Guidance on COVID-19

Summary of Key Guidance Points for Infection Prevention and Control and Outbreak Control in a Long-Term Residential Care Facility

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Key Points:

Summary of Key Guidance Points for Infection Prevention and Control and Outbreak Control in a Long-Term Residential Care Facility

This summary of key practical points is a quick guide to the more detailed guidance document available here. For additional details please refer to the corresponding section of the comprehensive guidance document.

Preventing and controlling the risk of infection of COVID-19 in a residential care facility depends on three elements.

1. Take all practical measures to reduce or prevent any introduction of virus into the residential care facility. If the virus is not introduced by a person with infection, then it cannot spread.
2. Even when all practical precautions are taken, the virus can still be introduced at any time, so, you need to have all practical measures in place to reduce the risk of spread of the virus if that happens
3. Have processes in place to minimise the risk of harm to residents and staff if both other elements fail and the infection has been introduced and spreads.

Please note that experience and knowledge about 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/

1 Introduction

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. This summary document addresses measures needed to achieve all of the 3 key elements outlined above.

1.1 Roles and responsibilities

The primary role and 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).

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. The IPC service should provide ongoing training to staff with a particular emphasis on Standard Precautions including hand hygiene, respiratory hygiene, cough etiquette and environmental cleaning.

1.2 Legislation and legal requirements

It is the law that a doctor 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. link here (Statutory Notifications Guidance for registered providers and persons in charge of designated centres. January 2016)

1.3 Clinical features of COVID-19

COVID-19 is caused by infection with a virus called SARS-CoV-2. COVID-19 infection is acquired as a result of exposure to a person shedding viable virus. It is generally accepted that the highest risk of transmission occurs at about the time an infected person develops symptoms. Routes of

transmission are via droplet spread, contact with droplets or via airborne transmission (aerosol generating procedures)

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

- fever (though this may be absent in the elderly)
- cough
- shortness of breath
- loss of sense of smell or taste
- lethargy
- confusion
- loss of appetite
- unexplained change in baseline condition

It is important to remember that older people with COVID-19 very often do not have fever and respiratory symptoms.

1.4 Laboratory testing

- Laboratory testing is needed to confirm a diagnosis of COVID-19 infection
- 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.
- Alternatively a deep nasal/mid-turbinate swab may be collected.
- 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.

2 Prevention and Control Measures

2.1 RCF Planning

- Identify a lead for COVID-19 preparedness and response in the RCF.
- RCF settings must have COVID-19 preparedness plans in place.
- Maintain an up-to-date line list of all residents in the RCF and all staff working in the RCF, along with contact telephone numbers

- Each RCF should have an area identified where a resident with suspected or confirmed COVID-19 could be isolated
- Where possible, each ward or floor should try to operate as a discrete unit or zone, meaning that staff and equipment are designated to a specific area and are not rotated from other areas (this includes night duty).
- 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
- Supplies of PPE should be sufficient to ensure that items of PPE, including visors and goggles, that are intended for single use are used only once and then disposed of safely.

2.2 Vaccination

Vaccination for COVID-19 began in Ireland in late December 2020. At this time, partially or fully vaccinated healthcare workers and residents are advised to adhere to all IPC measures in this guideline in the same way as they did prior to vaccination.

2.3 Education

2.3.1 Staff

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

2.3.2 Residents

- Residents should be consulted on and kept informed of the measures being taken and the reason for these measures during this time.

2.4 Physical distancing measures & Pods

- As the pandemic persists it is increasingly onerous for many residents to stay in their room substantially all of the time. It is appropriate therefore for each RCF to consider how and when social activity can safely be facilitated for residents who have no symptoms of COVID-19 and who are not contacts of COVID-19. Refer to detailed guidance document available here

2.5 Group Activities

- Group activities are important for residents' welfare and should be assessed by weighing up the risks and benefits to residents for each activity. Appropriate IPC measures should be applied when risk assessment indicates that group activities may be held.

2.6 Controls to minimise risk of inadvertent introduction of virus

2.6.1 Staff

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

2.6.2 Movement across facilities

- The movement of staff between facilities should be minimised

2.6.3 Staff occupational health & workforce planning

1. Before attending work each day, all staff should check and make sure they do not have symptoms of COVID-19, such as fever, cough, and shortness of breath, difficulty

breathing, loss or change in sense of smell or taste. Staff should NOT attend work if they have any of these symptoms OR if they are close contacts of COVID-19 suspected or confirmed cases. More details are available in Isolation: Quick guide for adults and within the Occupational Health guidance available at https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/covid-19-guidance/.

2. Staff with symptoms of COVID 19 should NOT come to work, even if the residential care facility is understaffed, or if they have only mild symptoms. Staff who are symptomatic should contact their GP by telephone. **Coming to work with any symptoms will make the situation worse.**

3. For healthcare workers designated close contacts: in line with advice from NPHET there will be day 0 and day 10 testing for all close contacts, with exit from restricted movements if the Day 10 test is reported as 'not detected' and are asymptomatic. If this testing cannot be organised for practical reasons the healthcare worker remains off duty for 14 days.

4. Staff should follow the national public health guidance related to social distancing (when possible), hand-hygiene and respiratory etiquette while at work and encourage residents to do the same.

5. Staff should be allocated to one zone within the RCF if at all possible

6. Staff should be informed that they must not attend work if they have fever or cough or shortness of breath or any kind of new respiratory symptoms.

2.6.4 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/residentialcarefacilities/Guidance%20on%20visits%20to%20RCF.pdf

An information leaflet for 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

2.6.5 Resident transfers

Guidance on resident transfers is addressed as an **appendix H** to the accompanying main document and summary table at the end of this document. here

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

- Surveillance (monitoring for illness) is an essential component of any effective infection prevention and control programme
- RCFs should ensure that they have means in place to identify a new case of COVID-19 and control transmission, through active monitoring of residents and staff for new symptoms of infection, rapid application of transmission-based precautions including isolation here to those with suspected COVID-19, prompt testing of symptomatic residents and referral of symptomatic staff for evaluation. Current case definitions can be found here.

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

- The initial assessment of the resident should be performed by their doctor by telephone
- If COVID-19 is suspected, the doctor will arrange testing
- 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
- Residents should be placed in a single room with transmission-based precautions and appropriate use of PPE by staff
- 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 the resident during the period when they are infectious; however use of a surgical mask and face shield also affords substantial protection. Please refer to detailed guidance document available here

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

2.9 Cohorting residents with possible or confirmed COVID-19

- Placement of residents with possible or confirmed COVID-19 in a designated zone, with designated staffing (where staffing levels permit) to facilitate care and minimise further spread is known as cohorting. As the lay-out for each RCF will differ, the zoned area might be a floor, a wing or a separate annex. In these zoned areas, heightened infection prevention and control measures are critical.
- Where single room capacity is exceeded and it is necessary to cohort residents in a multi-occupancy room:
    - Only residents with **a confirmed diagnosis of COVID-19** can be cohorted together;
- There should be clear signage indicating that the area is a designated zone which alerts staff about the cohorting location in the RCF. A zone may have multi-occupancy rooms or a series of single rooms.
- Minimise unnecessary movement of staff in cohort areas and ensure that the number of staff entering the cohort area is kept to a minimum
- 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.

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

- Residents who are close contacts of a confirmed case should be accommodated in a single room with their own bathing and toilet facilities. If this is not possible, Cohorting in small groups (two to four) with other close contacts is acceptable. Testing of contacts applies.

- 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.
- 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. Refer to the detailed guidance document available here

2.11 Infection prevention and control measures

2.11.1 Standard precautions

Standard Precautions are the minimum infection prevention practices that apply to the care of all people, regardless of whether they have COVID-19 or not, 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/Interim%20HSE%20Guidance%20on%20IPC.pdf

With regard to COVID-19, key IPC elements include:

2.11.2 Hand hygiene

- HSEland hand hygiene training is available online and staff should be encouraged to do refresher training at www.hseland.ie

2.11.3 Respiratory hygiene and cough etiquette

- Respiratory hygiene and cough etiquette refer to measures taken to reduce the spread of viruses via respiratory droplets produced when a person coughs or sneezes

2.11.4 Personal Protective Equipment (PPE)

- Full guidelines on the appropriate selection and use of PPE see the main document and the following links

https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/

- Educational videos are also available on www.hpsc.ie at https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/videoresourcesforipc/
- All staff must be trained in the proper use of all PPE that they may be required to wear

Note on uniforms.

- Staff uniforms are not considered to be personal protective equipment but should be clean and appropriate to the work performed
- Uniforms should be laundered:
    - separately from other household linen;
    - in a load not more than half the machine capacity;
    - at the maximum temperature the fabric can tolerate

2.11.5 Transmission-based Precautions for COVID-19

- Transmission-based Precautions should be applied immediately to all suspected cases of COVID-19. Details are provided in the accompanying main document.

2.11.5.1 Duration of transmission based precautions

- A test is not appropriate to help decide the duration of transmission based precautions for residents who have been diagnosed with COVID-19. Transmission based precautions can be **discontinued fourteen days after symptom onset, where a person has been fever free for five days.**

2.11.6 Care Equipment

- Where possible, use single-use equipment for the resident and dispose of it as healthcare risk waste into a designated healthcare risk waste bin inside the room
- Where single use equipment is not possible, use designated care equipment in the resident's room or cohort area
- There is no need to use disposable plates or cutlery.

2.11.7 Management of waste

- Dispose of all waste from residents with confirmed or suspected COVID-19 as healthcare risk waste (also referred to as clinical risk waste)

2.11.8 Safe management of linen (laundry)

- All towels, clothing or other laundry used in the direct care of residents with suspected and confirmed COVID-19 should be managed as 'infectious' linen

2.11.9 Environmental hygiene

- The care environment should be kept clean and clutter free in so far as is possible, bearing in mind this is the resident's home and they are likely to want to personalize their space with objects of significance to them.

2.11.10 Routine cleaning in the relation to care of residents with COVID-19

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

2.11.11 Frequency of cleaning in the context of COVID-19

- All surfaces in the resident room/zone and cohort areas 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).

2.11.12 Terminal cleaning

- Terminal cleaning should always be performed after a resident has vacated the room and is not expected to return.

2.12 Communication & Support

- Good communication is essential for residents, family and staff members. Residents and staff may require support in dealing with the stress related to the outbreak. The facility management should consider how best this support can be provided.

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

- A compassionate, pragmatic and proportionate approach is required in the care of those who are dying
- The presence of a person close to the resident should be facilitated. They should be aware of the potential infection risk
- 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
- Visitors should avoid contact with people other than the person they are accompanying at the end of life

4 Care of the recently deceased

4.1 Hygienic preparation

- Any IPC precautions that have been advised before death must be continued in handling the deceased person after death. In relation to COVID-19 specifically if transmission-based precautions have been discontinued before death, then they are not required after death – see section on duration of transmission-based precautions

4.2 Handling personal possessions of the deceased

- Most personal items can be given to family or friends after appropriate cleaning and or a short delay.

- 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

4.3 Transport to the mortuary

- An inner lining is not required in terms of COVID-19 risk, but may be required for other practical reasons such as maintaining dignity or preventing leakage affecting the mortuary environment
- 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.

5 Management of an outbreak of COVID-19

When there is a case or suspected case of COVID-19 the MOH should be notified, who will perform a risk assessment to determine whether there is active transmission of infection in the facility.

As soon as a case or outbreak is suspected laboratory testing should be arranged as quickly as possible.

A local incident management meeting should be arranged promptly by the Person in Charge or other senior manager and involve key staff members including housekeeping, nursing staff, allied healthcare professional and medical staff.

5.1 Declaring an outbreak

The MOH will declare an outbreak if there are 2 or more confirmed cases of COVID-19 or if there is one confirmed case with other suspected case(s).

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. Following an assessment, the MOH will determine if there is an outbreak and convene an OCT.

5.3 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 (the Person in Charge or someone nominated by them) 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
- Reinforce active 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

5.4 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). An isolated positive result of SARS-CoV-2 in a resident or staff member is not of itself evidence of ongoing transmission.

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

Detailed guidance on admissions, transfers and discharges is provided in Appendix H of the main document that accompanies this summary and is summarised below.

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**

Table. Transfer/admission of a resident to a LTRCF

CLINICAL SCENARIO	RECOMMENDED PRECAUTIONS ON ARRIVAL TO LTRCF	PREADMISSION 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 COVID19:** Transfer when fit for discharge to LTRCF AND provided LTRCF can meet care needs **LTRCF has no other resident with COVID19** Remain in hospital until no longer infectious to others	Confirm date of onset/first positive test result Confirm date last febrile

CLINICAL SCENARIO	RECOMMENDED PRECAUTIONS ON ARRIVAL TO LTRCF	PREADMISSION TEST FOR SARS-CoV-2 (COVID-19)	TIMING OF TRANSFER TO LTRCF	DAY OF TRANSFER
CONFIRMED COVID-19 in past 12 weeks & no longer infectious to others (more than 14 days since onset/test date and afebrile for	No requirement for Transmission based Precautions	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

CLINICAL SCENARIO	RECOMMENDED PRECAUTIONS ON ARRIVAL TO LTRCF	PREADMISSION TEST FOR SARS-CoV-2 (COVID-19)	TIMING OF TRANSFER TO LTRCF	DAY OF TRANSFER
last five of those days)				
NO PRIOR CONFIRMATION OF COVID19/COVID-19 MORE THAN 12 WEEKS AGO & NO SUSPICION OF	Single room accommodation with monitoring for symptoms until 14 days reached Standard Precautions plus surgical face mask	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

CLINICAL SCENARIO	RECOMMENDED PRECAUTIONS ON ARRIVAL TO LTRCF	PREADMISSION TEST FOR SARS-CoV-2 (COVID-19)	TIMING OF TRANSFER TO LTRCF	DAY OF TRANSFER
COVID-19 **Test result available prior to transfer**				
NO PRIOR CONFIRMATION OF COVID-19/ COVID-19 MORE THAN 12 WEEKS AGO & NO SUSPICION OF COVID-19 **But Test result is NOT available prior to admission**	Transmission-based Precautions until test result is available	Test within one day of admission		Take sample for COVID-19 test Ensure no symptoms and not newly identified contact of a COVID-19 case

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
		Environmental cleaning	A high standard of cleaning is required at all times with particular emphasis on high touch surfaces and areas likely to be contaminated by body fluids or blood.
	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 – alert public health
	Communication of suspected outbreak	Notification of senior management, medical and public health staff, CHO and NH lead	
	Formation of outbreak control team (OCT)	OCT may be convened following risk assessment by MOH	
	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)
		Resident placement	Single rooms Cohorting or zone allocation
		Respiratory etiquette	

During an Outbreak	Infection Control Measures	Hand Hygiene	5 Critical points: • Before patient contact • Before 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
	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

ENDS