Preliminary Coronavirus Disease (COVID-19) Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities (RCF) and Similar Units

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Version	Date	Changes from previous version
1.1	30/03/2020	Added information re contact management Edited definition for outbreak of COVID-19 in RCF OCT must be Chaired by Public Health Doctor Hyperlink to case definition added where appropriate Changed term 'self-quarantine' to 'self-isolation' and hyperlinks included where appropriate Edited flow of document and formatting

Acknowledgements:

This guidance is adapted from the following guidance documents:

- 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)
- Public Health Guidelines on the Prevention and Management of Influenza Outbreaks in Residential Care Facilities in Ireland 2019/2020

Note:

This is preliminary guidance. The COVID-19 situation is rapidly changing. Guidance will be reviewed and update regularly.

Contents

1. Introduction

This guideline applies to all residential care facilities (RCF) in Ireland. This refers to any public or private aged care, disability services or other similar setting in Ireland where residents are provided with personal care or health care by facility staff.

Outbreaks of respiratory illness are a significant risk for older persons living in RCF. Such outbreaks commonly occur in winter. While all respiratory viruses can cause outbreaks and significant morbidity and mortality, COVID-19 is acknowledged as a particular threat to the RCF setting as there is currently no vaccine and the risk of severe illness from COVID-19 is increased in older people and individuals with co-morbidities or impaired immune function.

The prevention and control of outbreaks of COVID-19 in RCF requires urgent action and preparedness. These guidelines are designed to assist RCFs to manage the Infection Prevention and Control risks associated with COVID-19 and to prevent, plan for, detect and respond to COVID-19 outbreaks in their facility.

While this guideline focuses on RCF, the principles are applicable to many settings including residential facilities for people with physical and mental disabilities, other community-based health facilities (e.g. drug and alcohol services, community mental health) and any other setting where residents sleep, eat and live, either temporarily or on an ongoing basis.

1.1 COVID-19 General Background

It is not possible to differentiate between COVID-19 and other common respiratory infections based on symptoms alone. COVID-19 should be considered in residents in a RCF who have new onset of fever, new onset of symptoms of respiratory tract infection or acute deterioration of existing respiratory disease. All such patients should be discussed with their doctor to determine whether testing for COVID-19 is required. If testing is required the resident should be cared for as a Suspected Case of COVID-19 until a test result is available.

If the SARS-CoV-2 virus (the virus that causes COVID-19) is detected in a sample, the person is a Confirmed Case of COVID-19. It is important to acknowledge that no diagnostic test is 100% sensitive and specific; therefore, if there are a number of Suspected Cases of COVID-19 in a RCF it is important to interpret a test reported as 'not-detected' in the context of the resident's clinical features and the overall situation in the RCF.

2. Recognising COVID-19

2.1 Signs and symptoms of COVID-19

COVID-19 is a communicable viral infectious disease that causes respiratory illness in humans.

Signs and symptoms of COVID-19 include:

- Fever
- Cough
- Shortness of breath
- Other respiratory symptoms, including difficulty breathing

Older persons and those who are immunosuppressed may not always experience the typical signs and symptoms of COVID-19; therefore, it may be necessary, particularly in the setting of an outbreak, to consider COVID-19 in residents with common, non-specific signs and symptoms including:

- Increased confusion
- Exacerbation (acute deterioration) of chronic respiratory disease
- Loss of appetite

As these signs and symptoms are non-specific and relatively common among residents of RCF, a degree of clinical judgement is required in assessing these individuals.

It is not possible to confirm a diagnosis of COVID-19 based on clinical features alone; therefore, laboratory testing is required to confirm the diagnosis. The resident's doctor will advise if testing is appropriate and will arrange testing if necessary.

2.2 Incubation Period

People typically develop signs and symptoms of COVID-19, including mild respiratory symptoms and fever, an average of 5-6 days after infection (mean incubation period 5-6 days, range 1-14 days).

2.3 Route of Transmission

COVID-19 is transmitted via respiratory droplets typically produced by coughing or sneezing. Transmission may be direct or indirect. Direct transmission occurs through droplet transmission to the mouth, nose or

eyes during close unprotected contact with an infected person. Indirect transmission occurs through contact with a surface/object that has become contaminated with the virus – the virus may be transmitted from an individual's hands to their mouth, nose or eyes following contact with a surface contaminated with the respiratory secretions of an infected individual.

Airborne spread is not a concern in most setting. However, it is a concern in the context of aerosol-generating procedures conducted in health care settings.

2.4 Vulnerable Populations

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

People at higher risk of developing more serious illness include:

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

3. Roles and Responsibilities

3.1 Residential Care Facility

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

RCFs are legally required to:

- Detect and notify outbreaks to the regional Medical Officer of Health (MOH) at the regional Department of Public Health.

3.2 Regional Department of Public Health

- Regional Departments of Public Health are legally required to investigate cases and outbreaks of COVID-19.

4. Prevention and Preparedness

4.1 Prevention of Outbreaks

A well-functioning Infection Prevention and Control (IPC) programme is the basis for an effective IPC response to COVID-19. The information provided in this guideline has been developed to provide RCF and their staff with the information they need to prevent introduction of COVID-19 to the RCF and transmission within the facility. The importance of Standard Precautions with all residents at all times should be reinforced continuously, in particular hand hygiene, respiratory hygiene and environmental hygiene.

4.1.1 Education for Residents, Families and Friends

Education for staff, residents and their families is vital to inform their behaviour. This helps to prevent an outbreak and reduce the potential for ongoing transmission within the RCF in the event of an outbreak. Key messages include the importance of hand hygiene and respiratory hygiene.

Residents, and their friends and families, should be advised that all visiting may be suspended for periods of time during the current COVID-19 pandemic in the interest of protecting all residents. Relevant individuals should be made aware of the process for arranging a visit in very exceptional circumstances (for example end of life). Residents, friends and families should be encouraged to keep in touch by telephone or video applications if visiting is suspended.

Visitors should be advised to follow guidance below (section 4.2.1).

4.1.2. Education and Training for Staff

Staff should be made aware that they cannot come to work if they have fever or any kind of respiratory symptoms. They should be advised to contact the occupational health service or their doctor and follow guidance below (section 4.2.1). They may also wish to read the current occupational health guidance on the HPSC website. Available at https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/occupationalhealthguidance/

Each RCF is responsible for ensuring their staff are adequately trained in all aspects of IPC and their role in outbreak management. Staff should know the signs and symptoms of COVID-19 in order to identify and respond quickly to any possible case. Additionally, all staff (including casual, domestic, hospitality and volunteer workers) must be trained in the elements of IPC practice relevant to their role. RCFs should consider ensuring that one or more staff members is trained to collect a sample for testing for COVID-19.

4.1.3. Infection Prevention and Control Practice

There is currently no vaccination to prevent COVID-19; therefore, avoidance of exposure through good infection prevention and control (IPC) practice is the single most important measure for preventing COVID-19 in RCF.

The general strategies recommended to prevent the spread of COVID-19 in RCFs are the same IPC measures used every day to detect and prevent the spread of other respiratory viruses like influenza. The most important element is **Standard Precautions for all patients at all times**.

During the current COVID-19 emergency each RCF should focus on:

- reducing the risk of introducing COVID-19 into the RCF
- reducing the risk of transmission within the RCF if infection is unintentionally introduced

Although accepting admission or transfer of residents poses a risk of introducing COVID-19 to a RCF, this is considered a **necessary risk** in the context of maintaining access to a critical service and the risk can be mitigated by rigorously following this guidance.

4.1.4 Reducing the risk of introduction and spread of COVID-19 in RCF

The following measures should be taken to minimise the risk of introducing COVID-19 to the RCF and similar units.

Residents

Ask about current fever or symptoms of acute respiratory tract infection for all transfers or admissions before transfer or admission.

Pre-transfer, a medical opinion on all transfers or admissions with fever or signs/ symptoms of respiratory tract infection should indicate whether there is clinical suspicion of COVID-19.

All transfers or admissions with current fever or symptoms of acute respiratory tract infection should be accommodated in their own room with bathing and toilet facilities and encouraged to stay in their own room and avoid contact with other residents. If not already done they should ask their doctor for advice on testing for COVID-19. Subsequent management is determined by the outcome of the assessment.

All residents with fever or symptoms of acute respiratory tract infection should minimise time in shared space /group activities within the RCF and similar units even if COVID is not detected until at least 48 hours after recovery (this is because they may have infection with another respiratory virus).

Outward transfer of residents for attendance or care off site should be minimised to reduce introduction of the infection to the unit on their return.

Visitors

Visitors with fever or any kind of respiratory symptoms should never attend the RCF. If they fit the case definition for COVID-19 they should contact their doctor for advice on testing for COVID-19. If they are suspected to have COVID-19 they should follow guidance on self-isolation and should not visit the RCF. They can stop self-isolation at home when they have had no temperature for five days and it has been 14 days since they first developed any symptoms. After that, they should continue to abide by physical distancing advice and stay at home as much as possible. The need for physical distancing should be carefully considered when assessing whether or not a visitor can attend the RCF.

Visitors who are close contacts of a confirmed or probable case of COVID-19 should never attend the RCF. They should restrict their movements as much as possible for 14 days after the last exposure has occurred.

For all other visitors, if visiting is absolutely essential, it should occur under highly controlled conditions. The RCF should encourage and facilitate all visitors to perform hand hygiene on entry to the facility. Wherever possible, visitors should visit the resident in the resident's room rather than in a communal area and should at all times adhere to physical distancing advice in so far as is practicable. Visitors should only have contact with the resident that they specifically require to visit.

These messages should be reinforced by placing signage at all entry points to the facility and by any other practical means of communication with residents and their families and friends.

Staff

Staff members should be reminded to report immediately to their manager if they fit the case definition for COVID-19 and should be referred for medical assessment. If they are suspected to have COVID-19 they should follow guidance on self –isolation and should not present for work.

If they have COVID-19 and the disease is mild and managed at home, they can return to work 14 days after symptom onset (or date of diagnosis if no symptoms) AND after 5 days with no fever.

If they do not have COVID-19 but had another respiratory infection they should not return to work until fully recovered for at least 48 hours.

Staff who are identified as close contacts of a case either in the community or the occupational setting should not attend work for 14 days from the last exposure to the case and restrict their movements as much as possible. Derogations to work may be given by the management of the facility if the staff member is considered essential and remains asymptomatic.

Further information for staff and occupational health is available at the HPSC website: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/occupationalhealthguidance/

5. Care for Residents Identified as COVID-19 Contacts in a RCF

Resident is identified as a close contact

5.1 The Resident

Residents should be accommodated in a single room with their own bathing and toilet facilities. If this is not possible cohorting in small groups (2 to 4) with other Contacts is acceptable.

Residents are requested to avoid communal areas and stay in their room for their period of observation (until 14 days after exposure) and until Public Health advice confirms the resident can resume normal activity.

Residents may go outside if appropriate, alone or accompanied by a staff member maintaining a distance of at least 1m. An accompanying staff member in this situation is not required to wear PPE.

Note: testing of Contacts for COVID-19 is NOT appropriate unless they develop symptoms of infection. If they develop symptoms of infection they should be referred to their doctor for assessment.

5.2 Staff looking after resident

Staff members who can avoid physical contact and maintain a distance of 1 m do not require apron, gloves or mask but should attend to hand hygiene.

Staff members should check at least four times per day and record if the resident has developed symptoms of infection.

6. Infection Prevention and Control Aspects of Care for Residents Diagnosed with COVID-19 in a RCF

6.1 The Resident

If the resident's clinical condition does not require hospitalisation they should not be transferred from the RCF on infection prevention and control grounds.

The resident should avoid communal areas for a minimum of 14 days after onset of illness and until five days free of fever.

Resident may go outside alone if appropriate or accompanied by a staff member maintaining a distance of 1m. If the staff member can maintain this distance they do not need to wear PPE.

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.

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.

Residents with confirmed COVID-19 require appropriate healthcare support, including access to their GP for medical management.

6.2 Other Residents and Visitors

Group activities that involve close contact should be suspended if possible. If this is not possible given the overall welfare of residents, activities may be conducted with small groups of residents with maintenance of social distance as much as possible (for example, unaffected residents may be able to access communal areas or go outside in small groups on a rota basis with avoidance of direct contact or close contact).

If not already suspended, visiting should be suspended (see above).

6.3 Staff

All healthcare workers in the RCF should increase their attention to hand hygiene and respiratory hygiene but should not use additional PPE if they can remain 1 m distant from the resident (s) who have confirmed or suspected COVID-19.

Care for the resident who has tested positive should be delivered by a single nominated person on each shift to the greatest extent possible.

A register of staff members caring for patients with COVID-19 should be maintained by the RCF.
The RCF must ensure that staff members self-monitor for signs and symptoms of acute respiratory illness and self-exclude from work if unwell.
In addition to Standard Precautions, the person caring for the resident should implement Contact and Droplet precautions including use of PPE appropriate to the task they are performing – further information is available at

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/Interim%20Guidance%20for%20use%20of%20PPE%20%20COVID%2019%20v1.0%2017_03_20.pdf

If more than one resident has tested positive consider the feasibility of having one nominated person on each shift care for those residents who have tested positive and any patients awaiting testing or awaiting test results.

7. Surveillance for COVID-19

7.1 Case Definition

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

7.2 Surveillance

Surveillance (monitoring for illness) is an essential component of any effective infection control programme. A COVID-19 outbreak may occur in any RCF and staff of such facilities should monitor all residents and personnel for COVID-19 symptoms at all times. RCFs should ensure that they have processes in place to

promptly initiate measures to establish the diagnosis and to control the spread of COVID-19 within facilities if there is concern regarding an outbreak. 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.

It is also important to monitor staff absenteeism rates for unusual patterns i.e. more than expected numbers of staff absent from work.

8. Response to a suspected or confirmed outbreak of COVID-19

An outbreak of COVID-19 is defined as:

- two or more confirmed cases of COVID-19 acquired within the same RCF

  OR
- one confirmed case of COVID-19 in the RCF, in addition to other resident(s) with RCF-acquired symptoms of COVID-19 awaiting testing or test results

  OR
- a single confirmed case of COVID-19 in an RCF may prompt discussion with Public Health regarding the possibility of an outbreak, e.g. if there are other residents with acute onset atypical symptoms such as increased confusion or loss of appetite – clinical judgement should be exercised

This definition is subject to change as the COVID-19 pandemic evolves.

All outbreaks of COVID-19 in RCF must be reported to the regional Medical Officer of Health (MOH) at the Department of Public Health at the earliest opportunity. An outbreak control team (OCT) should be convened for each outbreak in a RCF or similar unit.

Note that it is important to stress that having one or more patients with COVID-19 in a RCF is not an outbreak if those patients already had COVID-19 before they transferred to the RCF. An outbreak means that there is evidence of spread of infection within the RCF.

8.1 The outbreak control team (OCT)

The OCT configuration should be decided at local level and will depend on available expertise. The OCT should be Chaired by a Public Health Doctor – ideally a Specialist in Public Health Medicine.

Members may include any of the following:

a) Specialist in Public Health Medicine

b) Medical consultant/medical officer/GP to RCF (dependent on nature of RCF)

c) Management representative from the RCF i.e. manager or CEO

d) Nursing representatives from the RCF

e) Consultant microbiologist

f) NVRL representative

g) Community Infection Prevention and Control Nurse (CIPCN)

h) Community Services General Manager

i) Public Health Senior Medical Officer

j) Public Health Surveillance Scientist

k) Public Health Department Communicable Disease Control Nurse

l) Pharmacist (if attached to RCF) or else HSE Primary Care Unit Pharmacist

m) Occupational Medicine Physician (if attached to RCF)

n) Representative from HPSC (if indicated)

o) Administrative support

p) Communications officer (if indicated).

8.2 Management of the Outbreak and actions required

1. At the first meeting, the RCF should provide the following information to the OCT:

    a. The total number of ill people (residents and staff)

    b. The spectrum of symptoms

c. The date of onset of illness, particularly for the first (index) case

d. The results of any laboratory tests available including the number of tests taken to date and the date sent to the laboratory

e. Any steps already taken to control the outbreak

2. From information obtained, determine if the cases meet COVID-19 case definitions

3. Once an outbreak of COVID-19 is confirmed:

a. Institute active daily surveillance for fever or respiratory symptoms, including cough, in residents and staff for 14 days after the date of onset of symptoms of the last resident COVID-19 case

b. Institute infection prevention and control measures

4. Formulate a case definition and assign an outbreak code

5. Define the population at risk, i.e. the total number of residents on-site at the time of the outbreak and during the identified incubation period and staff (including casual workers, volunteers and non-resident staff) working in the RCF

6. In consultation with Public Health, assign a contact category to all members of the population at risk. Three categories:

a. Close contact

b. Casual contact

c. Not a contact

7. Determine the number of residents and staff who meet the case definition and compile a line listing of cases (both staff and residents) (See Appendix D). Line lists should include

a) All cases (residents and staff) by unit if applicable (new cases should be highlighted)

b) Identification of residents who have recovered, developed complications, been transferred to acute hospitals and those who have died.

c) Details of staff cases

8. Determine if the attack rate varies between units/floors/wards or if the outbreak is confined to one unit only

9. This information will describe the extent of the outbreak and facilitate hypothesis generation regarding the index case and modes of transmission of the virus. It will also be possible to generate an epidemic curve

10. Collect appropriate sample from suspect cases (note: once there are laboratory confirmed cases it may be appropriate to make further diagnoses based on clinical and epidemiological features)

a. Contact the local laboratory or the National Virus Reference Laboratory (NVRL) in advance to discuss. Procedures for virology testing should be confirmed with the local laboratory as per local or national arrangements

b. For COVID-19, a nasopharyngeal swab should be collected as per approved technique

c. Specimens should be taken as early as possible during the course of the illness, i.e. within 48 hours of symptom onset, as the yield is likely to be optimal at this time. However, positive results may be obtained up to one week after illness onset. Appropriate swabs will be required as per guidance from the testing laboratory.

d. Notify the laboratory of the investigation and clarify with them who will receive results (both positive and negative) and by which method i.e. phone, fax encrypted email etc.

11. Prepare internal communications for residents, family and staff groups

12. Determine if education sessions are required for staff members and confirm who will conduct these

13. Discuss whether a media release is appropriate

14. Discuss and agree control measures i.e. infection prevention and control,

- Assign a designated person at the facility to ensure implementation
- Assign responsibility for all actions agreed

15. Review and implement staffing contingency plans

16. Discuss whether a site visit is required by Public Health

17. Determine the frequency of OCT meetings

18. Ensure that the incident is promptly reported to the Health Protection Surveillance Centre (HPSC) and surveillance details entered onto the Computerised Infectious Disease Reporting System (CIDR)

19. Provide updates on the investigation to the Assistant National Director for Public Health and Child Health, Health and Wellbeing when/if required

Updates to information should occur through daily meetings of the OCT, or more frequently if major changes occur in line with Public Health recommendations until the outbreak is declared over.

8.3 Staff

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

8.4 Admissions and Transfers

8.4.1 Patient Transfer

If the resident requires transfer to another facility, including hospital, advise the hospital and transport provider in advance that the resident is being transferred from a facility where there is potential or confirmed COVID-19.

8.4.2 New admissions and Re admission

New admissions and return of residents may occur during an outbreak subject to an assessment of the needs of the resident and the extent and status of the outbreak and the ability of the RCF to protect new admissions and returning residents from exposure to infection.

8.5 Monitoring Outbreak Progress

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

The nominated RCF liaison person should update the line listing with new cases or developments as they occur and communicate this to the OCT on a daily basis or more frequently if major changes occur in line with Public Health

recommendations until the outbreak is declared over. The review of this information should examine issues of ongoing transmission and the effectiveness of control measures.

8.6 Declaring the outbreak over

In order to declare that the outbreak is over, the facility should not have experienced any new cases of infection (resident or staff) which meet the case definition for a period of 28 days (two incubation periods).

9. Additional Infection Prevention and Control Detail

The key elements of IPC specific to COVID-19 are outlined in sections 4 and 6 of this document. Section 9 provides additional detail on general elements of Infection Prevention and Control relevant to implementing the IPC measures outlined in Sections 4 and 6.

9.1 Standard Precautions

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

9.1.1 Hand Hygiene

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

Refer to hand Hygiene Information Posters Appendix 1.

HSE land hand hygiene training is available and staff should be encouraged to do refresher training. There must be adequate access for staff, residents and visitors to hand hygiene facilities (alcohol based hand rub or

hand basins with liquid soap, water and paper towel) that should be adequately stocked and maintained. Hand basins for staff should, wherever possible, be hands-free (for example, elbow operated) to facilitate appropriate hand hygiene practices and prevent recontamination of hands when turning off taps. Staff should be made aware of the proper hand hygiene technique and rationale.

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

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

9.1.2 Respiratory Hygiene and Cough Etiquette

Respiratory etiquette relates to precautions taken to reduce the spread of viruses via respiratory droplets produced during coughing and sneezing. Residents, staff and visitors should be encouraged to practice good cough and sneeze etiquette, which includes coughing or sneezing into the elbow or a tissue, and disposing of the tissue then cleansing the hands. Further information on respiratory etiquette is included in Appendix 4.

9.2 Transmission Based Precautions

Transmission based precautions are infection control precautions used **in addition** to standard precautions to prevent the spread of COVID-19. COVID-19 is spread by respiratory droplets – transmission may be direct, through contact with the respiratory secretions of someone with COVID-19, or indirect, through contact with a contaminated surface/object. Less commonly airborne spread may occur e.g. during aerosol generating procedures.

9.2.1 Contact and Droplet Precautions

Staff must implement Contact and Droplet Precautions including use of PPE when performing specific tasks in caring for residents with COVID-19.

See

https://www.hpsc.ie/a-

z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/Interim%20Guidance%20for%20use%20of%20PPE%20%20COVID%2019%20v1.0%2017_03_20.pdf

RCF staff must be trained and deemed competent in the proper use of PPE, including donning and doffing procedures. Training is recommended for all existing staff, including non-clinical support staff, and is required for new staff. PPE should be removed in a manner that prevents contamination of the HCW's clothing, hands and the environment. PPE should be immediately discarded into appropriate waste bins. Hand hygiene should always be performed before putting on PPE and immediately after removal of PPE, as well whilst wearing PPE. See Appendix 3 for Donning and Doffing PPE and also refer to www.hpsc video on Donning and Doffing PPE illustration

RCF staff should ideally change their PPE and perform hand hygiene after every contact with an ill resident. However, in exceptional circumstances, if caring for a cohort of residents with a diagnosis of COVID-19 and not caring for other residents, it may be acceptable to limit this to a change of gloves and hand hygiene between individual residents if the PPE is not wet, soiled or damaged.

For further information on transmission based precautions when caring for residents with suspected or confirmed COVID-19 see Appendix 5.

9.3 Environmental Cleaning and Disinfection

Regular, scheduled cleaning of **all** resident care areas is essential during an outbreak. Frequently touched surfaces are those closest to the resident, and should be cleaned more often. During a suspected or confirmed COVID-19 outbreak, an increase in the frequency of cleaning with a neutral detergent is recommended. **Cleaning AND disinfection** is recommended during COVID-19 case and outbreak. Either a 2-step clean (using detergent first, then disinfectant) or 2-in-1 step clean (using a combined detergent/disinfectant) is required.

The following principles should be adhered to:

- Patient room/zone should be cleaned daily
- Frequently touched surfaces should be cleaned more frequently. These include

- bedrails, bedside tables, light switches, remote controllers, commodes, doorknobs,
- sinks, surfaces and equipment close to the resident e.g. walking frames, sticks
- Handrails and table tops in facility communal areas, and nurses station counter tops

Cleaners should

- observe contact and droplet precautions
- adhere to the cleaning product manufacturer's recommended dilution instructions and contact time as per manufacturer's instructions

The room should be terminally cleaned when the Ill resident is moved or discharged.

9.4 Patient Care equipment

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

9.5 Management of Linen

Linen should be washed using hot water (>65 degrees for 10 minutes) and standard laundry detergent. Linen should be dried in a dryer on a hot setting. Appropriate PPE should be used when handling soiled linen. Unbagged linen should not be carried out of the residents room. Place all laundry in an alginate stitched or water soluble bag and then place in an outer laundry bag clearly identified with labels, colour-coding or other methods All laundry bags should be secured until removed by the laundry services.

9.6 Crockery and cutlery

These should be washed in a hot dishwasher or if not available, by hand using hot water and detergent, rinsed in hot water and dried. There is no need to separate the crockery and cutlery for use by ill residents from that of other residents.

9.7 Signage

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

Appendix 1 Hand Hygiene Posters

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

May 2009

Appendix 2 Personal Protective Equipment

Current recommendations for the use of Personal Protective Equipment (PPE) in the management of suspected or confirmed COVID-19

Infection Prevention and Control practice supported by appropriate use of PPE is important to minimise risk to patients of healthcare associated
COVID-19. These measures are equally important in controlling exposure to occupational infections for healthcare workers (HCWs). Traditionally, a hierarchy of controls has been used. The hierarchy ranks controls according to their reliability and effectiveness and includes engineering controls, administrative controls, and ends with personal protective equipment (PPE). In the context of risk of respiratory infection PPE adds an extra layer or protection in the context of scrupulous attention to hand hygiene, respiratory hygiene and cough etiquette and environmental hygiene.

Minimizing exposure risk

Actions for Healthcare workers

- Implement Standard Precautions for infection prevention and control with all patients at all times
- Maintain a physical distance of at least 1 meter (3 feet) but ideally 2 from individuals with respiratory symptoms (where possible)
- Clean your hands regularly as per WHO 5 moments
- Avoid touching your face
- Promote respiratory hygiene and cough etiquette which involves covering mouth and nose with a tissue when coughing and sneezing or coughing into the crook of an elbow, discarding used tissue into a waste bin and cleaning hands

Actions for the healthcare facility

- Post visual alerts including signs, posters at the entrance to the facility and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCWs with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette.
    - Instructions should include how to use tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and

contaminated items in waste bins, and how and when to perform hand hygiene.

- Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR), tissues, and hands free waste bins for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins

- Use physical barriers (e.g., glass or plastic windows) at reception areas, registration desks, pharmacy windows to limit close contact between staff and potentially infectious patients

Personal protective equipment while important is the last line of defence

- **This guidance applies to <u>all</u> healthcare settings including primary, secondary, tertiary care and ambulance service.**
- **The requirement for PPE is based on the anticipated activities that are likely to be required**
- **The unnecessary use of PPE will deplete stocks and increases the risk that essential PPE will not be available for you and your colleagues when needed. This guidance <u>DOES NOT RECOMMEND</u> use of surgical facemasks in situations other than for contact with patients with droplet transmitted infection including COVID-19.**

1.0	**Non clinical areas such as administrative areas, medical records, staff restaurant and any other area where tasks do not involve**	
1.1	All Activities	**NO PPE REQUIRED**
2.0	**Receptions Areas**	
2.1	Administrative activities in reception areas where staff are separated by at least one metre from a case of suspected/confirmed COVID 19 infection	**NO PPE REQUIRED** but steps for minimising chance for exposure should be implemented
3.0	**Patient transit areas for example corridors, elevators, stairwells, escalators, waiting areas**	
3.1	Transfer of patients through public areas	Those physically transferring the patient should wear appropriate PPE as per section 5.0 For others **NO PPE REQUIRED**
3.2	All other activities e.g. providing security, moving equipment etc.	**NO PPE REQUIRED**

4.0	**Pathology/Laboratory Areas**	
4.1	All activities	PPE as per guidance
5.0	**Clinical Areas**	
5.1	Providing Care	
5.1.1	Patients with respiratory symptoms/suspected/confirmed COVID-19 who require an **aerosol generating procedure*** **Note:** • In situations where staff are in the room with a patient and there is a significant risk that an unplanned aerosol generating procedure may need to be performed	• Hand Hygiene • Disposable Single Use Nitrile Gloves • Long sleeved disposable gown • FFP2 respirator mask • Eye Protection
5.1.2	Patients with respiratory symptoms/suspected/confirmed COVID-19 who do not require an aerosol generating procedure but **do require high contact patient care activities that provide increased risk for transfer of virus and other pathogens to the hands and clothing** of healthcare workers including (but not limited to) • Close contact for physical examination / physiotherapy • Changing incontinence wear • Assisting with toileting • Device Care or Use • Wound Care • Providing personal hygiene • Bathing/showering • Transferring a patient • Care activities where splashes/sprays are anticipated	• Hand Hygiene • Disposable Single Use Nitrile Gloves • Long sleeved disposable gown • Surgical facemask • Eye Protection* *Eye protection is recommended as part of standard infection control precautions when there is a risk of blood, body fluids, excretions or secretions splashing into the eyes. Individual risk assessment must be carried out before providing care. This assessment will need to include • Whether patients with possible COVID-19 are coughing.

		• The task you are about to perform
5.1.3	Patients with respiratory symptoms/suspected/confirmed COVID-19 where the tasks being performed are unlikely to provide opportunities for the transfer of virus/other pathogens to the hands and clothing. Low contact activities for example • Initial Clinical Assessments • Taking a respiratory swab • Recording temperature • Checking Urinary Drainage Bag • Inserting a peripheral IV cannula • Administering IV fluids • Helping to feed a patient	• Hand Hygiene • Disposable Single Use Nitrile Gloves • Disposable Plastic Apron • Surgical facemask • Eye Protection* *Eye protection is required to be worn as part of standard infection control precautions when there is a risk of blood, body fluids, excretions or secretions splashing into the eyes. Individual risk assessment must be carried out before providing care. This assessment will need to include • Whether patients with possible
5.2	**Cleaning**	
5.2.1	Cleaning where patient is present	• Hand Hygiene • Disposable Plastic Apron • Surgical Facemask • Household or Disposable Single use Nitrile Gloves

5.2.2	Cleaning when patient is not present for example after the patient has been discharged, or the procedure is complete. Ensure adequate time has been left before cleaning as per guidelines.	• Hand Hygiene • Disposable Plastic Apron • Gloves Household or Disposable Single use Nitrile Gloves
6.0	**Internal transfer of patients with suspected or confirmed COVID-19 infection**	
6.1	Accompanying a patient between areas within the same facility e.g. when moving a patient from a ward to radiology / theatre, GP waiting area to assessment room.	Hand Hygiene If patient is walking and a distance of at least 1m can be maintained – the patient should wear a surgical face mask ^ but **NO PPE REQUIRED** for staff accompanying the patient If staff accompanying patient and within 1m then as in section 5.0
7.0	**External transfer for example between home and dialysis unit, inter hospital transfer, hospital to LTCF**	
7.1	Accompanying a patient but able to maintain a physical distance of at least 1m and no direct contact is anticipated	Hand Hygiene If a physical distance of at least 1m and contact is unlikely– the patient should be asked to wear a surgical face mask if tolerated* but **NO PPE REQUIRED** for staff accompanying the patient

7.2	Accompanying a patient within a 1m distance and likely to have direct contact	Hand Hygiene PPE as per section 5.0
8.0	**Involved only in driving a patient not loading or unloading from transport vehicle**	
8.1	No direct contact with patient and no separation between driver and the patient compartments	Hand Hygiene Patient to wear a Surgical Face Mask if tolerated, if not driver to wear a Surgical Face Mask
8.2	No direct contact with patient and the drivers compartment is separated from the patient	Hand Hygiene Maintain a physical distance of at least 1m **NO PPE REQUIRED**
9.0	**Individuals who may be accompanying the patient e.g. close family members**	
9.1	• Visiting should be restricted • If visitors are permitted they should be instructed how to correctly perform hand hygiene and supervised in donning/doffing PPE • Note that sensitivity to patient and visitor needs is required in the application of this recommendation for example with children and in end of life situations. Visitors should be informed of the risks but it must be accepted that in some situations people may not prioritise • Their own protection over their assessment of the needs of a loved one	• Hand Hygiene • Disposable Plastic Apron • Disposable Single Use Nitrile Gloves • Surgical Face Mask

Types of PPE

- **Disposable plastic aprons:** are recommended to protect staff uniform and clothes from contamination when providing direct patient care and when carrying out environmental and equipment decontamination.
- **Fluid resistant gowns:** are recommended when there is a risk of extensive splashing of blood and or other body fluids and a disposable plastic apron does not provide adequate cover to protect HCWs uniform or clothing.
- If non- fluid resistant gowns are used and there is a risk of splashing with blood or other body fluids a disposable plastic apron should be worn underneath.
- **Eye protection/Face visor:** should be worn when there is a risk of contamination to the eyes from splashing of blood, body fluids, excretions or secretions (including respiratory secretions)
    - Surgical mask with integrated visor
    - Full face shield or visor
    - Goggles / safety spectacles
- **Surgical Face Masks**
    - Surgical Face Masks (Fluid Resistant Type 11R)

Tips when wearing a surgical face mask

- Must cover the nose and mouth of the wearer
- Must not be allowed to dangle around the HCWs neck after or between each use
- Must not be touched once in place
- Must be changed when wet or torn
- Must be worn once and then discarded as health care risk waste (as referred to as clinical waste)

Theatre caps/hoods and shoe covers

There is no evidence that contamination of hair is a significant route of transmission for COVID-19 infection. Head covers are not required and are not recommended. HCWs with long hair should keep their hair tied up and off their face when working in clinical settings. Theatre shoe covers are not recommended

Decontamination of eye/face protection for example goggles where there is a shortage of equipment

In situations where there is a shortage of disposable eye protection **AND** the activity being undertaken involves a high risk of splash or spray to the eyes, HCWs may reuse goggles/safety spectacles.

Where reuse of eye protection is being considered

- Ensure there is no obvious signs of damage – Discard if signs of damage
- Ensure there are no cloth elements - items with cloth elements cannot be effectively decontaminated
- Check they are visibly clean before attempting to decontaminate – Discard if visibly soiled with blood/body fluids including respiratory secretions as heavily soiled items cannot be effectively decontaminated.
- The item should then be carefully decontaminated using a disinfectant wipe.

The risk of reusing Eye protection should be balanced against the risk to the user of a risk of splash or spray to the eyes.

Where practical to do so, decontamination of goggles should be centralised in a facility which normally reprocesses items may add additional margin of safety

Wearing PPE on a Cohort Ward/Unit

Surgical face masks do not need to be changed when moving between patients in a cohort area/ ward however the mask should be changed when wet and removed when leaving the cohort area for example going to break.

- Surgical face masks should not be reused once removed e.g. when going to answer the telephone
- Eye protection where used does not need to be changed in between patients on a cohort ward but should be removed when leaving the cohort area
- Gloves should be changed between patients and changed as appropriate when completing different tasks on the same patient
- Plastic aprons & gowns should be changed between patients

Appendix 3 Donning and Doffing Personal Protective Equipment

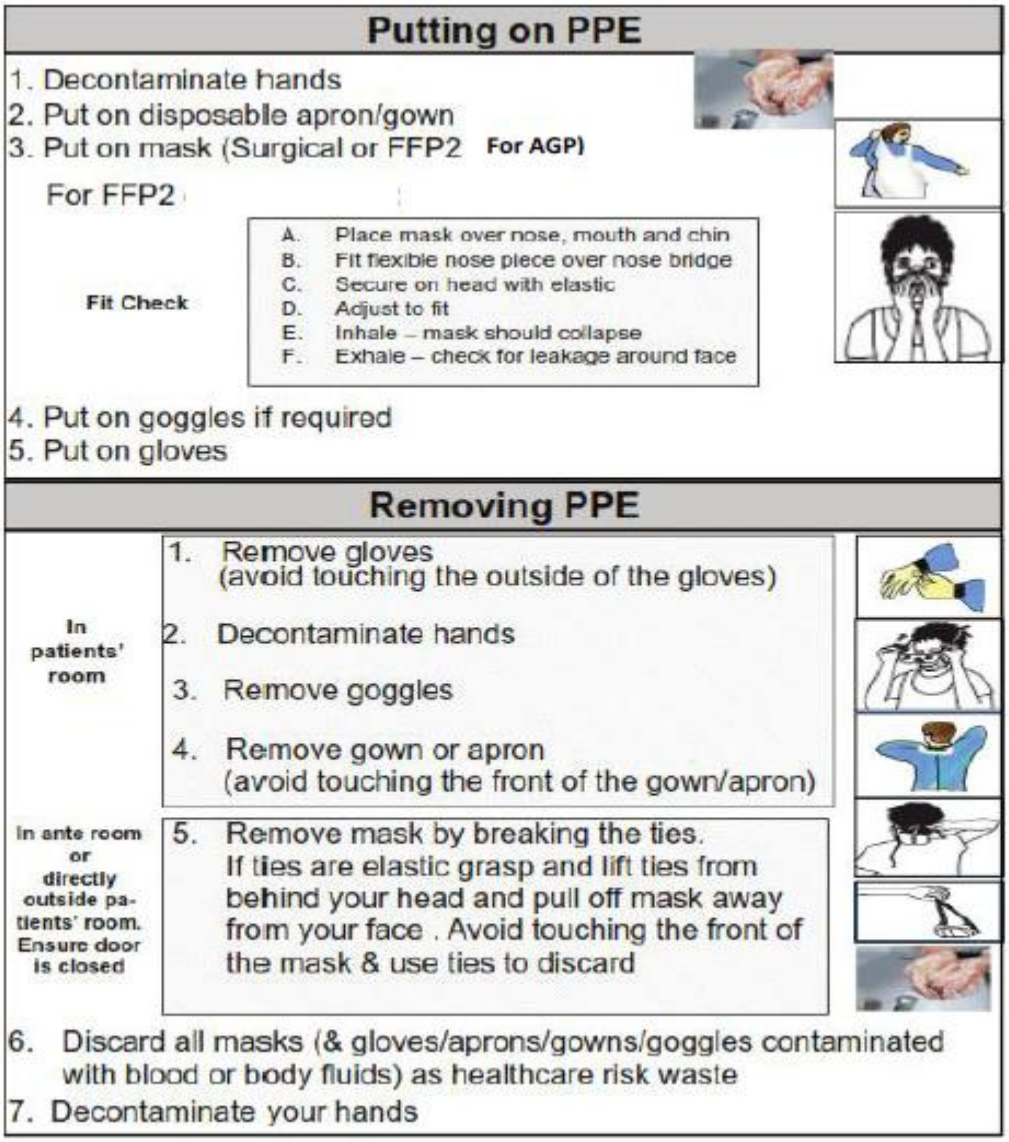

Figure 1: Fit Check for a FFP2 Respirator

Appendix 4 Respiratory Cough Etiquette

Appendix 5 Transmission Based Precautions

Table 1: Personal Protective Equipment Requirements by Precaution

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 patient, items in contact with the patient, and their immediate environment	As per standard precautions	As per standard precautions
Surgical Mask	When in close contact (less than 1m)	Yes	No
P2/N95 Respirator	Not required	Not required	Yes
Goggles/face shield	Not required	As per standard precautions	As per standard precaution