Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities

V6.1 28/07/20

Version	Date	Changes from previous version
1.1	30/03/2020	Added information re contact management Edited definition for outbreak of COVID-19 in RCF OCT must be Chaired by Public Health Doctor Hyperlink to case definition added where appropriate Changed term 'self-quarantine' to 'self-isolation' and hyperlinks included where appropriate Edited flow of document and formatting
2	07/04/20	Added acknowledgements Hyperlinks included where appropriate Roles and Responsibilities updated Added Survival in the Environment Added Laboratory testing Added and updated Transfers of Residents between Care Facilities Updated Section on General Preparedness Pastoral Care included Infection Prevention and Control Measures Section updated Environmental Hygiene updated Added Care of the Dying Added Care of the Recently Deceased Preventing and Control of Outbreaks updated Proposal for Occupational Health Supports added as appendix
3	10/04/20	Change in structure of document Change in outbreak definition for public health action purposes Updated management of outbreak Added tools and checklists for management as appendices
3.1	29/05/2020	Updated information on infectivity and the role of testing in assessing infectivity
3.2	17/04/20	Change in testing strategy to include all residents and staff Change in clinical presentation description Change in outbreak definition for surveillance purposes
4	21/04/20	Change to testing strategy in nursing homes Added mental health commission for reporting of COVID outbreaks Added physical distancing measures for staff while on break times Restructured transfer into RCF section Change to mask wearing guidance for HCW
4.1	04/05/2020	Added EAG advice regarding persistent PCR after recovery and discharge from acute hospital. Updated Occupational Health supports information
4.2	26/05/2020	Adjusted to reflect changes in transfer to and from RCF
5.0	02/06/2020	Includes reference to testing of contacts and that testing of staff at the end of their illness is not appropriate Guidance on transfers in the text replaced by an additional appendix H Updated to reflect requirement for testing of Contacts Updated to reflect that wearing of masks for encounters between staff is required if the encounter is expected to last longer than 15 minutes
5.1	08/06/20	Adjusted text in Appendix H to make clearer that isolation requirements on transfer to RCF differ for a resident without COVID and a resident who has previously had a confirmed diagnosis of COVID Updated links to HSE website for occupational health guidance Added update on visiting RCF

5.2	19/06/2020	Update definition of outbreak to reflect current phase of pandemic Removal of term 'similar units' from title for clarity of setting relevance
6.0	22/07/20	New Introduction & Acknowledgements moved to appendix H Update to section on Physical Distancing including consideration around use of Pods and replacement of 2m with maintain adequate distance as per Public Health Guidance Addition of Section on Group Activities Addition of section on staff movement across facilities Replacement of section 4.4.4 Others; with specific section on External Service Providers & link to guidance for external contractors/maintenance services Addition of a section on management of residents who leave the facility for day event or overnight stay Update to section on staff uniforms Addition on section on duration of transmission based precautions Update to section on care of the recently deceased. Revision of Appendix H – Admissions, Transfers and Discharges Appendix A- Occupational Health moved to Resources Document for RCFs

1 Introduction

Managing the risk of COVID-19 can be thought of as three elements. The first is to take all practical measures to reduce unintended introduction of the virus into the residential care facility. If the virus is not introduced by a person with infection then it cannot spread. Even when all practical precautions are taken it is still possible that the virus will be introduced unintentionally therefore the second element is to take all practical measures to reduce the risk of the virus spreading if introduced. The third element is having processes in place to minimise the risk of harm to residents and staff if both other elements fail and the virus is introduced and spreads. This guideline addresses measures needed to achieve all of the above elements. Controlling the risk of introduction, spread and harm from COVID-19 is challenging particularly as there is a need to balance the management of risk with respect for the autonomy and rights of residents.

Please note that experience and the evidence base related to COVID-19 are increasing rapidly. Therefore, it is essential that you confirm that you are using the latest version of guidance. https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/

2 Roles and responsibilities

2.1 Residential Care Facility

This guidance applies to residential care facilities (RCF) where residents are provided with overnight accommodation. This guidance was developed primarily for congregated care settings providing care for relatively large numbers of residents who are very vulnerable to severe disease because experience shows that spread of COVID-19 in these settings can have profound consequences. While the principles can be applied in all residential care settings the risks are lower in the context of residential care provided in the setting of community housing for groups of 5 people or fewer. In that context a pragmatic approach is required and in particular

restricting people to their room for extended periods is likely to be impractical and should only apply in the context of very specific risk. The anticipated duration of this accommodation may vary within and between different types of RCF. For example, some RCFs for older persons may offer a blend of long-term nursing home and shorter-term respite and convalescence care.

Facilities providing acute inpatient rehabilitation services are advised to refer to the 'Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting' https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/

The primary responsibility for managing the risk of infection with COVID-19 and for control of outbreaks lies with the RCF, within their responsibilities for resident care and infection control. This responsibility is referred to in the 2016 National Standards for Residential Care Settings for Older People in Ireland. All RCF should have in-house (or access to) infection control expertise, and outbreak management plans in place. The Infection Prevention and Control (IPC) service should provide ongoing training to staff with a particular emphasis on Standard Precautions including hand hygiene, respiratory hygiene, cough etiquette and environmental cleaning.

Under the Infectious Diseases Regulations 1981, Amendment February 2020, any medical practitioner who is aware of a case of COVID-19 or an outbreak, is obliged to notify the Medical Officer of Health (MOH) at the regional Department of Public Health. Contact details can be found here on the HPSC website.

Registered providers must notify the Chief Inspector (HIQA) of an outbreak of a notifiable disease within three working days. (Statutory Notifications Guidance for registered providers and persons in charge of designated centres. January 2016)

2.2 Regional Department of Public Health

The Regional Departments of Public Health are responsible for investigating cases and outbreaks of COVID-19 and providing overall leadership and oversight for outbreak management.

3 COVID-19 Background information

The virus which causes COVID-19 infection is called SARS-CoV-2 and belongs to the broad family of viruses known as coronaviruses. It was first identified in the Wuhan province in China in December 2019 and a global pandemic event was declared in March 2020.

3.1 Transmission

Like other respiratory viruses, the transmission of SARS-CoV-2 occurs mainly through respiratory droplets generated from the mouth and nose of an infected person during activities such as coughing, sneezing, talking or laughing. The droplets may carry virus directly to the mouth, nose and eyes of person standing nearby or may land on a nearby surface. Virus can remain viable on the surface for some time and be transferred to the mouth, nose and eyes of another person on their hands after they touch the contaminated surface. The virus does not penetrate through the skin and is not generally transmitted by the airborne route. However, certain procedures that may be performed known as Aerosol Generating Procedures (AGP) can create the potential for airborne transmission. Further information on AGPs in COVID-19 is available at:
https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/

Individuals are considered most infectious while they have symptoms. How infectious individuals are depends on the severity of their symptoms and the stage of their illness. Higher levels of virus have been detected in people with severe illness compared to mild cases. Peak levels of virus are found around the time of symptom onset. In general, virus remains detectable in respiratory secretions for up to eight days in moderate cases and longer in severe cases. The widely used tests for the virus can remain positive for much longer (for weeks in some people). The experience and research over the past few months has shown that positive tests results after the person has recovered do not mean that the person is still infectious to others. These tests should not be used to decide when a person is no longer infectious, except in very exceptional circumstances.

It is accepted that infection is also spread by people who do not have symptoms. People may be infectious for up to two days before they develop symptoms (pre-symptomatic transmission) and some people who never notice any symptoms may be infectious to others (asymptomatic transmission).

The virus has been detected in faeces, urine, blood samples from infected individuals, although it is not clear that these are a significant transmission risk.

The consistent application of Standard Infection Prevention and Control Precautions by all staff with all residents at all times will limit the introduction and spread of COVID-19 from people with recognised and unrecognised COVID-19 infection.

3.2 Incubation period

Current estimates suggest that the time between exposure to the virus and developing symptoms (incubation period) is from five to six days, but can range from one to 14 days.

3.3 Survival in the environment

The SARS-CoV-2 virus has an outer coating called a lipid envelope. The presence of the lipid envelope means that virus is likely to survive for shorter periods outside the human body compared to a non-enveloped virus like Norovirus (Winter vomiting virus). The virus is easily killed by common household cleaning products, and many disinfectants including bleach. Survival on environmental surfaces depends on the type of surface and the environmental conditions. One study using a SARS-CoV-2 strain showed that it can survive on plastic for up to 72 hours, for 48 hours on stainless steel and up to eight hours on copper when no cleaning is performed. However, the levels of virus declined very quickly over the time period.

3.4 Clinical features of COVID-19

Most people with COVID-19 will have mild disease and will recover. A minority will develop more serious illness. People at higher risk of developing more serious illness include:

- Older people – the risk increases progressively in people above the age of 60 years and is particularly high among individuals aged in their 70s and 80s
- Those who are immunocompromised
- Those with underlying medical conditions

In the general population the most common signs and symptoms include:

- fever (though this may be absent in the elderly)
- dry cough
- shortness of breath
- loss of sense of smell or taste

Other symptoms can include:

- sputum production
- fatigue
- sore throat
- headache
- myalgia/arthralgia
- chills
- nausea or vomiting
- nasal congestion
- diarrhoea
- haemoptysis
- conjunctival congestion
- anosmia (loss of sense of smell)
- dysgeusia (distortion of sense of taste)
- ageusia (loss of sense of taste)

For more information on symptoms and signs of COVID-19, refer to the latest case definition https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casedefinitions/.

It is important to remember that older people with COVID-19 very often do not have fever and respiratory symptoms and may only have symptoms such as:

- **lethargy**
- **increased confusion**
- **change in baseline condition**
- **loss of appetite**

Clinical judgement with a high index of suspicion should be used when assessing residents.

3.5 Laboratory testing

- Laboratory testing is helpful to confirm a diagnosis of COVID-19 infection
- Testing is performed in the same way as testing for influenza. A viral swab is collected from the throat and nasopharynx. Only one swab is used to collect both samples, with the throat site sampled first.
- **When testing is performed, ensure the correct swab type is taken (viral swab), sealed tightly to prevent leakage and it is appropriately labelled** with two matching resident identifiers on both the swab and request form, to include the resident's name and date-of-birth (DOB). Ensure that the name and contact details for the resident's doctor are on the request form, together with the address of the RCF and any other contact details required. These should include the name and telephone number (mobile preferably) for the designated person who will receive the laboratory result clearly visible on the request form. Deliver the sample to the testing laboratory as soon as possible. Confirm in advance that you are sending the sample to the designated laboratory to perform the test for your RCF and that samples taken from residents of RCF are being prioritised for testing, particularly in a suspected outbreak
- Current laboratory tests are accurate but no diagnostic test is perfect. If a test result comes back as "SARS-CoV-2 not detected" and the resident remains unwell with no alternative diagnosis, then a diagnosis of COVID-19 is still possible. If there is any concern, the resident's condition should be discussed with their doctor. Additional information is available in the section on Duration of Transmission Based Precautions

4 General measures to prevent a COVID-19 outbreak during the pandemic

4.1 Planning

- Identify a lead for COVID-19 preparedness and response in the RCF. The lead should be a person with sufficient authority to ensure that appropriate action is taken and may require support of a team, including a liaison person on each unit in the RCF
- RCF settings must have COVID-19 preparedness plans in place to include planning for cohorting of residents (COVID-19 separate from non-COVID-19), enhanced IPC, staff training, establishing surge capacity and promoting resident and family communication
- Maintain an up-to-date line list of all residents in the RCF and all staff working in the RCF, along with contact telephone numbers
- Each RCF should have an area identified where a resident with suspected or confirmed COVID-19 could be isolated
- Where possible, each ward or floor should try to operate as a discrete unit or zone, meaning that staff and equipment are designated to a specific area and are not rotated from other areas (this includes night duty). This may not always be feasible in smaller facilities, but in larger facilities this practice may reduce exposure to risk for staff and residents in the event COVID-19 is introduced into the facility. This may also allow outbreak response measures to be targeted in zones, rather than having to be implemented facility-wide
- Facilities should ensure the availability of supplies, including tissues, alcohol-based hand rub (ABHR), hand wipes, cleaning products, disinfectants and personal protective equipment (PPE) and liaise with relevant supply lines if there is difficulty in obtaining such supplies
- A summary table of key interventions for the prevention and management of a COVID-19 outbreak can be found in Appendix A

4.2 Education

4.2.1 Staff

- All staff should be aware of the early signs and symptoms of COVID-19 and who to alert if they have a concern. Staff should be able to contact an appropriate escalation pathway 24/7

  Please see the HPSC website for the most up to date case definition for COVID-19.

- All staff should have training in standard precautions, in particular hand hygiene, respiratory hygiene and cough etiquette, along with training in transmission-based precautions (contact, droplet and airborne), including the appropriate use of PPE for each situation
- RCFs should ensure that one or more staff members are trained to collect a viral swab sample for testing for SARS-CoV-2, the cause of COVID-19. Please refer to guidelines and video in relation to same available HERE

4.2.2 Residents

- Residents should be kept informed of the measures being taken and the reason for these measures during this time. This is particularly important where visiting has been restricted or suspended
- Residents should be encouraged and facilitated to clean their hands and actively assisted with this practice where necessary
- Key messages around cough etiquette (where appropriate) include:
  - Cover your mouth and nose with a disposable tissue when coughing and sneezing to contain respiratory secretions
  - Discard used tissues after use and clean your hands
  - If you don't have a tissue, cough into your forearm or the crook of your elbow
  - Clean your hands
- In line with guidance from the National Public Health Emergency Team (NPHET), the importance of maintaining a physical distance from others in accordance with Public Health Guidance where possible should be observed

- Where possible and appropriate, residents should be made aware of the need to report any new symptoms of illness to staff members

4.3 Physical distancing measures & Pods

- As the pandemic persists it is increasingly onerous for many residents to stay in their room substantially all of the time. It is appropriate therefore for each RCF to consider how and when social activity can safely be facilitated for residents who have no symptoms of COVID-19, who are not contacts of COVID-19 and who are not currently under transmission-based precautions.
- Where social activity can be facilitated this should be organised on the basis of limiting contact to small and consistent groups of residents to the greatest extent possible. For example, it may possible to develop "pods" of about 4 residents who tend to talk together or enjoy a specific activity together and arrange for people in that pod to sit and interact together. Residents engaged in social activity should be encouraged to maintain physical distance, hand hygiene and cough etiquette with other residents and staff. Residents engaged in social activity should also be advised to avoid touching other people (touching hands, hugging or kissing). Exceptions are appropriate for couples who reside in the same RCF.
- If a system of pods can be developed physical distance should particularly be maintained between individuals in different social pods.
- In order to support physical distancing, mealtimes may need to be staggered so that, for example, people in the same pods eat together or meals are served in the residents' rooms. Consider whether it is possible to use all available communal areas to allow groups of residents in the same pod to eat their meals together while maintaining social distancing from each other and in particular from other pods.
- If social interaction can be facilitated it is appropriate to use well ventilated indoor space or outdoors space where available.
- Staff members should also be required to adopt social distancing measures during their break and meal times

- During periods when there is evidence of sustained community transmission of the virus or there is an outbreak it may be necessary to implement more restrictive social distancing rules within the RCF for example residents who need to be more careful due to their medical vulnerability may be advised to further reduce their social contact or to avoid all social contact for a period of time.
- During periods when there is little or no evidence of sustained community transmission and no outbreak in the RCF, the risk associated with more social interaction is reduced. In that context there is less need to encourage residents to limit their interaction to their "pod" although it remains prudent to advise social distancing when practical, frequent hand hygiene and good cough etiquette.

4.4 Group Activities

- Group activities are important for residents' welfare and should be assessed by weighing up the risks and benefits to residents for each activity (Table 2)
- Before any group activity confirm that participants have no symptoms that suggest COVID-19
- Weather permitting, outdoor group activities are likely to be lower risk than indoor activities
- As above consider establishing small groups ("pods") who consistently attend group activities with each other, rather than having new ad-hoc groupings formed for each day/ activity
- Those group activities considered important to residents' welfare should be organised in such a way so as to reduce the risk of infection as much as practical (for example by organising for residents to be in pods and if those pods are combined for certain activities, they should be organised with the same consistent groupings) with minimisation of direct or close contact between individual residents.
- Ensure adequate supplies of hand sanitizer and appropriate cleaning products (for example detergent wipes) are available in each activity room/area

- Ensure staff and volunteers know that they should wear a surgical face mask when they cannot maintain physical distance from residents and that they should perform hand hygiene regularly especially after assisting a resident

Table 2 Examples of group activities

	Comment
Chair aerobics/yoga	Clean chairs between each session with detergent wipes
Ball games	Limit to members of one pod and hand hygiene before and after
Bingo	Individual answer sheets & markers
Dancing	Dancing alone with distance maintained is very low risk – if dancing with partners if limited to one consistent partner from the same pod this can reduce risk
Card games e.g. bridge	Limit to members of one pod and hand hygiene before and after
Computer skills	Cover keyboard and clean after use
Sing songs	Limit to members of one pod. Maintain as much distance and ventilation as practical. Standing in a circle /square all facing outwards may be expected to reduce droplet risk.
Knitting	Yes, if each person uses their own equipment
Art	Yes, if use own equipment
Flower arranging	Suggest limit to members of one pod and hand hygiene before and after
Table quiz	Individual answer cards. Hand hygiene before and after
Jigsaws	Limit to members of one pod and hand hygiene before and after
Pottery	Clean potter's wheel between users
Films	Social distancing
Wii Keep fit	Clean hand set and controls between residents

4.5 Controls to minimise risk of inadvertent introduction of virus

4.5.1 Staff

- All staff should be aware of the early signs and symptoms of COVID- 19 and who to alert if they have a concern. Staff should be able to contact an appropriate escalation pathway 24/7
- Please see the HPSC website for the most up to date case definition for COVID-19.

- All staff should have training in standard precautions, in particular hand hygiene, respiratory hygiene and cough etiquette, along with training in transmission-based precautions (contact, droplet and airborne), including the appropriate use of PPE for each situation
- RCFs should ensure that one or more staff members are trained to collect a viral swab sample for testing for SARS-CoV-2, the cause of COVID-19

4.5.2 Movement across facilities

- The movement of staff between facilities should be minimised where possible, it is recognised however that staff may have to work across multiple sites to ensure service provision. This is acceptable if adhering to all requirements below (4.5.3)

4.5.3 Staff occupational health & workforce planning

- Staff working in a facility that is experiencing an outbreak should not work in any other facility
- Staff should be allocated to one zone within the RCF if at all possible
- Staff should be informed that they must not attend work if they have fever or cough or shortness of breath or any kind of new respiratory symptoms. They should be aware of their local policy for reporting illness to their manager. Also, if one of their household contacts have respiratory symptoms the staff member should contact their manager for advice before attending work
- The NPHET requires that all staff have their temperature measured twice a day, once being at the start of each shift
- In addition, at the start of each shift, all staff should confirm with their line manager that they do not have any symptoms of respiratory illness, such as fever, cough, shortness-of-breath or myalgia. Where relevant staff should be asked to confirm that they are not currently working in a facility where there is an outbreak
- Staff members who become unwell at work should immediately report to their line manager and should be sent home and advised to contact their GP by telephone. If they

cannot go home immediately, they should be isolated in a separate room until they can go home

- Occupational health guidance for healthcare workers is available at: https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/covid-19-guidance/
    - Staff members who test positive for COVID-19 may return to work 14 days after symptom onset (or date when test was taken if no symptoms) provided they have had no fever during the last five days. Repeat testing at the end of the illness is generally not appropriate.
    - Staff members who have been identified as close contacts of a case either in the community or the occupational setting should not attend work for 14 days from the last exposure to the case and restrict their movements as much as possible. Close contacts will be offered testing for COVID-19 at day 0 and day 7
    - Derogations to return to work for healthcare workers who are close contacts of COVID-19 cases can be applied with appropriate caution in RCF, given the high risk of adverse outcomes in these groups in the event of severe staff shortages leading to resident safety issues
- Available Occupational Health supports are detailed in Appendix B.

4.5.4 External Service Providers

Persons providing services to residents including healthcare workers (physiotherapy/occupational therapists), professional services such as hairdressing, masseurs, aroma -therapists and those providing pastoral care should not be considered as visitors but rather as external service providers

- External services should be facilitated subject to risk assessment and with the following precautions in place
    - All external providers should liaise with the Director of Nursing/Person in charge or his/her deputy in the RCF prior to attending.
    - All of the requirements for attendance that apply to staff apply to external service providers (see above section 4.5.3).

- Adhere to all infection prevention and control measures appropriate to the task including use of PPE as appropriate to the task performed. Decontamination of equipment should be in line with the cleaning and disinfection guidance described herein.

4.5.4.1 Maintenance Staff & External Contractors

Guidance in relation to Maintenance Staff & External Contractors providing services in HSE health and social care facilities is available here

4.5.5 Visiting by Family and Friends

- Residents should be kept informed of the measures being taken and the reason for these measures during this time. This is particularly important where visiting has been restricted or discontinued
- As from the 9th of July NPHET recommends that visitors and outpatients to hospitals, residential settings and community health services (for example General practice, dental practice, pharmacy service) should wear a form of face covering to reduce the likelihood of spread of infection from the wearer. This does not remove the need for other combinations of protective measures (for example social distancing and hand hygiene) to reduce the risk of transmission of COVID-19
- Detailed guidance for visitors and friends is available is HERE
- Information leaflet for visitors is available HERE

4.5.6 Pastoral care

- Religious/cultural support and rites may be very important to some residents of RCF, in particular towards end of life
- Chaplaincy visits/cultural support are recognised as an important part of a resident's well-being. Visitors providing chaplaincy support should be reminded of the need to minimise physical contact and to follow advice particularly around hand hygiene, respiratory hygiene and cough etiquette
- If it is appropriate to the religious and cultural needs of the resident, pastoral care provided remotely for example by phone or video link may avoid the potential risk of exposure in particular during periods of intense community transmission.

4.5.7 Resident transfers

- Guidance on resident transfers is addressed as an appendix to this document. (**Appendix H**)

- For guidance on admission to facilities such as community hospitals and acute rehabilitation units please refer to the document - Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting located here.

4.6 Increase surveillance and early identification of cases COVID-19 infection

- Surveillance (monitoring for illness) is an essential component of any effective infection control programme
- RCFs should ensure that they have means in place to identify a new case of COVID-19 and control transmission, through active monitoring of residents and staff for new symptoms of infection, rapid application of transmission-based precautions to those with suspected COVID-19, prompt testing of symptomatic residents and referral of symptomatic staff for evaluation. Current case definition can be found here.
- The RCF should ensure that there is twice daily active monitoring of residents for signs and symptoms of respiratory illness or changes in their baseline condition (e.g., increased confusion, falls, and loss of appetite or sudden deterioration in chronic respiratory disease)
- There should be early identification of staff absenteeism, which may be due to COVID-19 infection or a requirement to restrict movements for close contacts of a COVID-19 case

5 Management of an outbreak of COVID-19

When there is a suspicion of COVID-19 the MOH should perform a risk assessment to determine whether there is either possible or confirmed active transmission in the facility. An isolated positive result of SARS-CoV-2 in a resident or staff member is not in itself proof of current active transmission. It is appropriate to consider if the test result may reflect a persistent positive

result related to a remote infection and if the person may have become infected outside of the RCF.

When an outbreak is suspected laboratory testing should be arranged as quickly as possible. However, it is not necessary to wait for laboratory test results before beginning initial investigation, contacting Public Health or implementing control measures. There should be heightened awareness among staff, so that other residents with symptoms are quickly identified.

A local incident management meeting should be arranged promptly and involve key staff members including housekeeping, nursing staff, allied healthcare professional and medical staff.

This group should:

- Try and establish whether it is likely an outbreak might occur, taking in to account the following:
    - Could onward transmission have already occurred? (e.g., resident had widespread contact with others in the 48 hours before symptom onset)
        - Are they in a single room or sharing?
        - Is the resident ambulatory?
        - Have they spent time with others in communal areas or group activities?
        - Are there behavioural characteristics which might be increased risk of transmission?
- Identify are any other residents symptomatic and if so, what are their symptoms?
- Identify are any staff symptomatic or has there been an increase in staff absenteeism?
- Identify residents and staff who were in close contact with the symptomatic resident in the 48 hours before symptom onset or before isolation and transmission-based precautions were implemented.

The initial management of the possible case and close contacts should be the same as for a confirmed case of COVID-19 until an alternative diagnosis has been identified

5.1 Declaring an outbreak

For surveillance purposes, the following outbreak definition applies:

Confirmed

A cluster/outbreak, with two or more cases of laboratory confirmed COVID-19 infection regardless of symptom status. This includes cases with symptoms and cases who are asymptomatic.

OR

A cluster/outbreak, with two or more cases of illness with symptoms consistent with COVID-19 infection (as per the COVID-19 case definition), and at least one person is a confirmed case of COVID-19.

Suspected

A cluster/outbreak, with two or more cases of illness with symptoms consistent with COVID-19 infection (as per the COVID-19 case definition)

5.2 Outbreak Control Team (OCT)

- All outbreaks of COVID-19 in RCF must be reported to the regional Medical Officer of Health (MOH) at the Department of Public Health at the earliest opportunity
- Public Health doctors from the Regional Department of Public Health will provide overall leadership for the management of the COVID-19 outbreak in the RCF
- Ideally, the OCT should have regular, active involvement of a Public Health Doctor. However, if that is not practically possible, following initial consultation and advice from Public Health, the OCT should liaise on a regular ongoing basis with the regional Public Health Department to provide updates on outbreak progress and seek further advice as appropriate
- The OCT membership should be decided at local level and will depend on available expertise
- An OCT Chairperson should be agreed

- Members of the OCT may include any of the following. However, in many settings it may not be possible to include all the expertise referred to below:
    - Specialist in Public Health Medicine and/or Public Health Department Communicable Disease Control Nurse Specialist
    - GP/Medical officer/Consultant to RCF (dependent on nature of RCF)
    - Director of Nursing or Nurse Manager from RCF
    - Management representative from the RCF i.e. manager or CEO
    - Community Infection Prevention and Control Nurse (CIPCN) where available
    - Administration support
- Other members who may need to be included, particularly if it is an extensive or prolonged outbreak include:
    - Community Services General Manager
    - Administrative support
    - Occupational Medicine Physician
    - Consultant Clinical Microbiologist
    - Representative from HPSC
    - Communications officer
- Every member involved should have a clear understanding of their role and responsibility
- The frequency required for the OCT meeting should be decided and they should be carried out in consideration of social distancing requirements via teleconference/videoconference facilities
- Public Health will formulate a case definition, assign an outbreak code and decide as to whether an on-site visit is required or not
- The RCF should inform HIQA or Mental Health Commission, as appropriate and the local CHO as per usual protocols

Before the first meeting of the OCT, the local incident team should gather as much information as possible to include:

- A line list of all residents and staff. Template can be found in Appendix C.
- Identify the total number of people ill (residents & staff), dates of illness onset and the spectrum of symptoms
- Identify staff and residents who have recently recovered, developed complications, been transferred to acute hospitals and those who have died
- Information on laboratory tests available including the number of tests taken to date and the date sent to the laboratory, along with the reported results
- Determine if the number of symptomatic residents/staff involves more than one unit/floor/ward or if the outbreak is confined to one area only
- Use the case definitions for possible, probable and confirmed COVID-19 available on the HPSC website HERE.
- A checklist for outbreak management can be found in Appendix D.

5.3 Management of a possible or confirmed case of COVID-19

- The initial assessment of the resident should be performed by their doctor by telephone
- If COVID-19 is suspected, the doctor will arrange testing
- If the clinical condition does not require hospitalisation, the resident should not be transferred from the facility on infection prevention and control grounds
- Where there is capacity and it is appropriate to their care needs, a resident with possible or confirmed COVID-19 should be placed in a single room with transmission-based precautions and appropriate use of PPE by staff (**Appendix F & Appendix G**)
- Room doors should be kept closed where possible and safe to do so
- When this is not possible, ensure the resident's bed is moved to the furthest safe point in the room to try and achieve a 2m physical distance to the door
- Display signage to reduce entry into the room, but confidentiality must be maintained
- Take time to explain to the resident the importance of the precautions that are being put in place to manage their care and advise them against leaving their room
- Ideally, the resident's single room should have en suite facilities
- If an en suite is not available, try to designate a commode or toilet facility for the

resident's use

- In the event of a commode being used, the HCW should exit the resident's room while wearing appropriate PPE, transport the commode directly to the nearest sluice (dirty utility) and remove the PPE in the sluice after placing the contents directly into the bed pan washer or pulp disposal unit. A second person should be available to assist with opening and closing doors to the single room and sluice room. If a second person is not available, change gloves and perform hand hygiene and put on a clean pair of disposable gloves
- If the resident must use a communal toilet ensure it is cleaned after every use
- Listen and respond to any concerns residents may have to ensure support and optimal adherence is achieved during their care
- If well enough, a resident may go outside alone if appropriate or accompanied by a staff member maintaining adequate distance from both staff and other residents. If the staff member can maintain this distance, they do not need to wear PPE
- If the resident passes briefly through a hallway or other unoccupied space to go outside, there is no requirement for any additional cleaning of that area beyond normal good practice
- If entry to an occupied shared space is unavoidable, the symptomatic resident should be encouraged to clean their hands and wear a surgical mask (if tolerated) or to cover their mouth and nose with a tissue
- Residents with confirmed COVID-19 will require appropriate healthcare and social support, including access to their doctor or GP for medical management and on -site support
- A care planning approach that reflects regular monitoring of residents with COVID- 19 infection for daily observations, clinical symptoms and deterioration should be put in place. Where appropriate there should be advance planning in place with residents and/advocates reflecting preference for end of life care and / or transfer to hospital in event of deterioration. Staffing levels / surge capacity

planning should reflect the need for an anticipated increase in care needs during COVID-19 outbreak.

- Residents with confirmed COVID-19 infection should remain in isolation on Contact and Droplet precautions until 14 days after the first date of onset of symptoms and they are fever free for the last five days
- Staff should be mindful that prolonged isolation may be stressful for some residents and to encourage relatives and other residents where practical to communicate with them regularly via phone or video calls

5.4 Cohorting residents with possible or confirmed COVID-19

- Placement of residents with possible or confirmed COVID-19 in a designated zone, with designated staffing (where staffing levels permit) to facilitate care and minimise further spread is known as cohorting. As the lay-out for each RCF will differ, the zoned area might be a floor, a wing or a separate annex. In these zoned areas, heighten infection prevention and control measures are critical
- Cohorting includes residents who are placed in single rooms close together, or in multi-occupancy areas within the building or section of a ward/unit
- Where possible, residents with probable or confirmed COVID-19 should be isolated in single rooms with en-suite facilities. If there are multiple residents and if it is practical to do so, these single rooms should be located in close proximity to one another in one zone, for example on a particular floor or area within the facility
- Where single room capacity is exceeded and it is necessary to cohort residents in a multi-occupancy room:
    - Only residents with **a confirmed diagnosis of COVID-19** can be cohorted together;
    - Residents with suspected COVID-19 should not be cohorted with those who are confirmed positive;
    - The risk of cohorting **suspected cases** in multi-occupancy areas is much greater than that of cohorting confirmed positive residents together, as the suspected cohort is likely to include residents with and without COVID-19;

- Where residents are cohorted in multi-occupancy rooms, every effort should be made to minimise cross-transmission risk:
    - Maintain as much physical distance as possible between beds; if possible reduce the number of residents/beds in the area to facilitate social distancing
    - Close privacy curtains if available between the beds to minimise opportunities for close contact
- There should be clear signage indicating that the area is a designated zone to alert staff about cohorting location in the RCF. A zone may have multi-occupancy rooms or a series of single rooms
- A designated cohort area should ideally be separated from non-cohort areas by closed doors
- Minimise unnecessary movement of staff in cohort areas and ensure that the number of staff entering the cohort area is kept to a minimum
- Staff working in cohort areas should not be assigned to work in non-COVID-19 areas
- In so far as is possible, the cohort area should not be used as a thoroughfare by other residents, visitors or staff, including residents being transferred, staff going for meal breaks and staff entering and exiting the building

5.5 Management of close contacts of a possible or confirmed case of COVID-19

- Residents who are close contacts of a confirmed case should be accommodated in a single room with their own bathing and toilet facilities. If this is not possible, cohorting in small groups (two to four) with other close contacts is acceptable
- Residents who are close contacts should be advised to avoid communal areas and stay in their room where it is practical to do so until 14 days after exposure
- Residents who are close contacts may go outside if appropriate, alone or accompanied by a staff member maintaining adequate distance. An accompanying staff member in this situation is not required to wear PPE
- Note: testing of close contacts for COVID-19 is now recommended at day 0 and day 7. Note that even if these tests for close contacts are reported as

SARS-CoV-2 not detected the requirement for restricted movement for 14 days will remain in place. Regardless of the outcome of these scheduled tests, the resident should be referred to their doctor for assessment at any time if they develop symptoms of infection.

- If the resident transits briefly through hallway or other unoccupied space to go outside, there is no requirement for any additional cleaning of that area beyond normal good practice
- It is understood that some residents may, due to underlying conditions (e.g. dementia with wandering behaviours) have significant difficulties with isolation and / or restricted movement. In these instances, the creation of a 'safe zone' may be the most appropriate support to prevent distress arising from confinement. Separate access to outdoor spaces or communal rooms not used by other residents may be appropriately used when followed by environmental cleaning and disinfection if required
- If entry to an occupied shared space is unavoidable, the resident should be encouraged to perform hand hygiene and wear a surgical mask or to cover their mouth and nose with a tissue

5.6 Infection prevention and control measures

5.6.1 Standard precautions

Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered. For further information on standard precautions and the chain of infection refer to HSEland online learning or www.hpsc.ie . With regard to COVID-19, key elements include:

5.6.2 Hand hygiene

- Hand hygiene is the single most important action to reduce the spread of infection in health and other social care settings and is a critical element of standard precautions

- Facilities must provide ready access for staff, residents and visitors to hand hygiene facilities and alcohol-based hand rub (ABHR)
- Staff should adhere to the WHO five moments for hand hygiene
    - Hand hygiene must be performed immediately before every episode of direct resident care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of PPE, equipment decontamination, handling of waste and laundry
- Residents should be encouraged and facilitated to clean their hands after toileting, after blowing their nose, before and after eating and when leaving their room. If the resident's cognitive state is impaired, staff must help with this activity
- **Gloves should not be used in routine care of residents to whom Standard Precautions do not apply unless contact with blood or body fluids (other than sweat), non- intact skin or mucous membranes is anticipated. When gloves are required they are not a substitute for hand hygiene. Hand hygiene is required before putting on gloves and immediately after they have been removed**
- HSEland hand hygiene training is available online and staff should be encouraged to do refresher training at www.hseland.ie

Refer to hand hygiene information posters Appendix E.

5.6.3 Respiratory hygiene and cough etiquette

- Respiratory hygiene and cough etiquette refer to measures taken to reduce the spread of viruses via respiratory droplets produced when a person coughs or sneezes
- Disposable single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose
- Used tissue should be disposed of promptly in the nearest foot operated waste bin
- Some residents may need assistance with containment of respiratory secretions. Those who are immobile will need a waste bag at hand for immediate disposal of the tissue. Hands should be cleaned with either soap and water or ABHR after

coughing sneezing, using tissues or after contact with respiratory secretions and contaminated objects

- Staff and residents should be advised to try to avoid touching their eyes, mouth and nose

5.6.4 Personal Protective Equipment (PPE)

- As part of standard precautions, it is the responsibility of every HCW to undertake a risk assessment PRIOR to performing a clinical care task, as this will inform the level of IPC precautions needed, including the choice of appropriate PPE for those who need to be present
- Full guidelines on the appropriate selection and use of PPE **Appendix F** and **G** and https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/
- Current guidance in the context of COVID-19 for the use of surgical masks by HCW states that:
    1. HCW's should wear surgical masks when providing care to residents within 2m of a resident, regardless of the COVID-19 status of the resident
    2. HCW's should wear surgical masks for all encounters with other HCWs in the workplace where a distance of 2m cannot be maintained and the encounter is expected to last longer than 15 minutes
- Surgical face masks that are worn by HCW's in the circumstances outlined above (points 1 and 2) may be disposed of in the domestic waste stream
- Educational videos are also available on www.hpsc.ie at https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/videoresourcesforipc/
- All staff must be trained in the proper use of all PPE that they may be required to wear
- Note that in outbreak situations or other exceptional circumstances where extended use of some items of PPE (other than gloves) when moving between patients with a confirmed diagnosis of COVID-19 might be considered, it is important to make every

effort to avoid generalised use of PPE throughout the facility without considering the level of risk.

- In the event of extended use of PPE being necessary, define clean and contaminated zones. PPE should be donned before entering the contaminated zone and doffed and hand hygiene performed before entering clean zones. Where staff members are having meals on a unit to minimise staff interaction, it is essential that the staff refreshment area is a clean zone. Corridors between units should be designated clean zones. Clinical stations should normally be clean zones
- Transiting through the hallway of a contaminated zone without providing resident care does not require use of PPE, if the residents are in their rooms and there is no physical contact with other staff wearing PPE

5.6.5 Transmission-based precautions for COVID-19

- Transmission based precautions are IPC measures which are implemented in addition to standard precautions when standard precautions alone are insufficient to prevent the onward transmission of specific infectious diseases. See Appendix G. They include contact, droplet and airborne precautions. In general, COVID-19 is spread by respiratory droplets – transmission may be direct, through contact with the respiratory secretions of someone with COVID-19, or indirect, through contact with a contaminated surface/object. Less commonly, airborne spread may occur for example during aerosol generating procedures (AGP). https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/
- Transmission-based precautions should be applied immediately to all suspected cases of COVID-19:
    - It is recognised however that there can be significant challenges in applying transmission-based precautions in residential settings, which resemble household settings more than acute hospitals. Transmission-based precautions may need to be modified to take into account that the setting is also the

resident's home. A pragmatic, compassionate and proportionate approach may be necessary when considering the care needs of the resident balanced against the risk to others

5.7 Duration of transmission based precautions

- A test of clearance is not appropriate for COVID-19 patients. Transmission based precautions can be **discontinued fourteen days after symptom onset, where they have been fever free for five days.**
- In exceptional circumstances where a Physician is concerned on clinical grounds that there may be an ongoing risk of transmission beyond 14 days repeat testing may be considered in advance of ending Transmission Based Precautions. In such circumstances if virus nucleic acid is detected and if a decision is made to extend Transmission Based Precautions the extension may be for up to 7 additional days (that is for a total of 21 days). No further testing is required at that time in advance of ending Transmission Based Precaution. This includes patients who are immunocompromised or require haemodialysis where care can be provided with Standard Precautions after that time.
- Note: some patients who meet the above criteria (14 days post onset with 5 days fever free) may have a persistent cough. There is no evidence that such patients pose a specific infection risk or that Transmission-based Precautions should be continued. An extended period of Contact and Droplet Precautions may be considered in some such cases if there is clinical concern. In such cases the period of Contact and Droplet precautions should not be extended beyond 28 days.

5.7.1 Care Equipment

- Where possible, use single-use equipment for the resident and dispose of it as healthcare risk waste into a designated healthcare risk waste bin inside the room
- Where single use equipment is not possible, use designated care equipment in the resident's room or cohort area. In a cohort area, the equipment must be

decontaminated immediately after use and before use on any other resident following standard cleaning protocols. This designated equipment should not be shared with other residents in non COVID-19 areas (e.g., lifting devices, commodes, moving aides etc.)

- If it is not possible to designate pieces of equipment to the resident or cohort area these must be decontaminated immediately after use and before use on any resident following standard cleaning protocols
- There is no need to use disposable plates or cutlery. Crockery and cutlery should be washed after use in a dishwasher or by handwashing, using household detergent and hand-hot water

5.7.2 Management of blood and body fluid spillages

- Should be managed in line with local policy

5.7.3 Management of waste

- Dispose of all waste from residents with confirmed or suspected COVID-19 as healthcare risk waste (also referred to as clinical risk waste)
- When removing waste, it should be handled as per usual precautions for healthcare risk waste
- The external surfaces of the bags/containers do not need to be disinfected
- All those handling waste should wear appropriate PPE and clean their hands after removing PPE
- Hands-free healthcare risk waste bins should be provided in single rooms and cohort areas
- If a healthcare risk waste service is not available in the RCF, then all consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, tie the bag, place in a second bag and leave for 72 hours. This should be put in a secure location prior to usual waste collection
- Bodily waste, such as urine or faeces from individuals with possible or confirmed COVID-

19 does not require special treatment and can be discharged into the sewage system

5.7.4 Safe management of linen (laundry)

- All towels, clothing or other laundry used in the direct care of residents with suspected and confirmed COVID-19 should be managed as 'infectious' linen
- Linen must be handled, transported and processed in a manner that prevents exposure to the skin and mucous membranes of staff, contamination of their clothing and the environment
- Disposable gloves and an apron should be worn when handling linen
- All linen should be handled inside the resident room/cohort area. A laundry skip/trolley should be available as close as possible to the point-of-use for linen deposit, for example immediately outside the cohort area/isolation room
- When handling linen, the HCW should not:
    - rinse, shake or sort linen on removal from beds/trolleys;
    - place used/infectious linen on the floor or any other surfaces (e.g., a bedside locker/table top);
    - handle used/infectious linen once bagged;
    - overfill laundry receptacles; or
    - place inappropriate items in the laundry receptacle (e.g., used equipment/needles)
- When managing infectious linen, the HCW should:
    - Place linen directly into a water-soluble/alginate bag and secure;
    - Place the alginate/water-soluble bag into the appropriately-coloured linen bag (as per local policy)
    - Store all used/infectious linen in a designated, safe area pending collection by a laundry service
    - If there is no laundry service, laundry should be washed using the hottest temperature that the fabric can withstand and standard laundry detergent
    - Laundry may be dried in a dryer on a hot setting

5.7.5 Environmental hygiene

- The care environment should be kept clean and clutter free in so far as is possible, bearing in mind this is the resident's home and they are likely to want to personalize their space with objects of significance to them.
- Residents observation charts, medication prescription and administration records (drug kardexes) and healthcare records should not be taken into the resident's room to limit the risk of contamination

5.7.6 Routine cleaning

- Decontamination of equipment and the care environment must be performed using either:
    - A combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
    - A general-purpose neutral detergent in a solution of warm water, followed by a disinfectant solution of 1,000 ppm av.cl.
    - Only cleaning (detergent) and disinfectant products supplied by employers are to be used. Products must be prepared and used according to the manufacturer's instructions and recommended product "contact times" must be followed
- Hoovering of carpet floor in a resident's room should be avoided during an outbreak and while the patient is infectious. When the resident is recovered the carpet should be steam cleaned
- All shared spaces should be cleaned with detergent and disinfectant
- Equipment used in the cleaning/disinfection of the isolation area should be single-use where possible and stored separately to equipment used in other areas of the facility.
- Household and care staff should be trained in the appropriate use and removal of PPE (**Appendix F**)
- In practical terms, single room cleaning may be undertaken by staff who are also providing care to the resident while in the single room

5.7.7 Frequency of cleaning

- All surfaces in the resident room/zone should be cleaned and disinfected at least daily and when visibly contaminated. These include high-touch items; bedrails, bedside tables, light switches, remote controls, commodes, doorknobs, sinks, surfaces and equipment close to the resident (e.g., walking frames, sticks, phone or other mobile device).
- Handrails and table tops in facility communal areas, along with nurses station counter tops and equipment require regular cleaning
- Cohort areas and clinical rooms must be cleaned and disinfected at least daily and when visibly contaminated and a documented cleaning schedule should be available to confirm this.

5.7.8 Terminal cleaning

- Terminal cleaning should always be performed after a resident has vacated the room and is not expected to return. In addition to the routine cleaning protocols, a terminal clean is needed.
    - Removal of all detachable objects from a room or cohort area, including laundry and curtains;
    - Removal of waste;
    - Cleaning (wiping) of lighting and ventilation components on the ceiling;
    - Cleaning of the upper surfaces of hard-to-reach fixtures and fittings;
    - Cleaning of all other sites and surfaces working from those at higher level down to floor level
- A terminal clean checklist is good practice to support cleaning or household staff to effectively complete all environmental cleaning tasks, which should be signed off by the cleaning supervisor before the room reopens for occupancy

5.7.9 Staff uniforms/clothing

- Staff uniforms are not considered to be personal protective equipment

- The appropriate use of PPE will protect staff uniforms from contamination in most circumstances.
- Uniforms should be laundered:
    - separately from other household linen;
    - in a load not more than half the machine capacity;
    - at the maximum temperature the fabric can tolerate
- The risk of virus transmission from contaminated footwear is likely to be extremely low. The use of shoe covers is not recommended. However, HCW could consider designating a pair of comfortable, closed, cleanable shoes for wearing in a COVID-19 care area
- Staff should avoid bringing personal items, including mobile phones into isolation or cohort areas

5.8 Communication

- Good communication is essential for residents, family and staff members
- Provide regular information sessions and education on measures required for staff members and assign someone to do these

5.9 Support services for staff and residents

- The effect on staff and residents during outbreak events should not be underestimated especially where there have been deaths in the RCF. Every effort should be made to support those who are impacted by outbreak events

6 Care of the dying

- A compassionate, pragmatic and proportionate approach is required in the care of those who are dying
- The presence of a person close to the resident should be facilitated. They should be aware of the potential infection risk
- Pastoral care team where requested by the person or their family and who are willing to attend should NOT be restricted from entering the facility

- All persons in attendance should be advised to wear a surgical mask and plastic apron. Gloves are not essential, so long as those in attendance understand the risks; perform hand hygiene after touching the person and before leaving the room
- Visitors should be instructed on how to put on and take off the PPE and how to perform hand hygiene. Where practical, visitors should be supervised when donning and doffing PPE
- For the anointing of the sick or other rites where only transient physical contact is required, gloves are not necessary, so long as hand hygiene is performed immediately after anointing or touching the person
- Visitors should avoid contact with people other than the person they are accompanying

7 Care of the recently deceased

7.1 Hygienic preparation

- Any IPC precautions that have been advised before death must be continued in handling the deceased person after death. In relation to COVID-19 specifically if transmission based precautions have been discontinued before death, then they are not required after death – see section on duration of transmission based precautions
- Hygienic preparation includes; washing of the face and hands, closing the mouth and eyes, tidying the hair and in some cases, shaving the face
- Washing or preparing the body for religious reasons is acceptable if those carrying out the task wear long-sleeved gowns, gloves, a surgical face mask and eye protection, if there is a risk of splashing

7.2 Handling personal possessions of the deceased

- Most jewellery including watches, rings, bracelets, earrings and items like photo frames can be wiped down using a detergent/disinfectant wipe. Alternatively, items of jewellery (with the exception of watches) can be placed in hot, soapy water and cleaned first, then rinsed and dried using disposable paper towels

- Items of clothing and soft toys should be placed directly into a washing machine and washed on the hottest setting that the fabric can withstand
- Paper materials (e.g. books, prayer books/bible) or items that cannot be wiped should be placed in a plastic bag and left aside for 72 hours before handling
- Clothing that needs to be hand washed should be placed in a plastic bag and stored for 72 hours, after which it can be washed
- Personal belongings that family members wish to discard should be placed in a plastic bag and tied securely, then placed in a second plastic bag and set aside for 72 hours after which it can go out for collection in the appropriate general waste stream

7.3 Transport to the mortuary

- An inner lining is not required in terms of COVID-19 risk, but may be required for other practical reasons such as maintaining dignity or preventing leakage affecting the mortuary environment
- A surgical face mask or similar should be placed over the mouth of the deceased before lifting the remains into the inner lining
- Those physically handling the body and placing the body into the coffin or the inner lining should wear, at a minimum, the following PPE:
    - Gloves
    - Long sleeved gown
    - Surgical face mask
- Play close attention to hand hygiene after removal of PPE
- The family should be advised not to kiss the deceased and should clean their hands with alcohol hand rub or soap and water after touching the deceased

PPE is not required for transfer, once the body has been placed in the coffin.

8 Monitoring outbreak progress

- Monitoring the outbreak will include ongoing surveillance to identify new cases and to update the status of ill residents and staff
- The nominated RCF liaison person should update the line listing with new cases or developments as they occur and communicate this to the OCT on a daily basis or more frequently if major changes occur, in line with Public Health recommendations until the outbreak is declared over
- The review of this information should examine issues of ongoing transmission and the effectiveness of control measures
- Institute active daily surveillance for fever or respiratory symptoms, including cough, in residents and staff for 28 days after the date of onset of symptoms of the last resident COVID-19 case

9 Declaring the outbreak over

In order to declare that the outbreak is over, the RCF should not have experienced any new cases of infection (resident or staff) considered as likely to have been acquired in the RCF which meet the case definition for a period of 28 days (two incubation periods). As above isolated positive result of SARS-CoV-2 in a resident or staff member is not of itself evidence of ongoing transmission.

Appendix A: Prevention and control of outbreaks of COVID-19 in RCF

	Domain	Action	Comment
Pre-Outbreak Measures	Planning and Administration	Written Policies	Immunisation policies Standard transmission based precautions including droplet and contact Written outbreak management plan
		RCF Lead (Named person)	To oversee development, implementation and review of policies and procedures
		Training and Education	For all staff Ongoing training – standard and transmission-based precautions, PPE Measures to improve compliance
		Provision of supplies	Hand hygiene supplies, PPE, disinfection materials, viral swabs, request forms and arrangements for prioritised testing of samples
	Standard Precautions	Standard infection control procedures	SP should be practiced by all staff at all times
	Surveillance	Awareness of signs and symptoms of COVID	Formal process to record any new symptomatic residents twice daily
Early recognition	Case Definition	As per HPSC guidance	Case definition may change as pandemic progresses
	Outbreak Definition	Action threshold for outbreak control measures	One suspected or confirmed case for public health action
	Communication of suspected outbreak	Notification of senior management, medical and public health staff, CHO and NH lead	Follow RCF algorithm
	Formation of outbreak control team (OCT)	OCT may be convened following risk assessment	
	Testing	Viral swab	As per current guidance
	Initial Actions	Daily Case list	
		Activate Daily surveillance	
		Appropriate IPC precautions in place	Contact and Droplet precautions in the cohorted area/zone
		Resident placement	Single rooms Cohorting or Zone allocation
		Respiratory etiquette	

During an Outbreak			
	Infection Control Measures	Hand Hygiene	5 Critical points: • Before patient contact • Before septic task • After body fluid exposure • After patient contact • After contact with patient surroundings Hand hygiene after PPE removal
		PPE	Gloves Aprons Gowns Face protection
		Aerosolised generating Procedure	See HPSC guidance document. Highest level of PPE (FFP2/3) available if performing a high risk AGP
	Environmental control measures		Resident environmental cleaning and disinfection Residential Care Equipment Laundry Eating utensils and crockery
	Containment Measures		New admissions restricted Transfers restricted Restricted communal activities Staffing precautions Visitor restrictions
Post Outbreak	Declaration of end of outbreak		As advised by Public Health
	Final evaluation	Review of management of outbreaks and lesson learned	Coordination with Public Health and OCT if this was convened

Appendix B: Details for line listing

1. Outbreak code (on top of line list as title)
2. Name of case
3. Case ID
4. Location (unit/section)
5. Date of birth/age
6. Gender
7. Status i.e. resident, staff member, volunteer, visitor
8. Date of onset of symptoms
9. Date of notification of symptoms
10. Clinical symptoms (outline dependent on case definition) e.g. fever, cough, myalgia, headache, other
11. Samples taken and dates
12. Laboratory results including test type e.g. RT-PCR,
13. Date when isolation of resident was started
14. Date of recovery
15. Duration of illness
16. Outcomes: recovery, pneumonia, other, hospitalisation, death
17. Also include work assignments of staff and last day of work of ill staff member
18. State if staff worked in other facilities

Have separate sheets for both staff and residents

Appendix C: Part 1 – Respiratory outbreak line listing Form – Residents ONLY*

Name of Facility: …… Name of Outbreak: …… Outbreak Code:……

ID	Surname First name	Location (unit/section)	Sex	DOB (dd/mm/yy)	Age	Onset (date)	Fever ≥38°C (Y/N)	Cough (Y/N)	Shortness of breath (Y/N)	Other symptoms (state)

Key: (Y =Yes, N=No, U=Unknown)

***Please complete for all current and recovered cases**

Appendix C: Part 2 –Residents ONLY

Name of Facility: …… Name of Outbreak: …… Outbreak Code……..

	Test Results		Outcome			
ID	Laboratory Test Done Yes/No, If yes, date:	Type of Test and Result	Pneumonia	Hospitalisation (Date)	Death (Date)	Recovered to pre-outbreak health status. Yes/No. If Yes, date:

Key: (Y =Yes, N=No, U=Unknown)

Appendix C: Part 3 – Respiratory outbreak line listing form – Staff ONLY*

Name of Facility: …….. Name of Outbreak: …… Outbreak Code…….

ID	First name Surname	Position	Location	Sex	DOB (dd/mm/yy)	Age	Onset (date)	Fever ≥38°c (Y/N)	Cough (Y/N)	Shortness of breath (Y/N)	Other symptoms (state)	Work at any other facility? (Y/N) If YES, state location

Key: (Y =Yes, N=No, U=Unknown)

***Please complete for all current and recovered cases**

Appendix C: Part 4 –Staff ONLY*

Name of Facility: …… Name of Outbreak: …… Outbreak Code:……

	Test Results		Outcome				Work exclusion
ID	Pathology Test Done Yes/No, If yes, date:	Type of Test and Result	Pneumonia	Hospitalisation (Date)	Death (Date)	Recovered to pre-outbreak health status. Yes/No. If Yes, date:	Excluded from work until (Date)

Key: (Y =Yes, N=No, U=Unknown)

Appendix D: Checklist for outbreak management

	Discussion point	Decision/action to be taken (date completed)	Person responsible
1	Declare an outbreak and convene an OCT following Public Health risk assessment		
2	Agree the chair		
3	Formulate an outbreak code and working case definition		
4	Define the population at risk		
5	Active case finding, request line listing of residents and staff from the RCF		
6	Discuss whether it is a facility-wide outbreak or unit-specific		
7	Confirm how and when communications will take place between the RCF, CIPCN, CHO NH lead, Public Health and the laboratory		
8	Review the control measures (infection control necessary to prevent the outbreak from spreading). Confirm that the management of the facility is responsible for ensuring that agreed control measures are in place and enforced		
9	Discuss which specimens have been collected. Notify the laboratory of the investigation.		
10	Confirm the type and number of further laboratory specimens to be taken. Clarify which residents and staff should be tested.		
11	Confirm with the laboratory that it will phone or fax results (both positive and negative) directly to the requesting doctor and that this person will notify Public Health. Review the process for discussing laboratory results with the RCF's designated officer.		
12	Liaise with the RCF and laboratory regarding specimen collection and transport		

13	Identify persons/institutions requiring notification of the outbreak e.g. families of ill or all residents of the facility; health care providers e.g. GPs, physiotherapists etc.; infectious disease consultants, consultant microbiologists, infection prevention & control specialists, Emergency Departments; local hospitals, other RCF, HPSC		
14	Discuss whether a media release is required		
17	Ensure that the incident is promptly reported to HPSC and surveillance details entered onto CIDR		
18	Provide updates on the investigation to the Assistant National Director, ISD-Health Protection when/if required		
19	Discuss communication arrangements with HSE management ± HSE crisis management team		
20	Discuss communication arrangements with local GPs and Emergency Departments		
21	Decide how frequently the OCT should meet and agree criteria to declare outbreak over		
22	Prepare/circulate an incident report/set date for review meeting		

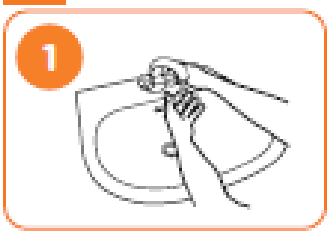
Appendix E Hand Hygiene poster

Seirbhís Sláinte Níos Fearr a Forbairt | Building a Better Health Service

How to hand wash

Wash hands when visibly soiled. Otherwise, use handrub with hand sanitiser.

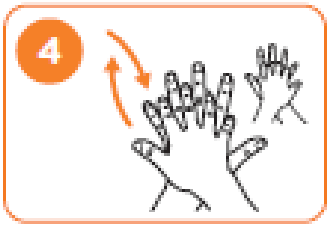
Length of time to spend washing: 40-60 seconds



Wet hands with water

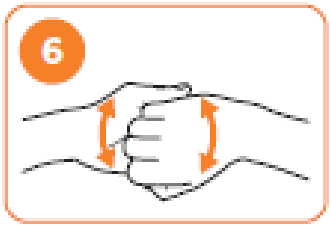
Apply enough soap to cover all hand surfaces

Rub hands palm to palm



Right palm over the back of the left hand with interlaced fingers and do same on other hand

Palm to palm with fingers interlaced

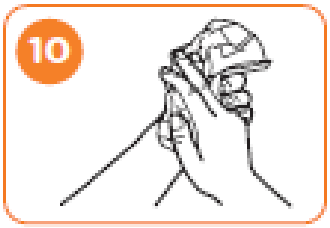


Backs of fingers to opposite palm with fingers interlocked

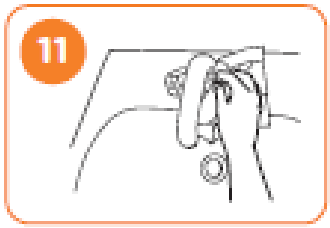
Rotational rubbing of left thumb clasped in right palm and do same on other hand

Rub in a circle with clasped fingers of right hand in left palm do same on other hand

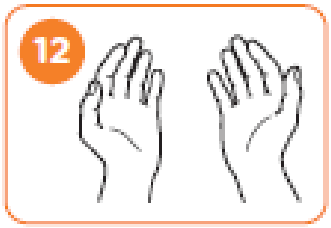
Rinse hands with water



Dry hands thoroughly with a clean towel or single use towel



Use single use towel or piece of tissue to turn off tap



Your hands are now safe

RESIST

www.hse.ie/infectioncontrol

Appendix F Donning and Doffing PPE

A full range of resources including posters, videos and webinars relating to the safe donning and doffing of PPE is accessible here

Appendix G Transmission based precautions

Table 2: Personal Protective Equipment (PPE) Requirements by Precaution Type

Personal Protective Equipment			
Precaution	**Contact**	**Droplet**	**Airborne**
Gloves	Yes	As per standard precautions	As per standard precautions
Gown/Apron (impermeable)	When healthcare worker's clothing is in substantial contact with the resident, items in contact with the resident, and their immediate environment	As per standard precautions	As per standard precautions
Surgical Mask	When adequate distance cannot be maintained	Yes	No
FFP2/N95 Respirator	Not required	Not required	Yes
Goggles/face shield	Not required	As per standard precautions	As per standard precautions

Appendix H: Admissions, Transfers to and Discharges from Residential Care Facilities during the COVID-19 Pandemic

Readers should not rely solely on the information contained within these guidelines. Guideline information is not intended to be a substitute for advice from other relevant sources including, but not limited to, the advice from a health professional. Clinical judgement and discretion will be required in the interpretation and application of these guidelines. These guidelines are aligned with the principles of Art 3 IHR.

Introduction

Residential care facilities (RCF) are a critical part of health and social care services.
RCFs should put in place clear processes that facilitate the return of residents from an acute setting and the admission of new residents, where it is clinically safe to do so.
It is recognised that accepting admission or transfer of residents poses a risk of introducing COVID-19, even where processes to manage the risks are in place however it is essential that this risk is balanced against the consequences of restricting access to a facility/service or disproportionately impacting on the wellbeing of residents.

In all instances, careful attention to Standard Precautions will assist in minimising risk of infection to residents and staff. Key elements of Standard Precautions include; hand hygiene, respiratory hygiene and cough etiquette, use of personal protective equipment (PPE), for example wearing disposable gloves when in contact with blood or other body fluids (other than sweat), non-intact skin or mucus membranes and regular environmental cleaning

It is essential that residents and clients and their significant persons are informed of the issues and risks of decisions related to their care and that their preferences are taken into account in applying this guidance.

Background on testing for COVID-19

The key point about testing is that interpretation is not straightforward

1. **A test result that says not-detected or "negative" does not prove the person is not infectious to others**
2. **A test result that says a virus is detected does not prove the person is still infectious to others**

Over the course of the COVID-19 pandemic, there has been significant learning about the role of testing for COVID-19 and its role in determining levels of asymptomatic infection and tracking spread of infection, especially in congregated settings, such as RCF.

Experience to date indicates that a test may fail to detect the virus in a significant proportion of people who have COVID-19 infection. A single test may be reported as not-detected or "negative" in a substantial proportion of people with infection. The test is more likely to miss infection in people with pre-symptomatic or asymptomatic infection. Therefore, a not-detected or "negative" test makes COVID-19 infection less likely, but it does not prove the person is not infected.

Equally, for those who have been infected and infectious with COVID 19, a continued positive test result does not mean they are still infectious to others. Some people have a positive test for weeks after onset of symptoms, but latest evidence shows they do not spread infection after they have fully recovered. **People with COVID-19 infection who are 14 days after onset of infection and have not had a fever for the last five of the 14 days are no longer infectious.** Retesting for COVID-19 beyond 14 days has no value, other than in very exceptional circumstances.

The role of COVID-19 testing in assisting with decision-making regarding transfers to congregated settings

- Patients for admission to a RCF should be tested for COVID 19. This is to help identify most of those who have infection, but it will not detect all of those with infection.
- Testing should be performed within 3 days of planned admission to the RCF.
- Where testing is not performed before admission it should be carried out within one day of admission.
- Irrespective of testing all residents should be assessed before admission to ensure they are not known COVID-19 contacts and have no clinical symptoms suggestive of COVID-19

Note this requirement for testing (and single room placement) is not intended to apply to

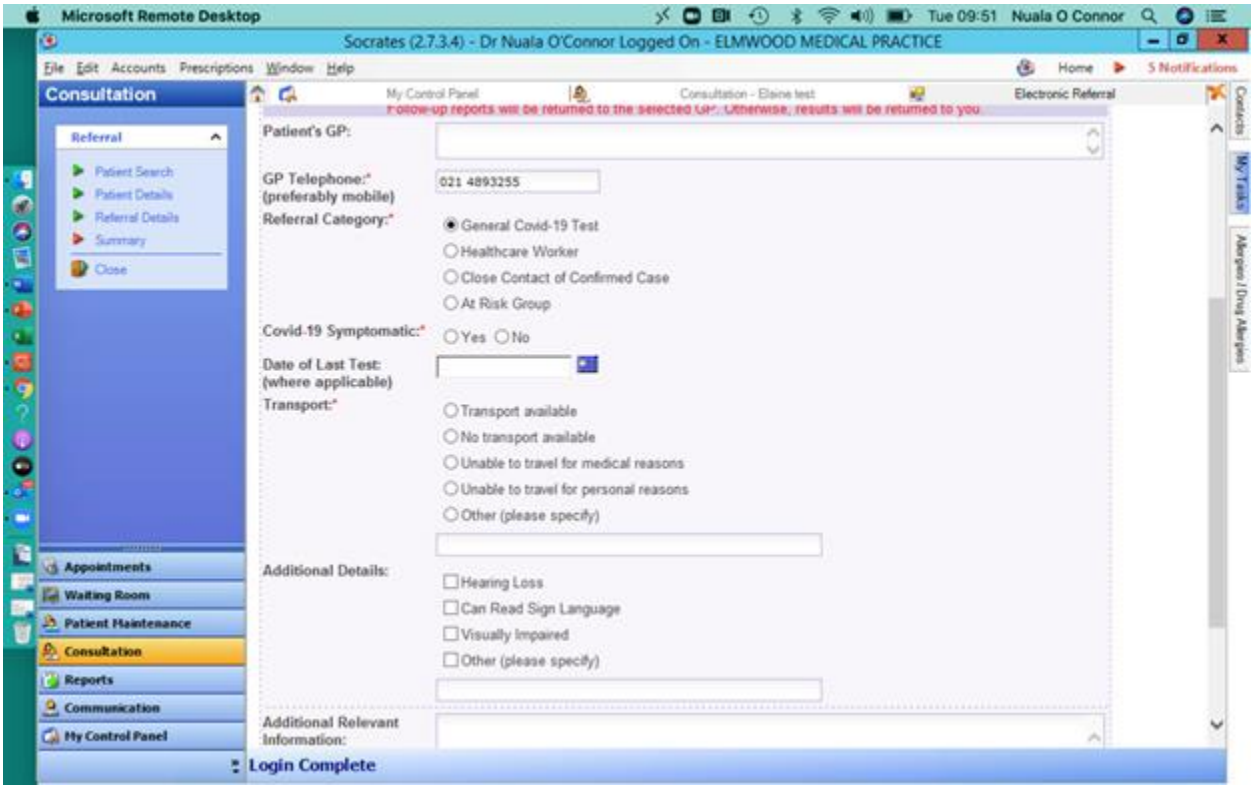
- Patients who have already had confirmed COVID-19, who are fully recovered and are no longer considered infectious to others (minimum 14 days since onset of symptoms and no fever for the last five days).
- Settings caring for children under the age of 18
- Persons who are returning to supported/assisted living or small group homes (generally less than 5 residents) following discharge from hospital where the facility is more reflective of a household setting

It is also acknowledged that some residents may decline testing, or may find the process too distressing and that testing may not be appropriate in every situation (Refer to DoH Guidance on Ethical Considerations Relating to Long-Term Residential Care Facilities in the context of COVID-19)

Procedure for Testing of Patients Pre-transfer/Admission to a RCF

- If a patient is being transferred from an acute hospital to a RCF, the hospital should arrange for the patient to be swabbed up to 72 hours before. The patient will need to be isolated for 14 days regardless of the test result if the patient is being admitted to the RCF from home, where possible, the GP should arrange for the patient to be swabbed up to 72 hours before. This can be done using Healthlink. If the patient cannot travel to the test centre, a home test can be ordered by clicking on the 'no transport available' option as shown on the screenshot below. The patient will need to be isolated for 14 days regardless of the test result

- If a test pre-admission cannot be arranged, the patient should be admitted as planned. The patient will need to be isolated for 14 days. The facility can then arrange swabbing after admission. This can be done by the patient's own GP or the GP/Medical Officer who provides medical care for the residents in the facility.



Patient placement requirements as part of transfer protocols

- All transfers or new admissions should have a risk assessment, to ensure sufficient resources are available within the RCF to support social distancing and patient placement.
- In general residents transferred or directly admitted to a RCF should be accommodated in a single room (or room with no other residents) for 14 days after arrival and monitored for new symptoms consistent with COVID-19 during that time.
- The requirement for a single room applies even if the person;
    - Has had a test for COVID-19 reported as “not-detected” or “negative”
    - Is only being admitted for short periods of respite or convalescence which may have an anticipated duration of less than 14 days

    - Although the resident has single room accommodation and may be encouraged to avoid or limit interaction with other residents in so far as practical, care delivered within the room can be delivered with Standard Precautions plus surgical mask and the resident may leave their room as per guidance below on transfers.
- The requirement for a single room does not apply
    - to residents who have already recovered from confirmed COVID-19 who are no longer considered infectious to others (minimum 14 days since onset of symptoms and no fever for the last five days).
    - In certain situations where persons are being admitted to community hospitals or rehabilitation facilities where implementing this requirement would have a disproportionate impact on service provision (See section below)
- A move to a multi-occupancy room (where this is the planned accommodation in the longer term for the resident) will be appropriate after the 14 day period, once the resident is symptom free and there is no evidence of infection in residents within the room it is proposed for the resident to move to.

Planning

- All RCF should review their accommodation to identify areas where new residents can be safely isolated. It is understood that the creation of such areas may be constrained by existing accommodation availability (e.g., rooms already in use by existing residents).
- Where possible the use of single rooms in RCF with significant numbers of multi-occupancy rooms should be prioritised for new transfers and admissions from community or other healthcare facilities (acute hospital or other RCF), regardless of the pre-admission COVID 19 test result
- For those RCF providing a blend of longer-term nursing home and short-term respite or convalescence care, it is advised to consider where the longer and shorter-term residents will be accommodated and where it is feasible, to try and place residents for

shorter-term accommodation in an area separate to those for longer-term accommodation.

- The identification of space for the 14 day isolation period needs to be managed carefully with residents, families and others. Existing residents should not be required to move from their room / accommodation in order to facilitate the creation of new areas to facilitate transfers.
- Careful consideration should also be given to the consequences of closing facilities/rooms within a service for the purpose of having an isolation area should a need arise – the potential harms of such decisions should be balanced against the likely requirement

Admissions to RCF from acute hospitals and rehabilitation facilities or other RCF

(1) Transfer of Patients post COVID Recovery

- Any resident transferred to a RCF before the 14 days have elapsed since date of onset of symptoms or date of first positive test (if symptom onset undetermined/asymptomatic), must be isolated with transmission based precautions up to day 14 on return to the RCF. Provided the resident has remained afebrile for the last five of the 14 days, the resident is no longer infectious to others after day 14 has elapsed.
- In particular existing residents from a RCF who require transfer to hospital from the RCF for assessment or care should be allowed to transfer back to that RCF following assessment / admission if clinically fit for discharge and risk assessment with the facility determines there is capacity for them to be cared for there with appropriate isolation and where that transfer represents the most appropriate place of care for the resident (e.g. ongoing need for palliative care).
- If the resident has been diagnosed with COVID-19 while in hospital, it is important to assess if the person was infected in the RCF before transfer to the hospital or if this is a hospital-acquired infection. If there are no other known cases of COVID-19 in the RCF, transfer back to the RCF should be delayed until the resident is no longer infectious to others.

- The public health team should be notified in advance of all discharges where COVID-19 has been newly-diagnosed within the RCF.
- In all instances the discharging hospital should provide the RCF with the following information on the arrival of the resident:
    - The date and results of COVID-19 tests (including dates of tests reported as not-detected)
    - The date of onset of any symptoms of COVID-19
    - Date of last documented fever while in hospital (particularly important where resident is being transferred to RCF within 14 days of COVID-19 diagnosis)
    - Details of any follow-up treatment or monitoring required

(2) Admission of patients with no diagnosis or clinical suspicion of COVID 19 from acute hospital to RCF

- Testing for COVID 19 should be undertaken within the three days prior to discharge from the acute hospital. A single test is sufficient.
- Result should be available before the patient is discharged.
- Resident must be accommodated in a single room for 14 days on arrival in the RCF, regardless of test result
- Residents should be cared for using Standard Precautions plus a face mask where no other indication for transmission based precautions exists (HCW are advised to wear a face mask where a 2m distance cannot be maintained in line with NPHET recommendations)
- The resident is not required to remain in strict isolation but should practice restricted movement
    - The resident may leave their room but should remain separate to other residents e.g. to go the garden or for a short walk
    - The resident should not dine in communal dining areas
    - The resident should not attend group activities

(3) Admission of patients from community / home settings

- Testing for COVID 19 should be carried out. If testing can be facilitated in the community prior to the anticipated admission date, the test should be taken within the 3 days prior to admission.
    - Residents should be cared for using standard precautions plus a face mask where no other indication for transmission based precautions exists (HCW are advised to wear a face mask where a 2m distance cannot be maintained in line with NPHET recommendations)
    - The resident is not required to remain in isolation but should practice restricted movement
        - The resident may leave their room but should remain separate to other residents e.g. to go the garden or for a short walk
        - The resident should not dine in communal dining areas
        - The resident should not attend group activities
- If the testing prior to admission is not feasible or the result is not yet available, provided the new resident has not developed new symptoms or signs of COVID-19 and has not been informed they have been in contact in the past 14 days with a person confirmed to have COVID-19, the planned admission can go ahead, with a viral swab to be taken within 24 hours of admission to the RCF
    - The person should remain in isolation with Contact and Droplet Precautions until the results of the swab are available
    - If the swab result is reported as not detected/negative then Contact and Droplet Precautions can be discontinued (if there are no other indications for them) and the resident can practice restricted movement
        - The resident may leave their room but should remain separate to other residents e.g. to go the garden or for a short walk
        - The resident should not dine in communal dining areas
        - The resident should not attend group activities

- Irrespective of whether or not the COVID-19 test result is available if the person is symptomatic or a known contact, a medical assessment is required prior to further decisions being made about admission.

Residents who become symptomatic during admission

- Following transfer/admission to a RCF, the resident should be evaluated by their doctor if they become symptomatic, including changes in the resident's overall clinical condition and a further viral swab for COVID-19 sent for testing.
- The rationale for this recommendation is that, in the context of a pandemic, there may have been contact between the resident and healthcare workers or other people who may have had COVID-19 infection, but who may have been in the pre-symptomatic incubation period or have had minimal symptoms/been asymptomatic at the time. In that case, there would be an associated risk of unrecognised onward transmission to the resident.

Community Hospitals and Rehabilitation Facilities

- There are a number of specific challenges for community hospitals and rehabilitation centres, distinct from residential care facilities in two key respects;

  • Many have very few single patient rooms and are largely dependent on multi-bed rooms that is two, four, six bed or larger areas.

  • They have higher turnover compared with residential care facilities as the length of stay is typically two to four weeks even though it is understood that some patients may have longer lengths of stay as part of their rehabilitation

- The current guidance for residential care facilities specifies that each new admission should have a surveillance test of COVID-19 and should go into a room with no other person. It is

recognised that implementing this requirement in community hospitals/rehabilitation facilities would have a disproportionate impact on service provision.

- The following is therefore suggested

  • In facilities where care is provided for both long-term care residents and for short stay patients distinct wards and areas should be identified for to meet the different requirements for care of both groups.

  • The facility should have plans in place for the management of patients who develop symptoms during their admission this includes planning for isolation or cohorting should the need arise

  • All patients are assessed before admission to ensure they are not known COVID-19 contacts and have no clinical symptoms suggestive of COVID-19

  • Everyone is tested for COVID-19 either within the 3 days BEFORE admission (Particularly if coming from an acute facility) or within one day AFTER admission (for example when coming from the community)

  • For elective admissions from the community testing in the community before admission should be considered however it is necessary to take account of practical difficulties the person may experience in traveling to access testing. Admission should not be delayed because testing in the community is not practical. In such cases the test should be performed promptly after admission (as above).

  • With these controls in place patients can be admitted to a multi-bed cohort areas with other newly admitted patients if there are no available single rooms and provided there is no other requirement for Transmission-based Precautions.

  • Where cohorting in a multi-bed area is necessary the cohort areas for admission should

include as few beds as possible (for example a 2-bed or 4-bed area is preferred to a 6-bed area)

• Where practical to do so those admitted from the community and who are awaiting test results should be accommodated in a single room or in separate areas until the test result is available and reported as not detected

• During the initial 14 day period patients should remain in the cohort area as much as is practical and avoid contact with other patients in the hospital

• Staff caring for patients in the cohort areas should apply Standard Precautions plus face mask.

• Where patients leave the cohort room for therapy or other reasons then they should not mix with patients from other areas. Group therapy activities can be arranged for members of the same cohort.

• Each cohort area should have designated bathing and toilet facilities where practical to do so. Where this is not practical the bathing and toilet facilities should be shared with the lowest possible number of other patients.

• All patients should be monitored twice daily for symptoms of COVID-19

• Patients should be advised not to share personal items, including food/drink.

• Please note that cohorting may not be appropriate for mobile patients with behavioural challenges

• Patients should remain in their cohort area (in so far as is practical) until 14 days have elapsed. If patients in the cohort area are not all admitted on the same day then the 14 days for all patients should commence on the date that the last patient to the cohort

area was admitted.

• At the end of the fourteen days patients may remain together or can transfer to other areas of the facility.

(4) Cessation of new admissions to a facility during RCF COVID-19 Outbreak

- Following the declaration of an outbreak within a RCF, admissions of new residents to the facility (i.e. residents not previously living in the RCF) should be suspended until Public Health state that the outbreak is over.
- Residents normally cared for in the RCF who are admitted to hospital while an outbreak is ongoing may have their discharge to the same RCF facilitated if it is deemed to be clinically appropriate and a risk assessment has been carried out which identifies that the resident can be isolated and the facility has capacity to manage their care needs and where that transfer represents the most appropriate place of care for the resident (e.g. ongoing need for palliative care).

Transfers from RCF to an acute hospital

- COVID-19 positive status in itself does not preclude transfer to acute hospital and must not significantly delay transfer to an acute hospital, where it is deemed clinically appropriate. The national ambulance service (NAS) and the local receiving hospital must be informed by the RCF, in advance of transfer of any COVID-19 positive or suspected COVID-19 resident AND where there is a suspected or confirmed COVID-19 outbreak in the RCF.
- Patients with COVID-19 do not require to be hospitalised for the 14 days if RCF has appropriate facilities and capacity for isolation and can support care
- Residents do not require isolation on return to their RCF following hospital transfer to facilitate short investigations (e.g., diagnostics, haemodialysis, radiology, outpatient appointment.

- Residents will need to be isolated for 14 days on return to their RCF in the event that an episode of care in an acute hospital results in a longer period of time (12 hours or more) or an overnight stay in the acute hospital. During that 14 day period, restricted movement should apply and the resident should be monitored for symptoms

Table 3. Transfer/admission of a resident to a RCF

CLINICAL SCENARIO	RECOMMENDED PRECAUTIONS ON ARRIVAL TO RCF	PRE-ADMISSION TEST FOR SARS-CoV-2 (COVID-19)	TIMING OF TRANSFER TO RCF	DAY OF TRANSFER
CONFIRMED COVID-19 & will be still infectious to others on planned date of transfer (<14 days since onset/test date)	Transmission-based precautions* until 14 days reached and has been afebrile for last five of those days	Not required, as already confirmed COVID-19	**RCF has managed other resident(s) with COVID-19:** Transfer when fit for discharge to RCF AND provided RCF can meet care needs **RCF has not managed other resident with COVID-19** Remain in hospital until no longer infectious to others	Confirm date of onset/first positive test result Confirm date last febrile
CONFIRMED COVID-19 & no longer infectious to others >14 days since onset/test date and afebrile for last five of those days	No requirement for Transmission based Precautions**	Not required, as already confirmed COVID-19	When fit for discharge to RCF	Confirm date of onset/first positive test result is >14 days ago and was afebrile for last five days of that
NO PRIOR CONFIRMATION OF COVID-19 & NO SUSPICION OF COVID-19 Test result available prior to transfer	Single room accommodation with monitoring for symptoms until 14 days reached Standard precautions plus face mask	Test within the 3 days prior to scheduled transfer date	Test result-not-detected RCF can meet care needs	Confirm test result received Ensure no new symptoms and not newly-identified as a contact of a COVID-19 case
NO PRIOR CONFIRMATION OF COVID-19 & NO SUSPICION OF COVID-19	Transmission based precautions until test result is available	Test within one day of admission		Take sample for COVID-19 test Ensure no symptoms and not newly identified

But Test result is NOT available prior to admission				contact of a COVID-19 case

Acknowledgements

The following guidance documents were referred to in developing this guidance:

- Coronavirus Disease 2019 (COVID-19) Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities developed by the Communicable Diseases Network Australia (CDNA)
- COVID-19: Information and Guidance for Social or Community Care & Residential Settings Health Protection Scotland
- Public Health Guidelines on the Prevention and Management of Influenza Outbreaks in Residential Care Facilities in Ireland 2019/2020
- World Health Organization. Infection Prevention and Control Guidance for long-term care facilities in the context of COVID-19: interim guidance, 21 March 2020 World Health Organization; 2020
- HIQA-Rapid Review of Public Health guidance on infection prevention and control measures for residential care facilities in the context of COVID-19 30/30/20

Note:

The COVID-19 situation is rapidly changing. Guidance will be reviewed and updated regularly.