COVID-19

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

V6.6 07.07.2021

Note: If you have any queries on this guidance please contact the AMRIC team at hcai.amrteam@hse.ie

Ver.	Date	Changes from previous version
6.6	07.07.2021	Change in terminology and definitions on vaccine protection
6.5	24.06.2021	Inclusion of quotation from recent WHO update on transmission Revised to include significant vaccine protection. Removal of requirement for testing before transfer to LTRCF in people with significant vaccine protection Revision of section on social activity to simplify and encourage transition towards more normal activities **Specific statement that restrictions continue to apply to staff and residents with symptoms suggestive of COVID-19 after vaccination** Residents on CPAP or BiPAP to participated in activities subject to certain conditions Clarification in section 5.0 that the goal in terms of natural ventilation is gentle air flow /air exchange

Ver.	Date	Changes from previous version
6.4	19.04.2021	Removal of record of changes to versions prior to version 6.0 Removal of some duplicated content, Increased reference to maximising ventilation where practical to do so Update to section on vaccination and impact of vaccination Definition of fully vaccinated, Updated to reflect NPHET recommendation for extension of period of presumed immunity from 12 weeks to 6 months following COVID 19 infection Term extremely medically vulnerable replaced with 'very high risk'. Hyperlink to HSE definition of very high risk and high risk category groups. Changes to support greater social activity within the LTRCF in the context of vaccination Definition of a "high level of vaccination" Update to Appendix H on Admissions, transfers and discharges
6.3	01.03.21	Updated to align with NPHET recommendation for implementation of day 0 and day 10 testing for close contacts, with exit from restricted movements if the Day 10 test is reported as 'not detected'.
6.2	11.02.21	Hyperlink to updated guidance V1.3 Interim Guidance on Infection Prevention and Control for the Health Service Executive 2021 Statement that vaccination does not change the requirement for adherence to Infection Prevention and Control precautions Changes to the section of Transmission to reflect recent experience and emergence of new variants Updated guidance on use of FFP2 masks when for caring for suspect/positive COVID 19 patients/residents and COVID-19 residents who are contacts of COVDI-19 Updated to align with NPHET recommendation for implementation of day 5 and day 10 testing for HCWs designated as close contacts, with exit from restricted movements if the Day 10 test is reported as 'not detected'. Updates on derogation for the Return to Work of Healthcare Workers (HCW) who are Essential for Critical Services Hyperlink to updated guidance on visiting V 1.5 COVID-19 Guidance on visits to Long Term Residential Care Facilities (LTRCFs) Hyperlink to V1.1 COVID-19 Guidance on visits to and from residential facilities for people with disabilities Hyperlink to V 1.0 Guidance on COVID-19 Approach to risk assessment of visits to private home or similar setting by a resident from a LTRCF. Hyperlink to visitor information leaflet Update to align with V 1.2 Guidance on COVID-19 Admissions, transfers to and discharges from residential care facilities- appendix H Hyperlink to video for Self-isolation for people in residential care facilities who have been discharged from hospital. Reference to option to use a deep nasal/mid-turbinate swabs as a diagnostic sample Reference to antigen testing as less likely to detect low levels of virus compared to PCR tests Statement that novel disinfection technologies are not recommended
6.1	26/10/2020	Reference to the 2018 National Standards for infection prevention and control for community services Reference to the Five Level Framework for Public Health Restrictive Measures Recommendation that all congregated care settings have an IPC link-practitioner Updated section on sources of infection and transmission Expanded detail on categories of people considered extremely vulnerable Explicit statement that PPE items intended for single use are used only once Explicit statement that residents should be consulted on control measures Statement on the requirement to support extremely vulnerable people who may require additional precautions beyond those that are applied generally in the RCF Guidance on the possibility of derogation for close contacts to return to work framed as refer to relevant occupational health and public health guidance. Guidance on visiting, pastoral support and essential/important service providers referred to relevant other document Reference to Health and Safety Authority position on fit testing of those who need to use respirator masks. Clarification on some points related to admission to RCF from acute hospitals and rehabilitation facilities Term patient generally replaced by people/person/resident in keeping with terms commonly used in non-acute care settings Reference to use of masks by residents Clarification on management of residents who routinely use home ventilatory support
6.0	22/07/2020	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

All guidance should be read and interpreted in conjunction with the Government's Framework of Restrictions

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.

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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/

Application of this guidance document should take account of the Five Level Framework for Public Health Restrictive Measures and of the level in force nationally and in the specific locality at any time.

https://www.gov.ie/en/campaigns/resilience-recovery-2020-2021-plan-for-living-with-covid-19/

2 Roles and responsibilities

2.1 Residential Care Facility

This guidance applies to residential care facilities (RCF) where residents are provided with overnight accommodation. The anticipated duration of such 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.

This guidance was developed primarily for congregated care settings providing care for relatively large numbers of residents who are at high risk or very high risk of severe disease. 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 five 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 be considered in the context of very specific risk.

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 prevention and control (IPC). This responsibility is referred to in the 2016 National Standards for Residential Care Settings for Older People in Ireland. The 2018 National Standards for infection prevention and control in community services are also relevant. All RCFs should have in-house IPC expertise and should have outbreak management plans in place.

Congregated care settings, such as nursing homes, should have at a minimum one designated on-site IPC link practitioner who has protected time and the support of management to promote good IPC practice within the facility. An IPC link practitioner generally does not have a formal IPC qualification but should be supported in participating in link practitioner training at the earliest opportunity and avail of ongoing training as much as possible. The IPC link-practitioner 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. The IPC link practitioner is a key resource in supporting the Public Health Department in fulfilling its role.

3 COVID-19 Background information

3.1 Sources of Infection with COVID-19

COVID-19 infection is acquired as a result of exposure to a person shedding infectious virus. It is generally accepted that the highest risk of transmission occurs at about the time an infected person develops symptoms. Spread from **symptomatic people** is generally considered to be the primary driver of the pandemic.

It is accepted that infection can be transmitted from people with minimal symptoms, from people before they develop symptoms (**pre-symptomatic transmission**) and from people who never develop symptoms (**asymptomatic transmission**); however, symptomatic people are generally more infectious. HIQA have provided a useful summary of the evidence related to asymptomatic transmission at: https://www.hiqa.ie/reports-and-publications/health-technology-assessment/evidence-summary-asymptomatic-transmission

Children with COVID-19 may be less infectious than adults, however there is uncertainty on this issue. The level of IPC precautions required in the healthcare setting are generally the same for children and adults in most contexts but taking account of the needs of the child.

Transmission in the Healthcare Setting

The spread of COVID-19 in the healthcare setting is a specific concern. Experience in Ireland and elsewhere indicates that transmission in residential care facilities and hospitals can occur readily when the virus is introduced from the community into the healthcare setting. Transmission typically occurs when an unrecognised infectious person enters the facility. Control of entry to minimise risk of unrecognised introduction is therefore a key priority in preventing outbreaks. This requires a particular focus when rates of infection in the community served are high. In the context of long-term residential care facilities, the key group of people who move regularly between community and the facility is staff. Visitors also represent a risk of introduction of COVID-19. Guidance on managing risk associated with visiting is provided on the HPSC website.

Outbreaks of infection involving both residents and healthcare workers (HCW) have been frequent in RCFs during the major community surges in COVID-19. The control of spread in RCFs in this context has been very challenging. The increase in residential care acquired cases during the surge in late December 2020 and January 2021 may be related in part to the emergence of SARS-CoV-2 variants with higher transmissibility.

Vaccination of a high proportion of residents and staff in RCFs has had a major impact on reducing the impact of COVID-19 in RCFs. In this context, it is possible to manage the risk of spread of COVID-19 effectively with less restriction on the lives of residents. There is however, a continuing need for vigilance to prevent infectious staff members or other people from entering the RCF, to ensure that cases of COVID-19 are detected promptly and that transmission-based IPC precautions, including appropriate use of PPE, are implemented in the care of infectious residents to further reduce the risk of spread. RCFs must have systems in place to ensure that, to the greatest extent possible; residents with COVID-19 are rapidly identified and are cared for with appropriate transmission-based IPC precautions.

3.2 Routes of Transmission

The transmission of COVID-19 occurs mainly through liquid respiratory particles. The larger particles can be considered as droplets and the smaller as aerosols, although the particle sizes form a continuum rather than two discrete categories. In practice the infection prevention and control issue is whether transmission through the air occurs primarily within a short range of space and time of the source (considered to be associated with droplets/ larger particles) or over a long range of space and time (considered as associated with aerosols/ smaller particles and airborne transmission).

Respiratory particles are generated from the nose and mouth by actions such as breathing, coughing, sneezing, talking or laughing. Transmission to others may result from direct impact of infectious droplets on the mucosa of persons nearby and through contact with surfaces contaminated with infectious respiratory droplets and subsequent transfer of infectious material to the mucous membranes (droplet transmission).

The World Health Organisation (WHO) states that "*Recent clinical reports of health workers exposed to COVID-19 index cases, not in the presence of aerosol-generating procedures, found no nosocomial transmission when contact and droplet precautions were appropriately used, including the wearing of surgical masks as a component of the personal protective equipment (PPE). These observations suggest that aerosol transmission did not occur in this context. Further studies are needed to determine whether it is possible to detect viable SARS-CoV-2 in air samples from settings where no procedures that generate aerosols are performed and what role aerosols might play in transmission*." https://www.who.int/news-room/commentaries/detail/transmission-of-sars-cov-2-implications-for-infection-prevention-precautions (accessed 29 May 2021). Of note this Scientific Brief was published in July 2020 prior to the emergence of the B.1.1.7 variant.

Transmission by the airborne route (longer range transmission) has been acknowledged since the start of the pandemic, in particular in the context of certain medical procedures referred to as aerosol generating procedures associated with an increased risk of infection (AGPs). More recently, in the context of the emergence and spread of more infectious virus variants such as the alpha and delta variants the risk of airborne spread has increased. This is reflected in the

April 2021 update to the WHO website Frequently Asked Questions as follows. "*The virus can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe. These particles range from larger respiratory droplets to smaller aerosols. Current evidence suggests that the virus spreads mainly between people who are in close contact with each other, typically within 1 metre (short-range). A person can be infected when aerosols or droplets containing the virus are inhaled or come directly into contact with the eyes, nose, or mouth. The virus can also spread in poorly ventilated and/or crowded indoor settings, where people tend to spend longer periods of time. This is because aerosols remain suspended in the air or travel farther than 1 metre (long-range). People may also become infected by touching surfaces that have been contaminated by the virus when touching their eyes, nose or mouth without cleaning their hands*." https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-how-is-it-transmitted (accessed 29 May 2021)

Recent experience in hospitals in Ireland also highlights particular concerns regarding spread of infection over longer distances from patients supported by high flow oxygen devices in particular in multi-bed areas which is a recognised AGP.

Higher levels of virus have been detected in patients with severe illness compared to mild cases. Like influenza, peak levels of virus are generally found around the time of symptom onset. People can be infectious before they develop symptoms (pre-symptomatic spread) and some people who never notice symptoms may be infectious (asymptomatic spread). The overall importance of spread of infection from pre-symptomatic and asymptomatic people in driving the pandemic remains uncertain.

3.3 Control of Transmission

Vaccination

There is evidence that vaccination reduces the risk of transmission in addition to preventing severity of disease in those vaccinated. This serves to emphasise the importance of vaccination of healthcare workers in protecting the people that they care for.

Standard Precautions

In addition to vaccination, Standard Precautions applied to all people cared for in all settings at all times play a key role in managing the risk of infection for residents and for healthcare workers in every long-term residential care facility. For further information on Standard Precautions please see Interim Guidance on Infection Prevention and Control for the HSE (2020). Note the recommendations of the National Public Health Emergency Team (NPHET) on use of surgical masks in healthcare are reflected in the HSE guidance.

Transmission-based Precautions

Transmission-based Precautions are measures taken in addition to Standard Precautions to manage risk of transmission of infection when caring for people with known or suspected infectious disease for which Standard Precautions alone are not sufficient. Transmission-based Precautions include Contact, Droplet and Airborne Precautions. For details on Transmission-based precautions, please see the Interim Guidance on Infection Prevention and Control for the HSE (2021) available at:
https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/hseinfectionpreventionandcontrolguidanceandframework/

3.4 Vaccination

Vaccination for COVID-19 began in Ireland in late December 2020. The Government policy on Covid-19 vaccination identified residents and staff of RCF for older people as the first group for vaccine allocation. The vast majority of residents and staff in RCF for older people have now been offered vaccination and vast majority of residents in most RCFs have been vaccinated. Vaccination offers a high degree of protection to residents and healthcare workers when they have vaccine protection. There is also evidence that vaccination reduces the risk of transmission of virus by people who are vaccinated.

Individuals are considered to have vaccine protection if they are vaccinated as follows:

1. 15 days after the second dose of AstraZeneca (Vaxzevria);

2. 7 days after the second Pfizer-BioNTech dose (Comirnaty);
3. 14 days after the second Moderna dose (Spikevax);
4. 14 days after Janssen (one dose vaccination course).

If other vaccines become available the requirement for vaccination will be as advised by HSE.ie.

When people have vaccine protection one can expect that the vaccine will confer a very high degree of protection from severe COVID-19. However, vaccine protection is not perfect and the vaccine may not work so well in people who have a condition or who are on a treatment that interferes with their immune system. In the context of potentially intense exposure of caring for a person with infectious COVID-19 the protection afforded to healthcare workers is not total. At this time, partially or fully vaccinated healthcare workers and residents are advised to continue to adhere to all IPC measures in this guideline.

3.5 Incubation period

Current estimates suggest that the time between exposure to the virus and developing symptoms (incubation period) is from five to six days for most people, but can range from one to 14 days. Individuals are usually considered most infectious to others around the time they develop symptoms. How infectious an individual is and how long they remain infectious is related to some degree to the severity and stage of illness and may be influenced by the immune function of the individual.

3.6 Survival in the environment

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. Common household cleaning products and many disinfectants including bleach easily kill the virus.

3.7 Clinical features of COVID-19

Most people with COVID-19 will have mild disease and will recover. A minority will develop more serious illness.

The HSE has defined categories of people who are considered very high risk (also known as extremely medically vulnerable) and those at high risk for severe disease. See the following link https://www2.hse.ie/conditions/coronavirus/people-at-higher-risk.html

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

1. fever (though this may be absent in the elderly);
2. dry cough;
3. shortness of breath;
4. loss of sense of smell or taste.

Other symptoms can include:

1. sputum production;
2. fatigue;
3. sore throat;
4. headache;
5. myalgia/arthralgia;
6. chills;
7. nausea or vomiting;
8. nasal congestion;
9. diarrhoea;
10. haemoptysis;
11. conjunctival congestion;
12. anosmia (loss of sense of smell);

13. dysgeusia (distortion of sense of taste);
14. 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:

1. **lethargy;**
2. **increased confusion;**
3. **change in baseline condition;**
4. **loss of appetite.**

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

3.8 Laboratory testing

1. Laboratory testing is helpful to confirm a diagnosis of COVID-19 infection;
2. Testing is performed in a similar way to testing for influenza;
3. A viral swab may be collected from the throat and nasopharynx. Only one swab is used to collect both samples, with the throat site sampled first;
4. Alternatively, a deep nasal/mid-turbinate swab may be collected. This type of sample is often less distressing for people and is almost equally likely to detect the virus if it is present. Please note a HSE video demonstrating the sample collection technique is available at the following link https://bit.ly/3efCPO2 ;
5. **When testing is performed, ensure the correct swab type is taken (viral swab), sealed tightly to prevent leakage and 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;

6. Current PCR based 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;
7. Additional information is available in the section on Duration of Transmission Based Precautions;
8. Testing for infection by another method called **antigen testing** is now also used in some situations. Antigen testing is generally less likely to detect virus at low levels than PCR testing.

3.9 COVID-19 and Immunity after Recovery

There is still limited experience with immunity after recovery and therefore caution is required in interpretation. In general, patients who have recovered from COVID-19 have evidence of an immune response and they appear unlikely to acquire infection that makes them infectious for others, at least in the short-term (up to nine months following recovery). However, it is recommended that healthcare workers who have recovered from COVID-19 continue to follow the same IPC precautions as all other HCWs when in contact with patients to reduce the risk of transmission of COVID-19.

Currently, antibody testing is not recommended for routine use to assess immunity to infection, as there is no consensus on how to interpret the results.

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

4.1 Planning

1. 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 requires at a minimum the support of one designated on-site IPC link practitioner (see above) and may require a liaison person on each unit in the RCF;
2. 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;
3. 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;
4. Each RCF should have an area identified where a resident with suspected or confirmed COVID-19 could be isolated;
5. 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 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;
6. The risk associated with movement or rotation of staff is lower if staff have vaccine protection or are in the nine month period after they have had and recovered from COVID-19;
7. 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;
8. Supplies of PPE should be sufficient to ensure that single-use items of PPE, including visors and goggles, are used only once and then disposed of safely;

9. Note that the Health and Safety Authority indicate that where a risk assessment indicates that workers need to use a close-fitting respirator mask for their protection that every effort should be made to comply with the requirement for fit testing of the workers, as far as is reasonably practicable. When fit testing of all staff is not immediately possible, then fit testing should be prioritised for those at greatest risk;
10. 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

1. 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;
2. 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;
3. 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

1. Residents should be consulted on and 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 (refer to section 4.5.4);
2. Residents should be encouraged and facilitated to clean their hands and actively assisted with this practice where necessary;
3. Key messages around cough etiquette (where appropriate) include:

a. Cover your mouth and nose with a disposable tissue when coughing and sneezing to contain respiratory secretions;
b. Discard used tissues after use and clean your hands;
c. If you don't have a tissue, cough into your forearm or the crook of your elbow;
d. Clean your hands.

4. 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. However, if two residents with vaccine protection are visiting with each other in one room they do not need to wear a mask of maintain distance;
5. Where possible and appropriate, residents should be made aware of the need to report any new symptoms of illness to staff members;
6. Residents who may leave a RCF should be made aware of the general principles of staying well, details of which can be found here;
7. Residents who are in the high risk or the very high risk groups for severe disease with COVID-19 should be supported in taking any additional measures required to reduce their risk of infection over and above any general measures applied in the RCF until such time as the residents in those groups have vaccine protection. Once a resident at high risk or very high risk has vaccine protection or if they have had COVID-19 infection in the previous 9 months, public health measures advised for that person should be the same as for other people;
8. Residents may wish to wear a mask at certain times or in certain places within the LTRCF, and this should be facilitated. In addition, if tolerated, residents should be encouraged to wear a mask in busy areas of the RCF or during transport to and from the facility unless fully vaccinated.

4.3 Social activity, physical distancing measures & Pods

1. When a high level of vaccination of residents has been achieved, social activity within the LTRCF should resume unless there is a specific infection prevention and control or public

health reason not to resume social activity. If social activity is not resumed this should be based on a documented risk assessment;

2. Residents with symptoms of COVID-19 or other viral respiratory tract infection should be asked not to join in social activities until they are no longer infectious. **This continues to apply to people who have been vaccinated;**
3. Resumption of more normal social activity is associated with some risk but it is important to the overall wellbeing of residents. It is to be expected that some residents and staff will have concerns around this transition. A stepwise approach is recommended.
4. Note a high level of vaccination of residents should be understood to mean about 8 out of 10 residents with vaccine protection. This level of 8 out of 10 is intended as a general guide not as a sharp cut-off;
5. Through the pandemic it has been advised that social activity should be organized on the basis of limiting contact to consistent groups of residents to the greatest extent practical through organization of pods of 4 to 6 people. When residents are vaccinated and disease incidence is low this requirement can be relaxed in stages to move towards more normal social interaction in the RCF. Residents engaged in social activity should be encouraged to practice hand hygiene and cough etiquette. Residents engaged in social activity should also be advised to limit direct contact with other people (touching hands, hugging or kissing). Exceptions are appropriate for couples who reside in the same RCF;
6. In order to support physical distancing, mealtimes may need to be staggered to ensure that distance between people is maintained when dining;
7. In the context of social interaction it is appropriate, with due regard to the weather and comfort, to use well-ventilated indoor space or outdoor space where available;
8. Staff members should also be required to maintain physical distancing measures during their break and meal times;
9. Table 2 provides some suggestions on particular group activities.

4.4 Group Activities

1. See details above in section 4.3. Suggestions on specific activities are outlined in Table 2;

2. Before any group activity confirm on that day that participants have no symptoms that suggest COVID-19;
3. Weather permitting, outdoor group activities are likely to be lower risk than indoor activities;
4. Ensure adequate supplies of hand sanitiser and appropriate cleaning products (for example detergent wipes) are available in each activity room/area;
5. 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	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	Hand hygiene before and after
Computer skills	Cover keyboard and clean after use
Sing songs	Maintain as much distance and ventilation as practical and keep groups small
Knitting	Each person uses their own equipment
Art	Each person use own equipment or equipment cleaned between users
Flower arranging	Hand hygiene before and after
Table quiz	Hand hygiene before and after
Jigsaws	Hand hygiene before and after
Pottery	Clean potter's wheel between users
Films	Physical distancing
Wii Keep fit	Clean hand set and controls between residents

Controls to minimise risk of inadvertent introduction of virus

4.4.1 Staff

1. Vaccination of staff is expected to play a key part in reducing the risk of inadvertent introduction virus. LTRCFs should do all that is practical to encourage high level of vaccine uptake in staff;
2. Staff should participate in scheduled testing of asymptomatic staff if required.

4.4.2 Movement across facilities

1. See section 4.1.

4.4.3 Staff occupational health & workforce planning

1. Staff working in a facility that is experiencing an outbreak should not work in any other facility;
2. Staff should be informed that they must not attend work if they have fever, cough, shortness of breath, or any kind of new respiratory symptoms. **This continues to apply to staff after vaccination.** 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;
3. The COVID-19 NPHET requires that all staff have their temperature measured twice a day, once being at the start of each shift;
4. 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. **This continues to apply to staff after vaccination.** Where relevant staff should be asked to confirm that they are not currently working in a facility where there is an outbreak;
5. 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;

6. Occupational health guidance for healthcare workers is available at: https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/covid-19-guidance/ :
    a. Staff members who test positive for COVID-19 may return to work after the end of the isolation period. For staff who have not required hospitalisation for treatment of COVID-19, this will be 10 days after symptom onset (or date when test was taken if no symptoms) provided they have had no fever during the last five days and are medically well. For staff who have required hospitalisation for treatment of COVID-19, this will be after 14 days from symptoms onset (or date when test was taken if symptom onset less clear) provided they have had no fever during the last five days and are medically well. Repeat testing at the end of the illness is generally not appropriate;
    b. Staff members who have been identified as contacts of a case either in the community or the occupational setting should restrict their movements and remain off work unless they have vaccine protection or laboratory-confirmed COVID-19 in the previous 9 months. Staff members who have vaccine protection and who are asymptomatic generally do not need to stay off work if they are identified as contacts unless specifically advised to do so in particular circumstances;
    c. For healthcare workers designated as close contacts and who do not have vaccination protection or laboratory-confirmed COVID-19 in the previous 9 months: testing should be performed in accordance with current public health guidance. In general contacts who have vaccine protection or have had COVID-19 in the previous 9 months do not require testing if asymptomatic;
    d. Note that, as per HSE HR memo 14.01.21 the option to derogate healthcare workers who would normally require exclusion from work (close contacts without vaccine protection, including household contacts) may be considered, where this is essential to main care for residents. Only senior management can make the decision to derogate a HCW who is a close contact from exclusion from work and this must be based on a risk assessment. Derogation must only be used in **exceptional circumstances** given the inherent risks;

e. Any consideration regarding derogations to return to work should be in the context of current occupational health and public health guidance, available at the following link. https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/covid-19-guidance/derogation-for-the-return-to-work-of-healthcare-workers.pdf;

7. Available Occupational Health supports are detailed in Appendix B.

4.4.4 Visitors, Pastoral Support and other Essential/Important Service Providers

These issues are addressed in a specific document on Guidance on visitation in long-term residential care facilities available at the following link:
https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/visitorsvisiting/Guidance%20on%20visits%20to%20RCF.pdf
COVID-19 Guidance on visits to and from residential facilities for people with disabilities is available on the following link, it also includes detail on how to carry out a risk assessment in relation to visiting:
https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/COVID-19%20Guidance%20on%20visits%20to%20residential%20facilites%20for%20people%20with%20disabilities.pdf

An information leaflet for residents and their visitors is available at the following link: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/visiting%20nursing%20homes%20and%20residential%20care%20facilities%20during%20COVID-19..pdf

4.4.5 Resident transfers

1. Guidance on resident transfers is addressed as an appendix to this document. (**Appendix H**);
2. A video link for self-isolation for people in Residential Care Facilities who have been discharged from hospital is available at: https://youtu.be/wug2188UNC4 ;
3. 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. Guidance on admission to RCF applies to residents who routinely use ventilatory support such as CPAP or BiPAP. Use of CPAP or BiPAP is considered an aerosol generating procedure by many (see the following link https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/AGPs%20for%20confirmed%20or%20possible%20COVID19.pdf);
5. Recent experience in the acute hospital setting suggests there is a high risk of spread if a person on respiratory support with AGP develops infection therefore particular attention to infection prevention and control precautions and a high level of awareness for features of COVID-19 infection is required particularly in residents who have not vaccine protection or have not had COVID-19 in the previous 9 months;
6. Such residents should be admitted to single rooms with a window that can be opened to improve ventilation (subject to weather and security, the goal is gentle air circulation rather than strong air movements) and the door should remain closed as much as possible when ventilatory support is in use;
7. If not tested and reported as SARS-CoV-2 not detected in the 3 days before admission residents on CPAP or BiPAP should remain in their room with the door closed all of the time until a test result is available unless;
8. In the case that the test result is not available OR if they have any new clinical features to suggest viral infection any care delivered by staff during the use of CPAP or BiPAP, care

provided by staff should be delivered with airborne precautions (minimise numbers and time in the room, maximise ventilation as far as is practical and use of appropriate PPE);

9. If the test result is reported as not detected, the person is not a COVID-19 close contact and there are no clinical features to suggest viral infection, care provided by staff should be delivered with Standard Precautions plus use of a surgical mask;
10. As for all newly admitted residents who do not have vaccine protection or have not had COVID-19 in the previous 9 months, during the initial 14-day period following admission they should not participate in social activities within the LTRCF and should stay in their room most of the time. A link to a video for residents of LTRCF on self-isolation following discharge from hospital is available here;
11. If a person who does not have vaccine protection, is on CPAP or BiPAP, is not a contact of COVID19, if they have no new symptoms of respiratory deterioration to suggest acute infection and if the sample taken before or on admission was reported as COVID-19 not detected, they can move around outside their room and participate in activities subject to confirming each day that there is no deterioration in their condition that could suggest COVID-19;
12. If at any point during admission to the RCF a person who uses CPAP or BiPAP develops symptoms consistent with COVID19, airborne precautions should reintroduced immediately while arrangements are made for assessment by their doctor. Staff should follow the guidance on use of PPE for AGPs while managing a suspected or confirmed case of COVID19, found here: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/AGPs%20for%20confirmed%20or%20possible%20COVID19.pdf.

4.5 Increased surveillance and early identification of cases of COVID-19 infection

1. Surveillance (monitoring for illness) is an essential component of any effective infection prevention and control programme;
2. 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.

3. 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);
4. There should be early identification of staff absence/s, which may be due to COVID-19 infection or a requirement to restrict movements for close contacts of a COVID-19 case. Contact tracing guidance may vary for vaccinated staff.

5 Management of an outbreak of COVID-19

When there is a suspicion of cases 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:

1. Try and establish whether it is likely that an outbreak is occurring, taking in to account the following:

a. Could onward transmission have already occurred? (e.g., resident had widespread contact with others in the 48 hours before symptom onset)
    i. Are they in a single room or sharing?
    ii. Is the resident ambulatory?
    iii. Have they spent time with others in communal areas or group activities?
    iv. Are there behavioural characteristics, which might be increased risk of transmission?
    v. Are all or most residents vaccinated?
2. Identify if are any other residents symptomatic and if so, what are their symptoms?
3. Identify are any staff symptomatic or has there been an increase in staff absence?
4. 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.

The contact tracing guidance varies when VOCs are suspected/ confirmed. Please see https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/sars-cov-2variantsofconcern/Variants_guidance.pdf for further details

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 a 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:

1. Specialist in Public Health Medicine and/or Public Health Department Communicable Disease Control Nurse Specialist;
2. GP/Medical officer/Consultant to RCF (dependent on nature of RCF);
3. Director of Nursing or Nurse Manager from RCF;
4. Management representative from the RCF i.e. manager or CEO;
5. Community Infection Prevention and Control Nurse (CIPCN) where available;
6. Administration support.

Other members who may need to be included, particularly if it is an extensive or prolonged outbreak include:

1. Community Services General Manager;
2. Administrative support;
3. Occupational Medicine Physician;
4. Consultant Clinical Microbiologist;
5. Representative from HPSC;
6. 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:

1. A line list of all residents and staff. Template can be found in Appendix C;
2. The vaccination history of all residents and staff;
3. Identify the total number of people ill (residents & staff), dates of illness onset and the spectrum of symptoms;
4. Identify staff and residents who have recently recovered, developed complications, been transferred to acute hospitals and those who have died;
5. 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;
6. 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;
7. Use the case definitions for possible, probable and confirmed COVID-19 available on the HPSC website HERE.

8. A checklist for outbreak management can be found in Appendix D.

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

1. The initial assessment of the resident should be performed by their doctor by telephone;
2. If COVID-19 is suspected, the doctor will arrange testing;
3. If the clinical condition does not require hospitalisation, the resident should not be transferred from the facility on infection prevention and control grounds;
4. 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**). Staff assigned to care of a resident in these circumstances should preferably be staff who have vaccine protection. This is because vaccination is the most effective way to protect staff although good IPC practice provides substantial protection to staff;
5. Room doors should be kept closed where possible and safe to do so;
6. Practical measures to increase ventilation should be taken consistent with comfort and weather. Note the intention is to achieve gentle air circulation rather than strong air movements;
7. 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;
8. Display signage to reduce entry into the room, but confidentiality must be maintained;
9. 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;
10. Ideally, the resident's single room should have ensuite facilities;
11. If ensuite facilities are not available, try to designate a commode or toilet facility for the resident's use;
12. 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;

13. If the resident must use a communal toilet, ensure it is cleaned after every use;
14. Listen and respond to any concerns residents may have to ensure support and optimal adherence is achieved during their care;
15. 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;
16. 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;
17. 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;
18. 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 preferences 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;
19. 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. A respirator mask (such as an FFP2 mask) should be available for use by staff caring for such a resident during the period when they are infectious however use of a surgical mask and face shield also affords substantial protection;
20. Samples from residents with confirmed COVID-19 after completion of vaccination should be submitted for further testing to identify the SARS-CoV-2 variant if the sample is suitable. The laboratory that performed the test will forward the sample if the sample has

been stored;

21. Staff should be mindful that prolonged isolation is stressful for most residents and to encourage relatives and other residents where practical to communicate with them regularly via phone or video calls and where possible window visits.

5.4 Cohorting residents with possible or confirmed COVID-19

1. 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, heightened infection prevention and control measures are critical and practical measures to improve ventilation should be implemented;
2. 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;
3. Where possible, residents with probable or confirmed COVID-19 should be isolated in single rooms with ensuite 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;
4. Where single room capacity is exceeded and it is necessary to cohort residents in a multi-occupancy room:
    a. Only residents with **a confirmed diagnosis of COVID-19** can be cohorted together;
    b. Residents with suspected COVID-19 should not be cohorted with those who are confirmed positive;
    c. 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;
5. Where residents are cohorted in multi-occupancy rooms, every effort should be made to minimise cross-transmission risk:
    a. Maintain as much physical distance as possible between beds; if possible reduce the number of residents/beds in the area to facilitate social distancing;

b. Close privacy curtains if available between the beds to minimise opportunities for close contact.

6. 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;
7. A designated cohort area should ideally be separated from non-cohort areas by closed doors;
8. Minimise unnecessary movement of staff in cohort areas and ensure that the number of staff entering the cohort area is kept to a minimum;
9. Staff working in cohort areas should have vaccine protection if possible and should not be assigned to also work in non-COVID-19 areas;
10. 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;
11. A respirator mask (such as an FFP2 mask) should be available for use by staff working in the cohort area during the period when the residents are infectious however use of a surgical mask and face shield also affords substantial protection;
12. Improve ventilation in the cohort area in so far as practical consistent with comfort and safety, the goal is gentle air circulation rather than strong air movements.

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

1. Residents who are close contacts of a confirmed case should be accommodated in a single room with their own bathing and toilet facilities, unless they have vaccine protection or have had COVID-19 in the previous 9 months. If this is not possible, cohorting in small groups (two to four) with other close contacts is acceptable;
2. Although the risk for close contacts who have vaccine protection or have had COVID-19 in the previous 9 months is much lower than for residents who do not have vaccine protection, a high degree of caution as in the bullet point above remains appropriate in the initial stages of dealing with an outbreak;

3. 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, unless they have vaccine protection or have had COVID-19 in the previous 9 months. This may be reviewed for residents who have vaccine protection or have had COVID-19 in the previous 9 months when the scale of the outbreak is apparent and the characteristics of the associated virus are better defined;
4. 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 if distance can be maintained;
5. Note: testing of residents who are close contacts for COVID-19 should be performed in accordance with current public health guidance. In general, contacts who have vaccine protection or have had COVID-19 in the previous 9 months do not require testing if asymptomatic. 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 subject to the above qualification with regard to residents who have vaccine protection. 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;
6. 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;
7. 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. The associated risks are lower if the residents concerned have vaccine protection;

8. 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;
9. A respirator mask (such as an FFP2 mask) should be available for use by staff working in the cohort area during the period when the residents are infectious; however, use of a surgical mask and face shield also affords substantial protection.

5.6 Infection prevention and control measures

5.6.1 Standard precautions

Note that at present the recommendations with respect to Infection Prevention and Control Practice are the same for those who have vaccine protection as for other staff.

Standard Precautions are the minimum infection prevention practices that apply to the care of all people, regardless of suspected or confirmed infection status of the person, 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.

For most recent HSE guidance on IPC refer here: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/hseinfectionpreventionandcontrolguidanceandframework/.

With regard to COVID-19, key elements include:

5.6.2 Hand hygiene

1. 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;
2. Facilities must provide ready access for staff, residents and visitors to hand hygiene facilities and alcohol-based hand rub (ABHR);
3. Staff should adhere to the WHO five moments for hand hygiene:
    a. 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.

4. 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;
5. **Gloves should not be used in routine care of residents to whom Standard Precautions 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;**
6. 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

1. Respiratory hygiene and cough etiquette refer to measures taken to reduce the spread of viruses via liquid respiratory particles produced when a person coughs or sneezes;
2. Disposable single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose;
3. Used tissue should be disposed of promptly in the nearest foot operated waste bin;
4. 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;
5. 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 for the use of surgical masks by HCW in the context of COVID-19 states that:

1. HCWs should wear surgical masks when providing care to residents within 2m of a resident. If a resident has suspected or confirmed COVID-19 or is a COVID-19 contact staff should have access to a respirator mask (for example FFP2) as below;
2. HCWs 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;
3. HCWs are also required to wear a surgical mask in busy public areas of healthcare facilities even if they do not expect to be within a distance of 2m of another person for 15 minutes or more;
4. In the context of a ward or unit-based outbreak it is appropriate to consider all patients in that setting as suspected or confirmed COVID-19 cases while active transmission is ongoing. Decisions regarding when all patients should be considered as suspected or confirmed COVID-19 cases requiring use of general use of FFP2 masks should be made by the IPC team and outbreak control team;
5. A surgical mask and visor also offer a high degree of protection. These may be more comfortable for and preferred by some staff;
6. Facemasks that are worn by HCW's in circumstances other than contact with residents with suspected or confirmed COVID-19 or COVID-19 contacts may be disposed of in the domestic waste stream;
7. Educational videos are also available on www.hpsc.ie at

8. https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/videoresourcesforipc/ ;
9. All staff must be trained in the proper use of all PPE that they may be required to wear;
10. The Health and Safety Authority indicate that where a risk assessment indicates that workers need to use a close-fitting respirator mask for their protection that every effort should be made to comply with the requirement for fit testing of the workers, as far as is reasonably practicable. When fit testing of all staff is not immediately possible, then fit testing should be prioritised for those at greatest risk;
11. Note that in outbreak situations or other exceptional circumstances where extended use of some items of PPE (other than gloves) when moving between people care for 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. Note that extended use of PPE for the sole purpose of reducing PPE use is not appropriate, as PPE supplies should be sufficient to meet requirements;
12. 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;
13. 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

1. 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 liquid

respiratory particles; 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);

2. https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/ ;
3. Transmission-based Precautions should be applied immediately to all suspected cases of COVID-19.

5.7 Duration of transmission based precautions

1. Transmission based precautions can be **discontinued fourteen days after symptom onset, where a person has been fever free for five days, with the exception of people or respiratory support devices that are aerosol generating. For residents who are on respiratory support devices that are aerosol generating the period of should be extended to 21 days;**
2. A test of clearance is generally not appropriate for residents who have been diagnosed with COVID-19;
3. In exceptional circumstances where a physician is concerned on clinical grounds that there may be an ongoing risk of transmission beyond 14 days Transmission-based Precautions may be extended 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 Precautions. This includes people who are immunocompromised or require haemodialysis where care can be provided with Standard Precautions after that time;
4. Note: some people 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 people 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 Transmission based precautions of 21 days may be reasonable. In any case Transmission based precautions should not be extended beyond 28 days.

5.7.1 Care Equipment

1. 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;
2. 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.);
3. 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;
4. 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

1. Should be managed in line with local policy.

5.7.3 Management of waste

1. Dispose of all waste from residents with confirmed or suspected COVID-19 as healthcare risk waste (also referred to as clinical risk waste);
2. When removing waste, it should be handled as per usual precautions for healthcare risk waste;
3. The external surfaces of the bags/containers do not need to be disinfected;
4. All those handling waste should wear appropriate PPE and clean their hands after removing PPE;
5. Hands-free healthcare risk waste bins should be provided in single rooms and cohort areas;
6. 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;

7. 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)

1. 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;
2. 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;
3. Disposable gloves and an apron should be worn when handling linen;
4. 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;
5. When handling linen, the HCW should not:
    a. rinse, shake or sort linen on removal from beds/trolleys;
    b. place used/infectious linen on the floor or any other surfaces (e.g., a bedside locker/tabletop);
    c. handle used/infectious linen once bagged;
    d. overfill laundry receptacles; or
    e. place inappropriate items in the laundry receptacle (e.g., used equipment/needles).
6. When managing infectious linen, the HCW should:
    a. Place linen directly into a water-soluble/alginate bag and secure;
    b. Place the alginate/water-soluble bag into the appropriately coloured linen bag (as per local policy);
    c. Store all used/infectious linen in a designated, safe area pending collection by a laundry service;

d. If there is no laundry service, laundry should be washed using the hottest temperature that the fabric can withstand and standard laundry detergent;
e. Laundry may be dried in a dryer on a hot setting.

5.7.5 Environmental hygiene

1. 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;
2. Ventilation should be maintained in so far as practical taking account of comfort and weather. Note that the goal is to achieve reasonable air exchange with gentle air movement. Strong airflow into the room from outside that is readily felt and causes discomfort is not required and may contribute to airflow out of the room.
3. 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 in the context of COVID-19

1. Decontamination of equipment and the care environment must be performed using either:
    a. A combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or;
    b. A general-purpose neutral detergent in a solution of warm water, followed by a disinfectant solution of 1,000 ppm av.cl;
    c. 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.

2. Hoovering of carpet floor in a resident's room should be avoided during an outbreak and while the person is infectious. When the resident is recovered the carpet should be steam cleaned;
3. All shared spaces should be cleaned with detergent and disinfectant;
4. 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;
5. Household and care staff should be trained in the appropriate use and removal of PPE (**Appendix F**);
6. 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 in the context of COVID-19

1. All surfaces in the resident room/zone of people who have infectious COVID-19 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);
2. Handrails and table tops in facility communal areas, along with nurses' station counter tops and equipment require regular cleaning;
3. 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

1. Terminal cleaning should always be performed after a resident who has had infectious COVID-19 has vacated the room and is not expected to return. In addition to the routine cleaning protocols, a terminal clean is needed;
    a. Removal of all detachable objects from a room or cohort area, including laundry and curtains;

b. Removal of waste;
c. Cleaning (wiping) of lighting and ventilation components on the ceiling;
d. Cleaning of the upper surfaces of hard-to-reach fixtures and fittings;
e. Cleaning of all other sites and surfaces working from those at higher level down to floor level.

2. 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;
3. The use of novel technologies for room disinfection have not been shown to add value beyond standard cleaning and disinfection and are not recommended. If they are used, they must be used in addition to and not as a substitute for cleaning.

5.7.9 Staff uniforms/clothing

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

5.8 Communication

1. Good communication is essential for residents, family and staff members;
2. 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

1. 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;
2. One of the key supports to staff is to promote vaccination. It is important that staff with questions about the benefits and risks of vaccination have access to appropriate support.

6 Care of the person with suspected of confirmed COVID-19 or a Contact of COVID-19 who is dying

1. A compassionate, pragmatic and proportionate approach is required in the care of those who are dying;
2. The presence of a person close to the resident should be facilitated. They should be aware of the potential infection risk;
3. If the person who wants to be with the resident has vaccine protection or has had COVID-19 in the previous 9 months. the risk is much reduced;
4. 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;
5. All persons in attendance should be advised to wear a mask and plastic apron. A surgical mask is generally appropriate in this setting however a respirator mask should be available to those who wish to use them although it is unlikely that it will be practical to train most people in their correct use in this context. 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;
6. The use of PPE is less important if the person accompanying the dying person has vaccine protection or has had COVID-19 in the previous 9 months, but people should have access to PPE;

7. 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;
8. Visitors should avoid interacting with residents other than the person they are accompanying.

7 Care of the recently deceased

7.1 Hygienic preparation

1. 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;
2. Hygienic preparation includes; washing of the face and hands, closing the mouth and eyes, tidying the hair and in some cases, shaving the face;
3. 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

1. 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;
2. 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;
3. 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;

4. 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;
5. 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

1. 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;
2. A surgical face mask or similar should be placed over the mouth of the deceased before lifting the remains into the inner lining;
3. Those physically handling the body and placing the body into the coffin or the inner lining should wear, at a minimum, the following PPE:
    a. Gloves;
    b. Long sleeved gown;
    c. Surgical face mask.
4. Play close attention to hand hygiene after removal of PPE;
5. 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

1. Monitoring the outbreak will include ongoing surveillance to identify new cases and to update the status of ill residents and staff;
2. 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;

3. The review of this information should examine issues of ongoing transmission and the effectiveness of control measures;
4. Institute active daily surveillance for fever, respiratory symptoms, including cough and other symptoms suggestive of COVID-19, 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, an 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 and 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, cleaning and disinfection materials, viral swabs, request forms and arrangements for prioritised testing of samples
		Vaccination	Regularly review the uptake of vaccination in residents and staff.
	Standard Precautions	Standard infection control procedures	Standard Precautions and mask use should be practised 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. Note requirement for access to respirator masks (such as FFP2)

	Domain	Action	Comment
During an Outbreak		Resident placement	Single rooms Cohorting or zone allocation
		Respiratory etiquette	
	Infection Control Measures	Hand Hygiene	5 Critical points: • Before patient contact • Before an aseptic procedure • After body fluid exposure • After patient contact • After contact with patient surroundings Hand hygiene after PPE removal
		PPE	Gloves Mask (respirator mask or surgical mask) Aprons / Gowns Face protection (as required based on risk assessment)
		Aerosol Generating Procedure associated with increased risk of infection (AGP)	See HPSC guidance document. Ventilation, closed door, respirator mask (FFP2), gown, eye protection and gloves
	Environmental control measures		Resident environmental cleaning and disinfection Residential care equipment Laundry Eating utensils and crockery Practical measures to increase ventilation to the greatest extent practical consistent with comfort and weather (gentle movement of air rather than strong airflow is the objective)
	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. Sex;
7. Status i.e., resident, staff member, volunteer, visitor;
8. Vaccination status of resident, staff member, volunteer, visitor; vaccine protection;
9. Previous Covid-19 infection (last 9 months);
10. Date of onset of symptoms;
11. Date of notification of symptoms;
12. Clinical symptoms (outline dependent on case definition) e.g., fever, cough, myalgia, headache, other;
13. Samples taken and dates;
14. Laboratory results including test type e.g., RT-PCR;
15. Date when isolation of resident was started;
16. Date of recovery;
17. Duration of illness;
18. Outcomes: recovery, pneumonia, other, hospitalisation, death;
19. Also include work assignments of staff and last day of work of ill staff member;
20. 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)	Fully vaccinated Y/N	Previous Covid 19 infection in last 9 months	Sex	DOB	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	Fully vaccinated Y/N	Previous Covid 19 infection in last 9 months	Sex	DOB	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 prevention and 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	Review vaccination status of all residents and staff		
10	Discuss which specimens have been collected. Notify the laboratory of the investigation.		
11	Confirm the type and number of further laboratory specimens to be taken. Clarify which residents and staff should be tested.		
12	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.		
13	Liaise with the RCF and laboratory regarding specimen collection and transport		

	Discussion point	Decision/action to be taken (date completed)	Person responsible
14	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		
15	Discuss whether a media release is required		
16	Ensure that the incident is promptly reported to HPSC and surveillance details entered onto CIDR		
17	Provide updates on the investigation to the Assistant National Director, ISD-Health Protection when/if required		
18	Discuss communication arrangements with HSE management ± HSE crisis management team		
19	Discuss communication arrangements with local GPs and Emergency Departments		
20	Decide how frequently the OCT should meet and agree criteria to declare outbreak over		
21	Prepare/circulate an incident report/set date for review meeting		

Appendix E Hand Hygiene poster

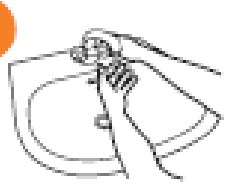
Seirbhís Sláinte Níos Fearr a Forbairt | Building a Better Health Service

How to hand wash

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

Length of time to spend washing: 40-60 seconds

1



Wet hands with water

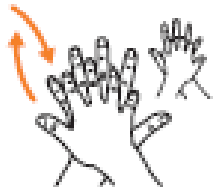
2

Apply enough soap to cover all hand surfaces

3

Rub hands palm to palm

4



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

5

Palm to palm with fingers interlaced

6

Backs of fingers to opposite palm with fingers interlocked

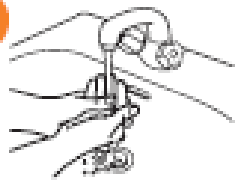
7

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

8

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

9

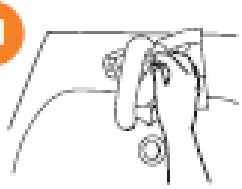


Rinse hands with water

10

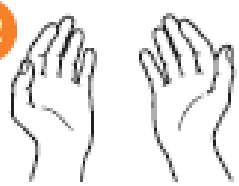
Dry hands thoroughly with a clean towel or single use towel

11



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

12



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	Gown
Surgical Mask	When adequate distance cannot be maintained	Yes	No
Respirator Mask (FFP or equivalent)	Not required	Not required (see text regarding access to respirator mask when caring for people with COVID	Yes
Goggles/face **shield**	Not required	As per standard precautions	Yes

Appendix H Admissions, transfers and discharges to and from residential care facilities

Note re testing of People Pre-transfer/Admission to a LTRCF

The requirement for testing before transfer or admission does not normally apply to people who have vaccine protection or who have had COVID-19 in the previous 9 months although it may be required in some people based on risk assessment (for example people with impaired immune function).

Introduction

Long-term residential care facilities (LTRCF) are a critical part of health and social care services. LTRCFs 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. The risk of harm from introduction of COVID-19 is greatly reduced when residents and staff have vaccine protection.

Residents transferring to a LTRCF from an acute hospital should generally have had the first dose of vaccine before transfer. While the vaccine should ideally be administered as long as possible in advance of transfer, there is no requirement to delay transfer of a person who is otherwise ready for discharge to allow time for an immune response to the vaccine. Arrangements to complete the vaccination in the LTRCF are essential.

In all instances, careful attention to standard precautions will assist in minimising risk of infection to residents and staff. Key elements 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 LTRCF.

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 are very unlikely to spread infection. For **people with a diagnosis of COVID-19 infection who are in a RCF or are planning to move into a RCF, the period of isolation is 14 days after onset of symptoms with no fever for the last five of this period.**

Note that if a person is detected by testing and subsequently develops symptoms the 14 days is counted from the date of symptom onset (not the sample date); however if they do not develop symptoms the 14 days is counted from the sample date.

The period of 14 days continues to apply in this setting although the infectious period is now 10 days with no fever for the last 5 days for people who do not require hospitalisation for care of COVID-19 and who are not resident in LTRCF. Note that repeat testing at the end of the isolation period is generally not appropriate though exceptions may arise in the context of discussion with Microbiology, Infectious Diseases or Public Health Clinicians.

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

1. People for admission to a LTRCF should be tested for SARS-CoV-2. This applies to transfer from a hospital or another LTRCF or to people admitted from the community. This is to help identify most of those who have infection, but it will not detect all of those with infection.
2. Testing should be performed within three days of planned admission to the LTRCF if transfer is from a hospital or another LTRCF and should also be performed whenever possible for admissions from the community.
3. Where testing is not performed before admission, it should be carried out within one day of admission.
4. 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.
5. The requirement for testing in advance of transfer or admission does not apply to people who have vaccine protection or who have had confirmed COVID-19 in the previous 9 months, and who are no longer considered infectious to others (minimum 14 days since onset of symptoms and no fever for the last five days).
6. The requirement for testing in advance of transfer or admission does not apply to settings caring for children under the age of 18
7. The requirement for testing in advance of transfer or admission does not apply to people who are returning to supported/assisted living or small group homes (generally less than five residents) following discharge from hospital, where the facility is more reflective of a household setting
8. For patients or residents who decline or are clearly distressed by collection of a nasopharyngeal sample a deep nasal sample (also known as a mid-turbinate swab) is often less uncomfortable. Deep nasals swabs should generally be used for surveillance testing on people who require very frequent testing and for those in whom a nasopharyngeal sample collection is difficult or distressing. An anterior nasal swab is NOT a suitable sample. 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 People Pre-transfer/Admission to a LTRCF

Note this does not normally apply to people who have vaccine protection or who have had COVID-19 in the previous 9 months although it may be required in some people based on risk assessment (for example people with impaired immune function). In this circumstance testing and restriction of movement after transfer is generally not required.

1. If a person is being transferred from an acute hospital to a LTRCF, the hospital should arrange for the person to be swabbed in the three days before transfer.
2. If a person is being admitted to the LTRCF from home where possible, the GP should arrange for the person to be swabbed within the three days before admission. This can be done using

Healthlink. If the person 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 (Figure 1).

3. If a test pre-admission cannot be arranged, including for urgent admissions, the person should be admitted as planned. The person will need to be isolated, with full contact and droplet precautions until the result of the test is available. The facility can arrange swabbing after admission. This can be done by the person's own GP or the GP/Medical Officer who provides medical care for the residents in the facility. If the sample is reported not detected the precautions that apply are those that apply at that point at those that apply to a person with sample reported not-detected before admission (see above).

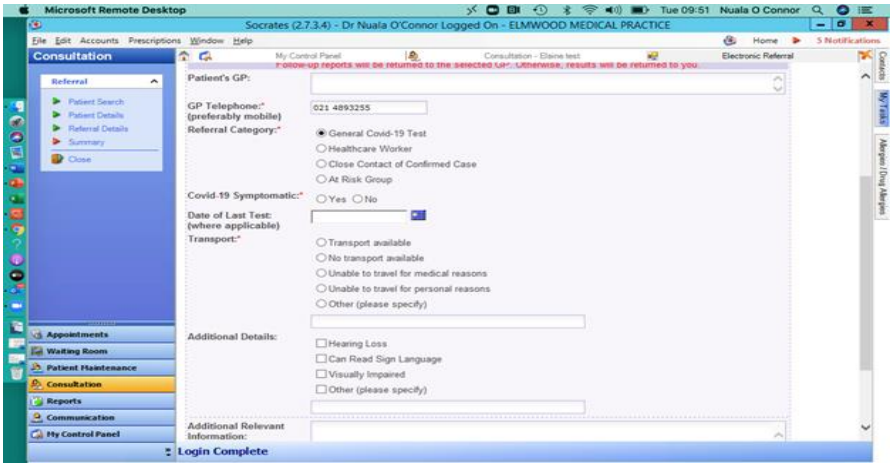


Figure 1. Snapshot of Health link web page

Requirements for placement and restricted movement of the person as part of transfer protocols
Planning

1. All LTRCF should review their accommodation to identify areas where new residents can safely restrict their movement. 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).
2. Where possible the use of single rooms in LTRCF 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 LTRCF), regardless of the pre-admission COVID-19 test result.
3. For those LTRCF 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.
4. The identification of space for the 14-day period of restricted movement 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.

5. 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.
6. All transfers or new admissions should have a risk assessment, to ensure sufficient resources are available within the LTRCF to support physical distancing and placement of residents.
7. Any person who does not have vaccine protection and has not been diagnosed with COVID-19 in the previous 9 months will need to restrict their movements for 14 days after transfer regardless of the test result.
8. If the person has vaccine protection restricted movement is not required if the test is reported not detected and they are asymptomatic.
9. If the person had COVID-19 in the past 9 months they do not need either testing or to restrict their movement after transfer
10. For those who require restricted movement the following applies:
11. Care delivered within the single room of a person on restricted movement can be delivered with Standard Precautions plus surgical mask and the resident may leave their room as per guidance below on transfers.
12. The resident is not required to remain in strict isolation, but should practice restricted movement:
13. The resident may leave their room, but should remain separated from other residents (e.g. to go the garden or for a short walk)
14. 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.

Transfer of people with COVID-19

Any resident transferred to a LTRCF 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 LTRCF. Such transfer should not proceed if the receiving LTRCF has no other residents with infectious COVID-19 at the time. Provided the resident has remained afebrile for the last five of the 14 days, the resident is generally no longer infectious to others after day 14 has elapsed. However if the hospital practice requires repeat testing or extended isolation for the patient for a specific reason the same level caution applies in advance of transfer to the LTRCF.

1. In particular, existing residents from a LTRCF who require transfer to hospital from the LTRCF for assessment or care related to COVID-19 acquired in the LTRCF should be allowed to transfer back to that LTRCF 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).
2. If the resident in an LTRCF has been diagnosed with COVID-19 while in hospital, it is important to assess if the person was infected in the LTRCF before transfer to the hospital or if this is a hospital-acquired infection. If it is likely that infection was acquired in hospital and there are no other known cases of COVID-19 in the LTRCF, transfer back to the LTRCF should be delayed until the resident is no longer infectious to others.
3. The public health team should be notified immediately where newly-diagnosed COVID-19 is assessed as acquired within a LTRCF.
4. In all instances the discharging hospital should provide the LTRCF with the following information on the arrival of the resident:
5. The date and results of COVID-19 tests (including dates of tests reported as not-detected)
6. The date of onset of any symptoms of COVID-19
7. Date of last documented fever while in hospital (particularly important where resident is being transferred to RCF within 14 days of COVID-19 diagnosis)
8. Details of any follow-up treatment or monitoring require

Residents who become symptomatic during admission to the LTRCF

1. Following transfer/admission to a LTRCF, 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 SARS-CoV-2 sent for testing.
2. The rationale for this recommendation is that, in the context of a pandemic, there may have been contact between the resident and HCW 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.

Cessation of new admissions to a facility during an outbreak of COVID-19 in a LTRCF

1. Following the declaration of an outbreak within a LTRCF, admissions of new residents to the facility (i.e. residents not previously living in the LTRCF) should be suspended until Public Health state that the outbreak is over.
2. Residents normally cared for in the LTRCF who are admitted to hospital while an outbreak is ongoing in the LTRCF may have their discharge to the same LTRCF 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 LTRCF to an acute hospital

1. COVID-19 positive status 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 LTRCF, 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 LTRCF.
2. People with COVID-19 do not require to be hospitalised for the 14 days if they are clinically fit for discharge, if infection was acquired in the LTRCF or if the LTRCF already has cases of COVID-19 and the LTRCF has appropriate facilities and capacity for isolation and can support care.
3. Residents do not require isolation on return to their LTRCF following hospital transfer to facilitate short investigations (e.g., diagnostics, haemodialysis, radiology, outpatient appointment).
4. Residents who do not have vaccine protection and have not had COVID-19 in the previous 9 months will need to restrict their movements on return to their LTRCF 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.
5. If an episode of care lasts longer than 12 hours but less than 3 days there is no requirement for testing before return to the LTRCF unless the person has new symptoms suggestive of COVID-19. This is because the test is not likely to be positive within that time frame even if the person was exposed after arrival at the hospital. In such circumstances, return to the LTRCF should not be delayed pending a test result however; a test should be performed in the LTRCF between day 5 and day 7 after arrival at the hospital if possible.
6. The resident should continue to restrict movement and be monitored closely for symptoms for 14 days after return even if the test at 5 to 7 days is reported as not detected/negative.
7. Residents who have vaccine protection or who have had COVID-19 in the previous 9 months will not need to restrict their movements on return to their LTRCF 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 but should have testing as above.

Table Transfer/admission of a resident to a LTRCF

CLINICAL SCENARIO	RECOMMENDED PRECAUTIONS ON ARRIVAL TO LTRCF	PRE-ADMISSION TEST FOR SARS-CoV-2 (COVID-19)	TIMING OF TRANSFER TO LTRCF	DAY OF TRANSFER
CONFIRMED COVID-19 & will be still infectious to others on planned date of transfer (less than 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	**LTRCF has other resident(s) with COVID-19:** Transfer when fit for discharge to LTRCF AND provided LTRCF can meet care needs **LTRCF has no 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 in past 9 months & **no longer infectious to others** (more than 14 days since onset/test date and afebrile for last five of those days)	No requirement for Transmission based Precautions or restricted movement	Not required, as already confirmed COVID-19	When fit for discharge to LTRCF	Confirm date of onset/first positive test result is more than 14 days ago and was afebrile for last five days of that
Vaccine protection against COVID-19	No requirement for Transmission based Precautions or restricted movement	No requirement for test within the 3 days prior to scheduled transfer date	When fit for discharge to LTRCF	Confirm details of vaccination
NO PRIOR CONFIRMATION OF COVID-19 or COVID-19 MORE THAN nine months previously & test result available before transfer	Single room accommodation with monitoring for symptoms until 14 days reached. Standard Precautions plus surgical face mask. Restrict-movement	Test within the 3 days prior to scheduled transfer date	Test result- not-detected LTRCF 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 or COVID-19 MORE THAN nine months previously & test result available before transfer But Test result is NOT available prior to admission	Transmission-based Precautions until test result is available then follow as per immediately above	Test within one day of admission	When fit for discharge to LTRCF	Take sample for COVID-19 test. Ensure no symptoms and not newly identified contact of a COVID-19 case