COVID-19, Influenza, Respiratory Syncytial Virus, and Other Acute Respiratory Infection Outbreaks in Residential Aged Care Facilities

Toolkit to support planning, preparedness and response

We acknowledge and respect Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we work and live and pay respect to Elders past and present. For around 40 000 years, Aboriginal people have lived on lutruwita/Tasmania, within strong and resilient communities. We acknowledge that as we work to strengthen resilience against respiratory illness across Tasmania.

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Abbreviations

ABHR	Alcohol-based hand-rub
ARI	Acute Respiratory Infection
CDNA	Communicable Diseases Network of Australia
CDPU	Communicable Diseases Prevention Unit (Public Health Services, DoH)
DoH	Department of Health
GP	General practitioner
ICEG	Infection Control Expert Group
ILI	Influenza-like illness
IPC	Infection Prevention and Control
OMCT	Outbreak management coordination team
OMT	Outbreak management team
PCR	Polymerase chain reaction
PHEOC	Public Health Emergency Operations Centre
PHS	Public Health Services
PPE	Personal protective equipment
RACF	Residential aged care facility
RAT	Rapid Antigen Test
RSV	Respiratory Syncytial Virus
TIPCU	Tasmanian infection prevention and control unit

Updates since earlier versions of this document

Content within this toolkit has been reviewed since version 10.0 to align with updated state and national guidance and CDNA guidelines.

Enquiries about this toolkit can be directed to Public Health Services by email, refer to below contacts.

Contacts

Unit	Reasons to contact	Email
Public Health Services (PHS) respiratory outbreak response team	To notify outbreaks of COVID-19, influenza, respiratory syncytial virus (RSV), or other acute respiratory infections (ARI). To make general enquiries about ARI in RACF or the toolkit.	respiratory.outbreaks@health.tas.gov.au Public Health CNC: 0499 577 953 (9am to 9pm)
Tasmanian Infection Prevention Control Unit (TIPCU)	To make general enquiries relating to infection prevention and control.	tipcu@health.tas.gov.au

Introduction

Scope and purpose of this document

The purpose of this toolkit is to assist aged care providers with the prevention, control, and public health management of COVID-19, influenza, respiratory syncytial virus (RSV), and other acute respiratory infection (ARI) outbreaks in residential aged care facilities (RACF) in Tasmania. It has been adapted to the Tasmanian context from the following national guidelines:

- Communicable Diseases Network of Australia (CDNA) national guidelines for the prevention, control and public health management of Acute Respiratory Infection (including COVID-19 and Influenza) in residential care facilities in Australia
- Infection Control Expert Group (ICEG)- endorsed resources for infection prevention and control | Australian Government Department of Health and Aged Care

The information about ARIs in this toolkit is purposely concise with links to key documents. It is recommended that staff involved in planning, preparing, and responding to ARI outbreaks in RACF review the linked documents above regularly.

This toolkit is primarily for RACFs but can also be used for disability residential care facilities and other residential settings.

Background

All respiratory viruses can cause outbreaks and significant morbidity and mortality for people aged over 65 years and people with co-morbidities or low immunity. Residential care facility residents are especially vulnerable, as communal living can facilitate the rapid spread of COVID-19, influenza, RSV and other ARIs.

COVID-19, influenza, RSV and other ARIs in residential aged care settings

Health services and RACFs have knowledge and skills to respond to the challenges posed by COVID-19, influenza, RSV and other respiratory viruses.

All respiratory viruses may present in a similar way, and robust systems for preventing, detecting, and managing ARI outbreaks safely are a key feature of any response in RACF. Additionally, influenza, RSV, and COVID-19 might occur together. Information for RACFs on preparing for ARI cases and outbreaks can be found in Appendix 1: Preparedness.

The management approach to COVID-19, influenza, RSV and other ARI are similar, however there are key differences, as detailed in Table 1: Overview of Similarities and Differences – COVID-19, influenza, Respiratory Syncytial Virus (RSV), and other Acute Respiratory Infections.

Table 1: Overview of similarities and differences – COVID-19, influenza, Respiratory Syncytial Virus and other Acute Respiratory Infections

	COVID-19	Influenza	RSV	Other ARIs
Vaccine available	Yes, including boosters	Yes, annual vaccine recommended	Vaccine not currently available in Australia	No vaccines available
Notifiable under the *Public Health Act* (1997)	Yes – laboratory confirmed case(s) RAT identified case(s) are recommended to be notified by individuals/facilities.	Yes – laboratory confirmed case(s)	Yes – laboratory confirmed case(s)	No
Notification process to Public Health	Individual cases: notified by laboratory (PCR) or by case or RACF (RAT). Outbreaks: RACF should notify Public Health of outbreaks by emailing respiratory.outbreaks@health.tas.gov.au	Individual cases: notified by laboratory Outbreaks: RACF should notify Public Health of outbreaks by emailing respiratory.outbreaks@health.tas.gov.au	Individual cases: notified by laboratory Outbreaks: RACF should notify Public Health of outbreaks by emailing respiratory.outbreaks@health.tas.gov.au	Not routinely notified. Outbreaks: RACF are recommended to notify Public Health of outbreaks by emailing respiratory.outbreaks@health.tas.gov.au
Outbreak definition	2 or more resident cases of COVID-19 within 72 hours	2 or more resident cases of influenza within 72 hours	2 or more resident cases of RSV within 72 hours	2 or more resident cases within 72 hours
Infection Control Precautions	Standard and Transmission based precautions. PPE as per Guidance on the use of personal protective equipment (PPE)	Standard and Transmission based precautions. PPE as per Guidance on the use of personal protective equipment (PPE)	Standard and Transmission based precautions. PPE as per Guidance on the use of personal protective equipment (PPE)	Standard and Transmission based precautions. PPE as per Guidance on the use of personal protective equipment (PPE)
Isolation of cases and suspected cases.	Yes, recommended	Yes, recommended	Yes, recommended	Yes, recommended
Outbreak stand down	No new resident cases within 7 days of the last resident case identified and negative test results for residents in the affected area(s), in consultation with Public Health.	No new resident cases within 7 days of the last resident case identified and in consultation with Public Health	No new resident cases within 7 days of the last resident case identified and in consultation with Public Health	No new resident cases within 7 days of the last resident case identified

Prevention

Key strategies for preventing introduction of ARIs into the facility are outlined below.

Vaccination

Vaccination, along with other risk reduction measures are essential to protecting residents, workforces, and the wider community. Annual seasonal influenza planning and the latest recommendations for COVID-19 vaccination should be integrated into planning for ARI outbreaks in RACF.

Immunisations for both influenza and COVID-19 are strongly encouraged for RACF staff and residents and are required in some instances following Work Health and Safety risk assessments.
See ATAGI advice on seasonal influenza vaccines in 2023 (health.gov.au) for influenza and Clinical recommendations for COVID-19 vaccines | Australian Government Department of Health and Aged Care and Information for aged care providers, workers and residents about COVID-19 vaccines | Australian Government Department of Health and Aged Care for COVID-19.

Reinforce hygiene measures

The following measures can help prevent introduction and transmission of respiratory illness within the facility:

- require that staff and visitors do not enter the facility if unwell with respiratory symptoms
- provide signage on hygiene promoting behaviours
- provide education to staff, residents, and visitors
- encourage appropriate use of personal protective equipment (PPE)
- support physical distancing where practicable
- support and encourage hand and respiratory hygiene by residents, staff, and visitors
- provide hand washing stations and alcohol-based hand rub throughout the facility
- provide tissues and rubbish bins throughout the facility
- ensure liquid soap, paper towels and rubbish bins are available at all hand basins

Manage entry to your facility

Transfers and admissions into the RACF

All residents being transferred or admitted into the RACF should be screened for symptoms of respiratory illness. If any symptoms are identified, organise testing and manage the resident with transmission-based precautions in line with a risk assessment.

There is no requirement for asymptomatic residents being transferred into an RACF from an acute care facility to be routinely tested for respiratory illnesses.

Recommendations for visitors

Public Health recommends facilities have a policy for risk mitigation measures for visitors and staff entering the facility, which considers the community risk level for respiratory illness, cases of respiratory illness in staff and the local community, the likely interaction between visitors/ staff and residents and the individual preferences of residents. This policy may include a number of actions including screening processes, testing and mask wearing for staff and visitors.

Additional information regarding visitation to RACFs can be found here: Aged care facility visits | Coronavirus disease (COVID-19).

Public Health recommends all staff and visitors entering RACFs are screened for acute respiratory

infection symptoms. If staff or visitors have symptoms, they should be advised not to enter the RACF until symptoms resolve or, where entrance to the facility is a necessity, ensure they have adequate Infection Prevention and Control (IPC) measures in place (i.e., wear a face mask, minimise movement through the RACF etc.)

Visitors who have tested positive for respiratory illnesses

Individuals who have tested positive for COVID-19 in the last 7 days or who are a close contact of a case who wish to enter a RACF are advised to notify the facility in advance and seek permission to enter. Individuals who have tested positive for influenza in the last 5 days who have not had at least 72 hours of antivirals, and individuals who have tested positive to RSV and are symptomatic who wish to enter an RACF are also advised to notify the facility in advance.

The RACF should have a process in place to assess these requests and, if approved, arrange for measures to minimise the risk to staff and residents, such as mask wearing, minimise movement through the RACF, avoiding shared spaces etc. Advice can be sought from Public Health as required.

For more information email respiratory.outbreaks@health.tas.gov.au.

Staff members who have contact with a case of COVID-19

RACF staff who have been in close contact with a case of COVID-19 should follow Public Health recommendations for close contacts and inform their employer (see Advice for contacts | Coronavirus disease (COVID-19).

Workplaces should have policies in place to manage close contacts which may include testing negative on a daily RAT and wearing a mask in the workplace. If able, staff may be encouraged to work from home.

RACF staff who have contact with a case of influenza, RSV or other respiratory pathogens are not required to stay at home or avoid high risk settings and can continue to work if they are well and do not have any symptoms.

Staff members returning from sick leave

Staff members who have been sick with an ARI should only return to work when their symptoms have resolved. If staff have tested positive for COVID-19, it is recommended they should not return to work until their acute symptoms have resolved AND it has been 7 days since their positive test date.

Identification of Acute Respiratory Infections in a RACF

Early identification of cases and rapid response is key to minimising transmission of ARIs within a RACF.

Transmission of respiratory viruses

The viruses that cause respiratory illness spread through:

- most common: inhalation of respiratory aerosols and droplets of various sizes from an infectious person
- less common (or rarely): touching objects or surfaces (like doorknobs, sink taps and tables) that have respiratory aerosols and droplets of various sizes (i.e., from coughing or sneezing) from an infectious person, and then touching your mouth or nose.

Signs and symptoms of acute respiratory infections

When residents develop symptoms of an ARI, it is not possible to know whether it is due to influenza, COVID-19, or another respiratory virus prior to testing.

Test, as a minimum, for COVID-19, influenza, and RSV (e.g., COVID-19 and respiratory virus panel) in any resident of a RACF with any new respiratory symptoms, however mild.

The most common symptoms of any ARI are (in the absence of an alternative diagnosis that explains the clinical presentation):

- fever (or symptoms of fever e.g., chills, night sweats),*
- acute respiratory infection symptoms (sore throat, shortness of breath, cough, runny nose), and/or
- tiredness or fatigue.

Other common symptoms include:

- muscle and joint pains,
- nausea, vomiting, and diarrhoea,
- headache,
- loss of smell or loss of taste (more frequent with COVID-19).

Older people may have mild or atypical presentations, such as:

- new or increased confusion,
- irritability,
- withdrawal from normal activities,
- worsening symptoms of chronic lung disease (e.g., increased sputum production),
- loss of appetite.

**fever may be absent in the elderly.*

Management of residents with fever or acute respiratory illness

Unwell residents should be assessed and clinically managed by their GP or other treating medical practitioner. Maintaining the health and wellbeing of residents and ensuring their care needs are met is the responsibility of the RACF.

If a resident has fever or symptoms of acute respiratory illness:

1. Isolate the resident (in a private/single room with ensuite if possible) and wear a P2/N95 and protective eyewear. Gown and gloves are required when providing direct care.
2. Inform the GP. Provide a comprehensive clinical history, current clinical observations, and facility details.

Tell the GP if there is a suspected or confirmed outbreak of influenza, COVID-19, or another ARI within the facility.

If it is after hours, contact the after-hours or locum service as per standard processes.

When to test residents for respiratory viral pathogens

If a resident has a fever or acute respiratory symptoms

1. Test for COVID-19, influenza and RSV.

   Performing a RAT for COVID-19 at the same time as completing a PCR test is supported by Public Health, particularly where there is a high prevalence of COVID-19 in the community (see: Managing the current COVID-19 risk | Coronavirus disease (COVID-19)) and/or PCR testing is not readily available**.** A PCR is recommended for all initial cases, regardless of RAT result (for example where there is not known to be COVID-19 in the facility) and for all symptomatic residents with a negative RAT.

   Clinical decisions should be discussed with the resident's GP or other treating medical practitioner.
2. While waiting for the test result, isolate the resident in a private room with ensuite if possible and use a P2/N95 mask, eyewear, gown, and gloves when providing direct care.

How to arrange testing

Information on testing for COVID-19 and other respiratory viruses, including a flowchart for managing testing and notification of results, can be found in Appendix 2: Summary of PCR testing process for COVID-19, influenza, RSV, and other acute respiratory infections in RACF.

Management of staff with fever or an acute respiratory infection

Any RACF worker with acute respiratory symptoms, even mild, should not attend the workplace and notify their manager. They should get tested and seek medical attention as required.

More information on testing specifically related to COVID-19 is available at Testing for COVID-19 | Coronavirus disease (COVID-19) and at PCR tests | Coronavirus disease (COVID-19).

Clinical care of unwell residents

Decisions regarding the clinical care of unwell residents, including whether the resident(s) should be managed in the RACF or transferred to hospital, should be made on a case-by-case basis. This applies even in the event of an ARI outbreak in a RACF. The needs of residents who test positive to a respiratory virus should be balanced with the needs and wellbeing of other residents in the RACF, and the infection control risks.

The needs of the resident(s) will be considered in consultation with the resident, their family, the facility, clinicians, and Public Health.

Transfer of residents from hospital or another residence to the RACF should be facilitated once the resident is well enough.

Isolation

Staff cases of COVID-19 should stay at home while they have acute respiratory symptoms or fever and should not enter high risk settings, including RACF, for at least 7 days from their positive test.

Resident cases should isolate from other residents for 7 days following the date of their first positive COVID-19 specimen, regardless of symptoms.

If the resident remains symptomatic on day 7, they should stay away from others until their symptoms have significantly resolved and they have not had a fever (or signs of fever such as chills or night sweats) for at least 24 hours.

Clinical queries about isolation for individuals with unknown or another pathogen should be discussed with the managing clinician. Additional information regarding isolation for COVID-19, influenza, and RSV can be found in the section Key actions for the RACF for specific outbreaks.

Key Actions for case and outbreak management

Key initial actions for the RACF on identification of a symptomatic resident(s)

As soon as acute respiratory symptoms are first identified in a resident(s), the following initial actions are recommended:

- **Implement IPC measures**
  - Isolate the symptomatic resident(s). A single room with ensuite is recommended.
  - For direct care of symptomatic resident(s), wear a P2/N95 mask, eyewear, plastic apron or long-sleeved gown, and gloves.
    - A plastic apron is adequate when there is minimal direct resident contact and/or there is a low risk of blood or body fluid splash.
  - P2/N95 and eyewear are recommended for staff providing care to contacts of symptomatic residents.
  - Implement enhanced environment cleaning.
- **Conduct testing**
  - Test the symptomatic resident(s) for COVID-19, influenza, and RSV via PCR

Performing a RAT for COVID-19 at the same time as completing a PCR test is supported by Public Health, particularly where there is a high prevalence of COVID-19 in the community (see: Managing the current COVID-19 risk | Coronavirus disease (COVID-19)) and/or PCR testing is not readily available**.**

A PCR is recommended for all initial cases, regardless of RAT result (for example where there is not known to be COVID-19 in the facility) and for all symptomatic residents with a negative RAT.

- **Consider**
  - Reducing movement and group activities within the facility.
  - Cohorting staff and residents within the facility.

Key general actions for the RACF in an outbreak

As soon as an outbreak of COVID-19, influenza, RSV, or other ILI is identified, the RACF should stand up the outbreak management team (see Appendix 1: Preparedness: Key Actions for Case and Outbreak Management) in accordance with their outbreak management plan. This team will be responsible for directing, monitoring, and overseeing the RACF outbreak response and management.

Scenarios may arise where a RACF is managing more than one respiratory virus within their facility. Where more than one pathogen is present, even when an outbreak definition is not met, the RACF should contact Public Health to discuss an appropriate response, which will be considered on a facility-by-facility basis. It is important that cohorting of residents occurs in such a way that residents with the same pathogen are cohorted together.

Action	Details
Isolate cases and symptomatic residents	• Isolate all cases and symptomatic residents • Allocate specific staff to care for the confirmed or suspected case(s).
Notify outbreaks	• Notify Public Health • Notify the Australian Government Department of Health and Aged Care through the My Aged Care Portal (required for COVID-19 outbreaks but encouraged for other ARI outbreaks as well).
Activate outbreak management team	• Activate the internal RACF outbreak management team. • Appoint outbreak management coordinator. • Meet and assign roles and responsibilities.
Ensure appropriate clinical management of case	• Liaise with the treating GP/s and provide appropriate clinical care including antivirals where indicated. • Arrange transfer if required for clinical care. • Ensure all visiting health professionals are aware of outbreak. • Review and communicate current Advanced Care Directives. • Provide appropriate antiviral treatment in line with current national guidance for COVID-19 and influenza and in consultation with the patient's GP.
Activate communication plan	• Provide information relating to the case and facility as requested by both Public Health and Australian Government Agencies to assist outbreak management. • Allocate staff to manage communications.
Support contact tracing	• Where indicated, identify contacts of cases and manage in line with current Public Health guidance. • Where required, provide a detailed site map and a line list of resident and staff cases to Public Health.

Action	Details
Enhance infection prevention and control	• Ensure current infection prevention control and guidance is implemented and followed as per national guidelines Australian Guidelines for the Prevention and Control of Infection in Healthcare (2022) (safetyandquality.gov.au) and relevant disease specific national guidelines. Cohort residents where possible. • Enhance hand hygiene, respiratory hygiene, and physical distancing. • Wear PPE in line with PPE guidance as per Guidance on the use of personal protective equipment (PPE). • Review current stock of PPE, obtain additional supplies from the usual supplier and if unavailable and required for COVID-19 outbreaks, request additional PPE via the Australian Government at: My Aged Care service provider portal. • Implement enhanced environmental cleaning and disinfection for all outbreaks. For a useful reference, see www.health.gov.au/resources/publications/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities.
Managing visitors	• Visitors should comply with any RACF requirements (e.g., PPE requirements, screening etc). • Admissions of new residents into the affected area(s) of the facility during an outbreak should be avoided where possible.
Conduct surveillance for additional cases	• Monitor for ARI symptoms in staff and residents. • Arrange testing for symptomatic staff and residents. • Maintain an up-to-date line list with information regarding staff and resident cases and share line list with Public Health. • Support any additional testing of staff and residents as per Public Health advice.
Manage staff	• Allocate specific staff to care for residents in isolation. • Cohort staff where possible. • Actively screen staff for symptoms. • Recommend staff work at a single site only during an outbreak. • Restrict staff close contacts who are returning to work with RACF approval to a single site only. • Plan for staffing shortages where large numbers of staff may be furloughed. Liaise with the Australian Government Case Manager about workforce support if required.
Monitor and support health and wellbeing of residents and staff	• Maintain primary and routine care. • Support wellbeing of residents, including nutrition, physical activity, boredom, loneliness, and fear. • Support residents with similar exposure or risk level to be cohorted together in an area away from other residents. • Support morale and mental wellbeing of staff.
Standing down the outbreak	• Liaise with Public Health about standing down the outbreak. • Return to routine activities. • Review and debrief on outbreak response. • Review and revise the outbreak management plan as required.

Recommended key actions for the RACF for specific outbreaks

COVID-19

Notification	PCR confirmed cases are notified by laboratories to PHS. RAT identified cases should be notified through the online RAT registration portal on the coronavirus website by the case or the RACF. RACF should notify Public Health of outbreaks by emailing: respiratory.outbreaks.@health.tas.gov.au
Outbreak definition	2 or more resident cases within 72 hours
Testing	*Initial testing* Initial testing sweep of the affected area(s) via RAT once an outbreak is declared. For small facilities, a whole facility testing sweep may be recommended by Public Health on a facility-by-facility basis. *Ongoing testing* Ongoing testing of residents and staff as advised by Public Health. This should include testing of any symptomatic residents and staff, as well as RAT testing of residents in affected areas every 3 to 5 days.
Infection prevention and control	Isolate cases and cohort where possible. Wear a P2/N95 mask, eyewear, plastic apron or long-sleeved gown, and gloves for direct care. — A plastic apron is adequate when there is minimal direct resident contact and/or there is a low risk of blood or body fluid splash. Wear a P2/N95 and eyewear when caring for contacts. Continue enhanced environment cleaning.
Isolation of cases	Isolate cases ideally in a single room with an ensuite. Resident cases should isolate away from others for 7 days from their positive test date and until their symptoms have significantly improved and they have not had a fever for at least 24 hours. Staff cases should follow the general advice for community cases (Recovery from COVID-19 | Coronavirus disease (COVID-19)), including not attending any high-risk settings (e.g., RACF) until 7 days after they test positive.
Close contacts	Identify contacts and ensure Public Health requirements for close contacts are attended to.
Monitoring for cases	Monitor for fever and acute respiratory symptoms in residents and staff and test accordingly.
Antivirals	Case management: Provide in line with current national guidance Oral treatments for COVID-19 | Australian Government Department of Health and Aged Care and in consultation with the GP. Post-exposure prophylaxis: not currently recommended. Obtain pre-consent for the use of antivirals. Additional information about obtaining consent and procurement of antivirals for COVID-19 can be found here: Use of molnupiravir in residential aged care and Use of Paxlovid in residential aged care.

Other considerations	Plan to support visitors with appropriate use of PPE. Reduce resident movement within the facility. Cohort staff and residents within the facility. Reduce or suspend group activities.
Stand down	An outbreak may be stood down, along with outbreak IPC precautions, once: • 7 days have passed with no new resident cases identified (where day zero is the date the case/s enter isolation or was last on-site) • The advised testing regime of residents in affected areas has been completed An outbreak may be declared over 14 days after the last case tested positive. New staff cases where appropriate PPE has been worn and where there were no breaches, should not delay the standing down of an outbreak where the above criteria are otherwise met.

Influenza

Notification	PCR confirmed cases notified by laboratory. RACF should notify Public Health of outbreaks by emailing: respiratory.outbreaks.@health.tas.gov.au
Outbreak definition	2 or more resident cases within 72 hours.
Testing	Symptomatic residents and staff.
Infection prevention and control	Isolate cases and cohort where possible. Wear a P2/N95 mask, eyewear, and a plastic apron or long-sleeved gown, and gloves for direct care. — A plastic apron is adequate when there is minimal direct resident contact and/or there is a low risk of blood or body fluid splash. Wear a P2/N95 and eyewear when caring for contacts. Continue enhanced environment cleaning.
Isolation of cases	Isolate cases ideally in a single room with an ensuite. Cases can be released from isolation 5 days after symptom onset or 72 hours after antivirals commenced.
Close contacts	Not applicable.
Monitoring for cases	Monitor for new onset of acute respiratory symptoms in residents and test accordingly.
Antivirals	Case management: Provide in line with current national guidance and in consultation with the GP. Post-exposure prophylaxis: Provide in line with current national guidance National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities | Australian Government Department of Health and Aged Care and in consultation with the GP. Obtain pre-consent for the use of antivirals.
Other considerations	Plan to support visitors with appropriate use of PPE. Reduce resident movement within the facility. Cohort staff and residents within the facility. Reduce or suspend group activities.
Stand down	A decision about standing down and closing an outbreak is made by the RACF in consultation with Public Health. An outbreak may be stood down once: • No new resident cases within 7 days of last resident case identified.

RSV and other respiratory viruses

Notification	PCR confirmed RSV cases notified by laboratory. Other ARIs are not routinely notified. RACF should notify Public Health of outbreaks by emailing: respiratory.outbreaks.@health.tas.gov.au
Outbreak definition	2 or more resident cases within 72 hours.
Testing	Symptomatic residents and staff only.
Infection, prevention, and control	Isolate cases and cohort where possible. Wear a P2/N95 mask, eyewear, plastic apron or long-sleeved gown, and gloves for direct care. A plastic apron is adequate when there is minimal direct resident contact and/or there is a low risk of blood or body fluid splash. Wear a P2/N95 and eyewear when caring for contacts. Continue enhanced environment cleaning.
Isolation of cases	Isolate cases ideally in a single room with an ensuite. Cases can be released from isolation once symptoms have resolved or when a clinician has determined that the acute phase of illness is over.
Close contacts	Not applicable.
Monitoring for cases	Monitor for new onset of acute respiratory symptoms in residents and test accordingly.
Antivirals	Not applicable.
Other considerations	Plan to support visitors with appropriate use of PPE. Reduce resident movement within the facility. Cohort staff and residents within the facility. Reduce or suspend group activities.
Stand down	A decision about standing down and closing an outbreak is made by the RACF in consultation with Public Health. An outbreak may be stood down once: • No new resident cases within 7 days of the last resident case identified.

Declaring the outbreak over and transition to business as usual

The decision to 'stand down' an outbreak and wind back IPC precautions, or declare an outbreak over, is **guided by Public Health in conjunction with the facility**.

In general, an outbreak may be stood down once:

- no new resident cases are identified *within 7 days* of the last resident case identified (see Key actions for the RACF for specific outbreaks for further details relating to individual pathogens).
- Any required testing of close contacts and recommended testing regimens of other staff and residents have been completed.

Once an outbreak has been stood down a transition to business as usual requires a return to preventative and preparatory activities.

Guidance on the use of personal protective equipment (PPE)

Where residents have, or are suspected to have, COVID-19, influenza, RSV or another acute respiratory infection (ARI), an increased level and use of PPE is required to protect staff, visitors, and residents.

The level of PPE required by staff and visitors in RACFs is dependent on the known or suspected diagnosis of the resident and the activity being undertaken.

Undertake all putting on (donning) and taking off (doffing) of PPE with a PPE buddy wherever possible to ensure PPE is worn correctly and that a fit check of the P2/N95 has been performed.

At designated PPE donning and doffing stations display signs outlining the:
- appropriate PPE needed for various roles and circumstances, and
- correct sequence of donning and doffing of PPE.

PPE used in RACFs are:
- Surgical mask – single use
- P2/N95 mask – single use
- Protective eyewear – single use or reusable
- Face shield – single use or reusable
- Plastic apron – single use
- Long-sleeved gown – single use
- Gloves – single use

The PPE required is task specific and is outlined in Table 2: PPE requirements for different activities.

The sequence for putting on and taking off PPE is outlined in Table 3: Sequence for putting on and taking off PPE.

Replace masks if they become damp, visibly soiled, accidently dislodged or have been in place for four hours. Do not touch the outside of the mask or leave the mask under the chin.

Staff who wear P2/N95 masks should ideally complete an initial fit test and must perform a fit check each and every time they don a P2/N95 mask. Where fit testing has not been performed and a P2/N95 mask is recommended for use, a fit-checked P2/N95 mask is preferred to a surgical mask.

To watch a fit check see Personal Protective Equipment demonstration videos | Tasmanian Department of Health.

The level of PPE required for visitors to wear is dependent on the infectious status of the resident and whether the visit is indoors or outdoors (Table 2).

Visitors must be made aware of the risks of visiting during a declared outbreak and must be instructed and observed on the use of PPE and how to perform hand hygiene.

Residents who have a diagnosed viral respiratory illness should wear a surgical mask when possible, during face-to-face visiting.

Definitions

- Direct care – where the resident is being physically touched by the carer. Most often occurs during assistance with activities of daily living.
    - Examples – assisting with bathing, dressing, toileting, ambulation, performing a procedure such as a wound dressing or catheterisation.
- Indirect care – where care is provided but there is minimal physical touching of the resident by the carer. There is a low risk of blood or body fluid splashes.
    - Examples – dispensing medication, taking observations, putting a meal tray down in the resident's room, giving the resident an electronic device such as an iPad.
- Direct contact with the physical environment.
    - Example – cleaning a resident's room, cleaning high-touch surfaces in common areas, cleaning bathrooms and waste removal.
- No direct or indirect care or contact with the physical environment.
    - Example – preparing food in the kitchen, office work or administrative work.
- Visiting/Visitors
    - Example – people not employed by the RACF such as friends or relatives or pastoral care.

Table 2: PPE requirements for different activities

Activity (work task or duty)	**COVID-19 positive resident** **Residents with diagnosed influenza, RSV or other ARI** **Resident with symptomatic undiagnosed ARI**	**COVID-19 close contacts**	**Residents negative and asymptomatic for a viral respiratory illness** **Residents who have ceased isolation following a diagnosed viral respiratory illness**
Direct care	P2/N95 mask Eye protection or face shield Plastic apron or long-sleeved gown depending on amount of direct contact and risk of blood or body fluid exposure Gloves	P2/N95 mask Eye protection or face shield Other PPE as required as per Standard Precautions	Wear PPE as required as per Standard Precautions
Indirect care	P2/N95 mask Eye protection or face shield Other PPE as required as per Standard Precautions	P2/N95 mask Eye protection or face shield Other PPE as required as per Standard Precautions	Wear PPE as required as per Standard Precautions
Direct contact with the physical environment	P2/N95 mask Eye protection or face shield Gown Gloves	P2/N95 mask Eye protection or face shield	Wear PPE as required as per Standard Precautions

		Other PPE as required as per Standard Precautions	
Visiting – face to face visits indoors (for example end of life)	Resident - Surgical mask if able to be worn Visitor – N95/P2 mask and eyewear. Gloves not required but hand hygiene must be performed	Resident - Surgical mask if able to be worn Visitor – N95/P2 mask and eyewear. Gloves not required but hand hygiene must be performed	Resident – no PPE required Visitor – no PPE required
Visiting - face to face outside	Resident – surgical mask if able to be worn Visitor – P2/N95 mask and protective eyewear	Resident – surgical mask if able to be worn Visitor – P2/N95 mask and protective eyewear	Resident – no PPE required Visitor – no PPE required
Visitors – window visiting with window closed	No PPE required	No PPE required	No PPE required

Table 3: Sequence for putting on and taking off PPE

PPE	Putting on (donning) sequence	Taking off (doffing) sequence
Mask + protective eyewear/face shield	1. Hand hygiene using alcohol-based hand-rub (ABHR) 2. Put on mask 3. Hand hygiene using ABHR 4. Put on protective eyewear/face shield 5. Hand hygiene using ABHR	1. Hand hygiene using ABHR 2. Take off protective eyewear Dispose of disposable eyewear/face shield **OR** Clean reusable eyewear 3. Hand hygiene using ABHR 4. Take off mask 5. Hand hygiene using ABHR
Mask + protective eyewear/face shield + apron/gown	1. Hand hygiene using ABHR 2. Put on apron/gown 3. Hand hygiene using ABHR 4. Put on mask 5. Hand hygiene using ABHR 6. Put on protective eyewear/face shield 7. Hand hygiene using ABHR	1. Hand hygiene using ABHR 2. Take off apron/gown 3. Hand hygiene using ABHR 4. Take off protective eyewear/face shield Dispose of disposable eyewear/face shield **OR** Clean reusable eyewear 5. Hand hygiene using ABHR 6. Take off mask 7. Hand hygiene using ABHR
Mask + protective eyewear + apron/gown + gloves	1. Hand hygiene using ABHR 2. Put on apron/gown 3. Hand hygiene using ABHR 4. Put on mask 5. Hand hygiene using ABHR 6. Put on protective eyewear/face shield 7. Hand hygiene using ABHR 8. Put on gloves	1. Take off gloves 2. Hand hygiene using ABHR 3. Take off apron/gown 4. Hand hygiene using ABHR 5. Take off protective eyewear/face shield Dispose of disposable eyewear/face shield **OR** Clean reusable eyewear 6. Hand hygiene using ABHR 7. Take off mask 8. Hand hygiene using ABHR

Table 4: Sequence for changing PPE

PPE	Sequence
Change apron/gown and gloves with mask and protective eyewear remaining on	1. Take off gloves 2. Hand hygiene using ABHR 3. Take off apron/gown 4. Hand hygiene using ABHR 5. Put on new apron/gown 6. Hand hygiene using ABHR 7. Put on new gloves

Useful IPC resources

Communicable Diseases Network Australia (CDNA)

- CDNA National Guidelines for Public Health Units

Infection Control Expert Group (ICEG) – endorsed infection prevention and control guidance

- Revised guidance on the use of personal protective equipment (PPE) for health care workers in the context of COVID-19
- Environmental cleaning and disinfection principles for health and residential care facilities
- Australian Commission on Safety and Quality in Health Care – hierarchy of control fact sheet

Tasmanian Infection Prevention and Control Unit (TIPCU) PPE video series

- Personal Protective Equipment demonstration videos | Tasmanian Department of Health

Information sharing

Notification to Public Health Services

For all notifications of respiratory virus outbreaks in RACF, please email the following information to respiratory.outbreaks@health.tas.gov.au:

- name and address of the facility,
- contact details and role/position of person notifying,
- number of residents and staff in facility,
- number of residents and number of staff unwell,
- respiratory pathogen (if known),
- names and date of birth of all residents and staff cases,
- date of specimen collection.

COVID-19

COVID-19 is a notifiable disease in Australia. Public Health is notified by the laboratory of all positive PCR tests. RAT identified cases should be notified by the case themselves or by the RACF. In addition, the **RACF should notify Public Health of any outbreaks of COVID-19.** Notification should occur by email to respiratory.outbreaks@health.tas.gov.au.

Notification to the Australian Government Department of Health and Aged Care

In the event of an outbreak of COVID-19, the RACF must notify the Australian Government Department of Health and Aged Care via the My Aged Care service provider portal | Australian Government Department of Health and Aged Care.

PHS may also liaise with the Australian Government Department of Health and Aged Care and/or the Aged Care Quality and SafetyCommission so that additional support can be offered.

Other respiratory illnesses

Laboratory confirmed influenza and RSV are notifiable diseases in Tasmania. Public Health is notified by the laboratory of all positive tests. **RACF should notify Public Health of any outbreaks of influenza, RSV and other ARI outbreaks.** Notification should occur by email to respiratory.outbreaks@health.tas.gov.au.

Notification to treating GPs and other healthcare workers

In addition to notifying Public Health, the RACF should notify all visiting GPs at the start of the outbreak. The RACF should also inform other healthcare providers (including transport/ambulance staff) before they attend the RACF.

Information sharing with Public Health

When a viral respiratory illness outbreak is suspected or confirmed and notified to Public Health, they will be in contact with the facility regularly. Public Health staff may request the following additional information from the RACF:

- resident and staff details, including total number of residents in the facility and in the affected area,
- description of the RACF in terms of size, buildings, layout, infrastructure, and staffing,
- total number of residents and staff with symptoms,
- date of onset and details of symptoms of each person,
- total number of staff that work in the facility and the affected area,
- capacity to isolate/cohort cases,
- whether respiratory specimens (nose and throat swabs) have been collected,
- number of people admitted to hospital with an acute respiratory illness,
- number of people with an acute respiratory illness who have died.

Line lists

A line list will be provided to the RACF (in the form of an Excel spreadsheet) to record key information about cases. The RACF should update the line list and send it to Public Health by email to respiratory.outbreaks@health.tas.gov.au. For COVID-19 only, the line list should be sent by email to Public Health at respiratory.outbreaks@health.tas.gov.au. See Appendix 4 for an example of a line list.

Notification of a death related to COVID-19, influenza or RSV

Public Health are required to notify the Australian Government of any death related to COVID-19 and gather information relating to deaths related to influenza or other ARIs.

Definition of a COVID-19 death: "a death in a confirmed or probable COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g., trauma). There should be no period of complete recovery from COVID-19 between illness and death. Where a Coroner's report is available, these findings are to be observed" (CDNA National Guidelines for Public Health Units).

When a resident who has COVID-19, or has recently recovered from COVID-19, dies, the RACF should notify Public Health by completing a 'Death Notification Form' and emailing it to respiratory.outbreaks@health.tas.gov.au. You can request a blank form by emailing Public Health.

Key resources

For additional and supporting information, please see:

- National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities | Australian Government Department of Health and Aged Care for additional guidance regarding influenza and ARI outbreaks
- ICEG-endorsed resources for infection prevention and control | Australian Government Department of Health and Aged Care
- Outbreak Management Planning in Aged Care – guidance from the Aged Care Quality and Safety Commission COVID-19 provider resources | Aged Care Quality and Safety Commission
- First 24 Hours Checklist - Managing COVID-19 in a Residential Aged Care Facility Australian Government Department of Health and Aged Care
- Tasmanian Infection Prevention and Control | Public Health (dhhs.tas.gov.au)
- CDNA National Guidelines for Public Health Units

Glossary

COVID- 19 case

An individual who has tested positive for SARS-CoV-2 on a polymerase chain reaction (PCR) or Rapid Antigen Test (RAT)

Close contact

- A person who has shared a defined area (e.g., a wing of a facility) and/or who has had a household like exposure with a case during their infectious period
- A person who has spent more than 4 hours in a residential setting with a confirmed case during their infectious period (over a 24-hour period)

If there is a case of COVID-19 identified at a RACF, all staff and residents should be made aware and should monitor for symptoms.

If the COVID-19 case or person exposed to the case was wearing a P2/N95 respirator mask for the whole time, the exposed person is not considered a contact.

COVID-19 outbreak

Two or more resident cases of SARS-CoV-2 within 72 hours.

Infectious period

The infectious period begins 48 hours prior to when symptoms start or, where asymptomatic, before the positive test was taken, and may continue for up to 10 days after symptoms begin.

Reinfection

Reinfection is a new COVID-19 infection in a person with a recent known history of COVID-19 that is determined to be separate to the previous infection based on epidemiological and/or laboratory findings. Automated surveillance systems will not routinely count positive results within 35 days of a case's previous positive test.

Appendix 1: Preparedness

RACF must prepare for respiratory illness cases and outbreaks. The following steps are key in ensuring preparedness. A useful checklist for RACF preparedness can be found at: Coronavirus Disease 2019 (COVID-19) Outbreaks in Residential Care Facilities (health.gov.au)

Outbreak management plan	• It is each service's responsibility to have an up-to-date **COVID-19, influenza, and ARI outbreak management plan** • **Talk with visiting GPs** and involve them in the planning process. See Appendix 3: Roles and responsibilities in a respiratory virus outbreak for the responsibilities of main organisations in COVID-19 outbreak management. • Train staff in **activation** of your outbreak management plan. • Include in your plan what will happen if a positive case is confirmed out-of-hours, such as arrangements for access to antivirals and primary care cover out-of-hours and contingency plans if usual GPs are unavailable.
Communication plan and resources	• **Provide information** to residents and their families about infection control policies (including isolation protocols) and communicate restrictions and guidelines. • Prepare a **communication plan** for communicating with staff, residents, volunteers, family members, GPs and other service providers (e.g. cleaners) during an outbreak. • Ensure appropriate IPC signage is readily available see Coronavirus Disease 2019 (COVID-19) Outbreaks in Residential Care Facilities (health.gov.au) • Confirm you have the latest contact details for each resident's nominated representative • Ensure you have an **up-to-date list of your GPs** (with contact email and phone numbers) and develop an engagement process to support communication before, during and after an outbreak. • Prepare **communication resources** that you may need in an outbreak (e.g. templates of letters to staff, residents, and families; signage/posters) ahead of time. This should also consider management of media enquires • Prepare how you will facilitate communication and **social connection** between residents and their families in the event of an outbreak
Workforce planning	• Prepare **staffing contingency plans** • Plan for a **dedicated staffing model** to be implemented, in which staff (clinical and non-clinical) do not work across units or sites. • Employee cohorting within the service where possible; this should be negotiated before any escalation of response and clearly documented.

Vaccination	• Encourage all staff who are employed, or engaged, by or on behalf of the RACF are up to date with COVID-19 vaccinations, including booster doses.
	• Encourage staff, residents and visitors to be vaccinated against influenza every year.
	• Encourage all residents and visitors to be up to date with their COVID-19 vaccinations.
	• Consider maintaining records of all persons sufficiently vaccinated.
	• Comply with the Australian Government's COVID-19 vaccination reporting requirements.
	• For further information on COVID-19 and influenza vaccination in RACF, visit:
	  ◦ Information for aged care providers, workers, and residents about COVID-19 vaccines
	  ◦ Responsibilities of residential aged care providers

Care for residents	• Discuss with residents and their families their preferences for treatment including antivirals and transfers to hospital in the event of a severe respiratory illness diagnosis. Medical interventions should consider the resident's condition and their preferences for care. Ensure preferences and choices are clearly documented. • Have **advanced care directives** and **goals of care** in place for appropriate clinical

	management in the event of severe respiratory illness. • Prepare for treatment of residents by establishing processes to support timely access and appropriate administration of antiviral medication for COVID-19 and influenza, in accordance with local regulations.
Information for PHS	• Provide a **map/plan** of your facility. • Ensure **resident and staff details** are current and collated in an Excel spreadsheet, including correct names (i.e., not nicknames), date of birth, contact details and vaccination status if available. Public Health will provide the RACF with a line list (in the form of an Excel spreadsheet) to record key information about cases (Appendix 4). In the event of an outbreak, **the RACF should update the line list and send it to Public Health daily to** respiratory.outbreaks@health.tas.gov.au

Engage with your visiting GPs	• Talk with your visiting GPs about your respiratory illness outbreak management plan including management of COVID-19 and influenza. Some areas for engagement include:
	  • Maintain an up-to-date list of visiting GPs and their contact details, including out of hours arrangements
	  • Involve GPs in discussions about goals of care, including access to antivirals, and advance care directives for your residents.
	  • Involve GPs in planning and preparedness activities; ensure they are aware of your outbreak management plan and their role in an outbreak. This may include establishing arrangements for prescribing and dispensing therapies for respiratory illnesses including COVID-19 and influenza.
	  • Consider contingency plans for delivering primary care to residents if your usual GPs are unable to attend in person during an outbreak; consider the arrangements for telehealth and GP cover.

PPE	• Train staff in the correct infection control practices, particularly Standard Precautions, Transmission-Based Precautions and safe PPE donning and doffing. See Tasmanian Department of Health Infection Prevention and Control • Ensure **appropriate and sufficient PPE available for an outbreak** (to last at least 72 hours but one week's supply is recommended). • Where possible, staff should be fit tested for use of P2/N95 masks and ensure a fit check is performed each time a P2/N95 mask is worn. • Identify how PPE will be sourced, stored and disposed of during an outbreak. • Identify donning and doffing stations within the facility in the event of an outbreak. • Prepare signage demonstrating donning and doffing PPE. • For COVID-19 outbreaks only, aged care providers that require additional PPE should make a request via My Aged Care service provider portal

Cleaning and waste management	• Prepare for additional environmental **cleaning and disinfection** requirements:
	  ○ Ensure adequate cleaning and disinfection supplies
	  ○ Liaise with contractors or hire extra cleaners as required
	  ○ Increase frequency of cleaning and disinfection for high-touch surfaces.
	  ○ Use a disinfectant that contains a minimum1000ppm of sodium hypochlorite or hydrogen peroxide OR makes label claims against COVID-19
	• Prepare waste management strategies including the safe storage and removal of waste, for dealing with an increase in volume of waste particularly PPE.

Appendix 2: Summary of PCR testing process for COVID-19, influenza, RSV and other acute respiratory infections in RACF

It is recommended that all facilities in Tasmania have available the equipment required to perform the collection of swabs for PCR testing, should this be required.

Hobart, Launceston and North West Pathology are able to provide specimen collection packs for this purpose. These contain detailed collection instructions, the swabs required and specimen transport bags. They may be obtained from your nearest laboratory by phoning:

- Hobart Pathology 6223 1955
- Launceston Pathology 6334 3636
- North West Pathology 6432 8800

Swabs for respiratory virus PCR testing may be collected by an appropriately trained RACF staff member or by a GP.

If you have a resident(s) with respiratory symptoms:

- Initiate appropriate infection control precautions, including isolation of the suspect case
- Liaise with the patients treating or covering GP to discuss the requirement for PCR testing.

If testing is indicated:

- Complete a specimen request form on behalf of the requesting doctor
- Ensure:
    - patient details are correct
    - if the patient has a mobile phone, its number written on the form
    - the requesting doctors' details are provided.

- In the test required section write ***COVID-19 and RVP PCR*** (RVP = respiratory virus panel).

Don appropriate PPE and collect the sample, as per the instruction sheet.

Please note:

- The optimal specimen for respiratory virus PCR testing is a single combined throat and naso-pharyngeal swab
- If this is not able to be obtained (e.g., due to patient reluctance or intolerance of naso-pharyngeal swabbing) a throat followed by a deep nasal swab is an acceptable alternative.

All specimens collected from a RACF will be tested for COVID-19, influenza, RSV and 5 other respiratory viruses that circulate commonly in our community.

Once the specimen has been collected call your nearest laboratory (details as above) between the hours of 8am and 6pm to arrange for the specimen to be collected. At that time, notify the lab if replacement collection kits are required.

The results of respiratory virus PCR testing are generally available within 24 hours of the specimen

arriving at the laboratory.

If the patient has a mobile phone number provided on the request form, they will receive a SMS with the results of COVID-19, influenza, and RSV testing as soon as it is completed.

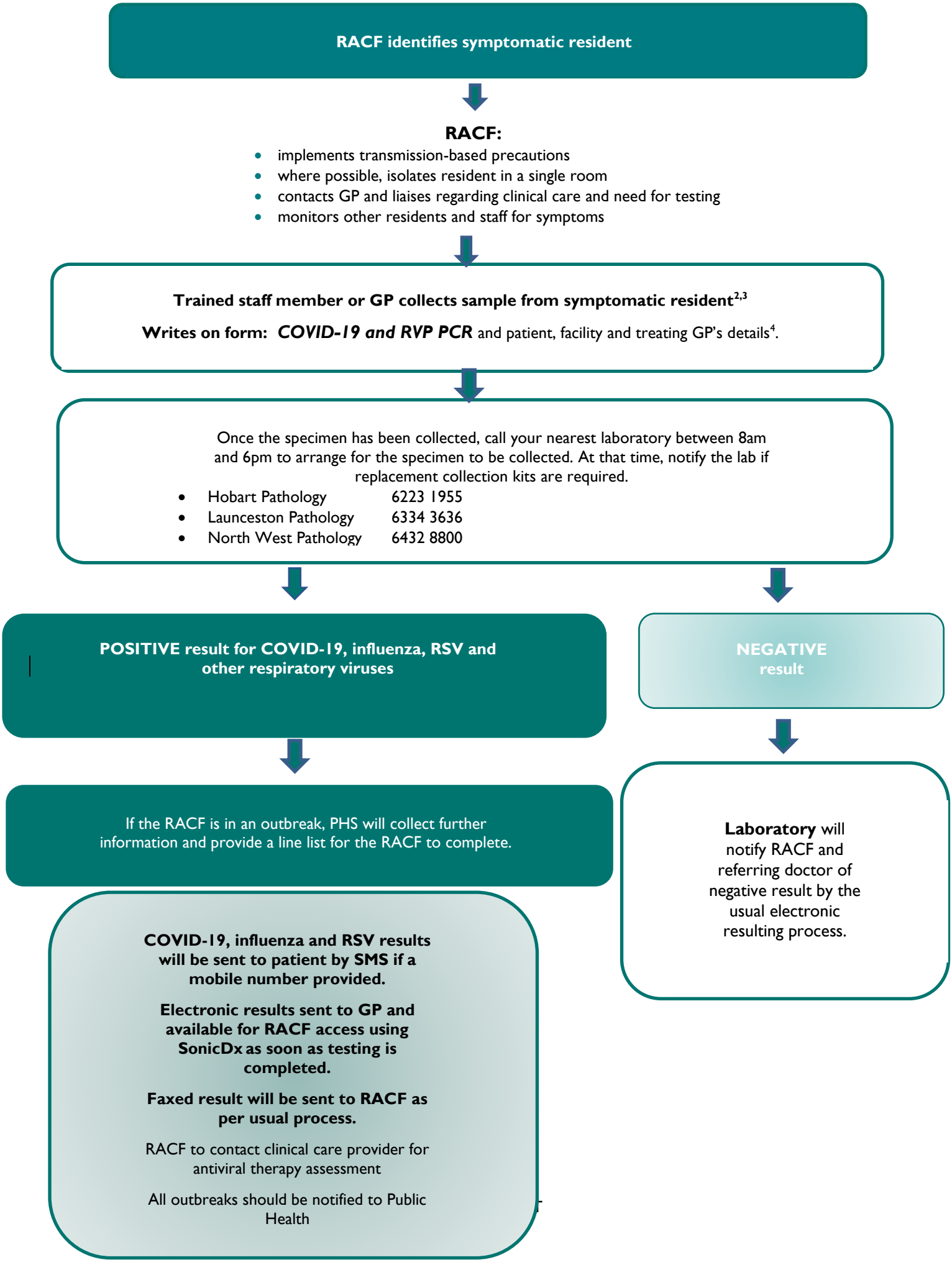
Results will also be sent electronically to the referring doctor as soon as they are available and will be able to be accessed by the RACF using the SonicDx[1] portal.

Results will also be sent to the RACF by fax as per usual practice.

While awaiting test results, please continue to follow infection control measures for symptomatic residents.

For testing in residential care facilities other than aged care, please follow site-specific protocols or call Public Health to discuss.

Figure 2: Flowchart for the management of a symptomatic resident



Notes:

1. If assistance is required in accessing SonicDx please contact clientservices@dspl.com.au

2. A RAT and PCR should be taken on initial symptomatic residents. If the RAT is positive initiate appropriate management while awaiting the PCR result.

3. It is suggested that each RACF keep on hand a small number (for example 5 – 6) of PCR Collection Packs. These contain detailed collection instructions, the required swabs and specimen transport bags and may be obtained from your nearest laboratory by phoning the numbers shown above.

4. When completing the request form please ensure the patient details are correct, the patient's mobile number is listed (if available) and the requesting doctor's details are documented.

5. If testing is part of an outbreak a resident with a positive RAT does not need a PCR test. If symptomatic and RAT negative a PCR should be collected.

Appendix 3: Roles and responsibilities in a respiratory virus outbreak

There are many stakeholders involved in management of a respiratory virus outbreak in an RACF. The following table outlines the key responsibilities of the main organisations involved.

Stakeholder	Key role and responsibilities
The facility	• Has main responsibility for managing ARI and COVID-19 outbreaks in that setting • Activates an internal outbreak response team • Implements its outbreak management plan and manages the outbreak in accordance with guidelines • Ensures infection prevention and control measures for confirmed and suspect case(s) are followed • Manages cases and outbreaks in line with Public Health requirements • Provides information on cases and contacts to Public Health as required • Where required, undertakes contact tracing in accordance with Public Health guidelines • Continues to provide high quality care to residents • Liaises with GPs and other clinical care providers • Communicates with residents, staff and families, in liaison with Public Health • Manages staffing • Monitors and supports health and wellbeing of residents.
Visiting GPs	• Provide clinical care for residents, including provision of antiviral medication where indicated • Assist with outbreak management • Liaise with secondary and tertiary care providers.
Public Health	• Provides outbreak management advice and support • Collates, analyses and disseminates information on cases and outbreaks • Advises on the management of cases and contacts • Advises on the public health aspects of the outbreak response • Monitors and reports on the outbreak • Works with the facility to coordinate on-site investigations if needed. • Has legal responsibilities under the *Public Health Act 1997* • Advises on infection prevention and control • Coordinates and supports integrated COVID-19 planning, preparedness and response across aged care services in Tasmania • Assists the organisation responsible for the facility with communications about the outbreak • Activates and coordinates the Outbreak Management Coordination Team (OMCT) in response to an outbreak in a RACF

The Australian Government Department of Health and Aged Care	• Only where a COVID-19 outbreak is identified, the Australian Government Department of Health and Aged Care:
	  • provides access to a Clinical First Responder who can assess infection prevention and control and provide ongoing oversight and training
	  • supports surge workforce supply
	  • supports PPE supply

Stakeholder	Key role and responsibilities
Aged Care Quality and Safety Commission	• Continues to act as regulator • Resolves complaints about the delivery of aged care services • Provides support as required.

The Outbreak Management Coordination Team

In the event of an outbreak of COVID-19, a multi-agency Outbreak Management Coordination Team (OMCT) will be activated, whose key role is to coordinate the various agencies involved in responding to the outbreak. The OMCT is generally coordinated by Public Health. The membership of the OMCT will vary depending on the specific outbreak but may include representation from the following organisations: Public Health, Aged Care Quality and Safety Commission, Australian Government Department of Health, and Aged Care, TIPCU, and representatives from the RACF.

Appendix 4: Example Line List

To assist management of cases and outbreaks of COVID-19, influenza, RSV or other respiratory viruses, Public Health will provide the RACF with a line list (in the form of an Excel spreadsheet) to record key information about cases. The RACF should update the line list and send it to Public Health daily by email to respiratory.outbreaks@health.tas.gov.au. Below is an example only of information that might be included in a line list provided by Public Health for completion.

Today's Date:	Organisation Name:	COVID ONLY																	
Disease	Resident/Staff	Location in Setting	First Name	Last Name	Date of Birth	Sex	Positive Test Date *(date the individual was tested)*	Report Date *(Date result reported on line list)*	Test Type	Date last worked	Symptoms Yes/No	symptoms onset (dd/mm/yyyy	Date into Isolation	Vaccination Status – Number of Doses	ntivirals Give	Case Outcome	Date of Death	Postcode	Mobile Number	Email Address
COVID-19	Staff	Garden	Easter	Bunny	01/01/2000	Female	22/04/2022	22/04/2022	RAT		Yes	01/06/2022	22/04/2022	4	No	Ongoing		7000	61447021213	bunny@bigpond.co
COVID-19	Staff	Roof	Santa	Claus	01/02/2000	Male	22/04/2022	22/04/2022	PCR	########	No	N/A	23/04/2022	1	Yes	Ongoing		7000	61447021213	s.claus@gmail.com

Appendix 5: PPE purchasing guidance

In Australia, all PPE used to provide healthcare, must meet:

- Therapeutic Goods Administration criteria for listing on the Australian Register of Therapeutic Goods (ARTG) as a Medical Device Included Class 1* (for example lowest level of potential harm)

For COVID-19 outbreaks only, aged care providers can request PPE from the Australian Government Department of Health and Aged Care, if supplies from the usual supplier are unavailable, by My Aged Care service provider portal | Australian Government Department of Health and Aged Care.

Appendix 6: TAS RACF quick guidance for COVID-19 outbreaks

	TAS RACF guidance for COVID-19 outbreaks
Notification and activate outbreak management plan	• Notify as per Notification to Public Health Services
Management of symptomatic individuals	• Staff who are symptomatic should leave the facility and undertake testing • Residents who are symptomatic should be managed with appropriate IPC precautions and undertake testing as per Key initial actions for the RACF on identification of a symptomatic resident(s)

Case management	• Staff: Should not attend work for a minimum of 7 days from their positive test date and symptoms have significantly resolved
	• Residents:
	  ○ Isolate away from other residents and implement appropriate IPC precautions for a minimum of 7 days from their positive test date and symptoms have significantly resolved. See Isolation
	  ○ Liaise with GP for clinical assessment and provision of antiviral treatment as soon as possible
	  ○ Cases can be supported to cohort together

Contact Management	• Undertake contact tracing to identify close contacts- see Glossary
	• Staff:
	  ○ Inform employer
	  ○ It is recommended that staff who are close contacts avoid the workplace where possible until 7 days from exposure to a case
	  ○ If required to come to work, check your workplace policy and consider additional risk mitigation strategies i.e., PPE and RAT prior to shift
	• Residents:
	  ○ who are sharing the same wing/area are recommended to be managed as close contacts,
	  ○ in general residents should be given the choice to continue to mix with other residents with similar exposure or to remain in their rooms.
	• If the COVID-19 case or person exposed to the case was wearing an P2/N95 respirator mask for the whole time, the exposed person is not considered a contact.

What is an affected wing/area	• A specific wing or defined area of a facility with one or more cases

Initial testing in an outbreak	Initial testing:
	• Initial sweep of the affected area(s) via RAT once outbreak identified/declared.
	  ○ For smaller RACF, testing of the whole facility *may* be recommended by Public Health on a facility-by-facility basis
	
	Testing within the 5-week window
	• All people who develop new acute respiratory symptoms within 35 days since their previous positive test should be tested for other respiratory viruses such as influenza and respiratory syncytial virus (RSV) along with a repeat COVID-19 test.
	
	Testing after the 5-week window
	• If more than 35 days have passed since their previous positive test, recovered cases should be:
	  ○ tested for SARS-CoV-2, and other respiratory pathogens, if they develop new respiratory symptoms and meet criteria for testing,
	  ○ managed as a case if they test positive for SARS-CoV-2,
	  ○ managed as a close contact if they meet the close contact definition.
	
	Testing refusal
	• If a resident in the affected wing/area refuses testing, consider additional precautions.
	• Other asymptomatic residents not residing in affected wings/areas who refuse testing would not generally have any restrictions.
	• Discuss specific concerns with Public Health.

Ongoing testing regimen - Staff	• Every two to three days RAT pre-shift until outbreak stood down (if staff not rostered during this period, one RAT pre returning to work).
Ongoing testing regimen - Residents	• After initial test of affected area(s), residents in proximate areas (to case/cases) require repeat testing every 3 days. • Once a full round of testing has been completed with all negative results, can continue to test every 3-5 days until outbreak stood down.
PPE	Guidance on the use of personal protective equipment (PPE)
Managing visitors in an outbreak	• Workplaces should have a policy in place to manage visitors during an outbreak. • See Key general actions for the RACF in an outbreak

Standing down an outbreak	An outbreak may be stood down, along with outbreak IPC precautions, once: • 7 days have passed with no new resident cases identified (where day zero is the date the case/s enter isolation or was last on-site). • The advised testing regime of residents in affected areas has been completed. • New staff cases where appropriate PPE has been worn and where there were no breaches, should not delay the standing down of an outbreak where the above criteria are otherwise met.