COVID-19 Evidence Update

COVID-19 Update from SAHMRI, Health Translation SA and the Commission on Excellence and Innovation in Health

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Optimal methods of reducing spread in long term care facilities

Executive Summary

Aged care facilities and other institutional settings (including prisons and psychiatric facilities) are high risk settings for significant outbreaks of COVID-19, if the SARS-COV-2 virus is introduced.

While there are **no studies** reporting on effective methods of reducing spread of COVID-19, there are many **well-developed guidelines** for different settings and COVID-19.

Residential care facilities:
In aged care facilities, the advanced age of individuals, high number of co-morbidities, and high frailty, as well as the physical characteristics of the facilities, staffing factors and external visitors, mean long-term aged care residents are among those at highest risk for COVID-19 morbidity and mortality, if exposed. Rapid transmission and high fatality rates have been observed in aged care facilities overseas.

The **World Health Organization COVID-19** recommendations align around three core objectives:

1. Do not carry in: Prevent staff/carer and family members from carrying infectious disease into a facility or home.
2. Do not carry out: Prevent staff/carer and family members from carrying infectious disease out of a facility or home to local communities.
3. Do not spread: Prevent spreading of infectious disease both within and outside a facility or home. Ensure that there is an infection prevention and control.

Communicable Diseases Network Australia (CDNA) has released comprehensive *National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia* (13 March 2020) to guide Australian practice (See Appendices A and B for workflow).

Key recommendations for COVID-19 prevention and control: The following strategies are routinely recommended in the literature and guidelines:

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prevention strategies such as reduced visitation; active encouragement of unwell staff and visitors staying away; vigilant symptom monitoring and notifying of suspected or confirmed cases; effective infection control procedures to minimise risk of exposure; comprehensive and effective use of PPE (personal protective equipment), hand hygiene, environmental decontamination and social distancing; use of signage, notices and factsheets to convey key messages about hygiene, self-monitoring for symptoms and self-exclusion if symptomatic.

COVID-19 Presentation: It has been observed that initial symptoms can be milder, and frail older adults often **present atypically**. Further, other health issues highly prevalent in this population (e.g. dementia, stroke) may mask manifestations of COVID-19 infection. Thus any significant change in clinical status from baseline in older adults that has no immediate explanation should be evaluated for COVID-19 infection.

Other important considerations: The social and emotional needs of residents must be accommodated, and transparency for families must be maintained, while protecting residents and others from risk of COVID-19. Australia currently has an active **Royal Commission into Aged Care Quality and Safety**, which has delivered an *Interim Report: Neglect*. Concerns have been raised by the community about the effect that COVID-19 and associated disease prevention and control measures may have on quality and safety of clinical and wholistic care of these older Australians.

Correctional and detention settings: CDNA has released *National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Correctional and Detention Facilities in Australia*. (Released 31 March 2020; also endorsed by ANPPC). Key recommendations from the literature for correctional and detention settings are similar to those for aged care facilities, with the addition of moving inmates with symptoms to a single room or area, wherever possible.

Psychiatric settings: In addition to same recommendations as for aged care settings, the following have been recommended for psychiatric settings: considering online mental health services; reducing outpatient visits; tightening admission criteria; shortening length of hospitalisation; implementing traffic limits and quarantine measures outside of wards.

Context

1. Residential aged care

- In general, the older individuals may have weakened immunity and underlying comorbidities.
- Older people are known to be at substantially higher risk of severe COVID-19.
- The health needs of people within long-term care facilities makes close contact between health care workers and residents inevitable. Additionally, the high prevalence of cognitive impairment and dementia among residents may make contact precautions and isolation a practical impossibility [1, 2].
- Residents may be in shared rooms.
- Aged care workers may move across multiple sites.

2. Correctional and detention facilities

- Although correctional facilities face risks similar to those of community care systems, social distancing is challenging in these settings for different reasons.

3. Psychiatric facilities

- Psychiatric facilities face risks similar to those of other long-term care facilities, and social distancing can be challenging in these settings for different reasons. For example, some patients may have lower insight or acute illnesses which make them less able to practice social distancing.

1. RESIDENTIAL AGED CARE

Evidence of COVID-19 outbreaks in aged care

Kings County, Washington, USA - Outbreak

- An outbreak was reported in a long term skilled nursing facility in King County, Washington USA [3]. A health care worker was reported to be the source. 16 days after introduction, facility wide testing indicated that 30% (23 of 76 tested residents) were positive for SARS-COV-2. Half of those testing positive were asymptomatic.
- A further report on the King country outbreak reported in the NEJM observed 167 confirmed cases of Covid-19 affecting **101 residents**, 50 health care personnel, and 16 visitors were found to be epidemiologically linked to the facility [4]. **Most cases among residents included respiratory illness** consistent with Covid-19; however, in **7 residents no symptoms** were documented. Hospitalization rates for facility residents, visitors, and staff were 54.5%, 50.0%, and 6.0%, respectively. The **case fatality rate for residents was 33.7%** (34 of 101).
- 30 skilled nursing and assisted living facilities in King County had identified at least one confirmed case of Covid-19 [4]. Staff working in multiple facilities while ill and transfers of patients from one facility to another potentially introduced Covid-19 into some of these facilities.
- 10 aged care facilities across the county have cases of COVIC-19, according to official Government reports (last updated 10 March 2020) [5].

Australian outbreaks (from media reports)

- Two major clusters of outbreaks in NSW aged care facilities. These include the:
    - Baptist Care Dorothy Henderson Lodge Aged Care Centre (**Macquarie Park, NSW**) - after an aged care nurse who had worked with 13 residents tested positive for COVID-19. The nurse was reportedly symptomatic from 24th February and was diagnosed on 3rd March. As at 14th April there were 21 confirmed cases, 16 of which were residents (six of which have since died) and five were staff.
    - Anglicare Newmarch House (**Caddens, NSW**): after a worker had reportedly worked six consecutive days at the centre (between 30th March and 6th April) prior to testing positive for COVID-19. Reports are mixed as to whether the worker was mildly symptomatic or asymptomatic while working. As at 20th April there were 41 confirmed cases, 27 of which were residents (equating to over a quarter of the residential population; two of which have since died) and 14 staff. All residents are undergoing testing and have been isolated in their rooms and 40 staff have been quarantined.
- There have also been reports in late March of a small cluster of cases in the Opal Aged Care Centre (**Bankstown, NSW**) where five cases (two residents and three staff) contracted COVID-19, resulting in two deaths.
- Further, there was a scare of potential outbreaks among three Tasmanian aged care facilities in **North West Tasmania**, in mid-late April after a single health care worker at the three centres tested positive for COVID-19. The health care worker had also worked at 2 hospitals in the region, which were closed for cleaning. All 500 of the residents and staff at the three aged care facilities were tested and only one case returned positive for COVID-19 and has been transferred to hospital for treatment. At the time of writing, all residents and staff of these centres remain under active surveillance.

International media reporting (examples):

- BBC News (31 March 2020) reports on large outbreaks and fatalities in aged care homes in France, Spain and Italy. Deaths are reportedly not included in national statistics (for France). Staff, staff shortages and inadequate PPE are reportedly creating risks to residents [6].
- ABC News (Aus; 16 April) reports that COVID-19 has infected 2000 aged care facilities in the UK (18% of all facilities in England and Wales) but that deaths are under-reported in national statistics. It is reported that outbreaks are very difficult to control [7].
- New York Times (15 April) Reports on fatalities in a New Jersey Nursing home. It is reported that the death rate is disproportionately high and that COVID-19 "spreads like wildfire" [8].

Presentation of COVID-19 symptoms in aged care residents

- D'Adamo et al. [9] notes older people with comorbidities may be afebrile and not have cough. The paper reports **on informal reports from U.S. physicians** who have cared for older patients with COVID-19, indicating that the most common presentation of infection began with malaise, muscle pains, low-grade fever, and cough, which progressed to respiratory difficulty in the second week of illness; fever was not prominent in several cases (Citing [10]).
  Many LTCF residents have dementia, history of strokes, or other health issues that may mask manifestations of COVID-19 infection. Thus, the paper recommends that **any significant change in clinical status from baseline** in older adults that has no immediate explanation may be caused by infection or sepsis and must be evaluated for COVID-19 infection during the current epidemic.

Evidence from SARS in residential aged care

- Protocols from SARS in Singapore included mandatory use of personal protection equipment ((PPE); N95 mask, gown, goggles, and gloves) for all healthcare workers who had contact with patients, restriction of visitors to healthcare facilities, and the restriction of movement of healthcare workers between institutions [11]. This commentary piece indicates that these measures were instrumental to the control of SARS in Singapore.

Recommendations about prevention and containment in aged care

CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia (13 March 20202; Endorsed by CDNA)[1] [12].

This guideline was developed by the Communicable Diseases Network Australia (CDNA), in consultation with the Aged Care sector, and noted by the Australian Health Protection Principal Committee (AHPPC). It is provided to assist public health authorities, residential care services, healthcare workers and carers by providing best practice information for the prevention and management of COVID-19 outbreaks in residential care facilities (RCF). The guideline captures the knowledge of experienced professionals and provides guidance on good practice based upon the available evidence at the time of completion. These guidelines are extensive and include a **summary flowchart (Refer to Appendix A) for COVID-19 Management in Residential Care Facilities** in Australia.

[1] The document is adapted from previous work on Influenza Outbreaks in Residential Care Facilities (RCF) in Australia, Australian state and territory guidelines for respiratory illness outbreak management in RCF, documents and guidelines from the Australian Department of Health and other Australian health agencies, and documents and guidelines from various international health authorities including the World Health Organization, Centers for Diseases Control and Prevention, and the Public Health Agency of Canada.

Steps for prevention of COVID-19 into aged care facilities and include:

CRITICAL strategies:

- **Avoidance of exposure** - RCF must have, and be vigilant in implementing, effective infection control procedures.
- Risk assessments should be carried out for service environment, equipment, workforce training, systems, processes or practices that are related to personal and clinical care

General strategies - Prevention of exposure, introduction into the facility, and spread within and between facilities

- **Self-screening for staff**, volunteers and visitors (including workers, family members): check for early signs and symptoms, recent travel history, and exposure to possible COVID-19 cases. No-one should enter the premises if symptomatic or until symptoms have completely resolved.
- **Monitor residents** and actively screen resident admissions/readmissions for symptoms, especially fever and acute respiratory symptoms
    - Residents with symptoms should be restricted to their rooms; they should wear a face mask if leaving the room, if tolerated.
- Implement: **hand hygiene, cough and sneeze etiquette, environmental cleaning measures, isolation and cohorting, social distancing**.
- **Use of personal protective equipment** (PPE; facemasks, eye protection, gowns, gloves): provide correct supplies and ensure easy access (outside each resident's room) and correct use, including having a disposal receptacle near exit inside any resident room.
- RCF should advise **all visitors to be vigilant** with hygiene measures and to monitor for symptoms of COVID-19, especially fever and acute respiratory illness.
- **Implement signage,** factsheets, etc. to convey key messages about hygiene, self-monitoring for symptoms and self-exclusion if symptomatic. PPE information should be clearly signposted outside of each resident's room.
- **Ensure adequate facilities** - e.g. hand washing facilities, hand sanitizer, tissues, lined disposal receptacles at entrance of facility and in each resident's room.
- **Keep residents, staff and visitors informed** through regular communication.
- **Monitor evidence-based sources** including Commonwealth Department of Health and state public health information sources to understand COVID-19 activity in their community; consult these sources for guidance if evidence of community transmission in the area.
- **Identify dedicated employees to care for COVID-19 patients** and provide infection control training.
- Notify anyone who is likely to come into contact with a resident with an acute respiratory illness and suspected or confirmed COVID-19 (including facilities, transport services).
- Notify the relevant jurisdictional public health authority of any possible COVID-19 cases.

The CDNA Guidelines are complemented by advice for the health and aged care sector. This online advice includes up-to-date evidence and information about a range of topics including PPE, telehealth, testing, what employers should do, cleaning and training etc. [13]

The Australian Guidelines would be further enhanced with communication guidelines for the residents, and qualification about maintaining good, safe care.

Centre for Evidence Based medicine, University of Oxford Rapid Reviews (not peer-reviewed)

1. *Guidelines for preventing respiratory illness in older adults aged 60 years and above living in long-term care* [14]

   This review found that 'the most commonly recommended prevention strategies across clinical practice guidelines to prevent respiratory illness were: hand hygiene, wearing PPE, social distancing/isolation, disinfecting surfaces, droplet precautions, surveillance and evaluation, conducting diagnostic testing to confirm suspected respiratory illness, policies and procedures for visitors, policies and procedures for staff, and respiratory hygiene/cough etiquette.'

2. *How can pandemic spreads be contained in care homes?* [15]

   This review (based on literature covering Influenza and SARs-COV-1) found the most significant protective factors to be:

   - Hand hygiene – Access to hand hygiene facilities at the workspace, in addition to improved adherence to hand hygiene measures
   - Environmental decontamination – Daily cleaning of most touched surfaces and weekly deep clean
   - Staff rotation – Allocating staff to one facility consistently may reduce spread across several locations
   - Visitors – Restricting visitation to only emergency/critical cases
   - Testing – Creates rapid response in placing added measures to contain and prevent further spread
   - **Resident wellbeing** – education of residents can aid compliance and address considerations of quality of life and anxiety.

   Furthermore, and based on one case study of an outbreak of COVID-19 in an American care home, authors identified the following factors that contributed to the outbreak:

   - Staff continuing to work while symptomatic
   - Staff members working in more than one facility
   - Inadequate adherence to standard droplet and contact precautions, and eye protection recommendations
   - Poor infection control practices due, in part to inadequate supply of PPE
   - Delayed recognition of cases, limited testing availability and difficulty identifying COVID-19 cases based on signs and symptoms alone.

World Health Organization. *Guidance on COVID-19 for the care of older people and people living in long-term care facilities, other non-acute care facilities and home care.* [16] (23 March 2020)

The WHO guidelines state that 'Long-term care facilities and other non-acute care facilities, including mental health and disability services, should implement strong infection prevention and control practice to prevent transmission between staff, residents, and visitors. The three principles of controlling infectious disease in all health-care facilities, including at long-term care and other non-acute care facilities and for care at home are:

1. **Do not carry in**: Prevent staff/carer and family members from carrying infectious disease into a facility or home.
2. **Do not carry out**: Prevent staff/carer and family members from carrying infectious disease out of a facility or home to local communities.
3. **Do not spread**: Prevent spreading of infectious disease both within and outside a facility or home. Ensure that there is an infection prevention and control.

- Further, the **WHO commissioned a rapid review** to address the urgent question of the infection prevention and control practices/measures for respiratory viruses in long-term care facilities that could be applied to COVID-19 [17]. The review concluded that none of the clinical practice guidelines specifically focused on issues related to residents with respiratory illness and severe comorbidities or frailty. Most of the clinical practice guidelines failed to address multiple AGREE-II items, suggesting that they are most likely based on **expert opinion.**
  It was noted that the recommendations from current guidelines overall seem to support environmental measures for infection prevention and antiviral chemoprophylaxis for infection management as the most appropriate first-line response to viral respiratory illness in long-term care. However, these recommendations should be **viewed with caution** as it is unclear how many of these guidelines are based on the best available evidence due to their poor overall quality [18].

- Dosa et al. [1] provides Practical Guidelines. 5 key elements: 1) reduce morbidity and mortality among those infected; 2) minimize transmission; 3) ensure protection of health care workers; 4) maintain health care system functioning; and 5) maintain communication with worried residents and family members
  - To reduce the introduction of the virus into the building include **limiting visitors** to the long-term care building. Staff could be screened upon entry for fever or respiratory symptoms (the Australian guidelines do not currently recommend this). These measures would be in addition to active surveillance for an elevated temperature and even mild respiratory symptoms among residents.
  - Hand hygiene remains among the most fundamental measures to prevent disease transmission. Alcohol hand sanitizer should be available outside of every resident room, as well as in workspaces, dining areas, and other common areas throughout the building
  - Environmental services should be engaged to perform at least daily cleaning with Environmental Protection Agency (EPA) registered hospital grade disinfectants, particularly in high traffic areas (e.g., dining halls, treatment areas, living spaces, etc.)
  - The **CDC recommends Droplet and Airborne Precautions** during the care of individuals with suspected COVID-19 while the **World Health Organization recommends Droplet Precautions** (note: not airborne);
  - Precautions for respiratory disease need to protect against COVID-19 and influenza. Operationally, this means wearing gowns, gloves, facemask, and eye protection. This may be challenging in the nursing home environment, where supplies of these items may be limited and are prioritized for acute care hospitals.
  - All long-term care facilities must have a policy in place that identifies **workers who become sick and allows them to be absent from work**. It is noteworthy that many long-term care workers live pay check to pay check in an environment without reserve staffing; they therefore may be conditioned to report even when sick.
  - A key practical consideration for the long-term care environment will be to determine if or when to admit a resident who has been previously diagnosed with COVID-19, i.e. when recovering COVID-19 patients are safe to bring into a facility where rapid transmission of the virus to a susceptible population could occur.

- AMDA Update on COVID-19. The society for post-acute and long-term care facilities guidelines [19]:
    - Symptoms of COVID-19 include fever, cough, and shortness of breath, but **initial symptoms are milder and frail older adults often present atypically**.

- D'Adamo et al. [9] recommend all staff behave as if they can contract the virus without contact with a symptomatic person, and as if they can transmit the virus themselves. Based on Centers for Medicate & Medicaid guidance, Long Term Care Facilities must not allow any visitors except for very narrowly defined circumstances, and have therefore instituted screening procedures for all staff, contractors, and visitors. In addition, CMS recommends not using a common dining room and cancelling all group activities.

- Yen et al. [20] offer recommendations based on what they consider the **"gold standard"** for pandemic preparedness and response in long term care facilities (LTCF). The authors argue that "**enhanced traffic control bundling (eTCB)** can and should be adopted. Enhanced TCB uses **triage prior to entering the facility**, **separate zones of risk** within the facility and **checkpoint hand hygiene** throughout" (incl. Alcohol dispensers).

- Lynch et al. [21] make recommendations about 5 steps to reduce spread of infectious airborne droplets via **negative air pressure**, using strategies adapted from negative pressure isolation rooms in acute care facilities. ***Caveat***: The paper is working on the (unproven) premise that that SARS-COV-2 might be spread through the air and techniques for prevention of infection including social distancing, interception of droplet discharge during coughs and sneezes, regular cleaning and disinfection of surfaces, hand-hygiene and the use of Personal Protective Equipment (PPE) are not sufficient.

Other considerations:

The Conversation: ***Banning visitors to aged care during coronavirus raises several ethical questions – with no simple answers***

The article by Alison Wran, Western Sydney University highlights a number of issues of concern about COVID-19 control in aged care facilities that are not addressed in the majority of the Guidelines above.

It notes that Australian Government have restricted visitation to residential aged care facilities (people who have returned from overseas in the last 14 days, those who have been in contact with a confirmed COVID-19 case, fever or symptoms, children 16 years and under, and anyone who has not had an influenza vaccination from 1st May) [22]. Furthermore, each resident may have no more than 2 visitors at a time and they encourage the use of phone calls and video calls where possible. Further restrictions apply in Tasmania where only visitors providing end of life support or essential health care are permitted. However, anecdotal reports indicate that many aged care homes have gone a step further and banned visitors altogether.

The author flags that presents ethical challenges, and residents' **social and emotional needs may be overlooked**, may **increase risk of neglect or abuse** as independent oversight of residents' well-being, and alternative measures may need to be put in place to deal with related negative consequences. An important question remains about what matters most to residents, is it quality or life, or length of life? The conversation piece concludes that creative solutions need to be found to meet residents' needs without putting others at risk.

2. CORRECTIONAL AND DETENTION CENTRES

Evidence of COVID-19 outbreaks in Prisons

- First cases reported in US prison in mid-March 2020.
- At the time of writing there had been no public reports of positive cases or outbreaks from Australian correction and detention facilities.

Recommendations about prevention and containment in Prisons

- **Communicable Diseases Network Australia (CDNA)** *National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Correctional and Detention Facilities in Australia*. Released 31 March 2020 (endorsed by CDNA, AHPPC) [23]
    - Correctional and detention facilities are likely to be at increased risk of significant transmission and infection with COVID-19.
    - CDNA have provided guidelines which apply to all detention and correctional facilities in Australia, including prisons, juvenile detention centres and youth justice centres, community correctional centres and onshore Australian immigration detention facilities.
    - Keeping these facilities as safe as possible from the introduction of COVID-19 will assist in minimising the potential harm. This includes careful consideration of visitor access, screening (and potential quarantine) of new admissions to the facilities and regular surveillance of presentations within the facility of acute respiratory infections.

- **World Health Organization - *Preparedness, prevention and control of COVID-19 in prisons and other places of detention***. *Interim guidance. 15 March 2020 [24].* More vulnerable to the coronavirus disease (COVID-19) outbreak than the general population because of the confined conditions in which they live together for prolonged periods of time.

- Prisons can be epicentres for infectious diseases because of the higher background prevalence of infection, the higher levels of risk factors for infection, the unavoidable close contact in often overcrowded, poorly ventilated, and unsanitary facilities, and the poor access to healthcare services relative to that in community settings [25]. Lofgren [26] modelled the potential impact of COVID-10 for USA prisons, finding that operating in a ‘business as usual’ way will result in significant and rapid loss of life.

- The **Centers for Disease Control and Prevention** have developed a checklist for pandemic influenza preparedness in correctional settings [27].

- **Akiyama (NEJM)** Perspective Piece - advocates decarceration of inmates to reduce spread [28].

3. PSYCHIATRIC FACILITEIS

Three articles discuss mental health patients.

- Li et al. [29] reports on an **expert consensus** on the **admission of patients with severe mental illness** during the COVID-19 outbreak in mental health institutions in China. They recommend considering the **traffic limits** and **quarantine measures** in many areas, **online mental health services** have been widely adopted, such as hotlines and mobile application platforms. To prevent nosocomial infection, they recommend psychiatric hospitals should **reduce outpatient visits, tighten admission criteria**, and **shorten the length of hospitalization**. The authors also note that patients, health professionals, and the general public are under insurmountable psychological pressure which may lead to various psychological problems, such as anxiety, fear, depression, and insomnia.
- Recently, more than **300 Chinese patients with psychiatric disorders** were diagnosed with the 2019 novel coronavirus disease (COVID-19) [30]. Possible reasons quoted in the report were the lack of caution regarding the COVID-19 outbreak in January and insufficient supplies of protective gear. The authors outlined major challenges for patients with psychiatric disorders and mental health professionals during the COVID-19 outbreak, and also discussed how to manage these challenges through further mental health service reform in China. These include:
    - Depleting in hospital cases: Reducing outpatient visits tightening admission criteria; shortening hospitalisations; restricting access within areas.
    - Increase infection controls to a higher level than normal hospitals (restrict visitors, increases supplies of PPE, monitor temperatures of staff patients and visits, increase hand hygiene)
    - reform services to deliver them online and in the community.
- Three elements are responsible for the infection of **hospitalized psychiatric patients**: source of infection (patients), transmission route (human-to-human droplet transmission), and **susceptibility (patients without insight)** [31]. Psychiatrists ought to be aware that psychiatric patients are a susceptible group, so they should be carefully treated and fully prepared for admission and hospitalization. The key conclusions are: observation, threshold, isolation, and prevention. A 14-day clinical observation period is indispensable before formal hospitalization procedures. It has been suggested that an observation room outside the routine ward should be set up for isolation and observation, so as to ensure the safety of patients with mental disorders during isolation. In particular, patients who cannot control their behaviour should be more carefully assessed and stricter protective constraints than usual should be implemented.

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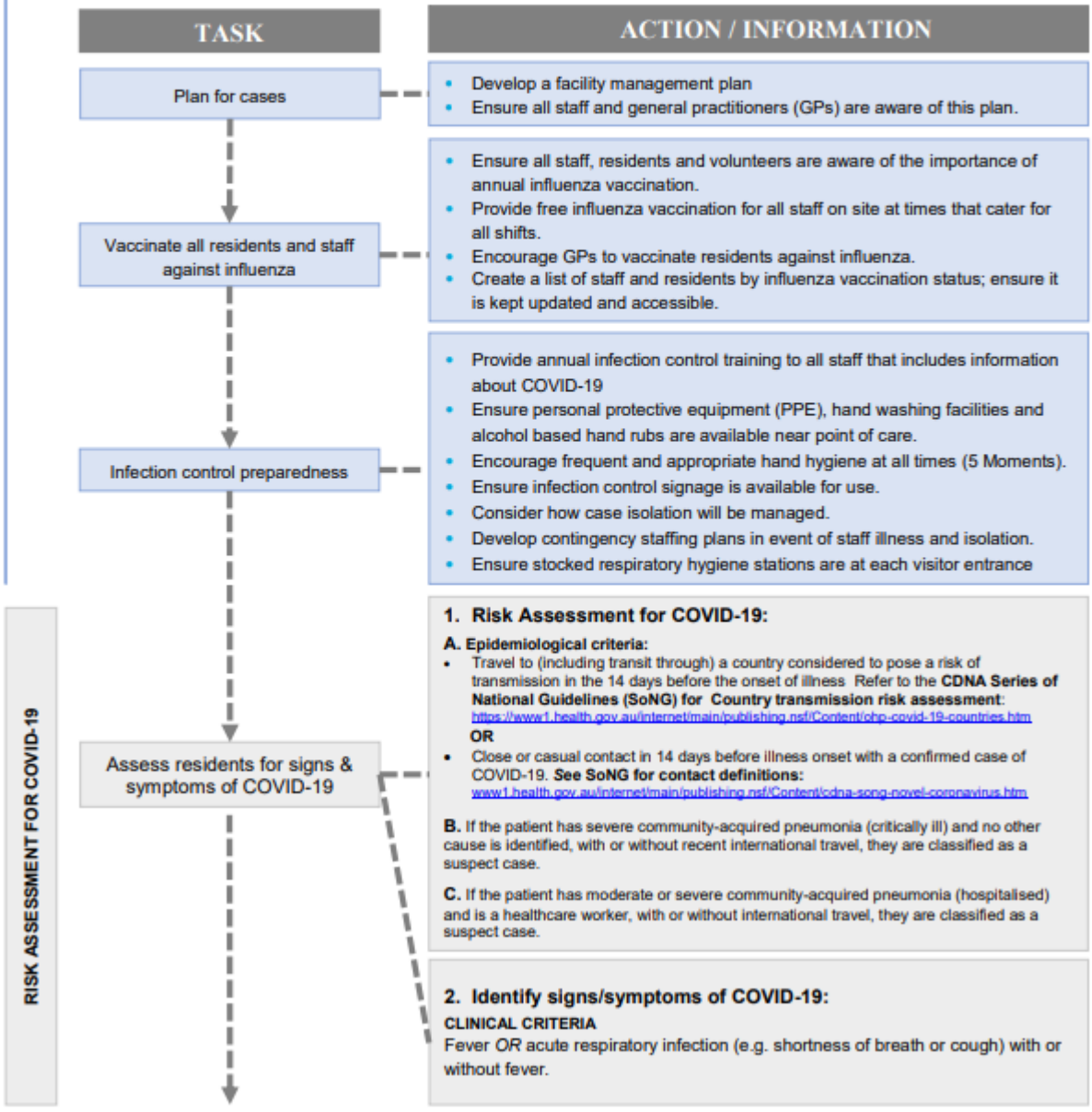
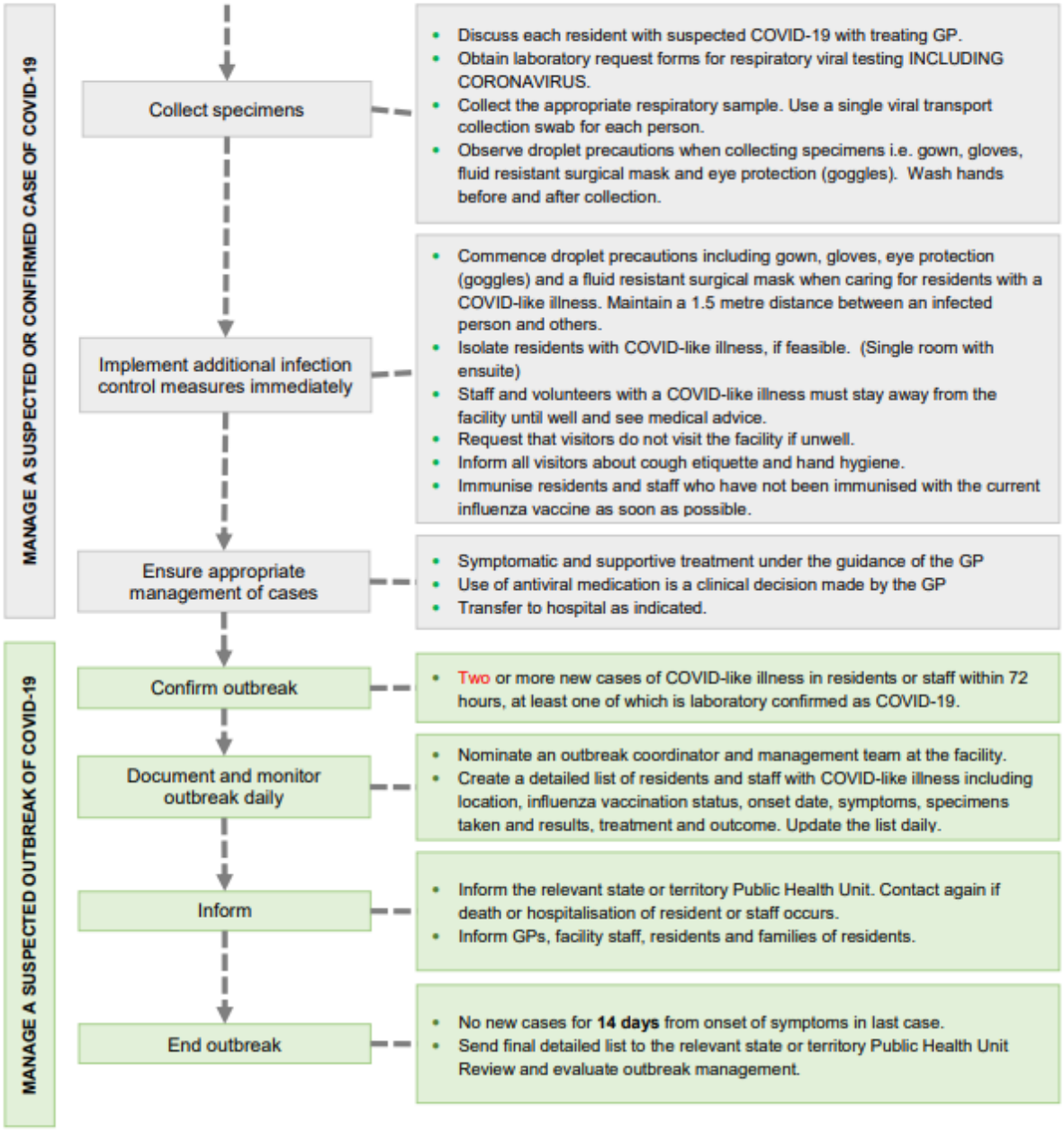
Appendix A:

Flowchart for COVID-19 Management in Residential Care Facilities in Australia

This guideline is intended for use within residential care facilities in Australia and has been adapted from Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units.
https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm
Note: the case definition may change over time




MANAGE A SUSPECTED OR CONFIRMED CASE OF COVID-19
Collect specimens
Discuss each resident with suspected COVID-19 with treating GP.
Obtain laboratory request forms for respiratory viral testing INCLUDING CORONAVIRUS.
Collect the appropriate respiratory sample. Use a single viral transport collection swab for each person.
Observe droplet precautions when collecting specimens i.e. gown, gloves, fluid resistant surgical mask and eye protection (goggles). Wash hands before and after collection.
Implement additional infection control measures immediately
Commence droplet precautions including gown, gloves, eye protection (goggles) and a fluid resistant surgical mask when caring for residents with a COVID-like illness. Maintain a 1.5 metre distance between an infected person and others.
Isolate residents with COVID-like illness, if feasible. (Single room with ensuite)
Staff and volunteers with a COVID-like illness must stay away from the facility until well and see medical advice.
Request that visitors do not visit the facility if unwell.
Inform all visitors about cough etiquette and hand hygiene.
Immunise residents and staff who have not been immunised with the current influenza vaccine as soon as possible.
Ensure appropriate management of cases
Symptomatic and supportive treatment under the guidance of the GP
Use of antiviral medication is a clinical decision made by the GP
Transfer to hospital as indicated.
MANAGE A SUSPECTED OUTBREAK OF COVID-19
Confirm outbreak
Two or more new cases of COVID-like illness in residents or staff within 72 hours, at least one of which is laboratory confirmed as COVID-19.
Document and monitor outbreak daily
Nominate an outbreak coordinator and management team at the facility.
Create a detailed list of residents and staff with COVID-like illness including location, influenza vaccination status, onset date, symptoms, specimens taken and results, treatment and outcome. Update the list daily.
Inform
Inform the relevant state or territory Public Health Unit. Contact again if death or hospitalisation of resident or staff occurs.
Inform GPs, facility staff, residents and families of residents.
End outbreak
No new cases for 14 days from onset of symptoms in last case.
Send final detailed list to the relevant state or territory Public Health Unit
Review and evaluate outbreak management.

Appendix B - Checklist

Appendix 2. COVID-19 Outbreak Preparedness Checklist

Planning actions	☑
Does your RCF have a respiratory outbreak plan that covers all the areas identified below?	
Has your RCF updated its respiratory outbreak plan this year?	
Have the relevant health care providers/organisations in the community (e.g. associated GPs, infection control consultants) been involved in the planning process?	
Are all RCF staff aware of the plan including their roles and responsibilities?	
Staff, resident and family education	
Has your RCF staff undergone education and training in all aspects of outbreak identification and management, particularly competency in infection control?	
Has your RCF run one or more staff education sessions?	
Has your RCF provided resident families with information regarding prevention of transmission?	
Staffing actions	
Does your RCF have a staffing contingency plan in case 20% to 30% of staff fall ill and are excluded for 14 days?	
Has your RCF developed a plan for cohorting staff in an outbreak?	
Stock levels	
Has your RCF acquired adequate stock of PPE, hand hygiene products, nose and throat swabs and cleaning supplies?	
Outbreak recognition actions	
Does your RCF routinely *assess* residents for respiratory illness, particularly for fever or cough (with or without fever)?	
Does your RCF *encourage* staff to report COVID-19 symptoms during the pandemic?	
Does a process exist to notify the facility manager and the state/territory Department of Health and Human Services as soon as practicable (and within 24 hours) of when a COVID-19 case is suspected?	
Communication actions	
Does your RCF have a contact list for the state/territory health department and other relevant stake holders (e.g. facility GPs and infection control consultants)?	
Does your RCF have a plan for communicating with staff, residents, volunteers, family members and other service providers (e.g. cleaners) during an outbreak?	
Does your RCF have a plan to restrict unwell visitors entering the facility as well as limitation of well visitors during an outbreak to reduce risk of transmission both within the facility and externally (e.g. security, signage, restricted access)?	
Cleaning	
Does the plan identify who is responsible for overseeing increased frequency of cleaning, liaison with contractors or hiring extra cleaners as necessary?	