



Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities

Frequently Asked Questions

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The following are a series of frequently asked questions (FAQ's) that have been received from a variety of staff working in or across residential care facilities. The FAQs will be updated regularly as further queries are received so it is important to check the HPSC website www.hpsc.ie regularly for further additions. In so far as it is practical, we have attempted to group the questions under subject headings to assist the reader.

Subject topic 1: Personal protective equipment (PPE)

Q. Is it appropriate to wear the same pair of gloves for multiple residents as long as I decontaminate the gloves with alcohol-based hand rub (ABHR)?

A. Gloves are single use disposable items and must be changed between each resident. Cleaning gloves with ABHR is not appropriate. If there is a concern that gloves are contaminated they must be removed safely, hand hygiene performed and a fresh pair of gloves donned if required to continue that task.

Q. Is double gloving recommended when caring for a resident with suspected/confirmed COVID-19?

Double gloving is not appropriate in the context of caring for residents with COVID-19

Q. Are vinyl gloves appropriate in a healthcare setting?

Vinyl gloves are not recommended for healthcare activities where there is anticipated contact with blood or body fluids. Vinyl gloves may be worn for food preparation. If for whatever reason vinyl gloves are the only gloves available to a staff member working in a RCF, they should be aware that while they do afford some protection they are not as effective as Nitrile or Natural Rubber Latex Gloves. If worn staff must ensure that; their hands are in good condition, that they cover all cuts and abrasions with a waterproof dressing and that they wash their hands immediately after removing the gloves.

Q. What is meant by extended/sessional use of PPE?

A. In a pandemic situation, it is recognised that circumstances such as a large number of patients with a specific infection and intense demand for supplies may arise and RCFs may need to make pragmatic decisions about the extended use of certain items of PPE. Where extended use is applied, it is very important to ensure the lowest possible risk to patients and healthcare workers.

- In certain circumstances, extended/sessional use of certain items of PPE such as surgical facemask/respirator mask, eye protection and gown if required may be used while attending to a series of residents with COVID-19 in succession in a single period of clinical activity in one ward or unit.

- Gowns should normally be changed between residents and after completion of a procedure or task. However, if necessary to cope with workload or to manage PPE supplies;
 - Extended use of gowns in confirmed COVID-19 cohort areas may be considered for healthcare workers engaged in low contact activities although note that for low contact activities a disposable apron is often appropriate
 - Where HCW are engaged in high contact activities, then gowns should be changed between residents, to minimise risk of cross-transmission of other pathogens commonly encountered in healthcare settings (e.g., antimicrobial resistant organisms, such as CPE, MRSA, VRE or *C. difficile*).
- If PPE is wet, soiled or torn it must be removed and disposed of.
- It is not appropriate to wear PPE that is worn for the care of residents with COVID-19 when moving between wards or units or when working in designated office spaces or in break areas on the ward or unit.

Q. Can we reuse eye/face protection?

A. Reuse of eye/face protection intended for single use is not good practice and should be avoided unless there is a failure of supply resulting in an emergency situation.

Q. For sessional use of PPE do I need to change my gloves between residents?

A. Yes. Gloves must be changed between all residents

Q. Can I wear the same PPE when I leave a cohort area to go to another area within the RCF?

A. No. See above.

Q. When should I change my mask/respirator?

A. When it becomes wet, soiled, torn or if removed to eat, drink, use a phone or for any other reason.

Q. How should face masks be disposed of?

A. Surgical masks that are worn when caring for people who are not suspected or confirmed to have a droplet transmitted infection can be disposed of in the normal waste stream. Surgical masks/respirators that are worn as part of PPE when caring for a

suspected/confirmed case of COVID-19 should be disposed of in healthcare risk waste stream.

Q. How do I determine what PPE I will need to for the care of residents who do not require transmission-based precautions?

A. The key principles to be considered when selecting PPE for residents who only require standard precautions are as follows and are summarised in table 1.

In situations where there is no physical contact between the staff member and a resident or the resident's immediate surroundings

If the tasks/activities you perform do not involve touching the skin or clothing of a resident and there is no or minimal contact with the resident's immediate surroundings.

Action: Hand hygiene as per WHO 5 Moments and surgical mask as per NPHEP guidance if distance from the resident cannot be maintained. NO additional PPE required.

Examples: removing medicines from packaging, prompting resident to take their medicines, preparing food for residents who can feed themselves without assistance, entering a resident's room to leave a food tray, giving out medication or switching off a call bell or alarm on a monitor.

In situations where there will be low contact with the resident or the resident's immediate surroundings AND there is NO risk of you being exposed to blood, body fluids, non- intact skin or mucous membranes of the resident

The tasks/activities being performed provide minimal opportunity for the transfer of viruses or bacteria to your skin or clothing.

Action: Hand hygiene as per WHO 5 Moments and surgical mask as per NPHEP guidance if distance from the resident cannot be maintained. Additional PPE is generally not required.

Examples include helping to feed a resident, assist a resident to sit up in bed, take residents observations, perform a clinical examination or check the contents of a urinary drainage bag.

In situations where there will be low contact with the resident or the resident's immediate surroundings AND there is a LOW risk of exposure to blood, body fluids, and non- intact skin or mucus membranes of the resident

The tasks/activities performed provide some opportunity for the transfer of viruses or bacteria to your skin or clothing, which can be minimised by performing hand hygiene as per WHO 5 Moments and wearing gloves.

Action: Hand hygiene as per WHO 5 Moments and surgical mask as per NPHEP guidance. Additional PPE: is required such as gloves +/- disposable plastic apron depending on the task undertaken.

Examples: Caring for intravenous fluid administration, obtain a nasopharyngeal or oropharyngeal sample, assist with oral hygiene, examine a wound or empty a urinary drainage bag.

In situations where there will be moderate contact with a resident or the resident's immediate surroundings and a low risk of exposure to blood, body fluids, non-intact skin or mucus membranes of a resident

The tasks/activities performed provide a low- moderate risk for transfer of virus or bacteria to your skin and clothing.

Action: Hand hygiene as per WHO 5 Moments and surgical mask as per NPHEP guidance. Additional PPE is required, gloves and a disposable plastic apron will be sufficient for the task being undertaken in most instances however in some instances it may necessary to wear a gown for example changing the bed clothes of a heavy immobile resident where a stoma bag has leaked

Examples include changing incontinence wear, assisting a highly dependent resident with toileting, wound care (leg ulcer).

In situations where there will be high contact with the resident or the resident's surroundings AND there is a HIGH risk of exposure to blood, body fluids, Non-intact skin or mucus membranes of the resident

There is an increased likelihood of spraying or splashing of body fluids, excretions and secretions including respiratory droplets during the tasks/activities performed.

Further information on which procedures are considered aerosol generating procedures is available [here](#).

Action: Hand hygiene as per WHO 5 Moments and surgical mask as per NPHEAT guidance. Additional PPE is required including; face mask, eye protection, gloves and fluid resistant gown

Further information on which procedures are considered aerosol generating procedures is available [here](#).

See Table 1. PPE required according to degree of anticipated contact with blood/body fluids, excretions or secretions, non- intact skin or mucus where COVID-19 is not suspected and there are no other indications for transmission-based precautions

Degree of anticipated contact	Likelihood of exposure to blood, body fluids, mucus membranes or non- intact skin	Disposable Gloves	Disposable Plastic Apron	Gown	Surgical Face mask for source control i.e. to protect from onward transmission	Surgical facemask for personal protection	FFP2/FFP3 Mask for personal protection	Eye/Facial Protection
No direct physical contact with the resident		No	No	No	As per NPHET recommendation May be sessional use	No	No	No
Low	No risk of exposure to blood, body fluids, non-intact skin or mucus membranes	No	No	No	As per NPHET recommendation May be sessional use	No	No	No
	Risk of exposure to blood, body fluid, non- intact skin or mucus membrane	Yes	generally not required but - may not be required in some scenarios	No	As per NPHET recommendation May be sessional use	No	No	Risk assess -unlikely to be required in most scenarios.
High	Low Risk of contamination with splashes, droplets of blood or body fluid	Yes	Yes	No	As per NPHET recommendation May be sessional use	No	No	Risk assess unlikely to be required in most scenarios
	High risk of contamination with splashes, droplets of blood or body fluid but procedure is not an aerosol generating procedure	Yes	Either a gown or plastic apron * depending on activity and amount of cover required		No	Yes And should be removed and replaced after leaving patient space	No	Risk assess -may be required in some scenarios
All	Aerosol Generating Procedure	Yes	Either a gown or plastic apron *depending on the activity and amount of coverage required		No	Yes** choice depends on a risk assessment- generally surgical mask unless there is an indication for FFP2 based on risk assessment		Yes

Disposable plastic aprons are sufficient in most instances and should be worn by healthcare workers to protect their uniform or clothes from contamination when providing direct patient care and during environmental and equipment decontamination.

Disposable fluid repellent long sleeved gowns or long-sleeved gowns or coveralls should be worn when a disposable plastic apron provides inadequate cover of staff uniform or clothes for the procedure or task being performed and when there is a risk of splashing of body fluids such as during AGPS in higher risk areas or in operative procedures.

**FFP2/FFP3 respirator face mask. The decision whether to wear a respirator or a surgical facemask when performing AGPs on NON COVID 19 resident depends on a risk assessment. Factors to consider include; whether any other transmissible infection is suspected, the current epidemiology of COVID-19, if the person was tested for COVID 19 in advance of procedure, whether the resident has signs or symptoms of respiratory illness, whether the resident is a close contact of a confirmed /suspected case of COVID 19.

Q. When should I wear a respirator face mask instead of a surgical mask?

A. A respirator face mask (FFP2) should be worn when an aerosol generating procedure (AGP) associated with an increased risk of infection is performed on any resident with suspected/confirmed COVID-19.

A list of AGPs is located [here](#).

Q. Do I need to wear a respirator face mask when performing an AGP on a resident who is not known to have COVID-19?

A. In general a surgical face mask and eye protection (if splashing with droplets is likely) is required when performing an AGP on a resident who is not suspected or confirmed to have a communicable respiratory tract infection. The decision to wear a respirator face mask instead of a surgical face mask in this setting is based on a risk assessment. Factors to consider include; whether any other transmissible infection is suspected, the current epidemiology of COVID-19, whether the person was tested for COVID 19 in advance of the procedure, whether the resident has signs or symptoms of respiratory illness, whether the resident is a close contact of a confirmed /suspected case of COVID 19.

Q. Should residents ever be asked to wear PPE?

A. Residents should never be asked to wear gloves, aprons or gowns for the purposes of infection prevention and control. There may be occasions when a resident may be asked to wear a surgical face mask or cloth face covering.

Examples

- A resident with suspected/confirmed COVID-19 positive who has to leave their room during the isolation period
- A resident who has to go out to attend an appointment in a hospital or other setting
 - If a mask is required consider whether the resident can tolerate a mask/face covering and whether they can wear the mask safely.

- Particular consideration should be given to specific resident groups including paediatric residents, those with dementia, claustrophobia, breathing difficulties, intellectual disability or communication difficulties.
- The risk of choking, strangulation or self-harm.
- The rationale for the service user to wear a facemask
- The wearing of a mask does not remove the need for social distancing and regular hand hygiene.
- Where residents are asked to wear a facemask/face covering and they can tolerate it they should be supported in the appropriate and safe use of the mask.

Q. If a resident who is regarded as a close contact of a case of COVID-19 later develops symptoms or is confirmed to have COVID-19, do staff who did not wear eye protection need to self-isolate?

A. When caring for a resident who is a contact and is asymptomatic and in isolation, Contact and Droplet precautions should be followed in addition to Standard precautions, Standard precautions are a series of measures including appropriate use of PPE. PPE may include; a gown, surgical face mask, protective eyewear, and glove. Eye protection is optional. If the resident is later diagnosed with COVID-19, staff who did not wear eye protection will not be considered close contacts solely on the basis that they did not wear eye protection and will not be required to self-isolate if they:

- Followed all other precautions
- Remain well
- Had no direct contact with respiratory secretions (i.e. a cough or sneeze directly into to the face).

Q. If a resident has a test result with “virus not detected” on admission and they are on “Restricted Movement” for 14 days, do the staff looking after that resident have to wear additional PPE?

A. Staff are still required to wear a surgical face mask as per NPHET decision. Routine use of additional PPE is not required for such residents but additional PPE may be required as part of Standard Precautions following a situational risk assessment by the

staff member in relation to the task/activity they will perform. See [HERE](#) for further information.

Q. Can I use PPE received through donations?

A. PPE that is received by donation needs to be assessed to ensure it conforms to regulatory requirements and CE certification. This process should be undertaken at local level by Community infection prevention and control nurses.

Subject topic 2: Visitations to RCFs

Q. Do family/friends visiting the facility need to wear PPE?

A. As from the 9th of July NPHET recommends that visitors and outpatients to hospitals, residential settings and community health services (for example General practice, dental practice, pharmacy service) should wear a form of face covering to reduce the likelihood of spread of infection from the wearer. This does not remove the need for other combinations of protective measures (for example social distancing and hand hygiene) to reduce the risk of transmission of COVID-19. Each facility should have policies on the requirement for visitors including external contractors and those who supply services to a residential setting to wear PPE

Q. What advice should be given to visitors regarding physical distancing, particularly as visits may not be supervised?

A. The resident and visitor should have the choice of whether they make physical contact where residents are asymptomatic visitors should also be reminded of the NPHET recommendation regarding the use of facial coverings. In the event of an outbreak or when a resident has symptoms, visitors should be advised of the possible risks and advised to minimise physical contact and apply appropriate precautions including regular hand hygiene, social distancing and the recommendation from NPHET regarding the use of facial coverings. Consideration must be given to the preferences of visitors and residents, particularly in stressful and emotional situations.

Subject topic 3: Environmental Hygiene

Q. Why is a high standard of environmental hygiene important in an RCF?

A. It ensures that there is a clean and odour free environment for residents, staff and visitors and one that is fit for purpose. This means that all surfaces are free from dirt, dust, rubbish, cobwebs, fingerprints, greasy marks and residue.

Q. How often should cleaning be performed?

A. The methods, thoroughness and frequency of cleaning and the products used for different surfaces are determined by risk analysis and should be reflected in each residential care facility's policy. Frequently touched surfaces should be cleaned with a detergent solution at least daily, when visibly soiled, and after every known contamination.

General surfaces and fittings should be cleaned when visibly soiled, immediately after a spillage and when part of a scheduled clean.

Q. What does “routine environmental cleaning” mean?

Routine environmental cleaning refers to cleaning which is carried out on a scheduled basis, at regular intervals rather than on an ad hoc basis or in response to an outbreak.

Table2. Routine environmental cleaning

Minimally touched surfaces- surfaces that have minimal contact with hands	Frequently touched surfaces – surfaces that have frequent contact with hands
Floors, ceilings, walls, mirrors, windows and blinds	Bedrails, over-way tables, doorknobs, telephone, call bells, light switches, edges of privacy curtains) and bathroom surfaces (toilet seat, flush button taps) Doorknobs, bed rails, table-tops, light switches

<p>A detergent solution (diluted as per manufacturer's instructions) is adequate for cleaning general surfaces and non-resident care areas.</p> <p>Damp mopping is preferable to dry mopping. Flat mops are recommended for effective cleaning and these should be decontaminated in washing machines dedicated for this purpose.</p> <p>Cleaning cloths should be colour coded in line with the area of the environment/function for which they are intended. They should be set aside for washing or disposal after each use.</p> <p>Walls and blinds should be cleaned when visibly dusty or soiled.</p> <p>Window curtains should be regularly changed in addition to being cleaned when soiled or exposed to multi-drug resistant organisms (MDROs)</p>	<p>Should be cleaned more frequently than minimally touched surfaces.</p> <p>Detergent solution (diluted as per manufacturer's instructions) can be used with the exact choice of detergent determined by the surface and likely degree of contamination.</p> <p>Detergent impregnated wipes may be used for a single piece of equipment or a small area but should not be used routinely as a replacement for the mechanical cleaning process.</p>
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Q. Is Terminal cleaning the same as discharge cleaning?

A. Yes, the terms are synonymous. A terminal clean/discharge clean is required after a resident has permanently vacated their bed space or room. It aims to remove organic material and significantly reduce and eliminate microbial contamination to ensure that there is no transfer of microorganisms to the next resident. It involves cleaning and disinfecting all low- and high-touch surfaces, including those that may not be accessible when the room/area was occupied (e.g., resident mattress, bedframe, tops of shelves, vents), and floors. The use of a terminal clean checklist is good practice to support cleaning or household staff to effectively complete all environmental cleaning tasks.

Q. What is the difference between a detergent and a disinfectant?

A. A detergent is a surface-active agent (surfactant) that helps the removal of dirt and organic matter. A surface-active agent is a substance that, when added to a liquid, reduces its surface tension, thereby increasing its spreading and wetting properties. Most hard surfaces can be adequately cleaned with warm water and a neutral detergent as per the manufacturer's instructions. Allowing the cleaned surfaces to dry is an important element of cleaning.

A disinfectant is a chemical agent that rapidly kills or inactivates most infectious agents. Disinfectants should not be used as general cleaning agents. In some cases disinfectant and detergent may be combined in a single product.

Q. Do I need to use a disinfectant for performing routine cleaning?

A. No, the routine use of disinfectants is not recommended. In settings where there is uncertainty about the nature of soiling on the surface (for example blood or body substance contamination versus routine dust or dirt) or where the presence of multidrug resistant organisms, *C. difficile* or other infectious microorganisms requiring transmission based precautions is known or suspected; all surfaces should be physically cleaned with a detergent solution followed or combined with a chlorine based product such as sodium hypochlorite or another hospital grade disinfectant.

Q. When are chemical disinfectants required?

A. Disinfectants are usually only necessary if a surface that has already been cleaned with detergent and water is suspected or known to have been contaminated by transmissible infections such as COVID-19, norovirus, multidrug resistant organisms and or other potentially infectious material including blood and other body fluids and after cleaning during a terminal/discharge clean.

- Disinfectants are used as either a
 - 2 steps clean - a physical clean using a detergent followed by disinfection with a chlorine-based product such as sodium hypochlorite or another appropriate disinfectant

- 2 in one clean - a physical clean using a combined detergent and a chlorine-based product such as sodium hypochlorite or another appropriate disinfectant.

It is essential to remember that physical (mechanical or manual) rubbing is the most important step in cleaning.

Q. Is there a recommendation regarding the use of alternative disinfection systems?

A. Some modes of disinfection have emerged and undergone further development for use in healthcare facilities in recent years.

These include:

- Ultraviolet light
- Hydrogen peroxide vapour
- Electrolysed water

The evidence of the effects of these emerging disinfection methods on clinical outcomes remains sparse. If emerging disinfectant technologies are being considered for introduction into healthcare facilities it is appropriate to consider carefully if there is evidence that they deliver patient benefits proportionate to the cost. They should be utilised in addition to standard cleaning practices rather than instead of.

Q. What should be done with soft furnishings that become soiled and stained and cannot be adequately cleaned?

A. Soft furnishings that are used in residential facilities should be chosen for ease of cleaning and compatibility with detergents and disinfectants. Ideally, they should be covered in a material that is impermeable, preferably seam-free or heat sealed. Fabric that becomes soiled and stained and cannot be adequately cleaned should be replaced.

Subject topic 4: Testing

Q. How does a residential care facility organise COVID-19 testing for a resident if they do not have a staff member trained to test?

A. Where testing is required, the patient's GP is the usual contact point with respect to testing people with suspected COVID-19. GP will arrange testing where individuals are suspected with COVID-19 symptoms. National Ambulance Service will provide the testing if there is no staff member locally available to undertake the procedure.

Q. If the result 'virus not detected' does not mean a resident is negative what does it mean?

A. Not detected on a nasopharyngeal swab test means the virus has not been detected from the sample taken at that point in time so they probably do not have infection. Do bear in mind that the test is not perfect so it is still possible that the person has COVID-19 so it is important to consider the patient's condition as well as the test result.

Subject topic 5: Care equipment

Q. Can hairdressers who visit the RCF use a hair dryer?

A. Yes. There is no evidence that hairdryers increase the risk of transmission of COVID-19.

Q. What is the difference between single use equipment, single patient use equipment and reusable equipment.

A. Non-invasive care equipment generally falls into three categories including:

- **Single-use** – equipment which is used once on a single resident and then discarded, it must never be reused even on the same resident. The packaging



carries the symbol below.

- Needles and syringes are single use devices. They must never be used for more than one resident or reused to draw up additional medication.
- Medications from a single-dose vial or intravenous (IV) bag should never be administered to multiple residents.
- **Single patient use** – equipment which can be reused on the same resident.
- **Reusable non-invasive equipment** (also known as communal equipment) – such equipment can be reused on more than one resident once it has been cleaned and if appropriate disinfected between use e.g. commode, patient transfer trolley.

Q. Is the use of a mobile fan/dehumidifier permitted in a resident's room?

A. In so far as possible, avoid the use of fans that re-circulate air. Open windows for ventilation if it is safe to do so and it does not cause discomfort for the resident.

It may be necessary to use mobile fans and/dehumidifiers during very warm weather to keep residents cool, in such instances these items should be cleaned regularly and maintained according to the manufacturer's instructions.

Position the fans in such a manner that they do not blow air across an open door causing cross currents of air.

ENDS