="4">Repeat the above Exposure steps for each case then progress with the following actions:</td></tr>
<tr><td>1. REPORT</td><td>STATE PHU: Immediately escalate to your relevant area PHU. Refer to appendix for QLD Health Public Health Unit - Contact details). Follow after hours prompts if necessary. Follow initial direction of the Public Health Communicable Disease Nurse in implementation of any further infection prevention strategy. Maintain daily update via updated line listing with PHU.

RISKMAN
Outbreaks as defined are to be entered in the Brief Module. Commence Outbreak Brief and update daily until outbreak resolved.</td><td></td><td></td></tr>
<tr><td>2. TESTING</td><td>Follow guidance from the PHU and adhere to any testing protocols recommended. Monitor staff and residents for symptoms.</td><td></td><td></td></tr>
<tr><td>3. RESTRICTIONS</td><td>With guidance from the PHU, determine extent of restrictions required.

Ensure maintenance of residents' social contact
• Arrange for enough staff to assist with IT equipment and technology where required.
• Clean shared IT equipment after each use.

Continue to Establish/Maintain Essential Visitor protocols where identified.</td><td></td><td></td></tr>
<tr><td>4. CONVENE DAILY MEETINGS</td><td>Convene daily Outbreak Management Team meetings to monitor progress and review efficacy of control strategies. Target control and declared end of outbreak is 7-14 days.

OMP meetings should include Key Representatives, other relevant parties within your site, where available state or territory PHU and the Department of Health's Case Management Team.</td><td></td><td></td></tr>
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OUTBREAK MANAGEMENT

Outbreak Response		Service Specific Requirements/Delegation	Date Completed
5. WORKFORCE MANAGEMENT	Plan your staff roster • Enact your workforce management plan developed from the preparedness planning checklist. Review staff levels daily and communicate needs to staff. • Support and use your existing workforce as efficiently as possible, including roles for furloughed staff, Partners in Care and volunteers. • Contact Community Blue Care to ascertain numbers of staff available to work at site • Contact Agency to ascertain numbers of staff available to work at site. • Contact ProcurementAdvisory@ucareqld.com.au if you require support or further information. • If you are still unable to fill your roster, escalate with your GM and Commonwealth Case Manager, application for Surge Workforce. Support your staff • Establish fatigue management plans and share support information. • Continue to offer support to staff who are isolating or quarantining. • Pre-plan and allocate offsite responsibilities to furloughed staff who are asymptomatic. • Consider a "buddy" system for peer support.		
6. ONGOING CLINICAL CARE	Continue to monitor Ensure ongoing care needs of all residents (irrespective of COVID status) continue to be met (including medication rounds, assistance with meals, assistance with toileting). Escalate any concerns or issues.		
7. COMMUNICATE	Maintain updated communication as per Step 6. Communication in exposure management Follow-up communications for families and or representatives with reference to the communications approved scripts.		
Declare Outbreak Over and Debrief			
	In consultation with Public Health Unit declare outbreak over and lift facility restrictions. • Additional precautions may be required as guided by the Public Health Unit. • Inform residents, staff, families and decision makers that the outbreak is over and any ongoing restrictions (i.e. heightened PPE requirements). Undertake debriefing meeting with key staff and seek feedback from residents. Evaluate data and final outcomes of Outbreak. Make recommendations for improved future management on the Outbreak Report. Upload report to the Outbreak Brief.		

KEY STAFF AND RESPONSIBILITIES – CONTROL TEAM

	Responsibilities
Residential Service Manager (RSM)/Outbreak Coordinator	Responsible for end to end outbreak management including: • Oversee all operations and preparations within the facility. • Escalation point to all internal and external teams including COVID 19 Outbreak Team and PHU. • Approve staffing workforce plan. • Oversee service closures and resource allocation. • Outbreak Control Meetings, setting meeting times, agenda and delegating tasks. • Dissemination point for communication with staff, residents, families and key stakeholders • Updates to Cluster COVID Lead and Infection Control Clinical Lead • Daily updates to Riskman Outbreak Brief. • Coordinate Pastoral Care. • Monitor updates staff, resident and resident representative wellbeing. • Follow Aged Care Directions regarding end of life/compassionate support. • Monitor fatigue management.
Residential Rosterer	Responsible for workforce planning and logistics including: • Manage staff rosters. • Coordination of training requirements with Site Orientation Officer. • Working with Resource Management Team Manager/ Residential Rosterer regarding staffing requirements. • Development of staffing workforce plan and escalation of identified issues to the RSM. • Attendance at daily Outbreak Control Meeting. • Contact with Community to ascertain numbers of staff available to work at site. • Contact Agency to ascertain numbers of staff available to work at site. • Support will be provided by our procurement team at Head Office. • Supporting the Workforce Coordinator with supply of existing staff and contingent workforce. • Escalation of identified issues to Workforce Coordinator. • Attendance at daily Outbreak Control Meeting.

KEY STAFF AND RESPONSIBILITIES – CONTROL TEAM

HR Advisor	Responsible for: • Informing HR practices including staff concerns, leave management. • Supporting the Residential Rosterer and escalating issues to the Outbreak Coordinator. • Review and make recommendations to Outbreak Coordinator regarding vulnerable workforce. • Attendance at daily Outbreak Control Meeting.
Maintenance Officer	Responsible for: • Coordinate maintenance requirements for site. • Assist with logistics of equipment and supplies. • Escalate issues to the Outbreak Coordinator. • Attendance at daily Outbreak Control Meeting.
Hospitality Team Leader	Responsible for: • Support to Hospitality teams regarding cleaning, hospitality, food services and laundry processes. • Support Site Orientation Officer with onboarding of hospitality staff. • Manage supplies including food, cleaning products. • Commence communication with waste contractor to ensure supply and collection of increased waste. • Working with the Infection Control Coordinator regarding additional requirements during outbreak. • Working with Workforce Coordinator for hospitality staffing. • Escalate issues to the Outbreak Coordinator. • Attendance at daily Outbreak Control Meeting.
Site Orientation Officer	Responsible for: • Orientating existing & contingent workforce to site/processes. • Work with Workforce Coordinator. • Ensure staff access to equipment, systems including agency login, COVID-19 FAQ and Benestar. • Working with Infection Control Coordinator/Representative. • Monitor staff welfare and escalate concerns to Outbreak Coordinator. • Coordinate all outbreak related training including Donning & Doffing/P2 Fit Test Training. • Escalate issues to Outbreak Coordinator. • Attendance at daily Outbreak Control Meeting.

KEY STAFF AND RESPONSIBILITIES – CONTROL TEAM

IPC Lead	Responsible for: • Oversight for ensuring all infection control decisions of the Outbreak Team are implemented. • Coordinate activities required to contain the outbreak. • Provide information and support regarding infection control practice. • Work with Workforce Coordinator and Site Orientation Officer to ensure completion of infection control training. • Monitor service infection control practice. • Oversee clinical monitoring of residents. • Escalate issues to Outbreak Coordinator. • Manage and coordinate PPE stock control. • Coordinate and monitor pathology sampling. • Ensure sufficient medical equipment and supplies are available in areas. • Coordination of Riskman. • Attendance at daily Outbreak Control Meeting.
Administration Officer	Responsible for: • Minute taking for Outbreak Control Meetings. • Assisting Workforce Coordinator with travel and accommodation requirements. • Copying and printing outbreak documentation for all roles and orientation material. • Other duties as directed by RSM/Outbreak Coordinator.

APPENDIX

Appendix No.	Document	Page/Link
001	Acute Respiratory Infection Preparedness Planning Checklist	Pg. 17-20
002	Acute Respiratory Infection – **IMPORTANT INFORMATION**	Pg. 19-27
003	Exposure and Outbreak Zone Posters	Pg. 28-30
004	Exposure and Outbreak Line Listing	Pg. 31
005	Outbreak Evaluation Report	Pg. 32
006	Laminated Site Map Identifying Zones	(Site to print and add to Outbreak folder/plan)
007	Blue Care Reporting Requirements	Quick Reference Guide - Reporting
008	Visitor Access – Supporting safe, quality care for older people in RAC	Visitor Access – Supporting safe, quality care for older people in RAC
	Outbreak Posters	
009	COVID-19 Blue Care STOP do not enter facility poster	COVID-19 Blue Care STOP do not enter facility poster
010	PPE donning and doffing guide	Blue Care PPE donning and doffing guide
011	Five Moments of Hand Hygiene (Hand Hygiene Australia)	5 Moments of hand Hygiene Poster
012	How to complete a Hand wash (for use for staff/resident/ family education)	How To Hand Wash Poster
013	How To complete a Hand Rub (for use for staff/resident/ family education)	How To Hand rub Poster
014	Cough Etiquette	Cough Etiquette Sign
	Other References	
015	Infection Control Monitoring Checklist	ACQSC Infection Control Management Checklist
016	Public Health Unit – Contact List	QLD Health Public Health Unit - Contact
017	COVID-19 Infection Prevention and Control Manual	COVID-19 Infection Prevention and Control Manual For acute and non-acute health care settings
018	Outbreaks of Acute Respiratory Infection in Residential Care Facilities	CDNA Guidelines for prevention, Control and Public Health Management of Outbreaks of ARI
019	CDNA National Guidelines for Public Health Units	National Guidelines for Public Health Units
020	First 24-hour checklist – Managing COVID-19 in a Residential Aged Care Facility	First 24-hour checklist – Managing COVID-19 in a Residential Aged Care Facility

Appendix 1: Acute Respiratory Infection Preparedness Planning Checklist
(Review at time of alerted increased community virus transmission or min Monthly)

Vaccination	
Ensure that all residents receive current vaccinations (unless contraindicated or resident declines) for: - ○ COVID-19 ○ Seasonal influenza ○ Pneumococcus	
Provide updates to residents and representatives to access information regarding vaccination as updated by Australian Technical Advisory Group on Immunisation (ATAGI) Resources available on the Blue Care COVID Tile under "Information/Factsheets"	
Provide updates to residents and their representatives of bookings dates of vaccination clinics organised by your service	
Record vaccination status of **residents COVID-19 and influenza in RMS (People Point)** IPC Lead to monitor vaccination status of residents monthly in Blue Care BI Power Dashboard	
Where resident immunisation is not current, document reason and record in RMS – ensure that residents and substitute health decision makers have been provided verbal and written information in their primary language to ensure that they are able to make an informed decision; ensure that GP is informed and reviews the resident, if resident declines vaccination	
Record vaccination status of **staff COVID-19 and influenza in Aurion** RSM to monitor vaccination status of staff in alignment with UCQ Vaccination Policy and via vaccination compliance alerts	
Details of staff and resident vaccinations are reported into the My Aged Care Portal by our Blue Care Customer Service MAC Administrator	

Anti-Viral Treatment	
Consider the clinical suitability of residents for flu and COVID-19 treatments and prophylaxis and obtain an indication of treatment preference or consent from residents and/or their representatives	
Encourage GPs to pre-assess residents for antiviral treatment including the most appropriate drug and any dose adjustment required because of renal impairment. Where possible, this assessment should be undertaken pre-emptively during routine appointments.	
Support residents and representatives to access information regarding antiviral treatments as published on the Blue Care COVID Tile under "Information/Factsheets" or released for distribution via the Commonwealth or Aged Care Quality and Safety Commission	
Maintain stocks (equivalent for up to 80% of residents) of anti-viral treatments or methods to access rapidly.	

Testing	
Establish laboratory testing arrangements, pathology request processes, and timely method of receiving results.	

Environmental Infection Control	
Provide alcohol-based hand sanitiser and soap / hand-washing facilities at the entrance to the facility and at other strategic locations.	
Identify changes that can be made to the environment to facilitate enhanced cleaning e.g. removal of clutter or extraneous furniture	
Waste bin vendor contacts are up to date and capacity to increase supply and services are possible should this be required during outbreak	
IPC Lead to review training and awareness of increased cleaning requirements during outbreak: - use of Hydrogen 2 in 1 chemical or a 2-step cleaning process with detergent and disinfectant. - increase twice a day touch point cleaning in common areas of infected lodges - daily touch point cleaning schedules remains the same, infected quarantine rooms use 2n1 chemical or 2 step clean - Refer to Blue Care Cleaning Manual and Cleaning Guideline on infection control process to clean	
Replace shared equipment with single-use equipment where feasible; where shared equipment is essential, ensure adequate cleaning and disinfection between residents consistent with infection control standards	

Stock Levels	
PPE Stock Take must be completed weekly and registered via https://www.ucqcovid19.com.au/blue-care	
Ensure adequate supplies of: • Personal Protective Equipment (PPE). Estimates range from 10 to 14 sets of PPE per resident per day • Appropriate face-fitting respirators • Cleaning supplies, hand hygiene products, Disposable crockery and cutlery • Diagnostic equipment supplies e.g. swabs, electronic thermometers, batteries where required • Impress medication, with emphasis on the core palliative medications - Oxygen supply (cylinders and concentrators) and associated consumables - Subcutaneous infusion devices and associated consumables	
Ensure that staff are familiar with the processes to access surge supply of PPE – where PPE cannot be sourced through usual supply channels, RACF clinical managers to email agedcareCOVIDPPE@health.gov.au	

Appendix 1: Acute Respiratory Infection Preparedness Planning Checklist
(Review at time of alerted increased community virus transmission or min Monthly)

IPC Lead Appointment and Training	
Dedicated rostered hours have been allocated to the training and ongoing role of IPC Lead	
Completion of the Department of Health COVID modules except 2.2 or 9.2 which relate to home care	
Completion of the Foundations of Infection Protection and Control course offered by the Australasian College for Infection Prevention and Control (ACIPC)	
IPC Lead attends monthly Infection Control Advisory Committee Meeting and supports Infection Control as a standing agenda item for service meetings	
Staff are aware of the nominated site IPC Lead and are orientated to the role function as outlined in the duty statement	
IPC Lead name, position, registration status, completion status of Departments online COVID 19 training modules are reported through the MAC Portal and updated when changes occur	

Staff Training and Wellbeing	
Ensure that **all** staff are familiar with this outbreak management plan including preparedness planning, definitions, early identification of symptoms and screening requirements	
Review SABA report for completion as per ACCS Learning Requirements Matrix. Specifically, the following modules: Infection Control, Infection prevention in the workplace, Hand Hygiene, Donning and Doffing and COVID-19 Modules Refreshers may be considered more frequently such as when alerted to increases in community virus transmission.	
Review staff understanding of Recommended PPE Escalation COVID Tile – “PPE Guide and Matrix” (pg. 40 Table 1)	
Review handling and disposal of clinical waste as per (completed monthly or when entering higher community virus transmission) COVID-19 Waste Management in Residential Care Fact Sheet	
Care Manager (or delegate) has provided clinical staff with training and debriefing on clinical management, treatment, and referral pathways for residents with COVID-19 Infection/Acute Respiratory Infection.	
Ensure staff are trained in the collection of Rapid Antigen Tests and competency uploaded to SABA Self-Testing Rapid Antigen Test Competency Assessment	
Provide clear, consistent and frequent messaging to the workforce (including contractors, service providers, students and volunteers) about the importance of ensuring that they arrange testing and do not work while unwell; that they follow screening, infection control, hygiene, PPE and social distancing protocols; and that they comply with any restrictions	
Ensure staff are aware of supports that are in place in the event that they are unable to work due to being unwell or have undergone testing including access to Pandemic Leave Payments if leave balance has been exhausted.	
Ensure promotion of the suite of resources and corporate offerings in the Health & Wellbeing Hub and/or Join the Health & Wellbeing Workplace Group	

Nominated Reporting, System Access and Training	
Identify staff who will complete reporting for Riskman, PHU and MAC Portal during an outbreak.	
Ensure identified staff have appropriate access e.g. MAC Portal and Riskman Briefs Module and are familiar with the Blue Care Reporting Requirements for RACF and the MAC Portal Quick Reference Guide	
Ensure all staff are aware of the internal reporting requirements for infections	

Floor Plan and Cohorting (Using a map of the facility identify the following)	
Establish a single secure point of entry and exit, allowing risk screening and assessment for all staff, visitors, contractors, and delivery drivers.	
Plan ahead with marking on a site map how to cohort / zone residents into green, amber and red zones within the facility - refer to guidelines page 4 of checklist	
Consider where and how residents can be feasibly cohorted according to risk and building layout.	
Consider segregation of zones by closed doors. Minimisation of thoroughfares between zones while maintaining fire safety	
Designate areas on the map that identify where to don and doff PPE, undertake appropriate hand washing	
Designated storage area on the map to facilitate safe storage of PPE	
Identify secured clinical waste storage area -area must be non- accessible for residents and public and not be stored on open ground and elements in a non-secured area, if you need a secured area due to extreme levels of outbreak, due to collection failures form waste vendor, organise a container with UCQ procurement	
Identify on the map safe waste management with separation of food service / delivery and clinical waste pathways	
Print wall and floor signage displaying warning of segregated areas should be pre-printed to control entry	
Include risk management of all staff profiles with particular reference to those moving between facilities and high movement staff or those accessing multiple zones on a daily basis, for example: - Leadership team e.g. Care manager, Maintenance staff, GPs and other visiting healthcare providers - Hospitality staff	

Appendix 1: Acute Respiratory Infection Preparedness Planning Checklist
(Review at time of alerted increased community virus transmission or min Monthly)

Workforce Planning	

Maximise allocation of base roster shifts including the following steps as required:
• Ongoing communication with staff regarding vacant shifts
• Maximise staff levels through strategies for retention and recruitment in partnership with the Talent Acquisition Advisor:
  ○ Provide regular updates of specific base roster vacancies
  ○ Ensure advertising and screening processes support filling gaps in the base roster	

Work with your Talent Acquisition Advisor and Regional Onboarding Manager to support in the development of processes to quickly on-board a large number of new staff.	
Identify staff to support contingent orientation for emergency workforce. Ensure familiarisation with Contingent Staff Checklists: COVID-19 Contingent Staff Orientation Checklist – Registered Nurse COVID-19 Contingent Staff Orientation Checklist – Personal Carer	
Determine minimum staffing requirements during an outbreak – staffing numbers will be higher than usual to support cohorting, care delivery, cleaning, safe PPE use and potential for a high proportion of staff requiring quarantine or sick leave. Identify appropriately skilled staff to care for residents with suspected or confirmed COVID-19. • Identify staff who have flexibility to work additional hours during outbreaks • Establish minimum numbers required in a casual pool to support predicted leave • Consider neighbouring Blue Care Residential Services in a partnership of casual pool utilisation • Establish regular communication with Talent Acquisition Advisor to ensure understanding of casual vacancies	
Development and maintenance of a contact list for casual staff.	
Identify additional staff from neighbouring services who are willing to work during an outbreak and explore any particular arrangements required to allow their ongoing work e.g. requirements for accommodation support, assigning responsibilities that can be performed remotely.	
Maintain agreements and list of external agencies to enable immediate activation during an outbreak: 1. Reach out to our labour hire agency providers via details in the Frontline Labour Nursing/Carer How to Buy Guide 2. Search for a labour hire agency provider on Smartek (our contractor compliance management system) 3. If you are using a labour hire agency provider who is NOT in Smartek, engage your Smartek Coordinator to on-board them Contact ProcurementAdvisory@ucareqld.com.au if you require support or further information.	
Identify roster adjustments that will prevent or reduce cross infection through cohorting of staff within wings or defined geographic areas within the facility (including designated break areas and bathrooms for staff working in different zones, and staggering of break times). Where feasible minimise movement of staff, residents and visitors across wings	
Utilise the “RACF COVID-19 Line Listing” located on the COVID Tile under Outbreak Resources for tracking which staff are in isolation or quarantine and when they are due for testing, retesting and return	
Identify how you could effectively utilise staff who are furloughed or otherwise unable to work on site to continue to support the service e.g. managing discussions with resident’s representatives and providing informed advice for care strategies, particularly for care of residents who they know well, Rostering support, Riskman entry and follow up – ensure that you have the necessary equipment / IT ready and available to support remote working	
Ensure staff are supported to identify and address stress and work fatigue early through supports - Benestar, Chaplaincy or Lifeline	
Notation: Once an outbreak of COVID-19 is registered in the MAC Portal a Commonwealth case manager will contact the service to discuss workforce strategies and the need for surge workforce support. Services must exhaust all existing partnerships and recruitment channels as listed in this checklist.	

Planning with Residents and their Representatives	
Ensure representatives and residents are aware of the symptoms of Acute Respiratory Infection and the need to report them when observed. Older residents and residents with a disability often have atypical symptoms including behaviour change and may not develop a fever. Family, representatives and friends who know residents well so can help detect subtle changes in condition or behaviour.	
Ensure that each resident has a current Advance Care Plan (statement of choice). Fax or email Statement of Choices, Advance Health Directive, Enduring Power of Attorney, QCAT orders and revocation documents to the Office of Advance Care Planning (Fax: 1300 008 227, email: acp@health.qld.gov.au) to make these accessible to Queensland Health clinicians, Queensland Ambulance Service and authorised GPs and RACF clinicians	
Arrange GP review of all residents who are currently prescribed nebulisers (regular or as required) to evaluate change of these to metered aerosols with spacers where clinically appropriate	
Using guideline on page 4 of this checklist, engage residents and their representatives in key decisions prior to an outbreak e.g. Planned cohorting areas, planning isolation specific to the care need, essential visitor requests, testing requirements.	

Appendix 1: Acute Respiratory Infection Preparedness Planning Checklist
(Review at time of alerted increased community virus transmission or min Monthly)

Guideline to support site cohorting

Red zone - cases in isolation: individuals with confirmed COVID-19 and have not yet met criteria for release from isolation. Isolation in rooms to reduce risk of transmission should be limited to the shortest time possible. These residents may mix with other confirmed cases in isolation
Amber zone - contacts in quarantine: individuals who have met the close contact or household-like contact definition
Green zone - released contacts: Includes contacts who have completed quarantine. Groups with similar exposure or assessed risk can be considered for management in a shared space. Recovered cases: Includes cases who have been released from isolation. If cleared, they may re-join other residents.
Blue zone - buffer areas between potentially contaminated and non-contaminated zones including transition points between areas where staff must put on or take off PPE

Guideline to support visitor planning with Residents and their Representatives

General Visitors when the access level is:
Green: visiting hours, the number of visitors on site and the length of time for visits should return to pre-COVID-19 visiting norms. Visitors may enter the home following completion of a Screening Declaration and Rapid Antigen Test. This will include adjustments for local community levels of COVID-19 such as requiring masks to be worn or increased frequency of Rapid Antigen Test Screening. Additional restrictions may also occur due to state health recommendations
Orange: reduced visiting hours, and/or limits on the number of visitors may be necessary. Extra requirements, such as more frequent Rapid Antigen Test screening may be imposed. Alternative ways to connect should be provided to help the resident remain connected with a range of other general visitors.
Red: stronger restrictions are necessary. Short term strict visiting restrictions will apply. Alternative ways to connect should be provided to help the residents remain connected with a range of visitors.

End of Life Visitors Visits to residents at or approaching the end of life should be facilitated for anyone and not be time limited. This may include facilitating out of hours visiting and may include facilitating visits while an exposure/outbreak is occurring, including during the initial few days

References

- National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities | Australian Government Department of Health and Aged Care
- Outbreak preparedness checklist | Australian Government Department of Health and Aged Care
- Industry_Code_for_Visiting_in_Aged_Care_Homes_v6.1_22Mar22.pdf (cota.org.au)

Appendix 2: IMPORTANT INFORMATION

RESIDENT DAILY SCREENING AND ESCALATION GUIDE

RESIDENT DAILY SCREENING (Everyone's Responsibility)

1. IS THE RESIDENT DIFFERENT FROM BEFORE? ARE THEY "NOT THEMSELVES" (compared to the last 24hrs)

Needing more help with tasks	Sleeping more	Seeming unwell
Eating less/refusing food	Trouble walking	Withdrawn
Irritability	Confusion	Restless, wandering, aggression
Trouble Talking	Upset/angry	

2. DOES THE RESIDENT HAVE ANY NEW TYPICAL SYMPTOMS OF COVID-19?

Cough	Fever/Chills	Runny Nose
Feeling tired/muscle aches	Change in taste or smell	Sore Throat
Shortness of Breath	Headache	Vomiting or diarrhoea

3. HAS THE RESIDENT HAD A FALL IN THE LAST 24 HOURS (outside of any known pattern)

If the answer is YES or DON'T KNOW to any of the above questions escalate to senior staff for further review and document the exception

ADDITIONAL DAILY SCREENING (Senior Staff Responsibility)

4. **IS THE RESIDENTS TEMPRATURE GREATER THAN 37.5°c?**
   (If a pattern of "low grade temperature" 37.0°c consider testing for COVID-19)
5. **IS THE RESIDENT'S RESPIRATORY RATE GREATER THAN 24 BREATHS PER MINUTE?**
6. **DOES THE RESIDENT HAVE A RECENT HISTORY OF EXPOSURE TO A CONFIRMED CASE OF COVID-19?**
   (Exposure means spending 15mins close contact or two hours in the same room as an infectious person)

If the answer is YES to any of the above 6 questions:
Isolate case and act as outlined in the Blue Care
COVID19CarePathway.pdf (bluecare.org.au)

Reference: COVID-19 screening tool for residential aged care services

SCREENING STAFF AND VISITORS ON ENTRY

Screening on entry to a residential aged care home is vital. Anyone who visits a residential care home should be well and free of respiratory symptoms.

To support screening a single-entry point to the facility must be established and during higher levels of community transmission supported by an employee trained in Point of Care Rapid Antigen Testing.

An Entry Screening Checklist is required to be completed as follows:

- The Entry Screening Checklist for Visitors is available as paper based or via the Organisational QR Code.
- The Entry Screening Checklist for employees, agency staff, regularly visiting medical officers, volunteers, students and contractors is paper based/QR Code.

Surveillance Rapid Antigen Test Screening arrangements are risk assessed in line with community COVID-19 case prevalence identified by Queensland Health Traffic Light Advice and/or identification of case prevalence within the individual residential aged care facility.

Recommended Rapid Antigen Surveillance Testing Regime:

	Employees	Residents	Visitors
Outbreak or Exposure[1]	Daily prior to entry into the facility on rostered shifts only	• Immediately upon identification of close contact or symptom presentation then • Day 2 and Day 6	Prior to entry for each visit (as allowed)
Surveillance testing[2]	Every 72 hours prior to entry into the facility on rostered shifts only[3]	N/A	Every 72 hours prior to entry for regular visitors (maximum 2 x per week)[3]
New Admissions	N/A	Prior to entry and ongoing as above	N/A
Residents returning to the service not on the same day	N/A	Prior to entry and ongoing as above	N/A

1 Outbreak or exposure is defined as per National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities.

2 Recommended frequency of surveillance testing may be adjusted up/down based on level of community transmission. Confirmation of this adjustment will be notified organisationally following review of government advice and assessment of risk

3 For information regarding recording and process refer to Rapid Antigen Testing Process for Blue Care Services

Appendix 2 IMPORTANT INFORMATION

Recommended PPE Escalation according to COVID-19 community levels (in addition to other precautions if indicated for another reason)

	COVID-19 community level→ Patient category↓	**Low** Standard and Transmission-Based Precautions	**Moderate** Standard and Transmission-Based Precautions, Plus measures to counter moderate risk of unexpected COVID-19 infection	**High** Standard and Transmission-Based Precautions, Plus measures to counter high risk of unexpected COVID-19 infection
PPE for HCWs caring for residents/patients in these categories	**NO symptoms** of COVID-19 and **NOT** a close contact[2]	Standard precautions	Surgical mask[4,6] or PFR[8] in high-risk clinical area[7] Protective eyewear[3] (within 1.5m)	PFR[8] Protective eyewear[3] (within 1.5m)
	Symptoms of COVID-19 and **NOT** a close contact[2]	Surgical mask[4,6] Protective eyewear[3] Gown or apron[5] Gloves	PFR[8] Protective eyewear[3] Gown or apron[5] Gloves	PFR[8] Protective eyewear[3] Gown or apron[5] Gloves
	Confirmed / Probable COVID-19 **OR** **Suspected COVID-19** (symptoms of COVID-19 and awaiting test results) **OR** Close contact[2]	PFR[8] Protective eyewear[3] Gown or apron[5] Gloves	PFR[8] Protective eyewear[3] Gown or apron[5] Gloves	PFR[8] Protective eyewear[3] Gown or apron[5] Gloves
PPE for HCWs doing activities other than direct patient care		Standard precautions	Surgical mask	Surgical mask
PPE for patients - symptoms of COVID-19 OR close contact[2] (excluding children under 12)		Patients to wear surgical mask where tolerated (excluding children under 12)	Patients to wear surgical mask where tolerated (excluding children under 12)	Patients to wear surgical mask where tolerated (excluding children under 12)
PPE for Support persons or other household members during healthcare interaction for non-COVID-19 patients		Nil additional	Surgical mask	Surgical mask

Footnotes:

HCWs who reside in an area that is designated a different risk level to the healthcare facility they work in are to comply with their workplace facility risk PPE requirements.

1 Includes all non-hospital paediatric health services (incl. multiple home visits, RACF and facilities).

2 Close contact: a patient who has been identified as a close contact of a case of COVID-19 in the last 7 days,

3 Protective eyewear is defined as a face shield, goggles, or dedicated safety glasses – note that prescription glasses alone are not considered adequate eye protection.

4 A particulate filter respirator (PFR) should be worn for AGPs (AGP), aerosol-generating behaviours (AGB), and upon entering a room within 30 min of an AGP where there have been no other risk mitigating strategies to reduce that time. AGP, AGB and other factors increasing the risk of transmission.

5 A long-sleeved, preferably fluid-resistant gown. An apron or a non-fluid-resistant gown may be used in situations where physical contact is minimal and there is little chance of body fluid splash.

8 PFR requires fit checking and fit testing

Reference COVID19 Infection Control Guidelines

EXPOSURE ASSESSMENT AND IDENTIFICATION OF CLOSE CONTACTS

The infectious period of a case is considered to be 48 hours prior to onset of symptoms and up to five days after the date on which the first positive specimen was collected. In assessing contacts of a positive case, the RACF should identify all staff and residents in the affected zone who have been potentially exposed during this period. This is called an Exposure Assessment.

The risk of developing COVID-19 increases with the amount of time and intimacy of contact a person has with an infectious case. The people at highest risk of developing COVID-19 are household and household like contacts of cases.

High-risk exposure (close contacts) among residents:

- Residents who have shared a defined area (e.g. a wing of a facility) and / or who have had a household-like exposure with a case during their infectious period, are considered close contacts

High-risk exposures (close contacts) among staff

- Staff who were not wearing airborne precautions (N95/P2 respirator, eye protection, gown and gloves) where aerosol generating behaviours or procedures were involved
- Had at least 15 minutes of face-to-face contact where both mask (surgical or N95/P2) and eyewear were not worn by the exposed staff member and the case was without a mask
- Greater than two hours (cumulative) in the same room with a case during their infectious period, where masks (surgical or N95/P2) were removed for this period

Other considerations:

To establish identification of close contacts, consider reference to visitor log, staff roster and area worked, resident activities calendar, dining room seating arrangements, movement within wings of the facility. Map staff, visitor and resident movements and consult with Staff/Residents/Representatives to assess level of exposure – A management plan should be developed for close contacts based on High/Moderate/Low level of exposure risk.

Reference: national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities.pdf

Appendix 2 IMPORTANT INFORMATION

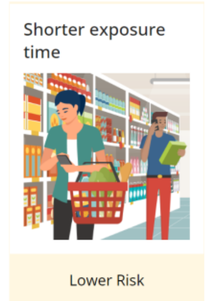
IDENTIFICATION HIGH/MODERATE/LOW RISK CLOSE CONTACTS

FACTORS THAT LOWER OR INCREASE RISK OF TRANSMISSION

Length of time: How long were you with the infected person?

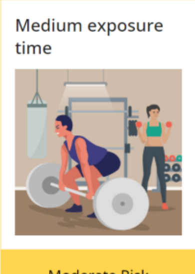
Longer exposure time **increases** the risk of transmission (for example, contact longer than 15 minutes is more likely to result in transmission than two minutes of contact).

Shorter exposure time



Lower Risk

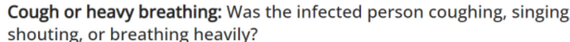
Medium exposure time



Moderate Risk

Longer exposure time

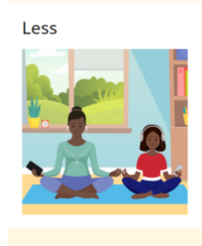
Higher Risk

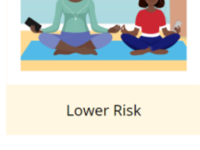


Cough or heavy breathing: Was the infected person coughing, singing, shouting, or breathing heavily?

Activities like coughing, singing, shouting, or breathing heavily due to exertion **increase** the risk of transmission.

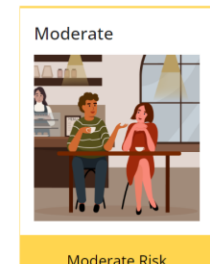
Less





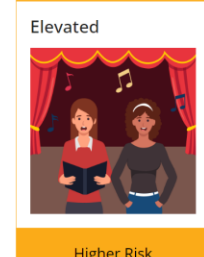
Lower Risk

Moderate



Moderate Risk

Elevated



Higher Risk

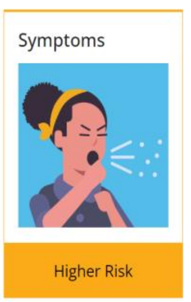
Symptoms: Did the infected person have symptoms at the time?[i]

Being around people who are symptomatic **increases** the risk of transmission.

No symptoms

Lower Risk

Symptoms

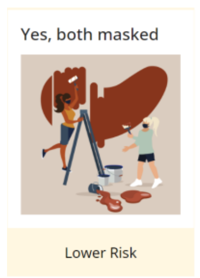


Higher Risk

Masks: Were you or the infected person or both wearing a respirator (for example, N95) or high-quality mask?

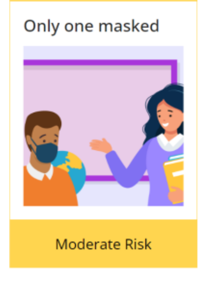
If one person was wearing a mask, the risk of transmission is **decreased**, and if both people were wearing masks, the risk is **substantially decreased**. Risk is also lower if the mask or respirator is a type that offers greater protection.

Yes, both masked



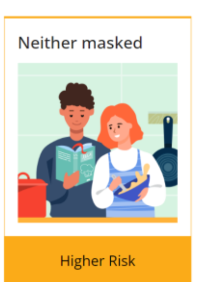
Lower Risk

Only one masked



Moderate Risk

Neither masked



Higher Risk

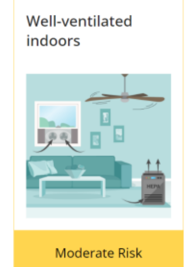
Ventilation and filtration: How well-ventilated was the space?

More outdoor air can **decrease** the risk of transmission. Being outside would be lower exposure risk than being indoors, even with good ventilation and filtration; both of those options would be lower risk than being indoors with poor ventilation or filtration. See the Interactive Home Ventilation Tool.

Outdoors

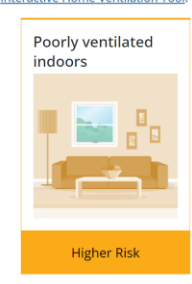
Lower Risk

Well-ventilated indoors



Moderate Risk

Poorly ventilated indoors

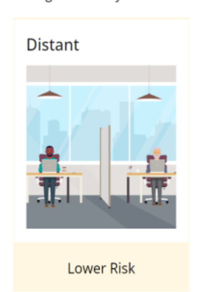


Higher Risk

Distance: How close was the infected person to you?

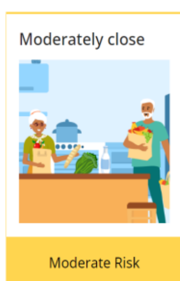
Being closer to someone who is infected with COVID-19 **increases** the risk of transmission. Crowded settings can raise your likelihood of being close to someone with COVID-19.

Distant



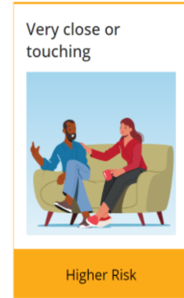
Lower Risk

Moderately close



Moderate Risk

Very close or touching



Higher Risk

Reference: Understanding Exposure Risks | CDC

Appendix 2 IMPORTANT INFORMATION

Note: the risk of transmission should be managed whilst balancing the risk related to social isolation and deconditioning through application of the least restrictive controls appropriate.

ZONING

Zone Colour	When Used	Personal Protective Equipment	Cohorting Arrangements	Visitor Management
Red Zone	During a resident case's infectious period until they are released from isolation	A single entry and exit point should be established with signage Staff should wear eye protection, N95/P2 mask, protective eyewear, a long-sleeved impermeable gown and gloves when entering a red zone. If the resident needs to leave their room (e.g. for urgent medical care), they should wear a mask (where possible). Donning and Dofffing stations should be set up and undertaken as per training and supported by the Donning and Doffing PPE poster	The resident should be isolated in their own single room with the door closed where practicable Residents who have a private (and not shared) courtyard or balcony adjoining their room, can use such facilities. If this is not possible, they may cohort with other cases of the same respiratory illness (i.e. COVID-19 cases can cohort with other COVID-19 cases)	Visitors who are not essential visitors may not attend residents who are cases. This group may be permitted as visitors through contactless visits. Essential visitors once nominated are required to complete training and comply with the outlined requirements. Details of this process are outlined on the COVID 19 Tile under **Essential Visitor Information.**
Amber Zone	Residents who are identified as high or moderate risk contacts of COVID-19 or ARI	A single entry and exit point should be established with signage Staff should wear protective eyewear and P2/N95 mask when entering the zone. Staff should wear protection, N95/P2 mask, long sleeved gown and gloves when providing close contact care to residents. Change gown when close personal care has been provided or the gown becomes soiled. Change gloves between resident contact and use 5 moments of hand hygiene between glove use. Residents should wear a surgical mask if they need to leave their room (where possible and appropriate)	**For high risk contacts**: Residents should quarantine in their own rooms with the door closed where practicable. Residents who have a private (and not shared) courtyard or balcony adjoining their room, can use such facilities. **Following a negative test result for low-moderate risk contacts**: Residents should remain cohorted as a wing and should not have contact with residents from other wings. Residents can use communal outdoors spaces but should not have contact with residents from other wings. This may require rostering of communal outdoor space use with cleaning program.	Visitors must comply with RACF-required risk mitigations (such as wearing P2 Mask). Visitors must be informed of and accept related risks of COVID-19 infection. Generic text, script and Q&A templates are available on the Organisational COVID Tile. Visitors should not move between areas in the facility. Where possible, these visits should occur outdoors or in an area with significant natural ventilation.
Green Zone	Residents who are not affected and reside in unaffected parts of the facility	PPE based on COVID19 infection prevention and control guidelines and community transmission.	Residents should be supported as per usual business operations including ongoing screening, cleaning schedules, hand washing, social distancing.	Residents in a green zone may continue to have visitors as per usual operation. Visitors must also be advised to avoid affected parts of the facility.

Reference Public health guidance for acute respiratory illnesses in residential aged care facilities - COVID-19 (act.gov.au)

Appendix 2 IMPORTANT INFORMATION

Case and contact management for COVID-19, influenza, and other confirmed respiratory pathogens.

			COVID-19 (RAT or PCR)	Influenza PCR	Other confirmed respiratory pathogen
CASE	Resident	Case isolation	7 days from positive test date. Case can cohort with COVID-19 positive residents.	5 days from symptom onset. Case can cohort with influenza positive residents.	Whilst symptoms remain. Case can cohort with residents with same confirmed pathogen.
		Release from isolation	After day 7 if substantial resolution of acute respiratory symptoms and no fever for 24 hours. No testing required.	After 5 days from symptom onset, or until they are symptom-free, whichever is longer or 72 hours after antivirals commenced. No testing required.	Once symptoms resolve. No testing required.
		Antiviral treatment	COVID-19 antivirals and other disease modifying therapies as indicated (via clinical review).		Nil – seek guidance from GP on clinical management.
	Staff	Return to work	After 7 days if no symptoms for 24 hours, no testing required. Full PPE day 8-14 when providing direct care. If identified an essential worker complete Return to Work Checklist	5 days from symptom onset, or until symptom-free, whichever is longer or 72 hours after antivirals commenced. No testing required.	Once symptoms resolve. No testing required.
	Visitor	Visitors to Facility	Can visit facility from Day 8 if no symptoms.	Exclude from facility for 5 days from symptom onset or until symptom-free, whichever is longer.	Exclude if symptomatic.
CONTACTS	Resident	Contact Testing	All residents in the affected zones (likely wing) upon identification of close contact/symptoms, then Day 2 and Day 6.	Symptomatic residents in the same zone (likely wing).	Symptomatic residents in the same zone (likely wing).
		Contact Isolation	Limit movement until test results pending and risk assessment completed.	Residents who are in the same zone(s) should avoid moving between zones.	Nil
		Contact post exposure prophylaxis	Nil	Influenza antivirals to be considered in outbreak.	Nil
	Staff	Return to work	Can attend from Day 6 if no symptoms and negative RAT. If the staff member is in a critically essential role they may return to work following a risk assessment and additional requirements as outlined in the Uniting Care Risk Assessment Process Critically Essential Workers.	Immediately if no symptoms. Must wear a mask and other PPE as required when at work. Unvaccinated staff should not work in affected areas.	Immediately if no symptoms.
	Visitor	Return to facility	Can attend from Day 6 if no symptoms and negative RAT	Consider influenza antivirals for unvaccinated staff and staff with comorbidities or pregnancy at higher risk of more serious disease. Immediately if no symptoms.	Immediately if no symptoms.

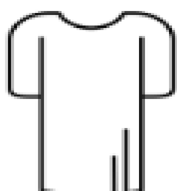
Reference: CDNA Outbreaks of Acute Respiratory Infection in Residential Care Facilities

This is a RED ZONE

Use Acute Respiratory Infection Airborne Precautions
Minimum Recommended PPE

Fit checked
P2/N95 respirator

Eye protection
Face shield or goggles



Following correct donning and doffing procedures.

Gowns and gloves worn in this zone must be doffed before exiting. If entering any other zones in the facility a new P2 respirator must be donned.

Visitors please check with staff before entering this area.

Remember standard precautions apply in all zones

Hand hygiene | Aseptic technique | Cleaning and disinfection.
Waste and sharps disposal | Respiratory etiquette | Linen handling.
Wear gown, gloves and eye protection when there is risk of splash or spray contamination with blood or body fluids, including respiratory secretions.

This is an AMBER ZONE

Use Acute Respiratory Infection Airborne Precautions

Miniumum Recommended PPE

Fit checked
P2/N95 respirator

Following correct donning and doffing procedures.

Gowns and gloves worn in this zone must be doffed before entering other zones.

Visitors are required to undertake RAT testing prior to entry, wear a mask and encourged to attend outdoors or in an area with significant natural ventilation.

Remember standard precautions apply in all zones

Hand hygiene | Aseptic technique | Cleaning and disinfection.
Waste and sharps disposal | Respiratory etiquette | Linen handling.
Wear gown, gloves and eye protection when there is risk of splash or spray contamination with blood or body fluids, including respiratory secretions.

This is an Green ZONE

PPE if required is indicated below

Fit checked
P2/N95 respirator

Surgical mask

Where possible movement between zones especially from red/amber into green zones should be avoided. Gowns and gloves worn in other zones must be doffed before entering this green zone. A P2 mask must be worn in a green zone if working across zones.

Visitors are required to undertake screening prior to entry and remember to maintain standard precautions at all times.

Remember standard precautions apply in all zones

Hand hygiene | Aseptic technique | Cleaning and disinfection.
Waste and sharps disposal | Respiratory etiquette | Linen handling.
Wear gown, gloves and eye protection when there is risk of splash or spray contamination with blood or body fluids, including respiratory secretions.

Appendix 4: Exposure and Outbreak Line Listing template

Serial No.	Person Name	Date of Birth	Vaccination status	Resident/ Staff/Visitor	Resident/ work Area	Staff/Volunteer Role	Symptom onset date	Area accessed while infectious	Antiviral start date	Test Collection type and Date	Result	Comments
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
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Appendix 5: Outbreak Evaluation Report

<table>
<tr><th colspan="2">OUTBREAK EVALUATION REPORT</th></tr>
<tr><td colspan="2">IDENTIFY MANAGEMENT SUCCESSES AND ISSUES (e.g. staffing, supplies, isolation methods, communications, services)</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">CORRECTIVE ACTION RECOMMENDATIONS: ensure completion within briefs module</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>RSM Signature:</td><td>Date:</td></tr>
</table>

Notes