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PUBLIC HEALTH MANAGEMENT of ACUTE RESPIRATORY INFECTIONS (ARI) in non-healthcare settings

Chapter 2: Cases & Contacts

Please note that this document should be used in tandem with other Public Health Management of ARI documents.

Readers should not rely solely on the information contained with these guidance outputs. Guidance information is not intended to be a substitute for advice from other relevant sources including and not limited to, the advice from a health professional. Clinical judgement and discretion will be required in the interpretation and application of this guidance document. This guidance document is regularly reviewed based upon emerging evidence at national and international levels and national policy decisions. In tandem with this, the guidance will be formally reviewed on a three-year cycle.

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2 CASES & CONTACTS

2.1 Case Definition

2.1.1 Standard Case Definition

The term **Acute Respiratory Infection (ARI)** includes presentations both of **influenza-like illness (ILI)** and other acute viral respiratory infections. The case definition is as follows:[1]

- Sudden onset of symptoms.
- **AND** at least one of the following four respiratory symptoms:
    a. cough,
    b. sore throat,
    c. shortness of breath,
    d. coryza.
- **AND** a clinician's judgement that the illness is due to an infection.

CAVEAT:

Individuals in non-healthcare community and **congregate settings**[2] with **mild clinical features of ARI** are advised to:

- **Limit contact with others** until acute symptoms have substantially or fully resolved — regardless of the virus causing the symptoms.
- **Not seek healthcare and/or testing** (self-performed or laboratory) to identify a specific virus, unless there is clinical or Public Health indication for testing.

People who work with individuals at high risk of complications from ARI — should not attend work while experiencing acute symptoms.

2.1.2 Laboratory Confirmation

Laboratory confirmation involves the detection of the pathogen using specific tests. These tests can include:

[1] This case definition aligns with the European Commission/ European Centre for Disease Prevention and Control case definition.

[2] **Congregate setting:** refers to a range of facilities where people (most or all of whom are not related) live or stay overnight and use shared spaces (e.g., common sleeping areas, bathrooms, kitchens) such as: homeless shelters, refuges, group homes and State-provided accommodation for refugees and applicants seeking protection. Those living or staying in the facility are referred to as residents.) The **risk of transmission is significantly higher**. In these environments, even general ARI cases may warrant **enhanced infection prevention and control precautions**, including temporary isolation, and improved ventilation.

- **Nucleic Acid Amplification Test (NAAT), including Polymerase Chain Reaction (PCR):** A highly sensitive laboratory method that detects the genetic material of respiratory pathogens—such as influenza viruses, SARS-CoV-2, and RSV—enabling accurate diagnosis even at low levels of infection.
- **Serological Tests:** These tests detect antibodies against infectious agents, indicating past infection or immune response. Serological tests are not typically used for diagnosing active infections but can be useful for epidemiological studies.

SUMMARY: Clinical symptoms and laboratory confirmation criteria for ARI

SYMPTOM	DESCRIPTION	LABORATORY TEST	CRITERIA for CONFIRMATION
Cough	With or without sputum	PCR/other NAAT	Detection of pathogen in respiratory samples
Sore throat*	Pain or irritation in the throat	PCR/other NAAT	Detection of pathogen in respiratory samples
Shortness of breath*	Difficulty in breathing	PCR/other NAAT	Detection of pathogen in respiratory samples
Coryza*	Nasal discharge or congestion	PCR/other NAAT	Detection of pathogen in respiratory samples
Sudden onset* of symptoms	Rapid development of symptoms	PCR/other NAAT	Detection of pathogen in respiratory samples
Clinician's judgement	Clinical assessment that the illness is due to an infection	PCR/other NAAT	Detection of pathogen in respiratory samples

Note:

1. The presence of a single symptom (marked with *) does not automatically warrant testing. Please refer to the indications for testing below for further guidance.
2. **Respiratory Sample collection:** Combined nasal and throat swabbing is generally recommended to ensure optimal diagnostic accuracy in respiratory testing. However, it is recognised that this procedure may cause discomfort or distress for some individuals. Clinical judgement should therefore be applied on a case-by-case basis to determine the most appropriate sampling approach. This decision should take into account the individual's clinical presentation, tolerance of the procedure, and the necessity of obtaining both sample types, aiming to balance diagnostic effectiveness with patient wellbeing.

2.2 Testing Pathways

2.2.1 Diagnostic Testing

Diagnostic testing is essential for identifying infections, guiding clinical management, and implementing appropriate public health measures, **while it is not indicated for most individuals with mild suggestive symptoms of ARI, there are instances where clinical management requires microbiological confirmation**. The criteria and protocols for diagnostic testing are explained here and include:

2.2.1.1 Indications for Testing

- **Clinical or Public Health Requirement:** Testing for viral infection (due to clinical severity or to manage risk of transmission in a particular setting) it is recommended that collection of sample is by an appropriately trained clinical practitioner (rather than self-administered) and that testing is by a quality assured process (laboratory or near-patient testing) for a **minimum of four respiratory virus agents** (SARS-CoV-2, RSV, Influenza A and Influenza B).
- **Asymptomatic Individuals:** Testing is not routinely recommended but may be indicated for asymptomatic individuals in specific scenarios, such as contact tracing for exposures to influenza of zoonotic origin or MERS-CoV, or routine surveillance in high-risk settings.
- **Exposure History:** Individuals with known exposure to infectious agents, such as close contact with a confirmed case of influenza of zoonotic origin or MERS-CoV, should be tested to determine infection status.

2.2.1.2 Testing Protocols

- **Specimen Collection:** Proper collection of specimens, such as nasopharyngeal swabs, oropharyngeal swabs, and saliva samples, is crucial for accurate results, details on swab type can be found **here**.
- **Handling and Transport:** Specimens should be handled and transported under appropriate conditions to maintain integrity, such as storing at 2-8°C for up to 48 hours or at -70°C for longer durations.
- **Laboratory Processing:** Diagnostic laboratories should follow standardised protocols for processing specimens and reporting results, ensuring timely and accurate diagnosis.

2.2.2 Testing in Specific Settings

Different settings require tailored testing strategies to address unique challenges and support effective infection prevention and control. This section outlines considerations for testing in specific settings where individuals may present with ARI symptoms that meet the clinical threshold for testing. The following settings include:

2.2.2.1 Paediatrics

- **Symptom Presentation:** Children may present with different symptoms compared to adults, and testing protocols should account for these variations.
- **Specimen Collection:** Techniques for collecting specimens from children should be child-friendly and minimise discomfort.
- **Targeted Testing:** Routine asymptomatic testing is not recommended; testing should focus on symptomatic children if there is a clinical or Public Health indication.

2.2.2.2 Maternity

- **Pregnant Women:** Testing protocols should prioritise the health of both the mother and the unborn child. Testing should only be conducted where there is a clear clinical or public health indication, with careful consideration given to the timing and type of tests used.
- **Labour and Delivery:** Testing for infectious agents prior to labour and delivery should be undertaken only when clinically or public health indicated. This ensures appropriate infection control measures are in place and helps prevent transmission to the newborn.

2.2.2.3 Congregate Settings

- **High-Risk Populations:** Settings such as prisons and places of detention, state-provided accommodation (specifically for underserved populations such as refugees and applicants seeking protection, or people who are homeless), shelters, schools and childcare facilities that may require targeted testing to mitigate for clinical severity and risk of transmission.
- **Outbreak Management:** Rapid identification and isolation of cases are crucial to prevent widespread transmission. Testing protocols should include immediate testing of symptomatic individuals. If individuals present with the same or very similar symptoms, not everyone with symptoms in this setting may need to be tested.

2.2.2.4 Outbreak Settings

- In the context of an outbreak of ARI in a congregated setting, diagnostic testing should be initiated to confirm the causative agent. Once the same viral pathogen (e.g. Influenza A virus) is identified in at least **three symptomatic individuals**, it is generally appropriate to assume that other individuals in the same setting with similar symptoms are infected with the same virus.
- Further routine testing is **not required** unless there are atypical presentations, concerns about co-infection, or specific clinical or public health indications. In some cases, Public Health or Infection Prevention and Control teams may advise additional testing based on the epidemiological context or operational needs.

Specific Pathogens

2.2.2.5 COVID-19

Surveillance

- The case definition (including details for confirmed, probable, and possible cases, and outbreaks) can be found **here**.
- The latest Irish epidemiology on cases and outbreaks as reported by the HPSC are available **here**.
- COVID-19 enhanced surveillance forms are available **here**.

Symptoms

- Fever
- Cough
- Shortness of breath
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhoea

Complications

- Pneumonia
- Acute respiratory distress syndrome (ARDS)
- Multi-organ failure
- Multisystem inflammatory syndrome in children (MIS-C)
- Severe respiratory distress in infants and older adults
- Long COVID-19 (persistent symptoms lasting weeks or months)

Laboratory Criteria

- PCR/other NAAT: Detection of SARS-CoV-2 RNA
- Serology: Detection of antibodies against SARS-CoV-2 (NB: not used for detection of acute infection).

2.2.2.6 SEASONAL INFLUENZA VIRUSES

Surveillance

- The case definition (including details for confirmed, probable, and possible cases) can be found **here**.
- The latest Irish epidemiology on cases and outbreaks as reported by the HPSC are available **here**.
- Seasonal influenza enhanced surveillance forms are available **here**.

Symptoms

- Fever (often high)
- Chills
- Muscle aches
- Headache
- Fatigue
- Cough (usually dry)
- Sore throat
- Runny or stuffy nose

Complications

- Pneumonia
- Bronchitis
- Sinus and ear infections
- Exacerbation of chronic medical conditions (e.g., asthma, heart disease)
- Severe respiratory distress in infants and older adults

Laboratory Criteria

- PCR/other NAAT: Detection of influenza virus RNA
- Viral Culture: Isolation of influenza virus (NB: not routinely performed, only under special circumstances).

2.2.2.7 INFLUENZAS of ZOONOTIC ORIGIN

Surveillance

- Influenzas of zoonotic origin surveillance forms are available **here**.

Symptoms

- Fever
- Cough
- Sore throat
- Shortness of breath
- Coryza

- Muscle aches
- Headache
- Fatigue
- Conjunctivitis (mild to severe)

The above is a list of known symptoms of current influenzas of zoonotic origin; symptoms may vary for an emerging virus/variant.

Complications

- Pneumonia
- Acute respiratory distress syndrome (ARDS)
- Multi-organ failure

Laboratory Criteria

- PCR: Detection of zoonotic influenza virus RNA
- Serology: Detection of antibodies against zoonotic influenza virus (NB: not routinely performed, only under special circumstances).

Epidemiological Criteria

- Recent exposure to animals (e.g., poultry, wild birds, pigs) or environments contaminated by their excreta
- Close contact with a confirmed case of zoonotic influenza

2.2.2.8 RESPIRATORY SYNCYTIAL VIRUS (RSV)

Surveillance

- The case definition (including details for confirmed case) can be found **here**.
- The latest Irish epidemiology on cases and outbreaks as reported by the HPSC are available **here**.
- RSV enhanced surveillance forms are available **here**.

Symptoms

- Runny nose
- Decrease in appetite
- Coughing
- Sneezing
- Fever
- Wheezing

Complications

- Bronchiolitis
- Pneumonia
- Severe respiratory distress in infants and older adults
- Apnoea
- Sepsis

Laboratory Criteria

- PCR/other NAAT: Detection of RSV RNA

- Viral Culture: Isolation of RSV

2.2.2.9 MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS (MERS-CoV)

Surveillance

- No details available.

Symptoms

- Fever
- Cough
- Shortness of breath
- Diarrhoea
- Nausea/vomiting

Complications

- Pneumonia
- Kidney failure
- Severe acute respiratory illness

Laboratory Criteria

- PCR: Detection of MERS-CoV RNA
- Serology: Detection of antibodies against MERS-CoV (**NB**: not routinely performed, only under special circumstances).

2.3 Clinical Health Risk Assessment for ARI

2.3.1 Risk Categories

2.3.1.1 Low Risk

Criteria

- Mild symptoms (e.g., cough, sore throat, runny nose).
- No underlying health conditions.
- No recent exposure to high-risk pathogens.
- No history of severe respiratory illness.
- Age group not typically associated with increased risk (e.g., healthy school-aged children or adults under 65).

Examples

- A healthy adult with a mild cough and sore throat.
- A child with a runny nose and no other symptoms.

2.3.1.2 Moderate Risk

Criteria

- Mild to moderate symptoms.
- Presence of well-managed underlying health conditions (e.g., asthma, diabetes).
- Pregnancy.
- Age-related vulnerability (e.g., infants under 6 months).
- No recent exposure to high-risk pathogens.

Examples

- A pregnant woman with mild cough and sore throat.
- An adult with well-managed diabetes presenting with mild respiratory symptoms.
- An infant under six months with mild coryza.

2.3.1.3 High Risk

Criteria

- Severe symptoms (e.g., high fever, shortness of breath).
- Complex or poorly controlled chronic conditions (e.g., COPD, heart failure, uncontrolled diabetes).
- Immunocompromised status (e.g., cancer treatment, organ transplant, HIV/AIDS, long-term immunosuppressive therapy).
- Recent exposure to high-risk pathogens (e.g., HPAI, MERS-CoV).
- History of hospitalisation due to respiratory illness.
- Age ≥ 65 years, especially with comorbidities.

Examples

- An elderly person with chronic obstructive pulmonary disease (COPD) experiencing high fever and difficulty breathing.
- A pregnant woman with diabetes presenting with severe cough and shortness of breath.
- A person undergoing chemotherapy presenting with fever and respiratory symptoms.

2.3.1.4 Sepsis

Sepsis is a time-critical medical emergency and a broader consideration in any setting, including non-healthcare environments. It can arise as a complication of any infection and requires prompt recognition and escalation.

- An adult or older child has had an infection and presents with any of the following signs may have sepsis:
    - New confusion, slurred speech, disorientation, or altered mental state
    - Difficulty breathing, breathlessness, or very rapid breathing
    - Blue or slightly blue lips
    - Palpitations
    - Cold, clammy, or pale hands and feet
    - Dizziness, fainting, or loss of consciousness
    - Reduced urine output (e.g., not urinating for a day)
    - Petechial or non-blanching rash

- Severe muscle pain (myalgia)

*They could have **sepsis**. Even if they have just one of these symptoms, they should seek urgent medical attention – they may not have all the symptoms.*

2.3.2 Public Health Risk Assessment for ARI

This section complements clinical risk assessment by considering broader factors that influence transmission, outbreak potential, and operational impact in community and institutional settings.

2.3.2.1 Low Public Health Risk

- Isolated case(s) with mild symptoms and no known exposure to high-risk settings.
- No vulnerable individuals in close contact (e.g., immunocompromised, elderly).
- No evidence of clustering or increased absenteeism.
- Adequate ventilation and hygiene measures in place.

Examples:

- A single child with mild symptoms in a well-ventilated classroom.
- An adult with mild symptoms in a low-density workplace.

2.3.2.2 Moderate Public Health Risk

- Multiple symptomatic individuals in a shared setting (e.g., classroom, dormitory).
- Presence of vulnerable individuals in the same environment.
- Limited ability to implement distancing or isolation.
- Early signs of clustering or increased absenteeism.

Examples:

- Several children with respiratory symptoms in a childcare facility.
- A symptomatic staff member in a non-healthcare congregate setting with vulnerable residents.

2.3.2.3 High Public Health Risk

- Rapid increase in symptomatic cases or confirmed outbreak.
- High-density settings with poor ventilation or hygiene.
- Presence of high-risk individuals and limited capacity to isolate or cohort.
- Recent exposure to high-risk pathogens or travel to outbreak areas.

Examples:

- A prison wing with multiple symptomatic residents and limited isolation capacity.
- A school with confirmed influenza outbreak and vulnerable staff.

2.3.2.4 Public Health Risk Modifiers

These factors may elevate the risk of transmission or outbreak potential, even if individual clinical risk is low:

- **Setting density** (e.g. PPDs, schools, non-healthcare congregate settings).
- **Presence of vulnerable populations** (e.g. immunocompromised, elderly).
- **Recent travel or exposure to high-risk environments**.
- **Vaccination status** (e.g. unvaccinated individuals in high-risk settings).
- **Operational constraints** (e.g. limited ability to isolate or cohort).

RISK MATRIX for ARI			
CRITERIA	**LOW RISK**	**MODERATE RISK**	**HIGH RISK**
Symptoms	Mild (cough, sore throat, coryza)	Mild to moderate (cough, sore throat, coryza)	Severe (difficulty breathing, acting confused, severe muscle pain, *see signs and symptoms of **sepsis**)*
Underlying Health Conditions	None	Well-managed chronic conditions	Chronic respiratory disease, heart disease, diabetes
Exposure to Pathogens	No recent exposure to high-risk pathogens	No recent exposure to high-risk pathogens	Recent exposure to HPAI/Zoonotic influenza, seasonal influenza, MERS-CoV, RSV, COVID-19, adenovirus, human metapneumovirus, parainfluenza, rhinovirus, virulent strains of common respiratory pathogens
History of Respiratory Illness	None	None	History of severe respiratory illness or hospitalisation

Refer to **Appendix A** for additional information on Risk Factors.

2.4 Public Health Measures for Case Risk Reduction

2.4.1.1 Considerations for Public Health Measures for Possible/Probable Case(s)

- **General Considerations:**
  - **For General Public:** Stay at home and avoid close contact with others, especially in indoor or crowded places, to help prevent spreading the infection.
  - **For Congregate Settings:** Minimise contact with others in shared or communal areas to reduce the risk of spreading infection within the setting, by provision with single room accommodation or consider referral to **National Infectious Disease Isolation Facility** (NIDIF) for case management if their environment is challenging, for example multiple occupancy rooms.
  - It is particularly important that symptomatic individuals avoid close contact with anyone who is at **very high risk or high risk** of severe **COVID-19 disease**, **influenza** and other respiratory infections, if they become infected, irrespective of vaccination status.
  - Anyone of any age and regardless of underlying health condition who has symptoms such that they are concerned due to **clinical deterioration**

    or
  - Anyone with an **underlying risk profile** who may be eligible for therapeutic intervention should **seek medical advice** which may include clinical assessment and testing for COVID-19, influenza and for other infections if appropriate.
- **Caveat:**
  - If an individual is **epidemiologically linked to a confirmed case of a named ARI** (e.g. COVID-19, influenza, RSV), they should follow the relevant public health advice for that specific infection (this is particularly relevant in congregate settings, but should be taken into account in public health risk assessment), including any testing or isolation requirements, as shown below for confirmed cases.

- **If no such link is identified,** the individual should **stay at home if unwell**, **avoid contact with others**, and **resume normal activities once symptoms have substantially or fully resolved for at least 48 hours**, in line with standard public health guidance. No fever for at least 24 hours without the use of antipyretics. Clinical improvement in respiratory symptoms, although a cough can persist for several weeks in some cases.

2.4.2 Case Risk Reduction Guidance

2.4.2.1 Considerations for Public Health Measures for Confirmed Case(s)

- **Testing**

Routine testing is not indicated for most individuals presenting with mild symptoms suggestive of acute respiratory infection (ARI). However, there are circumstances where clinical judgment and/or public health considerations—particularly following a Public Health Risk Assessment (PHRA)—may warrant microbiological confirmation. Where testing is deemed appropriate (e.g., due to clinical severity or the need to manage transmission risk in a specific setting), the following recommendations apply to confirmed cases:

- **General Considerations:**
  - **For General Public:** Stay at home and avoid close contact with others, especially in indoor or crowded places, to help prevent spreading the infection.
  - **For Congregate Settings:** Minimise contact with others in shared or communal areas to reduce the risk of spreading infection within the setting, by provision with single room accommodation or consider referral to **National Infectious Disease Isolation Facility** (NIDIF) for case management if their environment is challenging, for example multiple occupancy rooms.
- **Duration:**
  - **COVID-19:**

        - **Adults (18 years and over):** A minimum of **5 days** from symptom onset is recommended. Individuals should continue to follow Public Health advice until they feel well, and acute symptoms have substantially or fully resolved, up to a maximum of 10 days.
        - **Children and Young People (under 18 years):** If asymptomatic and testing positive, they are advised to stay at home and avoid contact with others for **3 days** after the day of the test. If symptomatic, they should follow the same guidance (3 days from day of symptom onset), but with consideration to the clinical condition and setting (e.g. school, congregate setting) when undertaking a PHRA.

    - **Influenza (excluding influenza of zoonotic origin):**
        - If treated with an antiviral: At least **3 days** or until acute symptoms have substantially or fully resolved, whichever is longer.
        - If not treated with an antiviral: At least 5 days or until acute symptoms have substantially or fully resolved, whichever is longer.
    - **Other or Unknown Viruses (excluding MERS-CoV):** From onset of acute symptoms until the case no longer feels unwell and no longer has a high temperature (unlikely to be less than 3 days).

- **Treatment:**
    - For **COVID-19** treatment may be recommended for people who are at the highest risk of becoming seriously ill**.** For more information, please see **here**.
    - **Antiviral treatment** can be considered in individuals with non-severe influenza at **high risk of progression to severe disease** (refer risk groups outlined in **Section 2.2.2**) following a risk benefit analysis at the clinician's discretion.

- **Conditions for Ending Public Health Measures:**
  - Substantial or full resolution of acute symptoms.
  - No fever for at least 24 hours without the use of antipyretics.
  - Clinical improvement in respiratory symptoms, although a cough can persist for several weeks in some cases.

2.4.3 Key Risk Considerations in Prisons and Places of Detention (PPDs)

PPDs are considered higher risk for transmission of acute respiratory infections (ARIs), including COVID-19, influenza, and RSV, due to:

- High-density living and frequent close contact among residents.
- Constant population turnover (receptions, transfers, releases).
- Higher prevalence of chronic respiratory illness, immunosuppression, and other comorbidities.
- Staff movement between the community and the facility, increasing risk of introduction and spread.
- Transmission risks associated with shared spaces and communal facilities.

2.4.3.1 General Principles

- **Healthcare Access**: Residents must receive healthcare equivalent to the community, including timely access to **vaccination (influenza, COVID-19)** and **treatments** in line with HSE guidance. They should be treated no differently to other members of the community in terms of healthcare provision.
- **Vaccination Promotion**: Encourage uptake among both residents and staff, especially those at higher risk of severe illness.
- **Symptom Monitoring**: Prompt identification and reporting of ARI symptoms among residents and staff is essential.
- **Education:** Raise awareness among residents and staff about the signs and symptoms of ARI.

2.4.3.2 Isolation and Operational Caveats

- **Symptomatic Individuals**: Those with ARI symptoms and a high temperature or who feel unwell should be advised to limit contact with others, but **full isolation may not be feasible**. In such cases, active symptom monitoring of individuals in close contact with the symptomatic person (whether resident or staff) may be necessary. Pregnant residents should be relocated away from individuals with symptomatic ARI, where feasible, to reduce the risk of exposure.
- **Outbreak Management**: If multiple linked cases arise, contact the Regional Department of Public Health team for outbreak assessment and testing strategy.
- **Operational Continuity**: Infection prevention and control measures must be **proportionate and tailored to the specific site**, ensuring that essential services, security operations, staff safety, and the health and wellbeing of residents are maintained. Measures should be risk-assessed and implemented in a way that supports both operational functionality and public health objectives.
- **Staffing Considerations**: Staff with symptoms should follow public health advice but may be risk-assessed for return to work if asymptomatic or mildly symptomatic, depending on role and staffing levels.

2.4.3.3 Additional Measures

- **Ventilation and Hygiene**: Maintain good ventilation and reinforce hand and respiratory hygiene practices.
- **High-Traffic Areas:** In areas with high footfall, maintain heightened vigilance and implement strict, regular cleaning protocols.
- **Communication**: Ensure residents and staff are informed about symptoms, prevention, and what to do if unwell.
- **Testing**: Routine testing is not required unless individuals are eligible for treatment or an outbreak is suspected.

2.4.4 Key Risk Considerations in school and childcare facilities

Settings for children and young people are considered higher risk for transmission of acute respiratory infections (ARIs), including COVID-19, influenza, and RSV, due to:

- Enclosed environments with frequent close contact between children, young people, and adults.
- High levels of social mixing during education, play, and care activities.
- Higher prevalence of conditions such as asthma and neurodevelopmental disorders among children in these settings.
- Staff movement between the community and the facility, increasing the risk of introducing infections.

2.4.4.1 General Principles

- **Healthcare Access**: Children and young people should receive equitable healthcare, including timely access to **vaccination (influenza, COVID-19, RSV)** and **treatments** in line with HSE guidance. They should be treated no differently to other members of the community in terms of healthcare provision.
- **Vaccination Promotion**: Encourage uptake among eligible children, young people, and staff, especially those at higher risk of severe illness.
- **Symptom Monitoring**: Early identification of ARI symptoms in children and staff is essential to reduce transmission. Where symptoms are observed in a child attending a school or childcare facility, staff should inform the child's parent or guardian promptly. Parents or guardians should be advised to seek medical advice if they are concerned about their child's symptoms, or if the symptoms seem to be getting worse or not improving. Public health teams may be consulted where clusters of illness occur or where further risk assessment is required.

2.4.4.2 Attendance and Isolation Guidance

- **Symptomatic Individuals**: Children, young people, and staff with a **high temperature and who feel unwell** should not attend the setting. They can return when they feel well and no longer have a fever.
- **Positive COVID-19 Cases**: Children and young people (under 18 years of age) who test positive should **not attend for 3 days** after the day of the test or onset of symptoms (whichever was first). Adults (18 years and over)

who test positive should **not attend for 5 days** after the day of the test or onset of symptoms (whichever was first).

- **Mild Symptoms**: Those with mild symptoms (e.g. runny nose, and headache) who are otherwise well **can continue to attend** to minimise disruption to education and care.

2.4.4.3 Operational Caveats

- **Continuity of Care and Education**: Infection control measures must be **proportionate** and **site-specific**, ensuring that essential educational and care services continue.
- **Outbreak Management**: If multiple linked cases arise, contact the local Public Health team for advice on testing and control measures.
- **Staffing Considerations**: Staff with mild symptoms may be risk-assessed for continued attendance, especially where staffing shortages could impact safe operation.

2.4.4.4 Additional Measures

- **Ventilation and Hygiene**: Maintain good ventilation and reinforce hand and respiratory hygiene practices.
- **Education and Communication**: Use age-appropriate materials (e.g. e-Bug resources) to teach children about hygiene, germs, and vaccinations. Please refer to the **HSE website** and **mychild.ie** for further information.
- **Testing**: Routine testing for ARIs is not required unless individuals are eligible for treatment or an outbreak is suspected. In the context of an outbreak, testing should be guided by the Regional Department of Public Health as part of the investigation and management process.

2.4.4.5 Complex or Severe Outbreak: Report and Public Health Response

In the event of a complex or severe outbreak of acute respiratory infections (ARIs) in a childcare or school setting, the following actions should be taken:

- **Reporting Criteria**: Facilities must report to the Regional Department of Public Health when any of the following occur:

    - Hospitalisation of children or staff due to ARI.
    - Rapid spread of illness within the facility.
    - Involvement of high-risk individuals (e.g. immunocompromised children or staff).
    - Operational disruption due to staff shortages or facility closure.
- **Judicious Use of Public Health Support**: Given the large number of educational and childcare settings, it is not practical for Public Health to respond to every ARI-related incident. Facilities should be mindful of when to escalate concerns and seek support—particularly in situations where the outbreak is complex, severe, or poses a risk to vulnerable individuals or operational continuity.
- **Public Health Risk Assessment (PHRA)**: Upon notification, Public Health will conduct a PHRA to determine appropriate outbreak control measures. This assessment will consider:
    - The nature of communal/shared activities.
    - Access by volunteers, parents, and the public.
    - The need to maintain operational continuity of care and education.
- **Infection Prevention and Control (IPC)**: Facilities must ensure IPC measures are in place and proportionate to the risk. These may include:
    - Enhanced cleaning and ventilation.
    - Temporary cohorting or zoning of affected groups.
    - Communication with parents and guardians regarding symptoms and attendance.
- **Testing and Surveillance**: Testing may be recommended by Public Health as part of outbreak management. Routine testing remains unnecessary unless individuals are eligible for treatment or the outbreak warrants further investigation.
- **Communication and Support**: Facilities should maintain clear lines of communication with Public Health, staff, and families. Support may be provided to manage staffing, operational continuity, and health education.

2.4.5 Key risk considerations for congregate non-healthcare settings[3]

Non-healthcare residential settings are considered higher risk for transmission of acute respiratory infections (ARIs), including COVID-19, influenza, and RSV, due to:

- Enclosed environments with frequent close contact between residents and staff.
- High levels of social interaction during shared activities and communal living.
- Higher prevalence of long-term conditions (e.g. asthma, diabetes) among residents.
- Staff and residents' movement between the community and the facility, increasing the risk of introducing infections.

2.4.5.1 General Principles

- **Healthcare Access**: Residents should receive healthcare equivalent to their peers in the community, including access to **vaccination (influenza, COVID-19)** and **therapies** such as antivirals, in line with HSE guidance.
- **Vaccination Promotion**: Encourage uptake among residents and staff, especially those at higher risk of severe illness.
- **Symptom Monitoring**: Early identification of ARI symptoms is essential to reduce spread and protect vulnerable individuals.

2.4.5.2 Isolation and Control Measures

- **Flexible Isolation Approaches**: Isolation of symptomatic individuals should be **proportionate and site-specific**:
    - **On-site isolation** may be feasible in facilities with individual rooms and adequate staffing.
    - **Off-site isolation** (e.g. temporary accommodation, NIDIF at St Ita's) may be considered if on-site capacity is limited.

[3] Given the diversity of congregate settings and the variability in staffing structures, this guidance does not prescribe specific role assignments for each task. It is intended as a flexible framework that facilities can adapt based on their available resources, staff skill mix, and operational context. Each facility is encouraged to review the document and determine appropriate task allocation in line with their internal governance and capacity.

- **Zoning and Targeted Measures**: In facilities with multiple units or wings, **control measures may only be required in affected areas**, with **increased vigilance elsewhere**.
- **Outbreak Management**: If multiple linked cases arise, contact the local Public Health team for outbreak assessment and tailored advice.

2.4.5.3 Operational Caveats

- **Continuity of Care and Support**: Infection control measures must not unduly disrupt essential services. Risk assessments should balance infection prevention with the need to maintain safe, person-centred care.
- **Staffing Considerations**: Staff with mild symptoms may be risk-assessed for continued attendance, especially where absence would compromise safe operation.
- **Visitor Policies**: Visiting should continue with appropriate precautions unless advised otherwise during an outbreak.

2.4.5.4 Additional Measures

- **Ventilation and Hygiene**: Ensure good ventilation and reinforce hand and respiratory hygiene practices.
- **Education and Communication**: Provide clear, accessible information to residents and staff about symptoms, prevention, and what to do if unwell.
- **Testing**: Routine testing is not required unless individuals are eligible for treatment, or an outbreak is suspected.

2.4.6 Key Risk Considerations for Pregnant Women

Pregnant women are at increased risk of complications from acute respiratory infections (ARIs), including COVID-19, influenza, and RSV, due to:

- Changes in the immune and respiratory systems during pregnancy.
- Pregnancy, due to an increased risk of severe respiratory illness, which may lead to higher rates of hospitalisation, admission to high-dependency or intensive care units (HDU/ICU), and associated complications. Severe illness during pregnancy is also linked to adverse pregnancy outcomes, including preterm birth and pregnancy loss.

- Frequent contact with healthcare, childcare, and community settings, increasing exposure risk.

2.4.6.1 General Principles

- **Equity of Care**: Pregnant women should receive healthcare equivalent to the general population, with **enhanced access to vaccination and treatment** in line with HSE guidance.
- **Vaccination Promotion**: All pregnant women should be offered:
  - **Influenza vaccine** at any stage of pregnancy during flu season.
- **Symptom Monitoring**: Pregnant women should be encouraged to report ARI symptoms early, especially if they have underlying health conditions or are in later stages of pregnancy.

2.4.6.2 Isolation and Control Measures

- **Stay-at-Home Advice**: Pregnant women with a **high temperature or who feel unwell** should stay at home and avoid contact with others until they feel better.
- **Mild Symptoms**: Those with mild symptoms (e.g. runny nose, sore throat) who feel well enough can continue with daily activities but should take precautions such as **avoiding contact with vulnerable individuals** and **practising good hygiene**.
- **Testing and Treatment**: Pregnant women may be eligible for antiviral or other treatments if diagnosed with influenza —clinical assessment is essential.

2.4.6.3 Operational Caveats

- **Continuity of Daily Life**: Public health advice should support pregnant women in **maintaining access to essential services**, including antenatal care, work, and childcare, while managing infection risk.
- **Workplace Considerations**: Employers should support risk assessments for pregnant employees, especially in high-contact roles or during outbreaks.
- **Support Networks**: Encourage safe continuation of support from family, community, and healthcare providers, with appropriate precautions during illness.

2.4.6.4 Additional Measures

- **Ventilation and Hygiene**: Maintain good airflow in homes and shared spaces and reinforce hand and respiratory hygiene.
- **Education and Communication**: Provide clear, culturally appropriate information about symptoms, prevention, and when to seek help.
- **Community Awareness**: Promote awareness among household members and close contacts to reduce exposure risk to pregnant women.

2.5 Public Health Measures for Close Contact(s)

2.5.1 Considerations for Exposed Contact(s)

2.5.1.1 COVID-19, RSV, Other or Unknown Respiratory Viruses:

- **Close Contacts:**
  - Defined as persons with more than 15 minutes of contact at less than 2 metres with a confirmed case.
  - Who do **not** have symptoms do not need to limit activity but should monitor for symptoms.
  - If **symptoms develop, individuals are advised to limit contact with other people until the symptoms have substantially or fully resolved in line with advice for cases**.
  - Unless they have been advised otherwise by their treating clinician (as related to clinical severity) or Public Health team (specifically to manage risk of transmission based on Public Health Risk Assessment (PHRA)), people with mild viral respiratory symptoms do not need to seek healthcare and they do not need a test (self-performed or laboratory) to identify a specific virus.
- **Household Contacts/Contacts in Congregate Settings:**
  - Defined as persons living in the same household/congregate setting as a confirmed case.
  - Who do **not** have symptoms do not need to limit activity but should monitor for symptoms.
  - If **symptoms develop, individuals are advised to limit contact with other people until the symptoms have substantially or fully resolved in line with advice for cases**.
  - Unless they have been advised otherwise by their treating clinician (as related to clinical severity) or Public Health team (specifically to manage risk of transmission based on PHRA), people with mild viral respiratory symptoms do not need to seek healthcare and they do not need a test (self-performed or laboratory) to identify a specific virus.
  - **Additional measures will be required for those in congregate settings.** **Refer to Section 2.4.5**

2.5.1.2 Influenza (excluding influenza of zoonotic origin):

- **Close Contacts:**
  - Defined as persons with more than 15 minutes of contact at less than 2 metres with a confirmed case.
  - Who do **not** have symptoms do not need to limit activity but should monitor for symptoms.
  - Individuals with non-severe influenza and at high risk of progression to severe disease may be offered antiviral prophylaxis (e.g., oseltamivir).
  - If **symptoms develop, individuals are advised to limit contact with other people until the symptoms have substantially or fully resolved in line with advice for cases**. Unless they have been advised otherwise by their treating clinician (as related to clinical severity) or Public Health team (specifically to manage risk of transmission based on PHRA), people with mild viral respiratory symptoms do not need to seek healthcare and they do not need a test (self-performed or laboratory) to identify a specific virus.
- **Household Contacts/Contacts in Congregate Settings:**
  - Defined as persons living in the same household/congregate setting as a confirmed case.
  - Who do **not** have symptoms do not need to limit activity, but should monitor for symptoms
  - Individuals with non-severe influenza and at high risk of progression to severe disease may be offered antiviral prophylaxis (e.g., oseltamivir). If **symptoms develop, individuals are advised to limit contact with other people until the symptoms have substantially or fully resolved in line with advice for cases**. Unless they have been advised otherwise by their treating clinician (as related to clinical severity) or Public Health team (specifically to manage risk of transmission based on PHRA), people with mild viral respiratory symptoms do not need to seek healthcare and they do not need a test (self-performed or laboratory) to identify a specific virus.

- **Additional measures will be required for those in congregate settings. Refer to Section 2.4.5**

Refer to **Appendix B** for a summary of these public health measures.

2.6 Access to Isolation Facilities

2.6.1 Available Isolation Facilities

While isolation in a designated facility is rarely required, it should be considered in certain circumstances, such as for individuals in congregate settings who do not have capacity to isolate safely and effectively within that setting, complex domestic environments (e.g. situations of overcrowding), or if the viral pathogen is classified as a High Consequence Infectious Disease (HCID)[4].

2.6.1.1 Low-Risk Cases:

- **HSE National Infectious Disease Isolation Facility (NIDIF):**
    - Location: St Ita's Hospital Campus, Portrane, Co. Dublin
    - Contact Information: Phone: +353 1 843 2201
    - Indications for Use: Mild symptoms, no underlying health conditions, no recent exposure to high-risk pathogens, unable to isolate outside of hospital, but circumstances at home do not allow this, referral can be made to this community isolation facility. For information on contact details and referral form please see **here**.[5]

2.6.1.2 Moderate and High-Risk (i.e. non-HCID) Cases:

- **Admit to Hospital closest to case(s):**
    - Indications for Use: Moderate to severe symptoms requiring hospital care, underlying health conditions.

2.6.1.3 High-Risk (i.e. HCID) Cases:

- **Mater Misericordiae University Hospital:**
    - Location: Eccles St, Dublin 7

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[4] **HCID:** High consequence infectious disease (HCID is defined as: an acute infectious disease; typically having a high case-fatality rate; not always having effective prophylaxis or treatment; often difficult to recognise and detect rapidly; able to spread in the community and within healthcare settings; and requiring an enhanced, individual, population, and system response to ensure it is managed effectively, efficiently and safely.

[5] The HSE National Infectious Diseases Isolation Facility on St. Ita's Campus in Portrane, Co. Dublin is a 43 bed, 24 hour facility for **self-caring individuals with infectious diseases who are aged 18 years and older and who are unable to isolate in their own environment**. Where **family circumstances require the isolation of babies and children, this can also be accommodated once the minors are accompanied by a parent or guardian**. Individuals who are not self-caring, but who can be escorted by designated carers, may also be accommodated.

- Contact Information: Phone: +353 1 803 2000
- Indications for Use: Severe symptoms, underlying health conditions, recent exposure to high-risk pathogens, HCID cases.

2.7 Infection Prevention and Control (IPC)

2.7.1 Guidance for Health & Care Workers and Individuals with Occupational Exposure in non-Healthcare settings

Health & Care Workers (H&CWs) and individuals in congregate settings, such as prisons and places of detention, state-provided congregate accommodation (specifically for underserved populations such as refugees and applicants seeking protection, or people who are homeless), shelters, schools and childcare facilities, play a crucial role in preventing and controlling infections. Effective IPC measures are essential to protect both workers and individuals linked to non-healthcare settings. Key IPC measures include:

2.7.1.1 Vaccination

- **Immunisation:** Encouraging H&CWs and eligible individuals in congregate settings to receive vaccinations for influenza, COVID-19, and other relevant diseases to reduce the risk of transmission.

2.7.1.2 Personal Protective Equipment (PPE)

- **Selection and Use:** Use appropriate PPE based on the type of care provided and the level of risk. The use of a point of care risk assessment (PCRA) for all individual(s) should aid rapid identification, selection of appropriate PPE and implementation of transmission-based precautions quickly. PCRA resources can be found **here**. This includes use of medical masks, eye protection, gloves, apron/gown (where available).[6]
- **Proper Donning and Doffing:** Training on the correct procedures for putting on and removing PPE to prevent contamination.
- **Fit Testing:** In high-risk occupational settings, respirators (e.g. FFP2/FFP3) must be fit tested to ensure they provide adequate protection when correctly used. This requirement does not apply to all non-healthcare settings.

[6] **PPE Recommended:** 1. Respirator Mask: FFP2/3, if person has respiratory symptoms. 2. Medical Face Mask, Type II R, if person has NO respiratory symptoms. 3. Eye protection (Goggles/Visor), if there is a risk of splash to the face and eyes e.g. taking diagnostic tests. 4. Disposable nitrile gloves. 5. Disposable plastic apron. Impervious Long-sleeved gown may be required as determined by the IPC point of care risk assessment.

2.7.1.3 Hand Hygiene

- **Hand Washing:** Regular and thorough hand washing with soap and water for at least 20 seconds applying correct hand hygiene technique, especially before and after patient contact, after removing gloves, and after contact with potentially contaminated surfaces.
- **Alcohol-Based Hand Sanitisers:** Use of hand sanitisers with at least 60% alcohol when soap and water are not available.

2.7.1.4 Environmental Cleaning

- **Routine Cleaning:** Regular cleaning and disinfection of surfaces and equipment, focusing on high-touch areas such as doorknobs, bed rails, and medical equipment and other shared equipment.
- **Cleaning Protocols:**
    - Perform disinfection using a chlorine-based product such as sodium hypochlorite or another appropriate disinfectant. For routine use, a chlorine-based disinfectant should be used with available chlorine at 1000-parts per million;
    - Activities such as dry dusting, sweeping, or vacuuming should be avoided. Wet cleaning methods are preferred; and
    - Vacuuming using a vacuum with a high-efficiency particulate air filter (HEPA filter)(renewed in line with manufacturer's instructions) may be deemed essential in some contexts, in which case ensure the person vacuuming wears a well-fitting mask or respirator and the room is well ventilated.

2.7.1.5 Respiratory Hygiene and Cough Etiquette

- **Covering Coughs and Sneezes:** Use of tissues or the elbow to cover coughs and sneezes, followed by hand hygiene.
- **Masks:** Wearing masks to prevent the spread of respiratory droplets.
- Posters and signs for use can be found **here**.

2.7.1.6 Occupational Exposure Management

- **Responsibility and Oversight:** Line managers in congregate settings have a key role in ensuring that occupational exposure risks are appropriately assessed and managed within their teams. This includes facilitating timely risk assessments, ensuring staff are trained in IPC measures, and supporting adherence to monitoring and reporting protocols. Managers should maintain clear communication channels to enable staff to report symptoms or exposures promptly and ensure appropriate follow-up actions are taken in line with public health guidance.
- **Risk Assessment:** Conducting regular risk assessments to identify potential exposure risks in congregate settings. When assessing the level of risk exposure to respiratory pathogens, consider the duration of exposure (transient versus prolonged), proximity to the case, case-specific factors such as catalogue of respiratory symptoms, or immune suppression, and the use of personal protective equipment (PPE). These elements are crucial in determining the overall risk and necessary precautions.
- **Training and Education:** Providing training on IPC measures and protocols to all staff and individuals linked to non-healthcare settings.
- **Monitoring and Reporting:** Implementing systems for monitoring and reporting occupational exposures and infections. An employee may continue to work post-exposure if they monitor for symptoms. If they develop any symptoms, they should stop working, leave work, and isolate. If the employee is not at work, they should inform their line manager and not return to work from the onset of symptoms until they no longer feel unwell and no longer have a high temperature (unlikely to be less than 3 days).

2.8 Outbreak Management

2.8.1 Outbreak Definition

2.8.1.1 Acute Respiratory Infection (ARI) Outbreak:

- **Definition:** An outbreak of ARI is defined as 2 or more ARI or influenza-like illness (ILI) cases in epidemiologically linked individuals within a 5-day window. This window accounts for the varying incubation and infectious periods of different respiratory viruses.
- **Detection:** Respiratory panel testing, such as multiplex PCR or other NAAT, is recommended for all ARI outbreaks where the pathogen is unknown and there are clinical or public health concerns.

2.8.1.2 COVID-19 Outbreak:

- **Probable COVID-19 Outbreak:** An ARI outbreak should be considered probable COVID-19 if there is one confirmed case of COVID-19 and no contradictory virological evidence from other symptomatic individuals. Alternatively, following a PHRA, if a Medical Officer of Health (MOH) judges the outbreak likely to be caused by SARS-CoV-2 based on symptoms, epidemiological indicators, and absence of contradictory evidence.
- **Confirmed COVID-19 Outbreak:** At least 2 confirmed cases of COVID-19 in an ARI outbreak. The possibility of dual outbreaks (e.g., SARS-CoV-2 and another pathogen) should also be considered.

2.8.1.3 Influenza Outbreak:

- **Probable Influenza Outbreak:** An ARI outbreak should be considered probable influenza if there is one confirmed case of influenza and no contradictory virological evidence from other symptomatic individuals. Alternatively, following a PHRA, if a MOH judges the outbreak likely to be caused by influenza based on symptoms, epidemiological indicators, and absence of contradictory evidence.
- **Confirmed Influenza Outbreak**: At least 2 confirmed cases of influenza in an ARI outbreak. The possibility of dual outbreaks (e.g., influenza and another pathogen) should also be considered.

2.8.1.4 RSV Outbreak:

- **Probable RSV Outbreak:** An ARI outbreak should be considered probable RSV if there is one confirmed case of RSV and no contradictory virological evidence from other symptomatic individuals. Alternatively, following a PHRA, if a MOH judges the outbreak likely to be caused by RSV based on symptoms, epidemiological indicators, and absence of contradictory evidence.
- **Confirmed RSV Outbreak**: At least 2 confirmed cases of RSV in an ARI outbreak. The possibility of dual outbreaks (e.g., RSV and another pathogen) should also be considered.

2.8.1.5 Closing Outbreaks

Criteria for Lifting Outbreak Measures:

- **Symptom Resolution:** The decision to lift outbreak measures should be based on the suspected or confirmed ARI pathogen and the timing of symptom onset in the most recent symptomatic individual.
- **Infectious Period Consideration:** Depending on the pathogen, outbreak measures should remain in place for at least **two full infectious periods (IPs)** from the **onset of symptoms in the last identified case**. This ensures sufficient time has passed to account for potential secondary transmission.
- **Monitoring:** Continue monitoring all individuals for new symptoms for at least 5 days after lifting outbreak measures. This period of heightened vigilance is recommended in accordance with prevailing respiratory virus activity in the community and seasonal trends, to support timely access to treatment and to help limit further transmission and should be based on Public Health Risk Assessment (PHRA).
- **Risk Assessment:** A local risk assessment should underpin the decision to lift outbreak control measures, considering the setting, population vulnerability, and pathogen characteristics.

2.8.1.6 Caveats When Closing Outbreaks

Even when criteria for lifting outbreak measures are met, the following precautions should be maintained or phased out cautiously:

Environmental Cleaning

- **Continue enhanced cleaning and disinfection** for at least 48 hours after the last symptomatic case, especially in high-touch and communal areas.
- Ensure **terminal cleaning** is completed in affected areas cleaning first with detergent and hot water and then disinfected.
- Avoid dry cleaning methods; use wet cleaning or HEPA-filtered vacuuming where necessary.

Visiting

- Visitors should be informed of the recent outbreak and advised to follow strict hand hygiene, respiratory hygiene and cough etiquette.
- Visitors who are experiencing symptoms of illness should **not attend the setting** under any circumstances.
- Facilities should consider alerting visitors and implementing **screening for symptoms measures**, where appropriate, which may include:
    - Displaying clear signage and posters at entry points to remind visitors not to enter if they are experiencing symptoms of ARI.
    - Providing guidance on recognising symptoms and encouraging self-assessment before visiting.

Transfers and Admissions

- **Delay non-urgent transfers and admissions** to and from affected areas until the post-outbreak period, unless a Public Health Risk Assessment (PHRA) determines that such movements can be carried out without posing a risk of wider contagion within the setting.
- Transfer of individuals should ***not be refused or delayed***, pending results of respiratory viral testing. Testing of asymptomatic individuals, as a condition of transfer is ***not*** acceptable or required. Testing of asymptomatic individuals at the receiving facility is ***not generally required***; however, it may be appropriate based on local risk assessment.

- If transfers are essential, ensure receiving facilities are informed of the recent outbreak and IPC measures taken.
- Individuals recently symptomatic should not be transferred until their symptoms have substantially or fully resolved for at least 48 hours.
- **Additional IPC considerations for transfers in outbreak settings:**
    - When an active outbreak is confirmed in a non-healthcare congregate setting, transfers out of affected areas should ideally be avoided, particularly for individuals who are symptomatic.
    - If transfer is required for operational, safety, or other essential reasons, the receiving facility must be informed in advance and appropriate IPC protocols must be in place. This includes isolation on arrival and implementation of measures to prevent onward transmission during and after transfer.

Communication and Monitoring

- Communicate clearly with staff, residents, and families about the rationale for continued precautions.

<table>
<tr><th colspan="3">SUMMARY: ISOLATION AND OUTBREAK DURATION for ARI</th></tr>
<tr><th>PATHOGEN</th><th>DURATION OF ISOLATION for CASES DURING an OUTBREAK</th><th>DECLARE OUTBREAK CLOSED AFTER LAST CASE LINKED to OUTBREAK</th></tr>
<tr><td>COVID-19</td><td rowspan="9">If a confirmed case has no or minimal residual symptoms, transmission-based precautions can be discontinued not less than three days from date of symptom onset based on Public Health Risk Assessment (PHRA).
OR
If a possible/probable case has no or minimal residual symptoms for 48 hours, transmission-based precautions can be discontinued not less than three days from date of symptom onset based on Public Health Risk Assessment (PHRA).*</td><td>10 days</td></tr>
<tr><td>Influenza</td><td>8 days</td></tr>
<tr><td>Respiratory Syncytial Virus (RSV)</td><td>12 days</td></tr>
<tr><td>Adenovirus</td><td>12 days</td></tr>
<tr><td>Human metapneumovirus (hMPV)</td><td>12 days</td></tr>
<tr><td>Parainfluenza</td><td>12 days</td></tr>
<tr><td>Rhinovirus</td><td>8 days</td></tr>
<tr><td>Seasonal coronavirus</td><td>8 days</td></tr>
<tr><td colspan="3">* Extension of the duration of isolation period may be required when acute and/or respiratory symptoms have not clinically improved, and is generally appropriate for medically vulnerable or immunosuppressed individuals.</td></tr>
</table>

2.8.1.7 General Considerations in non-Healthcare Facilities During Outbreaks

Visiting Guidelines:

- **Notification:** Families and regular visitors should be informed about the ARI outbreak, including display of signage at entrances.
- **Facilitation:** Visiting should be facilitated unless there are exceptional circumstances where facilitating a visit would pose a significant risk to the health or wellbeing of someone in the setting. End-of-life visits and visits from health professionals should always be facilitated.
- **Precautions:** Necessary and proportionate precautions should be put in place to enable visits safely. This includes medical mask-wearing (if available, following risk assessment to determine the utility), hand hygiene, and ventilation.
- **Risk Assessment:** Visits should be assessed on an individual basis, considering the risk to the visitor and implementing IPC measures to prevent transmission.
- **Meeting Spaces:**
    - During periods of heightened respiratory infection risk, in-person interactions should be carefully managed to minimise transmission. Where possible, in-room visits are preferable to gatherings in communal areas, as they reduce the risk of cross-exposure between residents.
    - Alternative meeting arrangements—such as speaking through open windows or doors without entering the room—may be considered when appropriate, particularly for individuals who are isolating or symptomatic. These approaches should be conducted in a manner that maintains privacy, dignity, and safety for all parties.
    - Where in-person meetings are necessary, spaces that are well-ventilated and easy to clean should be prioritised. Outdoor meetings may also be suitable, provided weather conditions are safe and the setting allows for appropriate distancing and infection control measures.

2.8.1.8 Staff and Occupational Exposure During Outbreaks

Occupational Exposure Management:

- **Risk Assessment:** Employers should conduct a risk assessment to identify appropriate risk mitigation measures before a workplace exposure to ARI occurs and in response to increased community or facility risk.
- **Sick Leave Policies:** Implement sick leave options that encourage reporting of potentially infectious exposures or illnesses, appropriate use of sick leave, and adherence to work restrictions.
- **Exposure Reporting:** Establish a timely, confidential, and non-punitive mechanism for staff to report potentially infectious exposures and access exposure and illness management services 24/7.
- **Work Restrictions:** Define criteria and methods for imposing work restrictions on exposed or ill staff and clearing them for return to work.
- **Testing and Treatment:** Facilitate prompt access to laboratory testing and treatment for managing exposures and illnesses.
- **Communication:** Ensure effective communication between occupational health services, staff, and other departments (e.g., human resources, managers) about work restrictions.

2.8.2 Outbreak Detection

Early detection of outbreaks is crucial for timely intervention and control. Surveillance strategies for early detection include:

2.8.2.1 Syndromic Surveillance

- **Definition:** Syndromic surveillance involves monitoring health data to enable the early identification of the impact of potential public health events/threats which require effective public health action. This can include data from emergency departments, primary care, acute hospital, and prescription usage.
- **Implementation in Ireland:** In Ireland, syndromic surveillance currently includes data from primary care settings, including general practitioners (GPs), both in-hours and out-of-hours (OOH) services and acute hospital settings. The sentinel GP surveillance programme, sentinel SARI surveillance programme and GP OOHs surveillance programme are the main syndromic

surveillance programmes in Ireland monitored on a year-round basis and reported by the HPSC. These surveillance programmes also include systematic testing (for SARS-CoV-2, influenza, RSV, and other respiratory viruses) of a subset of ARI patients consulting sentinel GPs and testing (for SARS-CoV-2, influenza and RSV) for all SARI patients admitted to SARI sentinel acute hospital sites.

- **Advantages:** Syndromic surveillance provides timely surveillance data, allowing for early warning for increased respiratory virus activity in the acute hospital and community settings.

2.8.2.2 Laboratory Reporting

- **Diagnostic Testing:** Laboratories conduct diagnostic tests, such as PCR and other NAATs, to identify infectious agents. Clinicians and laboratories are **legally required to report positive results** for **notifiable respiratory diseases** to the Medical Officer of Health of their regional Department of Public Health.
- **Computerised Infectious Disease Reporting (CIDR):** CIDR is a national information system in Ireland currently used for the surveillance, control of infectious diseases and reporting of notifiable cases and outbreaks. Laboratory, clinical, and epidemiological information are linked on CIDR, enabling reporting of epidemiological trends, case and outbreak detection.
- **Outbreak Clinical Information Management System (OCIMS):** OCIMS will be a dedicated system for managing clinical and operational aspects of outbreaks. It will enable real-time tracking of outbreak progression, case management, and IPC interventions, supporting timely and informed decision-making, including the closure of outbreaks.
- **Whole Genome Sequencing (WGS):** Advanced techniques like WGS are used to identify and track the genetic fingerprints of pathogens, aiding in the detection of clusters and outbreaks and for monitoring the impact and effectiveness of immunisation programmes.

2.8.2.3 Epidemiological Intelligence

- **Data Integration:** Combining data from various sources, including syndromic surveillance, laboratory reports, and field investigations, to identify and confirm outbreaks.
- **Tools and Platforms:** Tools like EpiPulse and EpiSignalDetection are used for linking and reporting epidemiological data, outbreaks and incidents in the EU. CIDR (and in the future OCIMS) plays a crucial role in outbreak recognition and management.

2.8.3 Outbreak Response

2.8.3.1 Prompt recognition and Isolation

- **Symptomatic Individuals:** Isolating individuals who exhibit symptoms of the infectious disease to prevent further transmission.
    - ***Identification:*** Promptly identify individuals exhibiting symptoms of ARI such as cough, fever, sore throat, runny nose, and shortness of breath. Early recognition is crucial to prevent further transmission within prisons and places of detention, state-provided congregate accommodation (specifically for underserved populations such as refugees and applicants seeking protection, or people who are homeless), shelters, schools and childcare facilities.
    - ***Isolation:*** Isolate symptomatic individuals immediately to minimise contact with other residents and staff. This can be done by confining them to their rooms and ensuring they do not participate in non-essential communal activities.
- **Confirmed Cases:** Ensuring confirmed cases are isolated in accordance with the transmission characteristics of the identified pathogen, using designated isolation spaces either onsite or in appropriate offsite facilities.
    - ***Isolation Spaces:*** Ensure that confirmed cases are isolated in designated spaces. These spaces can be onsite within the facility or offsite facilities specifically prepared for isolation purposes. See **Access to Isolation Facilities**.

- ***Infection Control Measures:*** Implement strict infection control measures in isolation areas, including the use of personal protective equipment (PPE) by staff, regular cleaning and disinfection, and minimising the movement of isolated individuals

- **Duration:** Determining the duration of isolation based on the infectious period of the pathogen and the resolution of symptoms.

OVERVIEW of INFECTIOUS PERIODS for INDIVIDUALS with ARI	
INFECTION	**INFECTIOUS PERIOD FOR CASE**
Confirmed COVID-19	**Adults:** Minimum 5 days from symptom onset for adults. Continue supporting to stay away from others until feeling well and acute symptoms have resolved or to a maximum of 10 days. **Children and Young People (<18 years):** Minimum 3 full days after the day they took the test or from the day their symptoms started (whichever was earliest) for children and young people (<18 years).
Confirmed or probable influenza, not treated with an antiviral	The case should be supported to stay away from others for at least 5 days or until symptoms have resolved if longer.
Confirmed or probable influenza and has been treated with an antiviral	The case should be supported to stay away from others for at least 3 days, or until symptoms have resolved if longer.
Other or unknown viruses	Support the case to stay away from others from onset of symptoms until the resident no longer feels unwell and no longer has a high temperature (unlikely to be less than 3 days).

2.8.3.2 Contact Tracing (related to influenza)

- **Identification:** Identifying individuals who have been in close contact with confirmed cases to assess their risk of infection.
- **Notification:** Inform contacts of their potential exposure and provide guidance on testing protocols, where there are clinical or public health indications.
- **Monitoring:** Regular follow-up with contacts to monitor for symptoms and ensure compliance with testing guidelines if they develop symptoms.
- **Chemoprophylaxis:** For high-risk contacts, such as those with pre-existing health conditions or immunocompromised individuals, consideration for chemoprophylaxis may be needed to prevent severe infection.

2.8.3.3 Communication

- **Transparency:** Providing clear and accurate information to individuals associated with non-healthcare settings and their next of kin about the outbreak, including the nature of the disease, affected areas, and preventive measures.
- **Guidance:** Offering practical advice on hygiene practices, and vaccination to reduce the risk of infection.

2.8.3.4 Co-ordination and Collaboration

- **Multi-Agency Response:** Collaborating with local, regional, and national health authorities, as well as other relevant organisations, in circumstances where the scale, complexity, or nature of the outbreak—such as in congregate settings, among vulnerable populations, across multiple jurisdictions, or in response to emerging infectious threats or pandemics—requires a coordinated and cross-sectoral response.
- **Resource Allocation:** Ensuring the availability of necessary resources, such as PPE, testing kits if needed, and medical supplies, to support outbreak management.
- **Evaluation and Adaptation:** Continuously evaluating the effectiveness of response measures and adapting strategies based on emerging data and feedback.

2.8.4 Escalation and Convening of an Outbreak Control Team (OCT)

2.8.4.1 Purpose

An Outbreak Control Team (OCT) should be convened to coordinate the response to complex or high-risk outbreaks of acute respiratory infections (ARIs), including COVID-19, influenza, and RSV, particularly in settings where transmission risk is elevated and standard control measures may be insufficient.

2.8.4.2 Criteria for Convening an OCT

An OCT should be considered when one or more of the following apply:

- **Multiple linked cases** of ARI are identified within a defined setting (e.g. prison, school or childcare facility, congregate setting), suggesting ongoing transmission.
- **High-risk setting** characteristics are present, such as:
    - High-density living or enclosed environments.
    - Frequent close contact among residents, staff, or attendees.
    - High turnover of individuals (e.g. admissions, transfers, discharges).
    - Vulnerable populations (e.g. immunocompromised individuals, those with chronic respiratory conditions).
    - Operational challenges limiting the implementation of standard infection prevention and control (IPC) measures.
- **Barriers to isolation or cohorting**, such as limited space, staffing, or infrastructure.
- **Disruption to essential services** (e.g. education, security) due to the outbreak or control measures.
- **Need for coordinated multi-agency response**, including public health, facility management, healthcare providers, and other stakeholders.

2.8.4.3 Steps for Initiating an OCT

1. **Initial Notification**

   Contact the Regional Department of Public Health promptly upon identification of a suspected or confirmed outbreak meeting the above criteria.
2. **Information to Provide**

   Include the following details where available:
    - Number of symptomatic and confirmed cases.
    - Onset dates and epidemiological links.
    - Description of the setting and population affected.
    - Control measures already implemented.
    - Specific challenges encountered (e.g. isolation capacity, staffing, access to testing or treatment).
3. **OCT Composition**

   The OCT should include representatives from (this is not an exhaustive list of participants and can be adapted to the setting):

- Public Health
- Facility management (Chair)
- Infection prevention and control (IPC)
- Clinical/healthcare services
- Communications (if required)
- Other relevant stakeholders (e.g. education, social care, prison services)

4. **OCT Objectives**
    - Confirm the outbreak and assess its scope.
    - Review and advise on testing strategy and case definitions.
    - Recommend proportionate IPC measures.
    - Support continuity of essential services.
    - Coordinate communication with staff, residents, families, and the public.
    - Determine criteria for declaring the outbreak over.
5. **Documentation and Follow-up**
    - Ensure minutes and action points are recorded.
    - Assign responsibilities and timelines.
    - Schedule follow-up meetings as needed.

2.9 Preventative Strategies

2.9.1 Vaccination and Immunisation Guidance

All vaccination efforts are guided by the most recent recommendations from the National Immunisation Advisory Committee (NIAC) and are implemented in accordance with national public health policy, and recommendations are listed **here**.

Annual vaccination remains a critical preventive measure to reduce the burden of acute respiratory infections (ARI), particularly during periods of heightened community transmission.

Vaccination is especially important for individuals at increased risk of severe illness or complications, including:

- Pregnant individuals
- Infants and children
- Older adults
- People with chronic medical conditions
- Healthcare and care workers
- Individuals with occupational exposure to animals (e.g., pigs, poultry, waterfowl)

These groups should be prioritised for immunisation based on their vulnerability to respiratory infections such as COVID-19, influenza, RSV, and pneumococcal disease. Vaccines should be administered in line with seasonal guidance and clinical indications, with flexibility to provide access outside of defined campaigns where appropriate

2.9.2 Hygiene Practices

Effective hygiene practices are essential in preventing the spread of ARI. Key practices include:

2.9.2.1 Hand Hygiene

See for further details - **Hand Hygiene**.

2.9.2.2 Respiratory Etiquette

See for further details – **Respiratory Hygiene and Cough Etiquette**.

2.9.2.3 Environmental Cleaning

See for further details – **Environmental Cleaning**.

2.9.3 Ventilation

Improving indoor air quality through proper ventilation is crucial in reducing the risk of ARI transmission. Recommendations include:

2.9.3.1 Natural Ventilation

- **Opening Windows and Doors:** Regularly opening windows and doors to increase airflow and reduce the concentration of respiratory virus particles indoors.

2.9.3.2 Mechanical Ventilation

- **HVAC Systems:** Heating, ventilation, and air conditioning (HVAC) systems should be properly maintained and operated to ensure adequate air exchange and ventilation. In **congregate settings** such as prisons and places of detention, emergency accommodation (specifically for underserved populations such as refugees and applications seeking protection, or people who are homeless), shelters, schools and childcare facilities, efforts should be made to optimise existing systems, even where full HVAC infrastructure may not be available. Practical solutions, such as increasing natural ventilation (e.g. opening windows and doors where safe and feasible), should be considered where mechanical systems are limited.
- **Air Filtration:** Where HVAC systems are in place, the use of **high-efficiency particulate air (HEPA) filters** is recommended to reduce airborne transmission of respiratory pathogens. In settings where HVAC upgrades are not feasible, **portable HEPA filtration units** may be considered as a practical alternative to improve indoor air quality, **where resources permit**.

2.10 Reactive Strategies

Acute respiratory infections (ARI) pose significant health risks, particularly in vulnerable populations such as care home residents. Effective management of ARI involves a combination of antiviral therapies, non-pharmaceutical measures and supportive treatments, guided by health policies and recommendations from organizations like the HSE, UKHSA, CDC, ECDC, and WHO.

2.10.1 Antiviral Therapies

HSE Policies and Recommendations: Antiviral therapies are crucial in reducing the severity and transmission of respiratory infections. The HSE provides specific guidelines for the use of antiviral medications:

2.10.1.1 Paxlovid (Nirmatrelvir-Ritonavir):

- **Usage:** Paxlovid may be considered for selected people who are highest risk of becoming seriously ill. For additional information refer to **Treatment for people at the highest risk from COVID-19.**
- **Indications:** Early administration of Paxlovid helps reduce the risk of progression to severe disease.

2.10.1.2 Oseltamivir (Tamiflu):

- **Usage:** Oseltamivir is recommended for both the **treatment and prophylaxis** of seasonal influenza. Treatment is most effective when initiated within **48 hours of symptom onset**, but may still be considered beyond this window in severe or progressive illness.
- **Indications:**
    - **Treatment:** Treatment should only be offered to those with severe illness (influenza/ILI) and the targeted use of antivirals for the treatment of non-severe influenza in individuals at high risk of progression to severe disease following a risk benefit analysis at the clinician's discretion.

- **Prophylaxis:**
  - For asymptomatic persons (at extremely high risk for hospitalization if they were to develop seasonal influenza) who have had recent close contact with a person with influenza or influenza like illness (ILI) in the same household or setting when influenza viruses are circulating in the community.
  - Chemoprophylaxis may be considered if the contact is not adequately protected by vaccination OR where the person has been exposed in the context of a local outbreak, regardless of vaccination status.
  - For additional information, refer to **Guidance on the use of antiviral agents for the treatment and prophylaxis of Influenza**.

- **Post-Exposure Prophylaxis for Influenza of Zoonotic Origin:** Oseltamivir is also recommended for individuals exposed to **Influenza of Zoonotic Origin** (e.g. H5N1, H7N9), which are associated with severe human disease. Prophylaxis should be initiated as soon as possible after exposure and continued for the duration of risk, typically **10 days**, or longer in high-risk occupational settings.
- **Emerging Threats and Pandemic Use:** In the context of emerging influenza strains or pandemic scenarios, oseltamivir remains a first-line antiviral. Its use may be extended to broader population groups based on public health risk assessments, and dosing regimens may be adapted in line with national pandemic preparedness protocols.

2.10.2 Supportive Therapies

- **Recommended Supportive Therapies**: Supportive therapies play a vital role in managing symptoms and improving patient outcomes during ARI outbreaks. These therapies focus on maintaining overall health and comfort.

Appendix A – Risk Factors

Detailed Risk Factors for Severe Disease

- **Age-related vulnerability:** Both ends of the age spectrum are associated with increased risk of severe disease:
    - Older adults (especially those over 65 years) are at higher risk.
    - Infants and young children aged less than five years (especially those ages less than six months)
- **Comorbidities:** Presence of chronic diseases such as:
    - Chronic respiratory diseases (e.g., asthma, COPD)
    - Cardiovascular diseases (e.g., heart failure, hypertension)
    - Diabetes
    - Chronic kidney disease
    - Liver disease
- **Immunocompromised Status:** Conditions that weaken the immune system, such as:
    - HIV/AIDS
    - Cancer treatments (e.g., chemotherapy)
    - Organ transplantation
    - Use of immunosuppressive drugs
- **Pregnancy:** Pregnant women are at higher risk due to changes in the immune system and respiratory function.

Examples/Case Studies

Example 1: High Risk

- **Patient:** 70-year-old male with a history of COPD.
- **Symptoms:** High fever, persistent cough, difficulty breathing.
- **Risk Factors:** Age, chronic respiratory disease.
- **Risk Assessment:** High risk due to severe symptoms and underlying health condition.
- **Management:** Immediate medical intervention, possible hospitalisation, and close monitoring.

Example 2: Moderate Risk

- **Patient:** 35-year-old female, pregnant, with no underlying health conditions.
- **Symptoms:** Mild cough and sore throat.
- **Risk Factors:** Pregnancy.
- **Risk Assessment:** Moderate risk due to pregnancy, despite mild symptoms.
- **Management:** Regular monitoring, supportive care, and advice on seeking medical help if symptoms worsen.

Example 3: Low Risk

- **Patient:** 10-year-old child with no underlying health conditions.
- **Symptoms:** Runny nose and mild cough.
- **Risk Factors:** None.
- **Risk Assessment:** Low risk due to mild symptoms and no underlying health conditions.
- **Management:** Home care, hydration, and rest.

Appendix B - Public Health Measures for Close Contacts

Virus	Contact Type	Definition	Activity Restriction	Symptom Monitoring	If Symptoms Develop	Additional Notes
COVID-19	Close Contact	>15 min at <2m with confirmed case	No restriction	Yes	Limit contact until symptoms resolve	No test needed unless advised by clinician or PH team
	Household / Congregate	Living with confirmed case	No restriction	Yes	Limit contact until symptoms resolve	No test needed unless advised by clinician or PH team
Influenza	Close Contact	>15 min at <2m with confirmed case	No restriction	Yes	Limit contact until symptoms resolve	High-risk may receive antivirals
	Household / Congregate	Living with confirmed case	No restriction	Yes	Limit contact until symptoms resolve	High-risk may receive antivirals
RSV	Close Contact	>15 min at <2m with confirmed case	No restriction	Yes	Limit contact until symptoms resolve	No test needed unless advised by clinician or PH team
	Household / Congregate	Living with confirmed case	No restriction	Yes	Limit contact until symptoms resolve	No test needed unless advised by clinician or PH team
Other/Unknown respiratory virus	Close Contact	>15 min at <2m with confirmed case	No restriction	Yes	Seek testing and medical advice	No test needed unless advised by clinician or PH team
	Household / Congregate	Living with confirmed case	No restriction	Yes	Seek testing and medical advice	No test needed unless advised by clinician or PH team

- From an **Infection Prevention and Control (IPC) and Public Health** perspective, mitigating acute respiratory infections (ARIs) in **congregate settings**—especially where individuals share rooms or bathrooms—requires a layered approach, and therefore not all within setting need to have restrictions applied.
- **Note:** *Until symptoms resolve refers to until 48hrs after symptoms have substantially or fully resolved*—meaning the individual is either no longer experiencing symptoms or symptoms have improved significantly to the point that they no longer indicate active infection or pose a risk of transmission. Clinical judgment should guide interpretation where needed.