Australian Government

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Infection Control Expert Group

Guidance on infection prevention and control for residential care facilities in the context of COVID-19

16 June 2021

Background

This guidance from the Infection Control Expert Group (ICEG) has been endorsed by the Australian Health Protection Principal Committee. It provides guidance on infection prevention and control (IPC) and the use of personal protective equipment (PPE), in residential care facilities (RCFs) during the COVID-19 pandemic.

The PPE guidance in this document was developed with advice from the National COVID-19 Clinical Evidence Taskforce Infection Prevention and Control Panel (IPC Panel).
The PPE recommendations in this document are consensus recommendations based on the combined expertise and experience of IPC Panel and ICEG members. They reflect current and emerging evidence concerning all potential modes of viral transmission and the increased transmissibility of SARS-CoV-2 variants of concern.

The guidance contained in this document outlines the **minimum national standards** for IPC and PPE for RCF staff[1] working within the resident zone,[2] in the context of COVID-19. This guidance is not meant to be exhaustive but instead aims to supplement more detailed guidance available at a state, territory and institutional level.

PPE is a critical part of IPC. However, PPE should be considered as the last line of defence within a broader 'hierarchy of controls' framework. This includes minimisation of risk through the implementation of administrative and engineering controls, and other interventions, in combination with appropriate PPE.

The consensus recommendations on PPE outlined in this guidance will be revised as new research evidence and information emerges. This guidance should be read in conjunction with the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021), whilst acknowledging the unique circumstance of COVID-19 and requirement for additional PPE in some circumstances.

Scope

This document provides guidance on IPC, including the use of PPE by RCF staff[1] who work within the resident zone.[2]

For additional guidance on IPC during the COVID-19 pandemic, see the Department of Health website. For additional guidance on COVID-19 outbreaks in RCFs, including maintaining a COVIDSafe workplace, see the guidance from the Communicable Diseases Network Australia.[3]

For current COVID-19 case definitions and testing criteria, see the Communicable Diseases Network Australia National Guidelines for Public Health Units.

[1] Includes all direct care workers, personal care workers and support staff who are exposed to residents of residential care facilities

[2] Includes being in the same room as a resident and in corridors, communal areas and other areas of a facility where residents may enter

[3] See Communicable Diseases Network Australia *Guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia*

General principles of IPC in RCFs

- Use a risk assessment process to ascertain and manage the risk of infection. Apply a range of IPC measures using the hierarchy of controls.
- Provide information about routine IPC to staff, residents and visitors (as appropriate).
- Train all staff (including agency and short-term contract staff) in basic IPC practices including standard and transmission-based precautions:
    - When they begin working at the facility
    - At regular intervals (annually or more frequently, as required, for example when the risk of an outbreak is higher due to a community outbreak).
- Training should be appropriate to staff's respective roles and should, at a minimum, include hand hygiene, cough etiquette and respiratory hygiene, and the correct use of appropriate PPE.

Routine IPC measures relevant to any infectious disease risk

- Do not come to work if unwell. If uncertain about whether to stay away and for how long, liaise directly with your line manager.
- Limit unnecessary movement of residents within the facility.
- Limit movement of staff between facilities, including implementing single site workforce arrangements, where appropriate.
- Strongly recommend annual influenza (and COVID-19, when available) vaccination to residents, staff and visitors to RCFs.
- Use standard, contact and droplet precautions (as a minimum) when caring for a resident with a respiratory infection.
- Frequently clean and disinfect (at least daily) floors, surfaces, and frequently touched or dirty objects and surfaces.[4]
- Ensure adequate provision and appropriate use of PPE, especially when caring for a resident with a respiratory infection.
- Strongly recommend cough etiquette and respiratory hygiene for staff, residents (if possible) and visitors.
- Strongly recommend hand hygiene using soap and water or alcohol-based hand sanitiser and provide alchol-based hand sanitiser for staff, residents and visitors.

Preparing for and responding to COVID-19 outbreaks in RCFs

The RCF should form an Outbreak Management Team to develop an Outbreak Management Plan.[5] In relation to IPC, the Plan should:

- Include easily found internal policies and procedures on routine, standard and transmission-based IPC precautions.
- Be informed by advice and on-site risk assessment from an IPC professional.

[4] See *Environmental cleaning and disinfection principles for health and residential care facilities*

[5] See Communicable Diseases Network Australia *Guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia*

- Ensure adequate supplies of PPE, alcohol-based hand sanitiser and cleaning materials.
- Ensure staff know and can recognise the symptoms and signs of COVID-19.
- Ensure staff have training in IPC procedures (as above), including donning and doffing of PPE.
- Consider the need to extend the use of PPE if the numbers of cases, contacts and/or resident areas or zones affected increase significantly. This may include using PPE beyond the situations recommended in this document.
- Include a systematic strategy for detecting cases and managing residents or staff who develop symptoms consistent with COVID-19.
- Consider the need for a program of repeat tests for those in quarantine as directed by the public health unit.
- Ensure daily handover for acute respiratory infection monitoring and outbreak detection for staff performing this task.
- Notify the local public health unit if an acute respiratory infection or COVID-19 case is suspected.

Visitor restriction and signage

Movement of visitors[6] into and within the facility should be limited and physical distancing measures maintained. Implement the following IPC precautions. These restrictions apply regardless of COVID vaccination status of the resident or visitor.

- Follow, and stay up to date with, relevant advice on outbreak management in high-risk settings[9] and visitor restrictions.
- Screen visitors on entry to the facility for epidemiological (recent travel, contact with a COVID-19 case, attendance at current exposure site as per public health unit advice) and clinical risk factors (acute respiratory infection, fever/history of fever or loss of smell or taste) and do not permit entry to those with epidemiological or clinical risk factors.
- If appropriate, implement IPC precautions to protect staff and other residents. Visiting restrictions may be relaxed in the context of end-of-life palliative care.
- Encourage and facilitate phone or video calls, or visits with physical barrier (for example window, balcony or ‘see-through’ fence) between residents and their friends and family members to maintain social contact while visiting restrictions are in place.
- Record contact details for all visitors to assist with contact tracing in the event of a COVID-19 outbreak.
- Ensure all visitors, including essential external providers:
    - Visit only one resident (or staff member).
    - Go directly to the resident’s room or area designated by the RCF, and avoid shared areas.
    - Stay 1.5 metres from residents, if possible.
    - Use alcohol-based hand sanitiser or wash their hands before entering and on leaving the RCF and the resident’s room.
    - Use appropriate PPE, as advised by the public health unit.
    - Practise cough etiquette and respiratory hygiene.

[6] Includes external contractors, external clinicians, general practitioners, allied health and other workers who may attend a facility

    - If visiting a resident who is in isolation or quarantine, follow appropriate IPC and PPE advice, as directed by RCF staff.
- Post signs or posters at the entrance and other strategic locations to remind visitors of the precautions, including donning and doffing instructions at PPE stations.

New admissions and readmissions during an outbreak

- RCFs should not admit new residents during an active outbreak at a facility.
- Residents who are in hospital for any reason, including COVID-19, should, if possible, be readmitted to the RCF as soon as they are well enough and no longer considered to be infectious for SARS-CoV-2.
    - Consider this case-by-case, including the patient's clinical condition, infectious status, and the circumstances within the facility.
    - If in doubt, talk to the hospital clinical and IPC teams, and facility's consultant IPC professional.
- Discuss appropriate next steps for placement of the resident with them, their representative, and their hospital team.
- Returning residents should be screened for relevant symptoms.

Resident movement during an outbreak

- Avoid non-essential resident transfers to minimise spread. If transfer is necessary, the resident should be tested for SARS-CoV-2 and quarantined until the result is known.
- Limit internal movement of residents, visitors and staff within the facility, as far as possible, to help stop the spread.
- Implement physical distancing measures in shared living and dining areas.
- Follow, and keep up to date with, relevant guidelines for outbreak management in RCFs.[8]

Placement of residents within the RCF

Whether or not residents with COVID-19, and their contacts can be safely cared for within the facility during an outbreak[7] depends on the circumstances and local epidemiological context. This includes local response plans and state or territory requirements.

There must be enough suitably trained staff, appropriate facilities, and adequate PPE to care for unwell residents and protect unaffected residents. Facilities should work with the local public health unit and state and national response team to facilitate safe care through surge staffing or transfer in accordance with current public health directions.

Resident and family preferences should also be considered.

Placement of residents with suspected or confirmed COVID-19

If residents with suspected or confirmed COVID-19 are cared for within the facility, isolate and care for them in single rooms.

- Residents should be isolated while they are infectious (as determined by the local public health unit).

[7] See the *Communicable Diseases Network Australia National Guidelines for Public Health Units*

- Isolated residents, if well enough, may be able to leave the room for exercise, following a risk assessment.
    - Exercise should take place outside.
    - Residents must be supervised and not come into contact with other residents.
    - If residents leave their room while infectious, they need to:
        - Wear a surgical mask
        - Perform supervised hand hygiene before leaving their room
        - Avoid touching objects or surfaces in common areas.
- Remind staff and residents of the need for cough etiquette and respiratory hygiene.
- Staff and visitors in contact with residents who are unwell or are suspected or confirmed cases of COVID-19 (even if asymptomatic), must wear appropriate PPE (see below).
- PPE supplies must be readily available and placed in a clean zone immediately adjacent to residents' rooms.
- Residents with dementia and the staff who care for them may need special arrangements to support these residents while in isolation.

Placement of residents who are close contacts of a confirmed COVID-19 case

- Residents who are asymptomatic but have been in close contact with a confirmed COVID-19 case should be quarantined in a single room for 14 days.[8]
- Monitor these residents for symptoms of COVID-19 (e.g. increase in baseline temperature, cough, acute respiratory symptoms, delirium, loss of appetite, diarrhoea, behaviour change) at least every shift.
- Test quarantined close contacts, as determined in consultation with the local public health unit. If a positive result is returned, immediately isolate the resident.
- Quarantined residents may leave their room for exercise or activity, under supervision, to ensure contact with other residents is avoided.
- If a single room is not available to quarantine close contacts, undertake a risk assessment considering the risk of COVID-19 transmission from the confirmed case.
- Residents in quarantine may share a room, only if they are able to fully cooperate with the same precautions as suspected or confirmed cases (see above).

Hospital transfer of residents with suspected or confirmed COVID-19

- The decision to transfer suspected or confirmed COVID-19 cases from their home or RCF to hospital should be made case-by-case.
- The following factors should be taken into account:
    - The resident's medical needs
    - The advice of public health experts and clinicians managing the outbreak
    - Whether the RCF has sufficient and appropriately skilled staff
    - Local health care system arrangements
    - The layout of the facility, adequacy of ventilation, and ability of providers to separate or cohort infected and non-infected residents onsite

[8] For current contact definitions and contact management advice, see the *Communicable Diseases Network Australia National Guidelines for Public Health Units*

    - The wishes of the resident and/or their family or representative and in line with documented goals of care or formal advanced care directives
    - Local state or territory response plans.
- Some residential aged care facilities across Australia have successfully managed outbreaks of COVID-19 while continuing to care for residents within the facility.
    - Staff must consistently practice appropriate IPC precautions, including correct use of PPE, to minimise the risk of transmission and avoid the need to quarantine as close contacts.
- If transfer to hospital occurs, advise the ambulance service and hospital in advance that the resident is from a RCF where COVID-19 is suspected or confirmed.
- If the resident needs urgent medical attention, call 000 and advise the operator of the COVID-19 risk.

Risk assessment to inform the use of PPE

The use of PPE within RCFs should be determined through a risk assessment. This should be undertaken within a standardised risk management framework, which includes higher order controls already in place at an organisational and state and territory level. This should be reviewed whenever the epidemiological circumstances change.

Risk assessment should consider the following factors:

a) Residents' pre-existing likelihood of COVID-19
- Known COVID-19 status
- Symptoms consistent with COVID-19
- Current prevalence and transmission of COVID-19 in the population and whether there are unlinked cases of COVID-19 in the community
- The presence of epidemiological evidence for COVID-19, such as:
    - Close contact, or secondary close contact, with a person with confirmed COVID-19 in the previous 14 days
    - Return from international travel in the previous 14 days, particularly from countries with high prevalence of COVID-19 but excluding green zone countries
    - Attendance at a currently designated COVID-19 exposure risk site in the previous 14 days
    - Residence in, or travel through, a geographically localised area with elevated prevalence or community transmission of COVID-19 in the previous 14 days.

b) Resident factors
- Potential for behaviours that increase the risk of SARS-CoV-2 transmission (e.g. cognitive impairment, inability to cooperate, challenging behaviours, coughing or increased work of breathing)
- Ability/appropriateness of resident to wear a surgical mask.

c) Nature of the care episode
- Duration and proximity of contact between the staff member and the individual
- Types of care that increase the risk of SARS-CoV-2 transmission (e.g. aerosol generating procedures such as airway management and respiratory treatments/procedures).

d) Physical location
- The presence of multiple individuals with suspected/confirmed COVID-19 in an enclosed space

- Whether the environment has low levels of ventilation or unexpected air movements which may facilitate wider distribution of droplets and/or aerosols in the air (or e.g. opening of doors between spaces of differential air pressure or temperature)
- Complex or less controlled care settings, including transport, home or community-based care.

Likely low risk of SARS-CoV-2 transmission

Where risk assessment[9] suggests a likely low risk of transmission, use PPE in accord with existing guidance for standard, contact and droplet precautions as specified in the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021). This may include the use of a surgical mask, gloves, gown, and eye protection, depending on the indications for use.

For further information on the use of PPE, see the ICEG guidance on PPE for health care workers.

Likely high risk of SARS-CoV-2 transmission

Where risk assessment suggests a likely high-risk of transmission, use a particulate filter respirator (PFR), such as P2/N95 respirators, rather than surgical masks, along with the other required PPE as specified in the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2021).

Room placement of high-risk residents should be in a single room with negative airflow. Avoid rooms with positive pressure airflow. Other design types require additional risk assessment (Australasian Health Facility Guidelines, part D, Infection Prevention and Control[10]).

Particulate filter respirators (PFRs)

All staff who work within the resident zone for individuals with suspected or confirmed COVID-19 should have access to P2/N95 respirators. PFRs, such as P2/N95 respirators, should be worn instead of a surgical mask if risk assessment suggests a likely high risk of transmission.

Staff who use P2/N95 respirators should be trained in their correct use. Complete fit testing before first use to select the most suitable PFR. Perform a fit (seal) check properly each time they are used. PFRs must be used correctly in order to provide protection against airborne pathogen transmission. A respiratory protection program should be developed to guide the selection, testing and use of P2/N95 respirators.

For further information on PFRs, including fit checking and fit testing, see the ICEG guidance on PPE for health care workers.

Protective eyewear

The eye is a potential route of transmission for SARS-CoV-2. Protective eyewear can protect the eye from contamination with particles and body fluids that may contain SARS-CoV-2. It also can prevent people from touching their eyes and spreading virus from their hands to their face and eyes.

[9] Refer to jurisdictional risk matrix on mask use

[10] See https://healthfacilityguidelines.com.au/part/part-d-infection-prevention-and-control-0

Use protective eyewear, in addition to other required PPE, when working within the resident zone with individuals:

- With confirmed, or suspected COVID-19
- Who have epidemiological risk factors and symptoms consistent with COVID-19
- Who have clear epidemiological risk factors and are either asymptomatic or have non-specific signs of infection.

Standard Precautions apply in all risk assessment and eyewear recommended where risk of exposure (splash) from blood or body fluids is anticipated.

For information on types and use of protective eyewear, see the ICEG guidance on PPE for health care workers.

Showering or bathing residents with confirmed COVID-19

RCF staff may consider continuing to shower residents with confirmed COVID-19, unless:

- Their medical condition interferes with the ability to shower safely, or
- The conditions pose an unacceptable risk to staff or other residents.

A risk assessment should be undertaken to determine whether showering conditions are acceptable.

Consider whether:

- The room is sufficiently ventilated
- The layout of the shower room enables safe showering
- An appropriate distance from other residents can be maintained
- The resident is able to cooperate

Also consider:

- The degree of support a resident needs to complete the activity
- The time spent by a staff member in very close proximity and the need for a shower

Provide alternative hygiene care, such as a bed bath, if the risk of a shower is unacceptably high.

If risk assessment suggests an acceptable risk, all staff helping with showering or bathing should wear appropriate PPE.

- Wear a surgical mask or PFR (depending on risk assessment), face shield, fluid resistant gown and water resistant boots or shoe covers.
- Turn on extractor fans while showering and leave the door open, if possible.
- Use a very gentle stream of water from a handheld shower head, to reduce the risk of droplet aerosols.
- Avoid getting the mask wet, as much as possible.
- Replace gowns and mask after the shower.
- Replace non-reusable face shields or clean and disinfect reusable face shields.

Exclusion from work for RCF staff for COVID-19

RCF staff who have epidemiological risk factors for COVID-19[7] (besides being a health or residential care worker with direct patient contact) or symptoms consistent with COVID-19[11] should:

- Seek medical advice and be tested
- Not attend work until a negative test has been returned and symptoms have resolved completely
- Remain in quarantine (if needed) until cleared.

Duration of isolation precautions for confirmed COVID-19 patients

- The local public health unit should determine, case-by-case, when isolation precautions for residents who have had COVID-19 should be stopped.[12]
- Outbreak precautions for the facility should stay in place until the outbreak is declared over, on advice from the public health unit.[9]

Environmental cleaning

- During an outbreak, RCFs need to increase cleaning and disinfection of shared areas and residents' rooms.
- Clean frequently touched surfaces and disinfect often.
- Any resident care equipment should be cleaned and disinfected between each use or used exclusively for individual residents.[13]

Handling of linen

- Soiled linen should always be treated as infectious.
- Routine procedures are sufficient for handling linen from residents in a RCF with a COVID-19 outbreak. This includes the linen of residents in quarantine or isolation.
- Relatives should not take linen home for washing.
- Place grossly contaminated / soiled linen in a soluble plastic bag and then in the linen skip. Alternatively, line the linen skip with a plastic bag for soiled linen.

Food service and utensils

- Follow the rules of food hygiene in food preparation and service.
- Perform hand hygiene before preparing or serving food to residents.
- Disposable crockery and cutlery are not needed.
- Wash crockery and cutlery in a dishwasher, if available. Otherwise wash with hot water and detergent, rinse in hot water and leave to dry.

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[11] See the Communicable Diseases Network Australia *COVID-19 National Guidelines for Public Health Units*

[12] See Communicable Diseases Network Australia *Guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia*

[13] See *Environmental cleaning and disinfection principles for health and residential care facilities*

- Cutlery and crockery from ill residents does not need to be washed separately. Hot water and detergent will kill the virus.
- Staff should wash or sanitise their hands after collecting or handling used crockery and cutlery. Trays and utensils can be contaminated with saliva or droplets from coughing or sneezing.
- Clean and disinfect trays and trolleys used for delivery of food after use.

Waste management

- Manage waste in line with routine procedures.
- Dispose of clinical waste in clinical waste streams.
- Dispose of non-clinical waste into general waste streams.

Management of deceased bodies

- Follow the relevant advice for handling of bodies affected by COVID-19.[14]
- Normal processes apply to managing deceased bodies.
- RCFs should follow the same precautions when handling the body as when caring for the resident during life. RCFs should follow contact and droplet precautions if the deceased person had COVID-19.
- Place deceased bodies in a leak-proof bag. Staff handling deceased bodies should wear a gown, surgical mask, protective eyewear and gloves.

[14] See *Advice for funeral directors*