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

V4. 22/04/20

Version	Date	Changes from previous version
1.1	30/03/2020	Added information re contact management Edited definition for outbreak of COVID-19 in RCF OCT must be Chaired by Public Health Doctor Hyperlink to case definition added where appropriate Changed term 'self-quarantine' to 'self-isolation' and hyperlinks included where appropriate Edited flow of document and formatting
2	07/04/20	Added acknowledgements Hyperlinks included where appropriate Roles and Responsibilities updated Added Survival in the Environment Added Laboratory testing Added and updated Transfers of Residents between Care Facilities Updated Section on General Preparedness Pastoral Care included Infection Prevention and Control Measures Section updated Environmental Hygiene updated Added Care of the Dying Added Care of the Recently Deceased Preventing and Control of Outbreaks updated Proposal for Occupational Health Supports added as appendix
3	10/04/20	Change in structure of document Change in outbreak definition for public health action purposes Updated management of outbreak Added tools and checklists for management as appendices
3.2	17/04/20	Change in testing strategy to include all residents and staff Change in clinical presentation description Change in outbreak definition for surveillance purposes
4	21/04/20	Change to testing strategy in nursing homes Added mental health commission for reporting of COVID outbreaks Added physical distancing measures for staff while on break times Restructured transfer into RCF section Change to mask wearing guidance for HCW

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 11
4 General measures to prevent a COVID-19 outbreak during the pandemic 12
4.1 Planning 12
4.2 Education 12
4.2.1 Staff 12
4.2.2 Residents 13
4.3 Physical distancing measures 13
4.4 Controls to minimise risk of inadvertent introduction of virus 14
4.4.1 Staff 14
4.4.2 Family and friends 15
4.4.3 Pastoral care 16
4.4.4 Others 16
4.4.5 Resident transfers 16
4.4.6 Prioritisation criteria for placement of transfers to single rooms within RCF 18
4.5 Increase surveillance and early identification of cases COVID-19 infection 18
5 Management of an outbreak of COVID-19 19
5.1 Declaring an outbreak 20
5.2 Outbreak Control Team 21
5.3 Management of a possible or confirmed case of COVID-19 22

5.4 Cohorting residents with possible or confirmed COVID-19 24
5.5 Management of close contacts of a possible or confirmed case of COVID-19 25
5.6 Infection prevention and control measures 26
5.6.1 Standard precautions 26
5.6.2 Hand hygiene 26
5.6.3 Respiratory hygiene and cough etiquette 27
5.6.4 Personal Protective Equipment (PPE) 27
5.6.5 Transmission-based precautions for COVID-19 29
5.6.6 Care Equipment 29
5.6.7 Management of blood and body fluid spillages 30
5.6.8 Management of waste 30
5.6.9 Safe management of linen (laundry) 30
5.6.10 Environmental hygiene 31
5.6.11 Routine cleaning 31
5.6.12 Frequency of cleaning 32
5.6.13 Terminal cleaning 32
5.6.14 Staff uniforms/clothing 33
5.7 Communication 33
5.8 Support services for staff and residents 33
6 Care of the dying 34
7 Care of the recently deceased 34
7.1 Hygienic preparation 34
7.2 Transport to the mortuary 35
8 Monitoring outbreak progress 35
9 Declaring the outbreak over 36
Appendix A: Prevention and control of outbreaks of COVID-19 in RCF 37
Appendix B Proposal for occupational health supports 39
Appendix C: Details for line listing 43
Appendix C: Part 1 – Respiratory outbreak line listing Form – Residents ONLY* 44
Appendix C: Part 2 –Residents ONLY 45
Appendix C: Part 3 – Respiratory outbreak line listing form – Staff ONLY* 46
Appendix C: Part 4 –Staff ONLY* 47

Appendix D: Checklist for outbreak management 48
Appendix E Hand Hygiene poster 50
Appendix F Donning and Doffing PPE 51
Appendix G – Transmission based precautions 52
Table 1: Personal Protective Equipment Requirements by Precaution 52

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 and 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 the public health management and 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.

The guidance is closely based on the "Public Health Guidelines on the Prevention and Management of Influenza Outbreaks in Residential Care Facilities in Ireland 2019/2020" as many of the key features such as planning preparing and managing a RCF in COVID19 pandemic are the same as in seasonal influenza.

Please note that this document is issued as preliminary guidance however elements of this document 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.

Under the Infectious Diseases Regulations 1981, any medical practitioner who is aware of a case of COVID-19 or an outbreak, is obliged to notify the Medical Officer of Health (MOH) at the regional Department of Public Health. Contact details can be found here on the HPSC website.

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

The Regional Department of Public Health is responsible for investigating cases and outbreaks of COVID-19 and providing overall leadership and oversight for outbreak management.

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

It is important to remember that elderly people often present atypically with symptoms such as:

- **lethargy**
- **increased confusion**
- **change in baseline condition**

- **loss of appetite**

Clinical judgement with a high index of suspicion should be used when assessing residents.

3.5 Laboratory testing

- Laboratory testing is helpful to confirm a diagnosis of COVID-19 infection.
- 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.
- 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. Confirm in advance with your local laboratory how samples from suspected outbreaks in RCF are being prioritised.
- 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.

As of 18/04/2021, the National Public Health Emergency Team adopted the following testing strategy in nursing homes:

- In the event of a case in a nursing home, all residents and all staff should be tested for COVID-19.
- In those nursing homes where there are current outbreaks, all residents and staff who have not yet been, should also be tested.
- In those nursing homes where there are currently no cases, all staff should be tested.

4 General measures to prevent a COVID-19 outbreak during the pandemic

4.1 Planning

- 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 and promoting resident and family communication.
- Where possible, each ward or floor should try and operate as a discrete unit or zone, 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 and will allow outbreak response measures to be targeted in zones, rather than having to be implemented facility wide.
- 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.
- A summary table of key interventions for the prevention and management of a COVID-19 outbreak can be found in Appendix A.

4.2 Education

4.2.1 Staff

- 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.

- 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.

4.2.2 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.

4.3 Physical distancing measures

- Residents should be encouraged to stay in their bedroom as much as practical but with regard for their overall wellbeing.
- Residents should be encouraged to maintain a distance of 1 to 2 m from other residents and staff. They 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 physical distancing measures, meals may need to be staggered or served in the residents' rooms.

- Each facility should undertake a review of their daily activities, workflow and staffing allocation and discontinue congregate activities such as watching TV in groups.
- Group activities that are necessary for residents' welfare should be risk assessed for necessity and only conducted with small groups of residents where possible. Consider discontinuing completely for a short period of few weeks.
- In this context, consider establishing small groups who consistently attend group activities with each other rather than having new ad-hoc groupings formed for each day/ activity.
- Those group activities considered 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).
- Staff members should also be advised to adopt physical distancing measures during their break and meal times.

4.4 Controls to minimise risk of inadvertent introduction of virus

4.4.1 Staff

- Staff should only work in one RCF and not move across settings.
- Staff should be allocated to one zone within the facility if at all possible.
- 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 twice a day, once being 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.
- Staff who become unwell at work should immediately report to their line manager and 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

- Occupational health guidance for healthcare workers is available at https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/occupationalhealthguidance/
    - Staff members who test positive for 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.
    - Staff that are 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 to return to work for healthcare workers who are close contacts of COVID-19 cases can be applied with appropriate caution in RCF, given the high risk of adverse outcomes in these groups in the event of severe staff shortages leading to patient safety issues.
- Available Occupational Health supports are detailed in Appendix B.

4.4.2 Family and friends

- Family and 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 visiting restrictions 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 and 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.**

- The 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 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.

4.4.3 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, pastoral care can be provided remotely e.g. by phone, video link this is preferable.

4.4.4 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.

4.4.5 Resident transfers

4.4.5.1 Transfer to an acute hospital

Outward transfer for attendance or care off-site should only be necessary to provide essential care to resident. In such cases, NAS and the local receiving hospital should be notified of the transfer in advance in either COVID positive or suspected COVID residents. COVID positive status in itself does not preclude transfer to acute hospital where it is deemed clinically appropriate.

4.4.5.2 Admissions from the community or acute hospitals

Although accepting admission or transfer of residents 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.

Transfer/admission of asymptomatic residents:

- Wherever possible, every resident transferred from an acute hospital to a RCF 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.

Transfer/admission of symptomatic resident:

- 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-19 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.
    - Residents who fulfil the above criteria are not infectious and do not need any special considerations in terms of placement within the RCF.

4.4.6 Prioritisation criteria for placement of transfers to single rooms within RCF

- 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 new symptoms consistent with COVID-19 infection for whom a laboratory test is not yet available.
    2) 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.
    3) 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.

4.5 Increase surveillance and early identification of cases COVID-19 infection

- Surveillance (monitoring for illness) is an essential component of any effective infection control programme.
- RCFs should ensure that they have means in place to promptly test symptomatic residents, get results prioritised and control the spread of COVID-19 within facilities such as staff education and active monitoring of residents. Current case definition can be found here.
- The facility should ensure that there is twice daily active monitoring of residents 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.

- There should be early identification of staff absenteeism which may be due to COVID-19 infection or restricted movements as close contact of a case.

5 Management of an outbreak of COVID-19

Given the severity of the consequences resulting from an outbreak in the RCF setting, it is prudent to take initial public health actions as that taken for an outbreak, even if 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 investigation, Contacting Public Health or implementing control measures. There should be heightened awareness amongst staff so that other residents with symptoms are quickly identified. This is even more important when a single or suspect case has occurred.

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

This 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?
- Identify are any other residents symptomatic and if so, what are their symptoms?

- Identify are any staff symptomatic or has there been an increase in staff absenteeism?
- 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 the possible case and close contacts should be the same as for a confirmed case of COVID-19 until an alternative diagnosis has been identified.

5.1 Declaring an outbreak

For the purposes of public health action, the threshold for an outbreak of COVID-19 is defined as*:

- a single suspected case of COVID-19 in a resident or staff member acquired in the RCF

OR

- one confirmed case of COVID-19 in a resident or staff member acquired in the RCF.

For the purposes of epidemiological surveillance, an outbreak of COVID-19 is defined as*:

- two or more cases of illness consistent with COVID-19 infection in residents or staff members and at least one person is a confirmed case of COVID-19

OR

- two or more cases of illness consistent with COVID-19 infection in residents or staff members and there is a strong suspicion that it is caused by COVID-19 (do not report as outbreak of ARI at this time)

**These definitions 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.

5.2 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.
- Public Health doctors from the Regional Department of Public Health will provide overall leadership for the management of the COVID-19 outbreak in the RCF.
- Ideally, the OCT should have regular, active 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 on a regular ongoing basis with the regional Public Health Department to provide updates on outbreak progress and seek further advice as appropriate.
- The OCT configuration should be decided at local level and will depend on available expertise.
- An OCT chair should be agreed.
- 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 from RCF
    - 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

- Every member involved should have a clear understanding of their role and responsibility.
- The frequency required for the outbreak meeting should be decided and they should be carried out remotely.
- Public Health will formulate a case definition, assign an outbreak code and decide as to whether an onsite visit is required or not.
- The RCF should inform HIQA or Mental Health Commission and the local CHO as appropriate and 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. Template can be found in Appendix C.
- Identify the total number of people ill (residents & staff) and the spectrum of symptoms.
- Identify staff and residents who have recently 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.
- A checklist for outbreak management can be found in Appendix D.

5.3 Management of a possible or confirmed case of COVID-19

- The initial assessment of the resident should be performed by their doctor by telephone.
- If COVID-19 is suspected, the doctor will arrange testing through the usual the National Ambulance Service or request testing by a RCF staff member if person who can take the sample if available.

- If the clinical condition does not require hospitalisation, they should not be transferred from the facility on infection prevention and control grounds.
- Where there is capacity, residents with possible 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 (dirty utility) 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 a second person not available change gloves and perform hand hygiene and put on a clean pair of disposable gloves
- 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.

- 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.
- 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.
- 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.

5.4 Cohorting residents with possible or confirmed COVID-19

- Placement of residents with possible or confirmed COVID-19 in a dedicated ZONE with dedicated staffing (where staffing levels permit) to facilitate care and minimise further spread is known as cohorting. As the lay-out for each RCF will differ, the zoned area can be a floor, a wing or a separate annex. In these zoned areas, heighten infection prevention and control measures are critical.
- 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 probable 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 in one zone 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 probable COVID-19 should not be cohorted with those who are confirmed positive;
    - The risk of cohorting **probable 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 that the area is a designated zone to alert staff of cohorting location in the RCF. 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.

5.5 Management of close contacts of a possible or confirmed case of COVID-19

- Residents who are contacts of a confirmed or possible 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.

5.6 Infection prevention and control measures

5.6.1 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:

5.6.2 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 E.

5.6.3 Respiratory hygiene and cough etiquette

- Respiratory hygiene and cough etiquette refer to measures taken to reduce the spread of viruses via respiratory droplets produced when a person coughs or sneezes.
- 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 Alcohol Based Hand Rub (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.

5.6.4 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 F and https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/
- Current guidance in the context of COVID-19 for the use of surgical masks by HCW states that:
    - Healthcare workers should wear surgical masks when providing care to patients within 2 m of a patient, regardless of the COVID 19 status of the patient
    - Healthcare workers should wear surgical masks for all encounters with other HCWs in the workplace where a distance of 2 m cannot be maintained
- 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) when moving between patients with a diagnosis of COVID-19, 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.

5.6.5 Transmission-based precautions for COVID-19

- Transmission based precautions 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. See Appendix G. They include contact, droplet and airborne precautions. In general, COVID-19 is spread by respiratory droplets – 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/
- Transmission based precautions should be applied immediately to all suspected cases of COVID-19.
    - 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 resident's home. A pragmatic, compassionate and proportionate approach may be necessary when considering the care needs of the resident balanced against the risk to others.

5.6.6 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

5.6.7 Management of blood and body fluid spillages

- Should be managed in line with local policy

5.6.8 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).
- 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.

5.6.9 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.

5.6.10 Environmental hygiene

- 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.

5.6.11 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 resident's 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.

5.6.12 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.

5.6.13 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.

5.6.14 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.

5.7 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.

5.8 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.

6 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.

7 Care of the recently deceased

7.1 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.

7.2 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
- Play 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 <u>not required</u> for transfer, once the body has been placed in the coffin.

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.

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).

Appendix A: Prevention and control of outbreaks of COVID-19 in RCF

	Domain	Action	Comment
Pre-Outbreak Measures	Planning and Administration	Written Policies	Immunisation policies Standard transmission based precautions including droplet and contact Written outbreak management plan
		RCF Lead (Named person)	To oversee development, implementation and review of policies and procedures
		Training and Education	For all staff Ongoing training Measures to improve compliance
		Provision of supplies	Hand hygiene supplies, PPE, disinfection materials, arrangements for prioritised testing of samples
	Standard Precautions	Standard infection control procedures	SP should be practiced by all staff at all times
	Surveillance	Awareness of signs and symptoms of COVID	
Early recognition	Case Definition	As per HPSC guidance	Case definition may change as pandemic progresses
	Outbreak Definition	Action threshold for outbreak control measures	One suspected or confirmed case for public health action
	Communication of suspected outbreak	Notification of senior management, medical and public health staff, CHO and NH lead	Follow RCF algorithm
	Formation of outbreak control team (OCT)	OCT may be convened following risk assessment	
	Testing	Viral swab	As per current guidance
	Initial Actions	Daily Case list	
		Activate Daily surveillance	
		Appropriate IPC precautions in place	Droplet and contact precautions in the cohorted area/zone
		Resident placement	Single rooms Cohorting or Zone allocation
		Respiratory etiquette	

During an Outbreak			
	Infection Control Measures	Hand Hygiene	5 Critical points: • Before patient contact • Before septic task • After body fluid exposure • After patient contact • After contact with patient surroundings Hand hygiene after PPE removal
		PPE	Gloves Aprons Gowns Face protection
		Aerosolised generating Procedure	See HPSC guidance document. Highest level of PPE (FFP2/3) available if performing a high risk AGP
	Environmental control measures		Resident environmental cleaning and disinfection Residential Care Equipment Laundry Eating utensils and crockery
	Containment Measures		New admissions restricted Transfers restricted Restricted communal activities Staffing precautions Visitor restrictions
Post Outbreak	Declaration of end of outbreak		As advised by Public Health
	Final evaluation	Review of management of outbreaks and lesson learned	Coordination with Public Health and OCT if this was convened

Appendix B 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)

Strengthened HSE National and Regional Governance Structures

Proposed Referral AND Escalation Pathway for OH supports

Local LTRC	Community Health Organisation	Designated OH Nursing Supports	Designated OH Medical Supports
Donegal Sligo, Leitrim Cavan, Monaghan Mayo, Roscommon Galway Limerick	**CHO 1** Donegal/Sligo/Leitrim/Cavan/Monaghan **Frank Morrison** Frank.Morrison@hse.ie **CHO 2** Galway/ Roscommon Mayo **Martin Greaney** Martin.Greaney@hse.ie **CHO 3** Clare/ Limerick/ North Tipp/East Limerick **Paschal Moynihan** Paschal.Moynihan@hse.ie	Supportregion1@centrichealth.ie	**Dr Muiris Houston**
Kerry, Cork, Waterford, Wexford, Tipperary, Kilkenny, Carlow	**CHO 4** North Cork North Lee South Lee West Cork Kerry **Gabrielle O'Keeffe** Gabrielle.Okeeffe@hse.ie **CHO 5** Waterford Wexford Carlow/Kilkenny Tipperary South **Kate Killeen White** Kate.Killeen@hse.ie	Supportregion2@centrichealth.ie	**Dr Peter O'Callaghan**
Wicklow, Kildare, South Dublin	**CHO 6** Dublin South East Dun Laoghaire Wicklow **John O'Donovan** John.Odonovan1@hse.ie **CHO 7** Dublin South City Dublin West Dublin South West Kildare/West Wicklow **Carol Cuffe** Carol.Cuffe@hse.ie	Supportregion3@centrichealth.ie	**Dr Lena Murphy**

Offaly, Longford, West Meath Laois, Cavan, Monaghan, Louth, North Dublin	**CHO 8** Laois/Offaly Longford/Westmeath Louth Meath **Jude O'Neill** CHO8.socialcare@hse.ie **CHO 9** Dublin North Central Dublin North West Dublin North **Olive Hanley** hosc.dncc@hse.ie	Supportregion4@centrichealth.ie	**Dr Fiona Kevitt**

Helpline 1850 420 420 8am-8pm Monday to Friday 9 am- 5 pm Weekends

(Fully staffed helpline for all HCW with medical and nursing OH advice)

Appendix C: Details for line listing

1. Outbreak code (on top of line list as title)
2. Name of case
3. Case ID
4. Location (unit/section)
5. Date of birth/age
6. Gender
7. Status i.e. resident, staff member, volunteer, visitor
8. Date of onset of symptoms
9. Date of notification of symptoms
10. Clinical symptoms (outline dependent on case definition) e.g. fever, cough, myalgia, headache, other
11. Samples taken and dates
12. Laboratory results including test type e.g. RT-PCR,
13. Date when isolation of resident was started
14. Date of recovery
15. Duration of illness
16. Outcomes: recovery, pneumonia, other, hospitalisation, death
17. Also include work assignments of staff and last day of work of ill staff member
18. State if staff worked in other facilities

Have separate sheets for both staff and residents

Appendix C: Part 1 – Respiratory outbreak line listing Form – Residents ONLY*

Name of Facility: …… Name of Outbreak: …… Outbreak Code:……

ID	Surname Firstname	Location (unit/section)	Sex	DOB (dd/mm/yy)	Age	Onset (date)	Fever ≥38°c (Y/N)	Cough (Y/N)	Shortness of Breath (Y/N)	Other symptoms (state)

Key: (Y =Yes, N=No, U=Unknown)

***Please complete for all current and recovered cases**

Appendix C: Part 2 –Residents ONLY

Name of Facility: …… Name of Outbreak: …… Outbreak Code……..

	Test Results		Outcome			
ID	Pathology Test Done Yes/No, If yes, date:	Type of Test and Result	Pneumonia	Hospitalisation (Date)	Death (Date)	Recovered to pre-outbreak health status. Yes/No. If Yes, date:

Key: (Y =Yes, N=No, U=Unknown)

Appendix C: Part 3 – Respiratory outbreak line listing form – Staff ONLY*

Name of Facility: …….. Name of Outbreak: …….. Outbreak Code……..

ID	First name Surname	Position	Location	Sex	DOB (dd/mm/yy)	Age	Onset (date)	Fever ≥38°c (Y/N)	Cough (Y/N)	Shortness of Breath (Y/N)	Other symptoms (state)	Work at any other facility? (Y/N) If YES, state location

Key: (Y =Yes, N=No, U=Unknown)

***Please complete for all current and recovered cases**

Appendix C: Part 4 –Staff ONLY*

Name of Facility: ……. Name of Outbreak: ……. Outbreak Code:…….

	Test Results		Outcome				Work exclusion
ID	Pathology Test Done Yes/No, If yes, date:	Type of Test and Result	Pneumonia	Hospitalisation (Date)	Death (Date)	Recovered to pre-outbreak health status. Yes/No. If Yes, date:	Excluded from work until (Date)

Key: (Y =Yes, N=No, U=Unknown)

Appendix D: Checklist for outbreak management

	Discussion point	Decision/action to be taken (date completed)	Person responsible
1	Declare an outbreak and convene an OCT following Public Health risk assessment		
2	Agree the chair		
3	Formulate an outbreak code and working case definition		
4	Define the population at risk		
5	Active case finding, request line listing of residents and staff from the RCF		
6	Discuss whether it is a facility-wide outbreak or unit-specific		
7	Confirm how and when communications will take place between the RCF, CIPCN, CHO NH lead, Public Health and the laboratory		
8	Review the control measures (infection control necessary to prevent the outbreak from spreading). Confirm that the management of the facility is responsible for ensuring that agreed control measures are in place and enforced		
9	Discuss which specimens have been collected. Notify the laboratory of the investigation.		
10	Confirm the type and number of further laboratory specimens to be taken. Clarify which residents and staff should be tested.		
11	Confirm that the laboratory will phone or fax results (both positive and negative) directly to the requesting doctor and that this person will notify Public Health. Review the process for discussing laboratory results with the RCF's designated officer.		
12	Liaise with the RCF and laboratory regarding specimen collection and transport		
13	Identify persons/institutions requiring notification of the outbreak e.g. families of ill or all residents of the facility; health care providers e.g. GPs, physiotherapists etc.; infectious disease consultants, consultant microbiologists, infection prevention &		

	control specialists, Emergency Departments; local hospitals, other RCF, HPSC		
14	Discuss whether a media release is required		
17	Ensure that the incident is promptly reported to HPSC and surveillance details entered onto CIDR		
18	Provide updates on the investigation to the Assistant National Director, ISD-Health Protection when/if required		
19	Discuss communication arrangements with HSE management ± HSE crisis management team		
20	Discuss communication arrangements with local GPs and Emergency Departments		
21	Decide how frequently the OCT should meet and agree criteria to declare outbreak over		
22	Prepare/circulate an incident report/set date for review meeting		

Appendix E Hand Hygiene poster

Appendix F Donning and Doffing PPE

Putting on PPE

1. Decontaminate hands
2. Put on disposable apron/gown
3. Put on mask (Surgical or FFP2 **For AGP)**

For FFP2

Fit Check

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

4. Put on goggles if required
5. Put on gloves

Removing PPE

In patients' room

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)

In ante room or directly outside patients' room. Ensure door is closed

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

6. Discard all masks (& gloves/aprons/gowns/goggles contaminated with blood or body fluids) as healthcare risk waste
7. Decontaminate your hands

Appendix G – 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