



**Interim Infection Prevention and Control Guidance including Outbreak Control in Residential
Care Facilities (RCF) and Similar Units for pandemic COVID-19**

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Version	Date	Changes from previous version
1.1	30/03/2020	<p>Added information re contact management</p> <p>Edited definition for outbreak of COVID-19 in RCF</p> <p>OCT must be Chaired by Public Health Doctor</p> <p>Hyperlink to case definition added where appropriate</p> <p>Changed term 'self-quarantine' to 'self-isolation' and hyperlinks included where appropriate</p> <p>Edited flow of document and formatting</p>
2	07/04/20	<p>Added acknowledgements</p> <p>Hyperlinks included where appropriate</p> <p>Roles and Responsibilities updated</p> <p>Added Survival in the Environment</p> <p>Added Laboratory testing</p> <p>Added and updated Transfers of Residents between Care Facilities</p> <p>Updated Section on General Preparedness</p> <p>Pastoral Care included</p> <p>Infection Prevention and Control Measures Section updated</p> <p>Environmental Hygiene updated</p> <p>Added Care of the Dying</p> <p>Added Care of the Recently Deceased</p> <p>Preventing and Control Of Outbreaks updated</p> <p>Proposal for Occupational Health Supports added as appendix</p>

Acknowledgements:	6
1 Introduction	7
2 Roles and Responsibilities	7
2.1 Residential Care Facility	7
2.2 Regional Department of Public Health	8
3 COVID-19 Background Information	8
3.1 Transmission	8
3.2 Incubation Period	9
3.3 Survival in the environment	9
3.4 Clinical features of COVID -19	9
3.5 Laboratory Testing	10
4 General Preparedness during pandemic COVID-19	11
4.1 Increase Surveillance for COVID-19 infection	12
4.2 Staff	13
4.3 Residents	14
4.4 Family & Friends	15
4.5 Pastoral Care	15
4.6 Others	16
4.7 Group Activities	16
5 Transfer of residents between care facilities	16
5.1 Transfer to an Acute Hospital	16
5.2 Admissions	17
5.3 Transfer of a resident from an acute hospital to a residential care facility	17
6 Infection Prevention & Control Measures	19
6.1 Standard Precautions	19
6.2 Hand hygiene	19
6.3 Respiratory hygiene and cough etiquette	20
6.4 Personal Protective Equipment (PPE)	20
6.5 Transmission-based precautions for COVID-19	21

6.6	Resident Placement	22
6.7	Cohorting residents with suspected or confirmed COVID-19	23
6.8	Care Equipment	24
6.9	Management of blood and body fluid spillages	25
6.10	Management of waste	25
6.11	Safe management of linen (Laundry).....	26
7	Environmental Hygiene.....	27
7.1	General Environment	27
7.2	Routine cleaning	27
7.3	Frequency of cleaning	28
7.4	Terminal Cleaning	28
7.5	Staff Uniforms/Clothing	28
8	Care of the Dying	29
9	Care of the recently deceased.....	29
9.1	Hygienic preparation.....	29
9.2	Transport to the Mortuary	30
10	Preventing and Controlling Outbreaks.....	31
10.1	Early identification of cases of COVID-19	31
10.2	Initial investigation following identification of a possible COVID-19 case	31
10.3	Outbreak Management.....	33
10.4	Outbreak Control Team.....	33
10.5	Implement Control Measures.....	35
10.6	Communication.....	35
10.7	Support services for staff and residents.....	35
10.8	Monitoring Outbreak Progress	35
10.9	Declaring the outbreak over	36
11	Appendix 1 Hand hygiene posters	37
12	Appendix 2 Personal Protective Equipment.....	39
12.1.1	Types of PPE	44
12.1.2	Decontamination of eye/face protection for example goggles where there is a shortage of equipment.....	45
12.1.3	Wearing PPE on a Cohort Ward/Unit	46

13	Appendix 3 Donning and Doffing PPE	47
14	Appendix 4 – Transmission based precautions	48
15	Appendix 5 Proposal for Occupational Health Supports.....	49

This guidance document replaces the previous issued document “Residential Care Facilities Preliminary Coronavirus Disease (COVID-19) Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities (RCF) and Similar Units” Publication.

Acknowledgements:

The following guidance documents were referred to in developing this guidance:

- Coronavirus Disease 2019 (COVID-19) Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities developed by the Communicable Diseases Network Australia (CDNA)
- COVID-19: Information and Guidance for Social or Community Care & Residential Settings Health Protection Scotland
- Public Health Guidelines on the Prevention and Management of Influenza Outbreaks in Residential Care Facilities in Ireland 2019/2020
- World Health Organization. Infection Prevention and Control Guidance for long-term care facilities in the context of COVID-19: interim guidance, 21 March 2020 World Health Organisation; 2020
- HIQA-Rapid Review of public Health guidance on infection prevention and control measures for residential care facilities in the context of COVID-19 30/30/20

Note:

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

1 Introduction

People living in Long Term Residential Care (RCF) settings (nursing homes, disability and mental health) are vulnerable populations and have been identified by the World Health Organisation as being at a higher risk of adverse outcomes from COVID-19 and at higher risk of infection due to living in close proximity to others. Factors contributing to high risk of adverse outcomes may include age, the high prevalence of underlying medical conditions. Factors contributing to higher risk of infection may include high care support with the activities of daily living in collective high physical contact environments. The response to COVID-19 in RCF should be based on preparedness, early recognition, isolation, care and prevention of onward spread.

This document provides guidance and information on infection prevention and control measures to inform and advise local planning and management in community residential facilities.

The guidance has been updated from the previous version to reflect the declaration of a pandemic and the increasing number of COVID-19 cases that are now being reported due to local transmission events.

Please note that this document is issued as preliminary guidance however elements of this guidance will be considered further by the Expert Advisory Group and further updates may follow within days. It is therefore essential that you confirm that you are using the latest version of guidance.

2 Roles and Responsibilities

2.1 Residential Care Facility

The primary responsibility of managing the risk of infection with COVID-19 and for control of outbreaks lies with the RCF, within their responsibilities for resident care and infection control. This responsibility is referred to in the 2016 National Standards for Residential Care Settings for

Older People in Ireland. All RCF should have in-house (or access to) infection control expertise, and outbreak management plans in place. The Infection Prevention and Control (IPC) service should provide ongoing training to staff with a particular emphasis on Hand Hygiene and Respiratory Hygiene and Cough Etiquette and environmental cleaning.

Any medical practitioner who is aware of a case of COVID-19 or an outbreak is obliged to notify outbreaks Medical Officer of Health (MOH) at the regional Department of Public Health.

Registered providers must notify the Chief Inspector (HIQA) of an outbreak of a notifiable disease within 3 working days. (Statutory Notifications Guidance for registered providers and persons in charge of designated centres. January 2016)

2.2 Regional Department of Public Health

Regional Department of Public Health is responsible for investigating cases and outbreaks of COVID-19.

3 COVID-19 Background Information

The virus which causes COVID-19 infection is called SARS-CoV-2 and belongs to the broad family of viruses known as coronaviruses. It was first identified in the Wuhan province in China in December 2019 and a global pandemic event was declared in March 2020.

3.1 Transmission

Like other respiratory viruses, the transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. The virus is not generally transmitted by the airborne route; however, certain procedures that may be performed known as Aerosol Generating Procedures (AGP) can create the potential for airborne transmission. Further information on AGP's in COVID-19 is available here

<https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/>

Individuals are considered most infectious while they have symptoms. How infectious individuals are depends on the severity of their symptoms and stage of their illness. Higher levels of virus have been detected in residents with severe illness compared to mild cases.

The extent of transmission from pre-symptomatic or asymptomatic people remains uncertain, although it is likely to occur in some cases. Peak levels of virus are found around the time of symptom onset. In general virus remains detectable in respiratory secretions for up to eight days in moderate cases and longer in severe cases.

The virus has also been detected in faeces, urine, blood and saliva samples from infected individuals although it is not clear that these are a significant transmission risk.

3.2 Incubation Period

Current estimates suggest that the time between exposure to the virus and developing symptoms (incubation period) is from five to six days but can range from 1 to 14 days.

3.3 Survival in the environment

The SARS-CoV-2 virus has an outer coating called a lipid envelope. The presence of the lipid envelope means that virus is likely to survive for shorter periods outside the human body compared to a non-enveloped virus like Norovirus (Winter-vomiting Virus). The virus is easily killed by common household cleaning products including bleach and disinfectants. Survival on environmental surfaces depends on the type of surface and the environmental conditions. One study using a SARS-CoV-2 strain showed that it can survive on plastic for up to 72 hours, for 48 hours on stainless steel and up to eight hours on copper when no cleaning is performed. However, the levels of virus declined very quickly over the time period.

3.4 Clinical features of COVID -19

Most people with COVID-19 will have mild disease and will recover. A minority will develop more serious illness. People at higher risk of developing more serious illness include:

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

- Those with underlying medical conditions

The most common signs and symptoms include:

- fever (though this may be absent in the elderly)
- dry cough

Other symptoms can include:

- shortness of breath
- sputum production
- fatigue

Less common symptoms include:

- sore throat
- headache
- myalgia/arthralgia
- chills
- nausea or vomiting
- nasal congestion
- diarrhoea
- haemoptysis
- conjunctival congestion

Older people may also have the following symptoms:

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

Elderly persons often have non-classic respiratory symptoms and clinical judgement should be used when assessing residents.

3.5 Laboratory Testing

- Laboratory testing is helpful to confirm a diagnosis of COVID-19 infection. The resident's doctor will advise if testing is appropriate and will arrange testing if necessary.

- Testing for COVID-19 is performed in the same way as testing for Influenza. A viral swab is collected from the throat and nasopharynx. Only one swab is used to collect both samples, with the throat site sampled first.
- Laboratory confirmation should be sought for initial cases in particular those who have a link to each other either directly or through shared staff. Once there are laboratory confirmed cases in two to three cases (including staff and residents) it may be appropriate to make further diagnoses based on clinical features particularly if there are significant delays in accessing testing.
- When testing is performed, ensure the correct swab type is taken (viral swab) and it is appropriately labelled. There must be two patient identifiers on both the swab and request form such as Name and DOB. These must match each other. Ensure that a contact name and telephone number (mobile preferably) for the person to receive the results is clearly visible on the request form. Deliver the sample to the testing laboratory as soon as possible. Sample from suspected outbreaks in RCF are currently being prioritised for testing.
- Current laboratory tests are accurate but no diagnostic test is perfect. If a test result comes back as “not detected” and the resident remains unwell with no alternative diagnosis then a diagnosis of COVID-19 is still possible.

4 General Preparedness during pandemic COVID-19

- Identify a lead for COVID-19 preparedness and response in the RCF. The lead should be a person with sufficient authority to ensure that appropriate action is taken and may require support of a team including a liaison person on each unit in the RCF.
- RCF settings must have COVID-19 preparedness plans in place to include planning for cohorting of residents (COVID-19 separate from non-COVID-19), enhanced IPC, staff training, establishing surge capacity, promoting resident and family communication.
- Each facility should undertake a review of their daily activities, workflow and staffing allocation. Discontinue congregate activities such as watching TV in groups.

- Where possible, each ward or floor should try and operate as a discrete unit meaning that staff and equipment are dedicated to a specific area and are not rotated from other areas (this includes night duty). This may not always be feasible in smaller facilities but in larger facilities this practice may reduce exposure to risk for staff and residents in the event COVID-19 is introduced into the facility.
- Measures to implement physical distancing should be taken:
 - Residents should be encouraged to stay in their bedroom as much as practical but with regard for the overall wellbeing of the resident.
 - Residents should be encouraged to maintain a distance of 1 to 2 m from other resident and staff. Residents should also be advised to avoid touching other people (touching hands, hugging or kissing). Exceptions are appropriate for couples who reside in the same RCF.
 - In order to ensure distancing measures meals may need to be staggered or served in the resident's room.
 - For all essential group activities ensure physical distancing is maintained. Consider stopping group activities (in view of severity pandemic in older people and scarcity of staff)
- The facility should ensure that there is active monitoring of residents, twice daily, for signs and symptoms of respiratory illness or changes in their baseline condition e.g. increased confusion, falls, and loss of appetite or sudden deterioration in chronic respiratory disease.
- Facilities should ensure the availability of supplies including tissues, alcohol based hand rub (ABHR), hand wipes, cleaning products (including disinfectants) and personal protective equipment and liaise with local CHO management if there is difficulty in obtaining such supplies.

4.1 Increase Surveillance for COVID-19 infection

- Surveillance (monitoring for illness) is an essential component of any effective infection control programme.

- RCFs should ensure that they have processes in place to promptly initiate measures to establish the diagnosis and control the spread of COVID-19 within facilities like staff education and active monitoring of residents.
- All staff should be aware of the early signs and symptoms of COVID-19 and who to alert if they have a concern. Staff should be able to contact an appropriate escalation pathway 24/7.

Please see the HPSC website for the most up to date [case definition for COVID-19](#).

4.2 Staff

- Minimise staff movement working across RCF settings.
- All Staff must be aware of the signs and symptoms of COVID-19 infection both for themselves and residents so that they can identify who may be symptomatic.
- All staff should have training in standard precautions, in particular hand hygiene, respiratory hygiene & cough etiquette and in transmission based precautions (Contact, Droplet & Airborne) including the appropriate use of PPE.
- RCFs should ensure that one or more staff members are trained to collect a sample for testing for COVID-19.
- Staff should be informed that they must not attend work if they have fever or cough or shortness of breath or any kind of respiratory symptoms. They should be aware of their local policy for reporting illness to their manager. Also if one of their household contacts has respiratory symptoms they should contact their manager for advice before attending work.
- The National Public Health Emergency Team requires that all staff have their temperature measured at the start of each shift.
- In addition at the start of each shift, all staff should confirm verbally with their line manager that they do not have any symptoms of respiratory illness, such as fever, cough, shortness-of-breath or myalgia. In the event new symptoms develop during a shift, to report immediately to the person-in-charge.
- Staff who become unwell at work should be sent home and advised to contact their GP by telephone. If they cannot go home immediately they should be isolated in a separate

room until they can go home by the most appropriate method that is practicable to reduce exposure to COVID to other staff and family members. (See section on outbreak management).

- Occupational health guidance for healthcare workers is available on www.hpsc.ie here <https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/occupationalhealthguidance/>
 - Staff members with clinical features consistent with COVID-19 may return to work 14 days after symptom onset (or date of diagnosis if no symptoms) provided they have had no fever during the last 5 days.
 - Staffs that is identified as close contacts of a case either in the community or the occupational setting should not attend work for 14 days from the last exposure to the case and restrict their movements as much as possible.
 - Derogations for healthcare workers who are COVID-19 contacts to return to work should be applied with appropriate caution in RCF given the high risk of adverse outcomes in these groups. This must be balanced with the need to maintain adequate care for residents.

4.3 Residents

- Residents should be kept informed of the measures being taken and the reason for these measures during this time. This is particularly important where visiting has been restricted or discontinued.
- Residents should be encouraged to wash their hands and actively assisted with this practice where necessary.
- Key messages around cough etiquette (where appropriate) include:
 - Cover your mouth and nose with a disposable tissue when coughing and sneezing to contain respiratory secretions
 - Discard used tissues after use and clean your hands
 - If you don't have a tissue, cough into your forearm or the crook of your elbow
 - Clean your hands

- In line with public health guidance, the importance of maintaining a physical distance of 2m where possible should be observed
- Where possible and appropriate, residents should be made aware of the need to report any new symptoms of illness to staff members.

4.4 Family & Friends

- Family & friends should be advised that all but essential visiting (for example end of life) is suspended in the interest of protecting residents at this time.
- While the restrictions on visiting above are very important in preventing accidental introduction of COVID-19 into an RCF, there may be emergency circumstances in which it may still be appropriate for family or other relevant persons who are able to do so to provide some support to the care of a resident in an RCF for example end of life.
 - Family & friends should be aware of the limited circumstances in which visiting is permitted.
 - They should be informed that such essential visits are permitted only when arranged in advance with the facility.
 - They should be made aware that any visitors with fever or respiratory symptoms **will not be admitted.**
- These messages around restricted visiting should be reinforced by placing signage at all entry points to the facility and by any other practical means of communication with their families and friends.
- The restriction of visiting can be extremely distressing for the resident and their family and friends and every effort should be made to encourage regular communication by telephone, mail or video messaging where possible.

4.5 Pastoral Care

- Religious/cultural support and rites may be very important to some residents of RCF, in particular towards end of life.
- Chaplaincy visits/cultural support are recognised as an important part of a resident's well-being. Visitors providing chaplaincy support should be reminded of the need to

minimise physical contact and to follow advice particularly around Hand hygiene and Respiratory Hygiene and cough etiquette.

- If it is appropriate to the religious and cultural needs of the person and pastoral care can be provided remotely e.g. by phone, video link this is preferable.

4.6 Others

- The visiting of essential contractors e.g. maintenance workers should be kept to a minimum.
- Only essential healthcare/cleaning/cooking professionals should be permitted to enter the facility.
- Non-essential services including volunteers should be suspended.

4.7 Group Activities

- Group activities that are necessary to residents' welfare should be risk assessed for necessity and only conducted with small groups of residents where possible. Consider discontinuing completely for short period of few weeks.
 - In this context consider establishing small groups who consistently attend group activities with each other rather than have new ad-hoc groupings formed for each day/each activity.
- Group activities essential to residents' welfare should maintain social distance as much as possible (for example small groups on a rota basis with avoidance of direct contact or close contact).

5 Transfer of residents between care facilities

5.1 Transfer to an Acute Hospital

Outward transfer for attendance or care off site should be limited to situations in which it is necessary to provide essential care to residents.

5.2 Admissions

Although accepting admission or transfer of resident's poses a risk of introducing COVID-19 to a RCF, this may be a **necessary risk** in the context of maintaining access to a critical service

- **Before transfer/admission** check if the person has a fever, cough or shortness of breath or any other symptoms of acute respiratory tract infection. If the person is symptomatic a medical assessment is required prior to transfer.
- All transfers/admissions with fever or symptoms of acute respiratory tract infection should be accommodated in their own room with en-suite toilet facilities and treated as a COVID case.
- People with confirmed COVID-19 should not be transferred to a residential care facility until 14 days after onset of symptoms with the last 5 days free of fever. In addition they should have two nasopharyngeal samples taken at least 24 hours apart reported as not detected.

5.3 Transfer of a resident from an acute hospital to a residential care facility

- The resident may be an existing resident returning to their usual residential care facility or a new resident being accepted by the facility.
- Wherever possible, every resident transferred from an acute hospital to a residential care facility should be accommodated in a single room with droplet precautions for 14 days after transfer and monitored for new symptoms consistent with COVID-19 during that time.
- The rationale for this recommendation is that in the context of a pandemic, there may have been contact between the resident and other residents or healthcare workers etc. who may have had COVID-19 infection but who may have been in the pre-symptomatic incubation period or have had minimal symptoms prior to COVID--19 being diagnosed, with the associated risk of unrecognised onward transmission to the resident.
- If accommodation in a single room for every newly-transferred resident is not possible, the following measures might also be considered:

- Placing the new resident in a room with a resident who has recovered from laboratory confirmed COVID-19 infection and has completed their isolation period.
 - The new resident should remain on droplet precautions.
 - If there is another resident who is not known to have had COVID infection also being transferred from the acute hospital setting they can both be cohorted together for 14 days, with droplet precautions for both during this time.
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- If the above options are not feasible, prioritisation for single room accommodation for a resident transferred from an acute hospital to a residential care facility during the COVID-19 pandemic should be undertaken as follows:
 - 1) Resident with laboratory-confirmed COVID-19 infection who has not yet met criteria for discontinuation of droplet precautions.
 - 2) Resident with new symptoms consistent with COVID-19 infection for whom a laboratory test is not yet available.
 - 3) Asymptomatic resident who has been identified as a contact of a person with laboratory-confirmed COVID-19 infection while an inpatient in the acute hospital. The isolation and droplet precautions will apply for 14 days after their last day of documented contact
 - 4) Asymptomatic resident who has not been identified as a contact of a person with laboratory-confirmed COVID-19 infection while an inpatient in an acute hospital. The precautions will apply for 14 days after the date of transfer back to the facility.

6 Infection Prevention & Control Measures

6.1 Standard Precautions

Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered. For further information on standard precautions and the chain of infection refer to HSEland online learning or www.hpsc.ie. With regard to COVID-19 key elements include:

6.2 Hand hygiene

- Hand hygiene is the single most important action to reduce the spread of infection in health and other social care settings and is a critical element of standard precautions.
- Facilities must provide ready access for staff, residents and visitors to hand hygiene facilities and alcohol-based hand rub.
- Staff should adhere to the WHO five moments for Hand hygiene
 - Hand hygiene must be performed immediately before every episode of direct resident care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of PPE, equipment decontamination, handling of waste and laundry.
- Residents should be encouraged to wash their hands after toileting, after blowing their nose, before and after eating and when leaving their room. If the resident's cognitive state is impaired, staff must help with this activity.
- **The use of gloves is not a substitute for hand hygiene. Hand hygiene is required before putting on gloves and immediately after they have been removed.**
- HSEland hand hygiene training is available online and staff should be encouraged to do refresher training at www.hseland.ie

Refer to hand Hygiene Information Posters [Appendix 1](#).

6.3 Respiratory hygiene and cough etiquette

- Respiratory hygiene and cough etiquette refers to measures taken to reduce the spread of viruses via respiratory droplets produced when a person coughs or sneezes (See appendix 2).
- Disposable single use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose.
- Used tissue should be disposed of promptly in the nearest foot operated waste bin.
- Some residents may need assistance with containment of respiratory secretion. Those who are immobile will need a waste bag at hand for immediate disposal of the tissue such as a bag Hands should be cleaned with either soap and water or an ABHR after coughing sneezing, using tissues or after contact with respiratory secretions and contaminated objects.
- Staff and residents should be advised to keep hands away from their eyes, mouth and nose.

Further information on cough etiquette is included in [Appendix 2](#).

6.4 Personal Protective Equipment (PPE)

- As part of standard precautions, it is the responsibility of every HCW to undertake a risk assessment PRIOR to performing a clinical care task, as this will inform the level of IPC precautions needed, including the choice of appropriate PPE for those who need to be present.
- Full guidelines on the appropriate selection and use of PPE Appendix 3 and <https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/>
- Educational videos are also available on www.hpsc.ie at <https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/videoresourcesforipc/>

- All staff must be trained in the proper use of all PPE that they may be required to wear.
- Note that in outbreak situations or other circumstances where extended use of one set of PPE (other than gloves) moving between patients with a diagnosis of COVID-19 is implemented it is important to make every effort to avoid generalised use of PPE throughout the facility without considering the level of risk.
- In the event of extended use of PPE define clean and contaminated zones. PPE should be donned before entering the contaminated zone and doffed and hand hygiene before entering clean zones. Where staff are having meals on a unit to minimise staff interaction, it is essential that the staff refreshment area is a clean zone. Corridors between units should be designated clean zones. Clinical stations should normally be clean zones.
- Transiting through the hallway of a contaminated zone without providing patient care does not require use of PPE if the residents are in their rooms and there is no physical contact with staff wearing PPE.

6.5 Transmission-based precautions for COVID-19

- Transmission based precautions (Appendix 4) are IPC measures which are implemented in addition to standard precautions when standard precautions alone are insufficient to prevent the onward transmission of specific infectious diseases. They include contact, droplet and airborne precautions. In general COVID-19 is spread by respiratory droplets – o transmission may be direct, through contact with the respiratory secretions of someone with COVID-19, or indirect, through contact with a contaminated surface/object. Less commonly airborne spread may occur for example during aerosol generating procedures.
<https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/>
- Where a resident develops new symptoms consistent with COVID-19, the resident's GP or the medical director should be contacted to advise on appropriate management and laboratory testing.

- If the clinical condition does not require hospitalisation they should not be transferred from the facility on infection prevention and control grounds.
- Transmission based precautions should be applied immediately to all residents where COVID-19 is suspected.
 - It is recognised however that there can be significant challenges in applying transmission precautions in residential setting which resemble household settings more than acute hospitals. Transmission based precautions may need to be modified to take into account that the setting is also the residents home. A pragmatic compassionate and proportionate approach may be necessary taking into account the care needs of the resident balanced against the risk to others.

6.6 Resident Placement

- Where there is capacity, residents with suspected or confirmed COVID-19 should be placed in a single room with en-suite facilities.
- If an en-suite is not available try to dedicate a commode or toilet facility for the resident.
- In the event of a commode being used, the HCW should leave the single room wearing full PPE, transport the commode directly to the nearest sluice and remove PPE in the sluice after placing the contents directly into the bed pan washer or pulp disposal unit. A second person should be available to assist with opening and closing doors to the single room and sluice room.
- If the resident must use a communal toilet ensure it is cleaned after every use.
- Room doors should be kept closed where possible and safe to do so.
- When this is not possible ensure the resident's, bed is moved to the furthest safe point in the room to try and achieve a 2m physical distance to the door.
- Display signage to reduce entry into the room but confidentiality must be maintained.
- Take time to explain to the resident the importance of the precautions that are being put in place to manage their care and advise them against leaving their room.

- Listen and respond to any concerns residents may have, to ensure support and optimal adherence is achieved during their care.
- If well enough, a resident may go outside alone if appropriate or accompanied by a staff member maintaining a distance of 1 to 2 m from both staff and other residents. If the staff member can maintain this distance, they do not need to wear PPE.
- If the resident passes briefly through a hallway or other unoccupied space to go outside there is no requirement for any additional cleaning of that area beyond normal good practice.
- Residents with confirmed COVID-19 infection should remain in isolation on contact and droplet precautions until 14 days after the first date of onset of symptoms and they are fever free for the last 5 days.
- If entry to an occupied shared space is unavoidable the symptomatic resident should be encouraged to clean their hands and wear a surgical mask (if tolerated) or to cover their mouth and nose with a tissue.
- Residents with confirmed COVID-19 will require appropriate healthcare and social support, including access to their GP for medical management.
- Staff should be mindful that prolonged isolation may be stressful for some residents and to encourage relatives and other residents where practical to communicate with them regularly via phone or video.

6.7 Cohorting residents with suspected or confirmed COVID-19

- Placement of residents with suspected or confirmed COVID-19 in a dedicated area with dedicated staffing (where staffing levels permit) to facilitate care and minimise further spread is known as cohorting. Cohorting includes patients who are placed in single rooms close together, or in multi-occupancy areas within the building or section of a ward/unit.
- Where possible, residents with suspected or confirmed COVID-19 should be isolated in single rooms with en suite facilities. If there are multiple residents, these single rooms should be located in close proximity to one another for example on a particular floor or area within the facility.

- Where single room capacity is exceeded and it is necessary to cohort residents in a multi-occupancy room
- Only Residents with a **diagnosis of COVID-19** can be cohorted together
- Residents with suspected COVID-19 should not be cohorted with those who are confirmed positive
 - The risk of cohorting **suspected cases** in multi-occupancy areas is much greater than that of cohorting confirmed positive residents together, as the suspect cohort is likely to include residents with and without COVID-19.
- Where residents are cohorted in multi-occupancy rooms every effort should be made to minimise cross-transmission risk:
 - Maintain as much physical distance as possible between beds; if possible reduce the number of residents/beds in the area to facilitate social distancing.
 - Use privacy curtains if available between the beds to minimise opportunities for close contact.
- There should be clear signage indicating the area is a designated cohort area to alert staff, as cohort areas may include an area within a ward or extend to an entire ward. It may have multi-occupancy rooms or a series of single rooms
- A designated cohort area should ideally be separated from non-cohort areas by closed doors.
- Minimise unnecessary movement of staff in cohort areas and ensure that the number of staff entering the cohort area is kept to a minimum.
- Staff working in cohort areas should not be assigned to work in non-COVID-19 areas.
- In so far as is possible, the area should not be used as a thoroughfare by other residents, visitors or staff, including residents being transferred, staff going for meal breaks, and staff entering and exiting the building

6.8 Care Equipment

- Where possible use single-use equipment for the resident and dispose of it as healthcare waste inside the room.

- Where single use equipment is not possible, use dedicated care equipment in the resident's room or cohort area. This should not be shared with other residents in non COVID-19 areas e.g. lifting devices, commodes, moving aides etc.
- If it is not possible to dedicate pieces of equipment to the resident or cohort area these must be decontaminated immediately after use and before use on any resident following standard cleaning protocols
- There is no need to use disposable plates or cutlery. Crockery and cutlery should be washed in a dishwasher, or by hand using household detergent and hand-hot water after use

6.9 Management of blood and body fluid spillages

- Should be managed in line with local policy

6.10 Management of waste

- Dispose of all waste from residents with confirmed or suspected COVID-19 as healthcare risk waste (also referred to as clinical risk waste) ([Appendix 2](#)).
- When removing waste, it should be handled as per usual precautions for healthcare risk waste.
- The external surfaces of the bags/containers do not need to be disinfected.
- All those handling waste should wear appropriate PPE and clean their hands after removing PPE.
- Hands-free health-care risk waste bins should be provided in isolations rooms and cohort areas.
- If healthcare risk waste service is not available in the facility then all consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, tied placed in a second bag and left for 72 hours. This should be put in a secure location prior to collection.
- Waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system.

6.11 Safe management of linen (Laundry)

- All towels, clothing or other laundry used in the direct care of residents with suspected and confirmed COVID-19 should be managed as 'infectious' linen.
- Linen must be handled, transported and processed in a manner that prevents exposure to the skin and mucous membranes of staff, contamination of their clothing and the environment.
- Disposable gloves and an apron should be worn when handling linen.
- All linen should be handled inside the resident room/cohort area. A laundry skip/trolley should be available as close as possible to the point-of-use for linen deposit, for example immediately outside the cohort area/isolation room.
- When handling linen, the HCW should not:
 - rinse, shake or sort linen on removal from beds/trolleys;
 - place used/infectious linen on the floor or any other surfaces (e.g., a bedside locker/table top);
 - handle used/infectious linen once bagged;
 - overfill laundry receptacles; or
 - place inappropriate items in the laundry receptacle (e.g., used equipment/needles)
- When managing infectious linen, the HCW should:
 - Place linen directly into a water-soluble/alginate bag and secure;
 - Place the alginate/water-soluble bag into the appropriately-coloured linen bag (as per local policy).
 - Store all used/infectious linen in a designated, safe area pending collection by a laundry service.
 - If there is no laundry service, laundry should be washed using the hottest temperature that the fabric can withstand and standard laundry detergent.
 - Laundry should be dried in a dryer on a hot setting.

7 Environmental Hygiene

7.1 General Environment

- The care environment should be kept clean and clutter free in so far as is possible bearing in mind this is the resident's home.
- Residents observation charts, medication prescription and administration records (drug karees) and healthcare records should not be taken into the room to limit the risk of contamination.

7.2 Routine cleaning

- Decontamination of equipment and the care environment must be performed using either:
 - A combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
 - A general purpose neutral detergent in a solution of warm water, followed by a disinfectant solution of 1,000 ppm av.cl.
 - Only cleaning (detergent) and disinfectant products supplied by employers are to be used. Products must be prepared and used according to the manufacturer's instructions and recommended product "contact times" must be followed
- Hoovering of carpet floor in a residents room should be avoided during an outbreak and while the patient is infectious. When the resident is recovered the carpet should be steam cleaned.
- All shared spaces should be cleaned with detergent and disinfectant.
- Equipment used in the cleaning/disinfection of the isolation area should be single-use where possible and stored separately to equipment used in other areas of the facility.
- Household and care staff should be trained in the appropriate use and removal of PPE (Appendix 3 Donning and Doffing of PPE).
- In practical terms isolation room cleaning may be undertaken by staff that are also providing care in the isolation room.

7.3 Frequency of cleaning

- All surfaces in resident room/zone should be cleaned and disinfected twice daily and when contaminated. These include bedrails, bedside tables, light switches, remote controllers, commodes, doorknobs, sinks, surfaces and equipment close to the resident e.g. walking frames, sticks. Handrails and table tops in facility communal areas, and nurses station counter tops
- The resident rooms, cohort areas and clinical rooms must be cleaned and disinfected at least daily & a cleaning schedule should be available to confirm this.

7.4 Terminal Cleaning

- Terminal cleaning should always be performed after a resident has vacated the room and is not expected to return. In addition to the routine cleaning protocols, a terminal clean is needed.
 - Removal of all detachable objects from a room or cohort area, including laundry and curtains *
 - Removal of waste
 - Cleaning (wiping) of lighting and ventilation components on the ceiling
 - Cleaning of the upper surfaces of hard-to-reach fixtures and fittings
 - Cleaning of all other sites and surfaces working from higher up to floor level
- A terminal clean checklist is good practice to support cleaning or household staff to effectively complete all environmental cleaning tasks, which should be signed off by the cleaning supervisor before the room reopens for occupancy.

7.5 Staff Uniforms/Clothing

- Staff uniforms are not considered to be personal protective equipment.
- Uniforms should be laundered daily and separately from other household linen; in a load not more than half the machine capacity at the maximum temperature the fabric can tolerate then ironed or tumble dried.

- Staff should avoid bringing personal items, including mobile phones into isolation or cohort areas

8 Care of the Dying

- A compassionate, pragmatic and proportionate approach is required in the care of those who are dying.
- The presence of a person close to the resident should be facilitated in so far as it is possible, they should be aware of the potential infection risk.
- Pastoral care team where requested by the person or their family and who are willing to attend should NOT be restricted from entering the facility
- All persons in attendance should be advised to wear a surgical mask and plastic apron. Gloves are not essential so long as those in attendance understand the risks perform hand hygiene after touching the person and before leaving the room.
- Visitors should be instructed on how to put on and take off the PPE & how to perform hand hygiene. Where practical visitors should be supervised when donning and doffing PPE
- For the anointing of the sick or other rites where only transient physical contact is required, gloves are not necessary so long as hand hygiene is performed immediately after anointing or touching the person.
- Visitors should avoid contact with people other than the person they are accompanying.

9 Care of the recently deceased

9.1 Hygienic preparation

- Any IPC procedures that have been advised before death must be continued in handling the deceased person after death
- Hygienic preparation includes washing of the face and hands, closing the mouth and eyes, tidying the hair and in some cases shaving the face

- Washing or preparing the body for religious reasons is acceptable if those carrying out the task wear long-sleeved gowns, gloves, a surgical face mask and eye protection if there is a risk of splashing which should then be discarded.

9.2 Transport to the Mortuary

- An inner lining is not required in terms of COVID-19 risk but may be required for other, practical reasons such as maintaining dignity or preventing leakage affecting the mortuary environment
- A surgical face mask or similar should be placed over the mouth of the deceased before lifting the remains into the inner lining
- Those physically handling the body and placing the body into the coffin or the inner lining should wear, at a minimum, the following PPE:
 - Gloves
 - Long sleeved gown
 - Surgical face mask
- Pay close attention to hand hygiene after removal of PPE
- The family should be advised not to kiss the deceased and should clean their hands with alcohol hand rub or soap and water after touching the deceased

PPE is not required for transfer, once the body has been placed in the coffin.

10 Preventing and Controlling Outbreaks

10.1 Early identification of cases of COVID-19

It is essential to have systems in place for the early identification of cases of COVID-19. This includes:

- Ensuring staff and residents are aware of the symptoms of COVID-19.
- Twice daily review of residents for symptoms.
- Early identification of staff absenteeism which may be due to COVID-19 infection or restricted movements as close contact of a case.

10.2 Initial investigation following identification of a possible COVID-19 case

Given the severity of the consequences if an outbreak occurs in the care setting, it is prudent to take initial actions as you would for an outbreak if even one case of COVID-19 is suspected.

Laboratory testing should be arranged as quickly as possible however it is not necessary to wait for laboratory test results before beginning initial investigations or implementing control measures.

A local incident management meeting should be promptly arranged and involve key staff members include housekeeping, nursing staff allied healthcare professional and medical staff where available.

This group should:

- Identify residents and staff who were in close contact with the symptomatic resident in the 48 hours before symptom onset or before isolation and transmission based precautions were implemented.
- The initial management of close contacts should be the same as for the suspected case until an alternative diagnosis has been identified.
- Residents who are contacts of a confirmed or probable case should be accommodated in a single room with their own bathing and toilet facilities. If this is not possible cohorting in small groups (2 to 4) with other contacts is acceptable.
- Residents who are contacts should be advised to avoid communal areas and stay in their room where it is practical to do so until 14 days after exposure.

- Residents may go outside if appropriate, alone or accompanied by a staff member maintaining a distance of 1m to 2m. An accompanying staff member in this situation is not required to wear PPE.
 - Note: testing of contacts for COVID-19 is NOT appropriate unless they develop symptoms of infection. If they develop symptoms of infection they should be referred to their doctor for assessment.
- If the resident transits briefly through hallway or other unoccupied space to go outside there is no requirement for any additional cleaning of that area beyond normal good practice.
- If entry to an occupied shared space is unavoidable, the resident should be encouraged to perform hand hygiene and wear a surgical mask or to cover their mouth and nose with a tissue.
- The incident management group should try and establish whether it is likely an outbreak might occur taking in to account the following:
 - Could onward transmission have already occurred e.g. resident had widespread contact with others in the 48 hours before symptom onset?
 - Are they in a single room or sharing?
 - Is the resident ambulatory?
 - Have they spent time with others in communal areas or group activities?
 - Are there behavioural characteristics which might be increased risk of transmission?
 - Are any other residents symptomatic and if so, what are their symptoms?
 - Are any staff symptomatic or has there been an increase in staff absenteeism?
- There should be heightened awareness amongst staff so that other residents with symptoms are quickly identified. This is even more important when a single case has occurred.
- If there is any suspicion that an outbreak is occurring or likely to occur then seek advice from public health or local IPC support where available. ACT RAPIDLY - DO NOT WAIT.

10.3 Outbreak Management

When residents are symptomatic or staff absenteeism has increased due to respiratory illness it is likely that spread has already occurred within the facility and a formal outbreak control team will be needed.

An outbreak of COVID-19 is defined as* :

- two or more confirmed cases of COVID-19 acquired within the same RCF (includes both staff & residents)

OR

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

OR

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

**This definition may be subject to change as the COVID-19 pandemic evolves*

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

10.4 Outbreak Control Team

- All outbreaks of COVID-19 in RCF must be reported to the regional Medical Officer of Health (MOH) at the Department of Public Health at the earliest opportunity. (LINK)
- The OCT configuration should be decided at local level and will depend on available expertise.

- Ideally, the OCT should have involvement of a Public Health Doctor. However, if that is not practically possible, following initial consultation and advice from Public Health the OCT should liaise regularly with the regional Public Health Department.
- Members of the OCT may include any of the following however in many settings it may not be possible to include all the expertise referred to below:
 - Specialist in Public Health Medicine and/or Public Health Department Communicable Disease Control Nurse Specialist
 - GP/Medical officer/Consultant to RCF (dependent on nature of RCF)
 - Director of Nursing or Nurse Manager
 - Management representative from the RCF i.e. manager or CEO
 - Community Infection Prevention and Control Nurse (CIPCN) where available
 - Administration support
- Other members who may need to be co-opted if it is an extensive or prolonged outbreak include
 - Community Services General Manager
 - Administrative support
 - Occupational Medicine Physician
 - Representative from HPSC
 - Communications officer
- Ensure everyone involved has a clear understanding of their role and responsibility.
- Decide on the frequency required for the outbreak meeting carried out remotely
- Public Health will formulate a case definition assign an outbreak code and make a decision as to whether an onsite visit is required or not.
- The RCF should inform HIQA as per usual protocols.

Before the first meeting of the OCT the local incident team should gather as much information as possible to include:

- A line list of all residents and staff.
- Identify the total number of people ill (residents & staff) and the spectrum of symptoms.

- Identify staff and residents who have recovered, developed complications, been transferred to acute hospitals and those who have died.
- Information on laboratory tests available including the number of tests taken to date and the date sent to the laboratory.
- Determine if the number of symptomatic residents/staff varies between units/floors/wards or if the outbreak is confined to one unit only.
- Use the Case definitions for possible, probable and confirmed COVID-19 available on the HPSC website [here](#).

10.5 Implement Control Measures

- Discuss and agree control measures i.e. infection prevention and control,
 - Assign a designated person at the facility to ensure implementation
 - Assign responsibility for all actions agreed
- In addition to control measures outlined previously, it is recommended that a decision is made on the need for closure of all or part of the facility to visitors and new admissions.
- Group activities should be temporarily suspended.

10.6 Communication

- Good communication is an essential and this includes for residents, family and staff members.
- Provide information sessions and education on measures required for staff members and assign someone to do these

10.7 Support services for staff and residents

- The effect on staff and residents during outbreak events should not be underestimated especially where the mortality rate is high. Every effort should be made to support those who are impacted by outbreak events.

10.8 Monitoring Outbreak Progress

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

- The nominated RCF liaison person should update the line listing with new cases or developments as they occur and communicate this to the OCT on a daily basis or more frequently if major changes occur in line with Public Health recommendations until the outbreak is declared over.
- The review of this information should examine issues of ongoing transmission and the effectiveness of control measures.
- Institute active daily surveillance for fever or respiratory symptoms, including cough, in residents and staff for 28 days after the date of onset of symptoms of the last resident COVID-19 case.


10.9 Declaring the outbreak over

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

11 Appendix 1 Hand hygiene posters

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

 **Duration of the entire procedure: 40-60 seconds**



0 Wet hands with water;



1 Apply enough soap to cover all hand surfaces;



2 Rub hands palm to palm;



3 Right palm over left dorsum with interlaced fingers and vice versa;



4 Palm to palm with fingers interlaced;



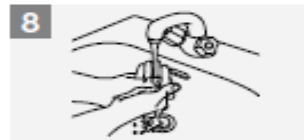
5 Backs of fingers to opposing palms with fingers interlocked;



6 Rotational rubbing of left thumb clasped in right palm and vice versa;



7 Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



8 Rinse hands with water;



9 Dry hands thoroughly with a single use towel;



10 Use towel to turn off faucet;



11 Your hands are now safe.



World Health Organization

Patient Safety
A World Alliance for Safer Health-Care

SAVE LIVES
Clean Your Hands

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May 2009

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

🕒 Duration of the entire procedure: 20-30 seconds

1a 	1b 	2 
<p>Apply a palmful of the product in a cupped hand, covering all surfaces;</p>	<p>Rub hands palm to palm;</p>	<p>Rub hands palm to palm;</p>
3 	4 	5 
<p>Right palm over left dorsum with interlaced fingers and vice versa;</p>	<p>Palm to palm with fingers interlaced;</p>	<p>Backs of fingers to opposing palms with fingers interlocked;</p>
6 	7 	8 
<p>Rotational rubbing of left thumb clasped in right palm and vice versa;</p>	<p>Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;</p>	<p>Once dry, your hands are safe.</p>

 World Health Organization	Patient Safety <small>A World Alliance for Safer Health Care</small>	SAVE LIVES Clean Your Hands
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May 2009



12 Appendix 2 Personal Protective Equipment

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

v1.0, 17.03.2020

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

Minimizing exposure risk

Actions for Healthcare workers

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

Actions for the healthcare facility

- Post visual alerts including signs, posters at the entrance to the facility and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide patients and HCWs with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette.

V2. 7.04.2020

- Instructions should include how to use tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste bins, and how and when to perform hand hygiene.
- Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR), tissues, and hands free waste bins for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.
- Use physical barriers (e.g., glass or plastic windows) at reception areas, registration desks, pharmacy windows to limit close contact between staff and potentially infectious patients

Personal protective equipment while important is the last line of defence

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

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

V2. 7.04.2020

3.2	All other activities e.g. providing security, moving equipment etc.	NO PPE REQUIRED
4.0	Pathology/Laboratory Areas	
4.1	All activities	PPE as per guidance
5.0	Clinical Areas	
5.1	Providing Care	
5.1.1	<p>Patients with respiratory symptoms/suspected/confirmed COVID-19 who require an aerosol generating procedure*</p> <p>Note: • In situations where staff are in the room with a patient and there is a significant risk that an unplanned aerosol generating procedure may need to be performed urgently for example accidental extubation it may be appropriate to wear an FFP2 mask while in the room</p>	<ul style="list-style-type: none"> • Hand Hygiene • Disposable Single Use Nitrile Gloves • Long sleeved disposable gown • FFP2 respirator mask • Eye Protection
5.1.2	<p>Patients with respiratory symptoms/suspected/confirmed COVID-19 who do not require an aerosol generating procedure but do require high contact patient care activities that provide increased risk for transfer of virus and other pathogens to the hands and clothing of healthcare workers including (but not limited to)</p> <ul style="list-style-type: none"> • Close contact for physical examination /physiotherapy • Changing incontinence wear • Assisting with toileting • Device Care or Use • Wound Care • Providing personal hygiene • Bathing/showering • Transferring a patient • Care activities where splashes/sprays are 	<ul style="list-style-type: none"> • Hand Hygiene • Disposable Single Use Nitrile Gloves • Long sleeved disposable gown • Surgical facemask • Eye Protection* <p>*Eye protection is recommended as part of standard infection control precautions when there is a risk of blood, body fluids, excretions or secretions splashing into the eyes. Individual risk assessment must be carried out before providing care. This assessment will need to include</p>

V2. 7.04.2020

	anticipated	<ul style="list-style-type: none"> • Whether patients with possible COVID-19 are coughing. • The task you are about to perform
5.1.3	<p>Patients with respiratory symptoms/suspected/confirmed COVID-19 where the tasks being performed are unlikely to provide opportunities for the transfer of virus/other pathogens to the hands and clothing. Low contact activities for example</p> <ul style="list-style-type: none"> • Initial Clinical Assessments • Taking a respiratory swab • Recording temperature • Checking Urinary Drainage Bag • Inserting a peripheral IV cannula • Administering IV fluids • Helping to feed a patient 	<ul style="list-style-type: none"> • Hand Hygiene • Disposable Single Use Nitrile Gloves • Disposable Plastic Apron • Surgical facemask • Eye Protection* <p>*Eye protection is required to be worn as part of standard infection control precautions when there is a risk of blood, body fluids, excretions or secretions splashing into the eyes.</p> <p>Individual risk assessment must be carried out before providing care.</p> <p>This assessment will need to include</p> <ul style="list-style-type: none"> • Whether patients with possible COVID-19 are coughing. • The task you are about to perform
5.2	Cleaning	
5.2.1	Cleaning where patient is present	<ul style="list-style-type: none"> • Hand Hygiene • Disposable Plastic Apron • Surgical Facemask • Household or Disposable Single use Nitrile Gloves
5.2.2	Cleaning when patient is not present for example after the patient has been discharged, or the procedure is complete.	<ul style="list-style-type: none"> • Hand Hygiene • Disposable Plastic Apron • Gloves Household or

V2. 7.04.2020

	Ensure adequate time has been left before cleaning as per guidelines.	Disposable Single use Nitrile Gloves
6.0	Internal transfer of patients with suspected or confirmed COVID-19 infection	
6.1	Accompanying a patient between areas within the same facility e.g. when moving a patient from a ward to radiology / theatre, GP waiting area to assessment room.	<p>Hand Hygiene</p> <p>If patient is walking and a distance of at least 1m can be maintained – the patient should wear a surgical face mask ^ but NO PPE REQUIRED for staff accompanying the patient</p> <p>If staff accompanying patient and within 1m then as in section 5.0</p> <ul style="list-style-type: none"> • ^Surgical facemask not available, cover mouth with a tissue if coughing
7.0	External transfer for example between home and dialysis unit, inter hospital transfer, hospital to LTCF	
7.1	Accompanying a patient but able to maintain a physical distance of at least 1m and no direct contact is anticipated	<p>Hand Hygiene</p> <p>If a physical distance of at least 1m and contact is unlikely– the patient should be asked to wear a surgical face mask if tolerated* but NO PPE REQUIRED for staff accompanying the patient</p>
7.2	Accompanying a patient within a 1m distance and likely to have direct contact	<p>Hand Hygiene</p> <p>PPE as per section 5.0</p>

V2. 7.04.2020

8.0	Involved only in driving a patient not loading or unloading from transport vehicle	
8.1	No direct contact with patient and no separation between driver and the patient compartments	Hand Hygiene Patient to wear a Surgical Face Mask if tolerated, if not driver to wear a Surgical Face Mask
8.2	No direct contact with patient and the drivers compartment is separated from the patient	Hand Hygiene Maintain a physical distance of at least 1m NO PPE REQUIRED
9.0	Individuals who may be accompanying the patient e.g close family members	
9.1	<ul style="list-style-type: none"> • Visiting should be restricted • If visitors are permitted they should be instructed how to correctly perform hand hygiene and supervised in donning/doffing PPE • Note that sensitivity to patient and visitor needs is required in the application of this recommendation for example with children and in end of life situations. Visitors should be informed of the risks but it must be accepted that in some situations people may not prioritise their own protection over their assessment of the needs of a loved one. 	<ul style="list-style-type: none"> • Hand Hygiene • Disposable Plastic Apron • Disposable Single Use Nitrile Gloves • Surgical Face Mask

12.1.1 Types of PPE

- **Disposable plastic aprons:** are recommended to protect staff uniform and clothes from contamination when providing direct patient care and when carrying out environmental and equipment decontamination.

V2. 7.04.2020

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

Tips when wearing a surgical face mask

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

Theatre caps/hoods and shoe covers

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

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

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

Where reuse of eye protection is being considered

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

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










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

12.1.3 Wearing PPE on a Cohort Ward/Unit

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

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

13 Appendix 3 Donning and Doffing PPE

Putting on PPE		
<ol style="list-style-type: none"> 1. Decontaminate hands 2. Put on disposable apron/gown 3. Put on mask (Surgical or FFP2 For AGP) 		
<p>For FFP2</p>	<div style="border: 1px solid black; padding: 5px;"> <p>Fit Check</p> <ol style="list-style-type: none"> A. Place mask over nose, mouth and chin B. Fit flexible nose piece over nose bridge C. Secure on head with elastic D. Adjust to fit E. Inhale – mask should collapse F. Exhale – check for leakage around face </div>	
<ol style="list-style-type: none"> 4. Put on goggles if required 5. Put on gloves 		
Removing PPE		
<p>In patients' room</p>	<ol style="list-style-type: none"> 1. Remove gloves (avoid touching the outside of the gloves) 2. Decontaminate hands 3. Remove goggles 4. Remove gown or apron (avoid touching the front of the gown/apron) 	  
<p>In ante room or directly outside patients' room. Ensure door is closed</p>	<ol style="list-style-type: none"> 5. Remove mask by breaking the ties. If ties are elastic grasp and lift ties from behind your head and pull off mask away from your face. Avoid touching the front of the mask & use ties to discard 	  
<ol style="list-style-type: none"> 6. Discard all masks (& gloves/aprons/gowns/goggles contaminated with blood or body fluids) as healthcare risk waste 7. Decontaminate your hands 		

14 Appendix 4 – Transmission based precautions

Table 1: Personal Protective Equipment Requirements by Precaution

Personal Protective Equipment			
Precaution	Contact	Droplet	Airborne
Gloves	Yes	As per standard precautions	As per standard precautions
Gown/Apron (impermeable)	When healthcare worker's clothing is in substantial contact with the patient, items in contact with the patient, and their immediate environment	As per standard precautions	As per standard precautions
Surgical Mask	When in close contact (less than 1m)	Yes	No
P2/N95 Respirator	Not required	Not required	Yes
Goggles/face shield	Not required	As per standard precautions	As per standard precaution

15 Appendix 5 Proposal for Occupational Health Supports

Staff Screening and Prioritisation for COVID -19 Testing

1. Fitness for work

- a. **Guidance on Pregnant Healthcare Workers (HCWs), Vulnerable HCWs and HCW with Other Pre-Existing Disease available at <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/occupationalhealthguidance/>**

2. Testing and Return to work

- b. **Priority Testing available to all HCW through GP Health-link**
- c. **Guidance on Testing and Return to Work available at <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/occupationalhealthguidance/>**
 - **Telephone Assessment, Testing Pathway and Return to Work of Symptomatic Healthcare Workers Algorithm**
 - **Guidance on Derogation for the return to work of Healthcare Workers**
 - **Leaflets for 'Essential' HCWs returning to work on active or passive monitoring.**
 - **Active twice daily temperature monitoring chart**

3. Contact Tracing

- a. **Access to CRM via either Public Health Outbreak Control Team or Occupational Health**
- b. **Deployment of contact tracing teams for complex cases as above**
- c. **Guidance on Contact Tracing available at <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/occupationalhealthguidance/>**
 - **Interim Guidance for Coronavirus - Healthcare Worker Management By Occupational Health**
 - **Leaflets for casual/close contacts and HCWs returning from travel**
 - **Risk Assessment of Healthcare Workers with Potential Workplace Exposure to Covid-19 Case**

4. Personal Protection Equipment

- a. **HSE single point of contact for the supply and replenishment of critical PPE stocks**

<https://www.hse.ie/eng/about/who/healthbusinessservices/procurement/hbs%20procurement%20covid-19%20.html>

- b. **Advice and Support for appropriate PPE for specific procedures on HPSC website with wide distribution of information through both HIQA and Nursing Home Ireland**
<https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/>
- c. **Training videos online**
 - i. **Education modules for putting on and taking off PPE safely on [HSELand](#) (One for staff working in acute hospital settings and one for staff working in the community settings).**
 - ii. **[Log in to HSELand](#) using private email address and search for ‘putting on and taking off PPE’)**

5. EAP supports

- a. **EAP/ WHWU published staff mental health guidance for HSE healthcare workers: “*Minding Your Mental Health during COVID-19*”:**
<https://healthservice.hse.ie/staff/news/coronavirus/staff-minding-your-mental-health-during-the-coronavirus-outbreak.html>
- b. **Health Sector Psycho-Social supports available to HCWs, delivered through CHO-based COVID psychosocial support teams.**
- c. **WHWU Guidance on Death in Service of a Colleague due to COVID-19 (available on request)**