



OUTBREAK MANAGEMENT IN RESIDENTIAL AGED CARE

4 June 2020

An outbreak of COVID-19 in a residential care facility is likely to be worse than an outbreak of influenza. There have been outbreaks of COVID-19 in aged care facilities in Australia.¹

Facilities must:

- have a plan in place ahead of an outbreak, and
- know of advanced care plans for individual residents.

Read this fact sheet in conjunction with [Coronavirus Disease 2019 \(COVID-19\) Guidelines for Outbreaks in Residential Care Facilities](#).

Information regarding the COVID-19 pandemic is continually evolving. Please visit the following websites often to review updated information:

- [Australian Government Department of Health website](#)
- your [local state or territory health department](#).

¹ The number of confirmed cases in Australian residential care recipients is updated daily on the [Department of Health website](#)

Symptoms of COVID-19

The most common signs and symptoms include:

- fever (note: fever may be absent in the elderly)
- dry cough

Other symptoms can include:

- shortness of breath
- coughing up thick mucus or phlegm
- fatigue
- loss of smell and/or loss of taste
- sore throat
- diarrhoea
- nausea or vomiting

Less common symptoms include:

- headache
- myalgia/arthritis (generalised muscle or joint pain)
- chills
- nasal congestion
- haemoptysis (coughing up blood)
- conjunctival congestion (red, swollen and watery eyes)

Older people may also have the following symptoms:

- increased confusion
- worsening chronic conditions of the lungs
- loss of appetite

When is it an outbreak?

The definition of an outbreak is:

A single confirmed case of COVID-19 in a resident, staff member or frequent attendee of a residential care facility.

This definition:

- does not include a single case in an infrequent visitor to the facility.
- is used as a guideline,
- is used by the state/territory public health unit to help decide whether to declare an outbreak.

If you think an outbreak has started

- **Notify the local state/territory public health unit.** Use the form in the Appendix in the [Coronavirus Disease 2019 \(COVID-19\) Guidelines for Outbreaks in Residential Care Facilities](#).
- **Establish an Outbreak Management Team.** This team will need to meet daily to monitor the outbreak and initiate changes. They should liaise with GPs and the local public health unit, as required. The team should not be part of day-to-day facility management. A small number of staff might need to perform multiple roles in the team.

Team members need to include:

- Chairperson
- Secretary
- Outbreak coordinator
- Media spokesperson
- Outside specialists if available: public health officer and general practitioner

Outbreak Management Team STEPS

1. Clarify roles and responsibilities of the team

Information on clarifying roles and responsibilities is available in the [COVID-19 Guidelines for Outbreaks in Residential Care Facilities](#).

2. Document the cases

Make a table similar to the example below and update it daily.

Patient name/ initials	Date the resident became unwell	Room location	Is the resident in a single room?	New location if moved
SD	13/3/2020	Lvl 2 Room 17	Yes	
LR	15/3/2020	Lvl 2 Room 18	No	Lvl 3 shared with other COVID case

3. Notify all staff, residents and visitors (if relevant), that a case of COVID-19 has occurred in the facility

Inform relevant people that there is:

- only one case (if applicable), and
- testing of members of the setting as a precaution.

Notify the [Australian Government Department of Health](#) and [Aged Care Safety and Quality Commission](#) early in the outbreak.

4. Ensure affected residents are not spreading the virus to others

Place the unwell resident/s in a single room with its own ensuite, if feasible. Where possible, restrict the resident to their room.

If single rooms are not available, the public health unit will help identify suitable sites. This enables housing together (cohorting) of individuals who are unwell or who are in quarantine. The following principles apply:

- Residents with the same virus, assessed by the facility as suitable roommates, can be cohorted in the same room.
- Ill residents sharing a room should be physically separated (more than 1.5 metre apart). Draw a privacy curtain between them to minimise the risk of droplet transmission.
- Staff in direct contact with ill residents should observe contact and droplet precautions (see below).
- Staff should not move between the cohorts of those with the disease (in isolation) and those in quarantine. They should only work within one of the cohorts.

Testing during the outbreak

The public health unit will assist the outbreak management team to coordinate testing in the facility:

- Test members of the facility including staff
- Isolate positive cases as outlined above
- Quarantine members of the community who test negative
- Individuals who test negative should be screened for symptoms and, where feasible, undergo a program of repeat tests (e.g. 72 hourly)
 - Repeat testing will identify those who are pre-symptomatic to enable rapid removal from the environment
- Staff should also be regularly screened for symptoms.

Ensure appropriate infection prevention and control measures are used

Keep up to date with the latest recommendations. These are outlined in the [COVID-19 guidelines for infection prevention and control in residential care facilities](#).

Standard precautions are infection prevention and control practices used routinely in health care. In a facility with a suspected or proven COVID-19 outbreak, **they must apply to all staff and all residents.**

Key elements are:

- Hand hygiene using soap and water or alcohol-based hand sanitiser. This must be done after going to the toilet, coughing, blowing nose, after touching hard surfaces, before eating and in line with the '5 moments'². Additional hand hygiene is required when caring for a resident with a respiratory infection.
 - Gloves are not a substitute for hand hygiene. When gloves are worn perform hand hygiene before putting them on and after taking them off.
- Use of personal protective equipment (PPE), especially when caring for a resident with a respiratory infection. PPE includes gloves, gown, mask and eye protection.
- Cough etiquette and respiratory hygiene.
 - Cough into a tissue (and discard tissue immediately) or into the bend of the elbow; perform hand hygiene.
- Environmental cleaning (at least daily) of floors and surfaces; more frequent cleaning of frequently touched or soiled surfaces.

Transmission-based precautions

These are infection prevention and control practices used **in addition to standard precautions**. Their use is to **reduce transmission** due to the specific route of transmission of a pathogen.

Respiratory infections, including COVID-19, are most commonly spread by contact and droplets. Airborne spread may occur during aerosol generating procedures.

- **Contact and droplet precautions** apply to:
 - care of all residents with suspected or confirmed COVID-19
 - all staff when in contact with ill residents
 - health care providers during clinical consultation or collection of diagnostic specimens.

Key elements are:

- standard precautions (as above)
- use of PPE, including gown, gloves, surgical mask, and eye protection when in contact with an ill resident
- isolation of ill residents in a single room, if unavailable see above

² <https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/national-hand-hygiene-initiative-nhhi/what-hand-hygiene/5-moments-hand-hygiene>

- enhanced environmental cleaning and disinfection of the ill resident's environment³
- limit number of staff, health care workers, and visitors in contact with the ill resident
- nebulisers have been associated with a risk of transmission of respiratory viruses and their use should be avoided. A spacer or puffer should be used instead.

Note: All facility staff should be **trained in the correct use of PPE**, appropriate to their role. Incorrect removal of PPE is associated with a risk of personal contamination and spread of infection.

- **Airborne precautions are recommended**, only when performing aerosol generating procedures. They must be used in addition to all precautions outlined above. Their use is unlikely to be needed in a residential care facility.⁴

Note: P2/N95 respirators should:

- only be used for aerosol generating procedures
- only be used by staff who have been trained in their use
- be fit checked with each use to ensure an adequate face seal is achieved.

5. Staff

Once cases are isolated, to further reduce the risk of transmission:

- specific staff should be allocated to the care of residents with COVID-19 who are in isolation
- staff members must not move between their allocated room/section and other areas of the facility or provide care for other residents.

Considerations in choosing dedicated staff: Ensure staff have recently completed infection control training. Do not assign staff who are at risk of having more severe disease if they are infected.

Information on people who are more at risk can be found in the [What you need to know](#) page.

³ Refer to: Environmental Cleaning and Disinfection Principles for COVID-19 <https://www.health.gov.au/resources/publications/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities>

⁴ Refer to: Interim recommendations for the use of personal protective equipment (PPE) during hospital care of people with coronavirus disease 2019 (COVID-19). <https://www.health.gov.au/resources/publications/interim-recommendations-for-the-use-of-personal-protective-equipment-ppe-during-hospital-care-of-people-with-coronavirus-disease-2019-covid-19>

Staff should be regularly screened for symptoms and tested during an outbreak. All staff should self-monitor for signs and symptoms of COVID-19. Staff must stay home from work if unwell, even if appropriate PPE is used. A register should be maintained for all staff and visitors to check for symptoms, including fever. This should be recorded at the beginning of every shift, in addition to maintaining regular visitor register protocols.

6. Raise awareness

Place signage to identify the need for droplet precautions in addition to standard precautions for infection control. Signage is available on the [Australian Commission on Safety and Quality in Health Care website](#).

Ensure relevant internal and external people are identified and informed.

Inform other relevant people such as families during an outbreak. This is important to:

- allow for extended testing,
- manage visiting expectations and
- give reassurance about the actions being taken.

Other agencies involved in the oversight of the facility should also be identified and contacted.

7. Prevent COVID-19 from spreading to outside the facility

Suspend group activities, particularly those that involve visitors (e.g. musicians, exercise leaders).

Postpone visits from non-essential external providers (e.g. hairdressers, podiatrists).

Inform regular visitors including families of the outbreak of COVID-19 and request only essential visits. Children under 16 should not attend unless there are extenuating circumstances.

Visitors that do attend on a humanitarian basis should:

- record their name and phone number on a register of visitors,
- visit only the ill resident,
- comply with PPE as directed by staff,
- only enter the patient's room, not communal areas, and
- perform hand hygiene after leaving the resident's room and the facility.

Facility staff, including casual and agency staff, should not attend work at another facility until the outbreak is declared as over.

8. Enhanced environmental cleaning

During an outbreak, enhanced cleaning of communal areas and residents' rooms is required.

Frequently touched surfaces should be cleaned often. All resident care equipment should be cleaned and disinfected between each use or used exclusively for individual residents.⁵

- Cleaning staff should wear impermeable disposable gloves, a surgical mask and eye protection or a face shield while cleaning.
- Use a Therapeutic Goods Administration (TGA) listed disinfectant <https://www.tga.gov.au/disinfectants-use-against-covid-19-artg-legal-supply-australia>, floors should be cleaned with a detergent solution.
- Perform routine cleaning and take care to disinfect frequently touched surfaces. Use a disinfectant solution/wipe at least daily or when visibly dirty.
- Equipment and surfaces to be cleaned should include:
 - bed rails,
 - bedside tables,
 - light switches,
 - remote controllers,
 - commodes,
 - door handles,
 - sinks,
 - walking frames,
 - walking sticks,
 - handrails,
 - food trays,
 - and table tops.
- Clean and disinfect equipment after each use (as per normal IPC practice).
- Clean and disinfect surfaces that have been in direct contact with or exposed to respiratory droplets between each patient episode.
- For terminal cleaning, use either a:
 - 2-step clean (detergent first then disinfectant) OR
 - 2-in-1 step clean (using a combined detergent/disinfectant).

⁵ Refer to: Environmental Cleaning and Disinfection Principles for COVID-19
<https://www.health.gov.au/resources/publications/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities>

9. Monitoring the progress of the outbreak

Increase active observation for disease in all residents, staff and other members of the facility. This includes monitoring for signs and symptoms of COVID-19. Where feasible, perform a program of repeat tests for those in quarantine. Update the table of cases every day.

Declaring the outbreak over

Repeat testing allows the outbreak to be closely observed. It also will make it clear when the outbreak can be declared over. In most circumstances, an outbreak can be declared as over 14 days post isolation of the last case.

The decision to declare the outbreak over should be made by the Outbreak Management Team. This should be done in consultation with the public health unit.