Guidance for disability care facilities on the public health management of acute respiratory infections (including COVID-19, influenza, and respiratory syncytial virus)

Revision history

Version	Date published	Summary of amendments
1.2	28th November 2023	• Outbreak preparedness section simplified • Overview of initial actions for ARI symptoms in a resident – flowchart adapted from CDNA guidelines • Changes to case and contact management in line with CDNA guidelines • Reporting - removal of requirement to register positive RAT results with Service NSW • Appendix 1 - key documents - additional resources have been included • Appendix 2 - risk assessment and management matrix updated

1.1	2nd November 2022	• Specific inclusion of respiratory syncytial virus (RSV)
		• Addition of isolation definition in the context of disability care facilities
		• PPE information consolidated into Step 6
		• Updated staff training content within preparedness plan
		• Updated case and contact management table for COVID-19:
		  ○ Removed consideration of immunocompromise from release of isolation for cases
		  ○ Visitors who are cases can visit facility after 7 days (changed from 10 days)
		  ○ Visitors who are contacts should not visit for at least 7 days
		• Staff exposed to COVID-19 are strongly recommended not to enter the DCF for at least 7 days
		• Cohorting and zoning advice updated to reflect the varying layouts of DCFs. Option of amber zone added for consideration if feasible
		• Recommendation for masks during essential offsite appointments for cases/contacts leaving facility
		• Facility consideration for resident/guardian consent when communicating with family and carers
		• Addition of other considerations relevant to an outbreak
		• Updates to Appendix 2 including: risk matrix, recommended actions and inclusion of note that contact assessment and management may differ from this document

1.0	13 July 2022	• Original Document

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Purpose

To provide guidance to disability care facilities (DCFs) on the management of exposures, single cases, and outbreaks of acute respiratory infections (ARI) including COVID-19, influenza, respiratory syncytial virus (RSV) and other respiratory viral infections.

The key resources used in the development of this document are included in Appendix 1.

Context

This guidance recognises that there are different care settings provided for people with disability, also that people with disability are diverse in age, risk of acute respiratory infections and ability to access mainstream health care.

In managing ARIs within disability settings, it is important to balance the level of intervention with the level of risk to the individual and those that they live with.

People with disability

The term 'people with disability' refers to a diverse group of people. Disability includes intellectual disability as well as musculoskeletal (physical), sensory, and psycho-social disability. Disability may be present since birth or acquired through illness, accident, or ageing, and can affect a person's vision, hearing, physical ability, learning or application of knowledge, communication, thinking, mental health or social relationships.

Disability care facilities (DCFs)

- DCFs include:
    - Supported independent living and/or specialised disability accommodation provided under the National Disability Insurance Scheme (NDIS)
    - Disability group homes
    - Assisted boarding houses
- This guidance is targeted at DCFs with 6 or more residents.
- A smaller DCF with less than 6 residents may choose to be managed as a household and follow the Testing positive to COVID-19 and managing COVID-19 safely at home and Advice for people exposed to COVID-19 or they may follow the guidance in this document, particularly where residents are at higher risk of severe illness if they develop COVID-19.

Some residents may be at higher risk of severe illness from ARI. A person with a disability or medical condition that affects their lungs, heart or immune system may be particularly vulnerable to ARI. Additional measures to protect these individuals should be explored.

Overview

- ARI encompasses a range of infections caused by respiratory viruses, including COVID-19, influenza, and RSV.
- Respiratory infections can transmit easily between people sharing common areas. An outbreak occurs when there is spread of the infection in a facility where 2 or more people are affected.
- ARI transmission is primarily via droplet and aerosol spread when infected individuals cough, sneeze, talk or shout.
- Many ARIs can be spread before symptoms appear in an infected person, meaning facilities must have systems for the assessment of residents, and response systems at the first sign of symptoms to contain any potential further spread.
- Symptoms of ARI are often similar regardless of the virus causing illness and therefore testing someone with symptoms is essential to diagnose the pathogen in the first case of illness in the facility.
- Outbreaks can be caused by the spread of more than one respiratory virus, similarly a resident may be infected with more than one respiratory virus at the same time. This may require the use of more than one management pathway at the same time as outlined below (e.g., precautions for COVID-19, influenza, and

RSV at the same time). In complex situations DCFs can consult their **local public health unit (PHU) on 1300 066 055** for advice.

- ARI definition: Recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion with or without other symptoms (see box below).

Other symptoms:

- Headache, muscle aches (myalgia), fatigue, nausea or vomiting and diarrhoea. Loss of smell, taste and appetite can also occur with COVID-19 but may be less common with new variants of the disease.
- Fever (≥37.5°C) can occur, however is less common in elderly individuals or the severely immunocompromised.
- Other symptoms to consider are new onset or increase in confusion, change in baseline behaviour, falling, or exacerbation of underlying chronic illness (e.g. increasing shortness of breath in someone with congestive heart failure).

Residents with non-respiratory symptoms should be assessed for appropriateness of testing for respiratory pathogens, especially if there are already ARI cases in the facility.

- Respiratory viral infections can vary from no symptoms to severe disease and death. Antiviral treatments are available for COVID-19 and influenza and therefore early recognition, testing and diagnosis are important for individual patient management and preventing spread to others.
- The severity of ARI may be increased in people with multiple comorbidities. Some populations are at especially high risk of severe disease and rapid deterioration (e.g., people with intellectual disability, Down syndrome).
- The DCF should ensure staff, family and residents are aware of these symptoms and the need to report them. Note that residents may experience mild symptoms, particularly in a vaccinated population. Residents may have atypical symptoms including behaviour change and may not develop a fever. Ideally, staff should monitor residents to detect subtle changes in condition or behaviour.

Preparedness

All DCFs should have appropriate preparedness plans in place to ensure a prompt and early response to a facility ARI outbreak. A preparedness plan should cover the following:

☐ Promoting vaccination of residents, staff, visitors, and contractors for seasonal influenza and COVID-19 as per ATAGI advice

☐ Encourage GPs to regularly review residents to assess a resident's vaccination status, arrange a pre-filled pathology form for respiratory viral testing (including preparing relevant consent from residents or guardians) and assess suitability for antiviral treatment using the Pre-assessment action plan for respiratory infections.

☐ Facilities should maintain systems for monitoring and recording vaccination status of residents and staff for COVID-19 and influenza

☐ Identify methods to access antiviral treatments rapidly

☐ Plan for potential cohorting of residents and staff with zoning of the DCF

☐ Implementing and monitoring appropriate infection prevention and control strategies, including regular staff training, remaining up to date with staff infection control and outbreak management competency assessment (donning and doffing of PPE and outbreak response actions)

☐ Arrangements for increased PPE, hand hygiene and cleaning supplies

☐ Establishing workforce surge capacity

☐ Ensure adequate supply of RATs or identify procurement methods

☐ Identifying and establishing a working relationship with a local private pathology provider who can assist in specimen collection, and considering logistical arrangements as needed

☐ Promoting regular resident and family communication in an outbreak situation

☐ Alternate arrangements for resident leisure and lifestyle maintenance in an outbreak situation

☐ Ensure alternate arrangement for clinician engagement (e.g. virtual care) as required in an outbreak situation

☐ All DCFs should consider the Advice to residential disability care facilities (RDCF) in relation to entry restrictions for visitors and staff

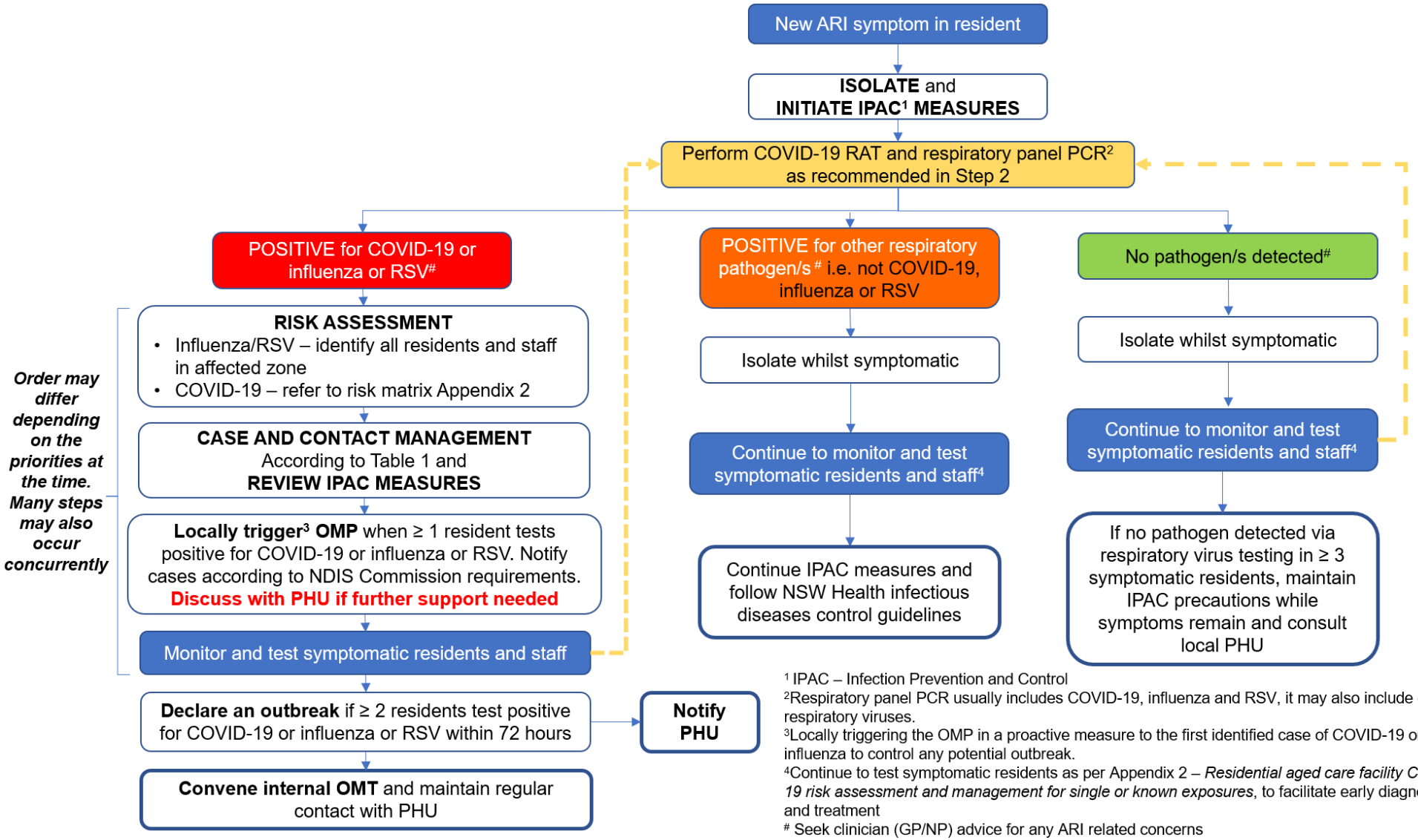
☐ Plan for management of residents with behaviours of concern during an outbreak, see NDIS Quality and Safeguards Commission guidance

See Management and operational plan for people with disability and CDNA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Disability Residential Services for more information.

Responding to ARI symptoms in a DCF resident, staff member or visitor

Some people with disability may experience difficulty communicating ARI symptoms to the people who support them. For some people with disability, changes in behavior may indicate they are unwell. A resident's GP may be able to advise what further investigations are suitable in this circumstance. It is important that residents are routinely monitored, and staff are aware of the range of presentations ARI may have in their clients.

Overview of initial actions- New Acute Respiratory Infection (ARI) Symptoms



[1] IPAC – Infection Prevention and Control
[2]Respiratory panel PCR usually includes COVID-19, influenza and RSV, it may also include other respiratory viruses.
[3]Locally triggering the OMP in a proactive measure to the first identified case of COVID-19 or influenza to control any potential outbreak.
[4]Continue to test symptomatic residents as per Appendix 2 – *Residential aged care facility COVID-19 risk assessment and management for single or known exposures*, to facilitate early diagnosis and treatment
Seek clinician (GP/NP) advice for any ARI related concerns

Initial actions – New ARI symptoms in a resident

The steps outlined below are a guide only, and the step-by-step order may differ depending on the priorities at the time. Many steps may also occur concurrently.

Facilities should have a COVID-19 occupational health and safety plan on how to manage cases within the facility which considers the wellbeing of the case/s as well as the vulnerability of others living within the facility.

The steps in this document should not stop DCF staff seeking urgent medical assistance if a resident's health is deteriorating. Staff should continue to be vigilant in monitoring residents and should refer to the person's care plan for guidance on management of health conditions.

Step 1: ISOLATE the symptomatic resident from other residents in the facility immediately and begin infection prevention and control (IPAC) steps including airborne and droplet precautions for staff in affected areas. Refer to Step 6 for IPAC precautions.

Step 2: TEST the symptomatic resident as soon as possible.

Early diagnosis of COVID-19, influenza, and RSV means earlier treatment and control of any potential outbreak.

- Facilities should work with the resident's GPs on a process to ensure rapid testing (this may include having tests pre-ordered on pathology forms). There should be a process to ensure timely notification of test results from the ordering clinician to the resident or facility as appropriate.
- The first symptomatic resident in a facility should be tested with both a COVID-19 RAT and full respiratory panel PCR to establish the pathogen (or COVID-19, influenza, and RSV PCR as a minimum). Facilities should ensure the pathology order forms include the name of the DCF and the doctor's details. Some people with disability may experience difficulty when having a test. Work with the GP to consider how to manage any barriers to testing and retesting.
- Ensure any symptomatic resident remains isolated until initial testing is complete, and a diagnosis known. Subsequent symptomatic residents during a COVID-19 outbreak should be tested with a COVID-19 RAT.
    - If the COVID-19 RAT is negative, the resident should have a respiratory panel PCR test.
    - If the COVID-19 RAT is positive, the resident should be managed as a COVID-19 case.
- If a false positive RAT result is suspected, facilities should consult with the resident's GP and the PHU.
- If **no** pathogen is detected for three or more symptomatic residents, facilities should contact their PHU for advice.

Step 3: RISK ASSESS resident, staff, and visitor contacts.

This step maybe done at the same time as Step 4.

- Trigger the outbreak management plan (Step 8) with the identification of the **first** resident who has tested positive for COVID-19, influenza or RSV while awaiting additional test results of other residents.
- Review the contacts of the symptomatic resident for ARI symptoms. Isolate if possible and test symptomatic residents as per Step 1 and Step 2. For symptomatic staff, test (RAT), furlough and direct to their general practitioner.
- If possible, establish a red zone for residents that test positive to COVID-19, influenza, or RSV as per IPAC measures (Step 6). Review the measures that have been implemented and identify and address any gaps.
- Once the diagnosis is known, cases and contacts should be managed according to Step 4.
- If the diagnosis is COVID-19 and the source is unknown, all residents in the affected zone should be tested by RAT or PCR (depending on availability) to find cases, irrespective of whether they have symptoms*. Generally, where an exposure is unknown or unclear, residents in the affected zone should be considered high risk.
- **COVID-19 risk matrix** (Appendix 2) provides information for assessment and management of contacts of a positive COVID-19 case for known or single exposures. This matrix should be used where there has been a known exposure (e.g., a staff member tests positive for COVID-19 after caring for several residents), or when there is a single case with a known source (e.g., a resident returns from a family event where people in attendance are

* Testing or isolation is not required for asymptomatic residents if it has been less than 4 weeks since recovery from a previous COVID-19 infection unless they become symptomatic. However, if symptomatic, they should isolate, even if they receive a negative result.

identified as having COVID-19). In outbreaks with multiple resident cases, the risk assessment can be discussed with the local PHU upon notification, as the management of contacts may differ.

- Staff identified as being in close contact with a COVID-19 positive individual should follow the *Advice for people exposed to COVID-19*. Staff exposed to COVID-19 are advised to have a risk assessment undertaken by their employer. It is strongly recommended staff exposed to COVID-19 do not enter a DCF for at least 7 days. However, if a staff member is critical to service delivery and their absence would compromise delivery of care to residents, additional risk mitigation measures may be required to return to work before 7 days such as regular RAT testing and additional PPE use. If further advice is required, mitigation measures can be discussed with the PHU.

  In assessing contacts of a positive influenza or RSV case, the DCF should identify all affected staff and residents and ensure they monitor for symptoms and limit movement in the facility (see Step 4). Staff should wear appropriate PPE as outlined in Step 6.

Step 4: CASE AND CONTACT MANAGEMENT

- A resident who has tested positive to an ARI should isolate away from other residents. Residents with ARIs should receive ongoing care onsite appropriate to their needs (e.g., mobilisation, allied health services, time sensitive pathology tests, routine catheter changes and wound reviews etc).
- Resident's GP should continue to provide routine primary care as needed either onsite and/or virtually.
- Facilities should promptly discuss a resident's option for antiviral medications or other treatments with the resident's GP. See Antiviral guidance.
- If a resident still has symptoms after 7 days, consider whether they need to be reviewed by their doctor based on their clinical condition.
- Essential off-site health appointments (e.g., for renal dialyses or administration of medication) should also continue, after consultation with the service provider if the resident has COVID-19, influenza or RSV or has been exposed to COVID-19, influenza, or RSV. Facilities should ensure that residents are provided with a mask and appropriate mask wearing advice if they need to leave the facility.
- Residents in the green zone (see Step 6) can attend external appointments.
- Staff should be reminded of appropriate use of PPE when returning to work after being exposed to COVID-19, influenza, and RSV as well as when moving between caring for residents that have COVID-19, influenza, or RSV and other residents.
- During a confirmed influenza outbreak, staff who are not up to date with their influenza vaccinations are recommended to work only if asymptomatic, wearing a mask, and taking appropriate antiviral prophylaxis, in keeping with the RDCF influenza outbreak management policy. Any antiviral use by staff should be documented.
- Refer to the CDNA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Disability Residential Services for more detailed information on current influenza management.
- If practical, where more than one resident case is positive (with the same pathogen) the residents should be cohorted together for ease of management. Residents who are identified as contacts with similar exposure can also be cohorted together. Please refer to Resident Choice around Isolation.
- Where residents cannot be effectively isolated, more frequent testing may be required.

Table 1 – Case and contact management for COVID-19, influenza, RSV, and other confirmed respiratory pathogens

			COVID-19 (RAT or PCR)	Influenza (PCR)	Other confirmed respiratory pathogen including RSV
CASE	Resident	Case isolation*	7 days from symptom onset or test date if asymptomatic	5 days from symptom onset	While symptoms remain. There may be guidelines for specific pathogens available from the NSW Health Control Guidelines
		Release from isolation*	After day 7 if substantial resolution of acute symptoms and no fever for 24hrs. No testing required. Refer to CDNA guidance for other scenarios	After 5 days from symptom onset, or until they are symptom-free, whichever is longer or 72 hours after antivirals commenced regardless of symptoms. No testing required	Once symptoms resolve. No testing required
		Antiviral treatment	COVID-19 antivirals (via GP). See Antiviral Guidance	Influenza antivirals (via GP). See Antiviral Guidance	Nil – seek guidance from GP on clinical management
	Staff	Return to work	After day 7 with negative RAT^ OR after day 10 if no symptoms for 24 hours (no testing) and in consultation with employer	After 5 days from symptom onset, or until they are symptom-free, whichever is longer or 72 hours after antivirals commenced. No testing required	Once symptoms resolve. No testing required.
	Visitors	Visitors to facility	Can visit facility after day 7 if no symptoms. See Advice to residential disability care facilities (RDCFs) on entry restrictions.	Exclude from facility for 5 days from symptom onset or if symptomatic	Exclude if symptomatic
CONTACTS	Resident	Contact testing (initial round of testing)	Test all affected residents. If single/known exposure, test as per risk matrix at Appendix 2	Symptomatic residents	Symptomatic residents
		Contact isolation*	See Appendix 2 Risk Matrix if single/known exposure	Where zoning is feasible, residents in same zone(s) should avoid communal areas, group activities and moving between different zones	Nil
		Contact post-exposure prophylaxis (action to prevent infection)	Nil	Flu antivirals to be considered in outbreak (via GP) See Antiviral Guidance	Nil
	Staff	Return to work	See Appendix 2 Risk Matrix	Immediately if no symptoms. Should wear mask and other PPE at work	Immediately if no symptoms
	Visitors	Visitors to facility	Should not visit facility for at least 7 days after they have been in close contact with a COVID-19 case or if they are symptomatic. See Advice to residential disability care facilities (RDCFs) on entry restrictions	If symptomatic, should not visit the facility	If symptomatic, should not visit the facility

* *Isolation for the purpose of this document includes keeping residents separated from other residents, which may involve keeping residents in their own room or mask wearing when residents are moving between rooms such as moving to a shared bathroom, in communal areas or when there are other people around.*

^ *If staff test positive by RAT on day 7, staff member should be excluded until after day 10, and may return on day 11 if symptom free and with suitable precautions (e.g.N95/P2 mask) until day 14.*

Step 5: NOTIFICATION AND REPORTING

- Discuss as required with the local **PHU** (1300 066 055) if advice or support is needed when one resident has tested positive for COVID-19, influenza, or RSV.
- Notify the local PHU of an OUTBREAK when 2 or more residents test positive to COVID-19, influenza, or RSV within a 72-hour period.
- Where PCR test results are delayed, and COVID-19 RAT is negative, notify the local **PHU** when 2 or more residents have ARI symptoms in a 72-hour period.
- Notify the **NDIS Quality and Safeguards Commission** of positive COVID-19 case(s) by completing the notification of event form online (for registered providers) or by calling 1800 035 544.
- Notify **other care facilities and hospitals** where residents have had a high-risk exposure and have subsequently been transferred or require immediate transfer for care.
- Record and report details of each resident and staff who tests positive.
- Check with the local PHU on preferred data format and template. Facilities must complete the required information for all affected residents and staff, this will include vaccination status, symptom onset, test results and other identifying information.

Step 6: IMPLEMENT INFECTION PREVENTION AND CONTROL (IPAC) MEASURES

- **Vaccination**
  - Review vaccination status (COVID-19 and influenza) of residents and staff (e.g., as part of contact reporting).
  - Consider supporting vaccination for those who have not received a seasonal influenza vaccine for the current calendar year or are not up to date with recommended COVID-19 vaccinations. For information on recommended COVID-19 vaccine doses see the latest ATAGI advice.
- **Cohort and Zone**
  - Zoning (cohorting, ring fencing) refers to the grouping of people with the same condition in the same area to minimise interaction between infectious and non-infectious persons as much as possible.
  - The feasibility of cohorting, zoning and relocating residents may be impacted by DCF size and layout. The priority should be to separate cases from others wherever possible.
  - Apply the risk assessment outcomes and test results to confirm areas in the facility that:
    - are cases (red zone)
      - e.g., a red zone can be the positive resident's room, if possible, to also have a designated bathroom/ensuite
      - Residents with different viruses should not cohort together

    OR
    - are likely to be completely unaffected and can be managed separately (green zone)
      - e.g., a green zone could be all other areas of the DCF except the red zone.
  - An amber zone can be considered for high-risk close contacts or suspected cases, if possible, based on the layout and size of the facility.
  - Correct signage should be displayed throughout the DCF.
- **PPE**
  - **Hand hygiene** must be practiced as per Five Moments for Hand Hygiene.
  - N95/P2 respirator mask and eye protection to be worn when caring for residents with **ARI symptoms until diagnosis.**

- N95/P2 respirator mask, eye protection, (gown and gloves as per standard precautions[†]) to be worn by staff caring for residents with **confirmed COVID-19.**
- Surgical mask and eye protection to be worn by staff caring for residents with **confirmed influenza, RSV,** and all other respiratory infections except COVID-19.
- Staff should be reminded to change and safely dispose of PPE between contact with residents.
- Where possible and where able, residents who are isolating should wear a surgical mask particularly when staff members or visitors are in their room.
- During a COVID-19 outbreak, if the DCF is unable to access sufficient PPE from their usual or other commercial suppliers, they can request additional emergency stock from the National Medical Stockpile via NDISCOVIDPPE@health.gov.au.

- **Environmental cleaning and disinfection**
  - Allocate trained staff for cleaning of affected areas – ensure they are skilled to perform routine, additional and terminal cleaning.
  - Schedule daily cleaning in line with Environmental cleaning and disinfection principles for COVID-19. This cleaning practice is applicable for COVID-19, influenza, or RSV.

Refer to COVID-19 Infection Prevention and Control Manual for more information.

Step 7: COMMUNICATE

- Ensure all affected **residents** are aware of their diagnosis, exposure status, testing and isolation requirements. Individual communication strategies need to be considered to meet the communication needs of some residents.
- Ensure all affected residents' **GPs** are aware of the diagnosis.
- Ensure residents' **family and carers** are aware of the exposure/outbreak at the DCF. Ensure family and carers are informed of the status of individual residents with resident's/guardian's consent, including their diagnosis and management. Maintain confidentiality of the identity of any residents who have tested positive as far as possible.
- Ensure **staff** are aware of the exposure/outbreak at the DCF and remain on high alert monitoring themselves and residents for ARI symptoms. Ensure that they know what to do if they or other residents develop symptoms.
- Ensure **visitors** are aware of the exposure/outbreak at the DCF and that **visitors** are permitted to continue to visit residents during an outbreak, including those considered to be high risk and in designated red zones. Visitors should comply with the DCF entry requirements, as outlined in the Advice to residential disability care facilities (RDCF).
- Put up notices of the outbreak at all entrances including information to minimise unnecessary visits that may lead to inadvertent transmission. Signage should also be displayed outside the room of affected residents on any PPE requirements or other precautions.

Step 8: ACTIVATE OUTBREAK MANAGEMENT PLAN

- See Management and operational plan for people with disability for information on how to develop an outbreak management plan (OMP).
- The facility should activate their DCF OMP on identification of the **first** resident who has tested positive for COVID-19, influenza, or RSV while awaiting additional test results of other residents.
- **An outbreak should be declared if 2 or more residents test positive within a 72-hour period for:**
  - **COVID-19 OR**
  - **Influenza OR**
  - **RSV**

[†] An impervious, non-fabric gown or apron, and nitrile gloves should always be used when direct care (contact) is being provided and exposure to blood of body substances is anticipated.

- Once an outbreak has been declared, the facility/provider should convene an internal outbreak management team (OMT) and confirm:
    - Outbreak management lead and
    - Infection prevention and control lead
- The DCF, NDIA (National Disability Insurance Agency) and/or NDIS Quality and Safeguards Commission representative/s will determine if an inter-agency OMT is required. The local PHU can be consulted if advice is required.

Step 9: DECLARING AN OUTBREAK OVER

A decision to declare the outbreak over should be made by the internal OMT in consultation with the PHU. This should be when at least 7 days have passed since the last date of identified transmission.

Outbreak closure should not occur if there are pending PCR test results for contacts or symptomatic residents. Where there is extensive or poorly understood transmission, or where there are a significant number of residents non- or under-vaccinated, the PHU may advise the DCF to undertake additional testing or measures in the 7 days following an outbreak being considered “over”.

- After the outbreak closure, facilities should remain on high alert and:
    - test anyone with new symptoms
    - carefully monitor residents with high-risk exposure for atypical symptoms such as behavioural changes, lack of appetite, and lethargy and test for COVID-19, influenza, and RSV, even if they do not have ‘typical’ ARI symptoms
    - ensure visitors (who may be at higher risk of COVID-19 themselves) are aware that there has been an outbreak.
- Individual cases should remain in isolation for the required period (as per Step 4) even if the outbreak has been declared over.
- Once an outbreak is over, facilities/providers should evaluate the response and management of the outbreak to identify strengths and areas for improvement. Consider conducting a facility debrief with all employees and contractors involved.

Other considerations relevant to an outbreak situation

Considerations around managing residents

There may be circumstances where separating residents who are positive for COVID-19, influenza, or RSV from others in the facility will pose a risk to residents (due to behavioural or other issues) and staff caring for them. Where there is difficulty in ensuring separation from other residents, ask the local PHU for advice.

It is recognised that in some circumstances mask wearing may be challenging or not possible. Mask use should be used whenever possible but should not be used if this causes distress, risks the person’s (or another’s) health and safety and/or if precludes from the proper provision of services.

New and returning residents to DCF from hospital or emergency department

The presence of an outbreak should not prevent new and returning residents from being admitted/re-admitted to the facility with appropriate infection prevention and control measures in place. Decisions should be based on the advice of the local OMT and in consultation with the PHU, residents, and their representatives.

Resident choice around isolation

Consumer dignity and choice is a foundational standard in the National Quality Standards for Disability Care

Residents should be given the choice to self-isolate while the outbreak is active, or to mix with people with similar exposure. Their preferences should be recorded in their care plan and regularly reviewed. Residents should be made aware that if they choose not to isolate during an outbreak this increases their risk of contracting or transmitting the infection. Continued implementation of appropriate IPAC measures should continue.

Where it is practical, and the facility can manage this risk by considering the following:

- Residents with the same ARI being permitted to engage in social activities together if they are well enough to do so and if they can be kept separated from residents who are unaffected
- Exposed residents may choose to leave their rooms to eat in shared dining rooms and participate in social activities with other residents from the affected area. Exposed residents should be supported to not socialise with positive cases or unexposed residents (i.e., with dedicated staff, dining room, social room).
- Unexposed residents can leave their rooms to participate in shared activities and dining with other unexposed residents.

Appendix 1 - Key documents

Australian Government

- National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Disability Residential Services
- Management and operational plan for people with disability
- **COVID-19 Oral Treatments**
    - The Australian Department of Health and Aged Care has information on Oral treatments for COVID-19, which includes links to an Information sheet for people with disability – COVID-19 oral medicines and a COVID-19 medicines – Easy read document.
- **COVID-19 Vaccination**
    - The Australian Department of Health and Aged Care has Information for people with disability about COVID-19 vaccines, Information for disability workers about COVID-19 vaccines, and Information for disability service providers about COVID-19 vaccines.

NSW Health

- Caring for the wandering person during COVID-19
- COVID-19 and delirium

Clinical Excellence Commission

- COVID-19 Infection Prevention and Control Manual - Clinical Excellence Commission (nsw.gov.au)

Further resources

Infection prevention and control

- The Australian Commission on Safety and Quality in Health Care's (ACSQHC) has published posters on standard and transmission-based precautions.
- The Australian Commission on Safety and Quality in Health Care's (ACSQHC) NHHI Learning Management System has a series of online learning modules on hand hygiene and infection prevention and control.
- The Australian Guidelines for the Prevention and Control of Infection in Healthcare has detailed guidance about standard and transmission-based precautions
- The Infection Prevention and Control Expert Group (ICEG) has endorsed a collection of resources for infection prevention and control.

Personal protective equipment

- The Australian Department of Health and Aged Care has published factsheets and videos on use of PPE.

Environmental cleaning

- ACSQHC has resources including:
    - Environmental cleaning: information for cleaners
    - Principles of Environmental Cleaning Product Selection factsheet
    - Flowchart - The process and product selection for routine environmental cleaning
    - COVID-19 Environmental cleaning and disinfection principles for health and residential care facilities factsheet.

NDIS Commission

- The NDIS Quality and Safeguard Commission has a range of resources for NDIS participants and NDIS providers. This information is to inform and support NDIS providers to continue to deliver quality and safe supports and services to NDIS participants during the pandemic in accordance with their obligations under the NDIS.

Appendix 2 – Disability care facility (DCF) COVID-19 risk assessment and management for single or known exposures

	Low risk	High risk
Requirements for staff	**Definition** Where staff have had transient, limited contact that: - Does not meet the definition of high-risk contact. **Management** - Continue to work with the following: ➢ Monitor for symptoms, test (RAT initially, if negative proceed to PCR if available), and isolate immediately if symptomatic. ➢ Daily RATs (until day 7).	**Definition** Where a worker has been exposed to COVID-19 at work and exposure is defined as high-risk. Considerations for high-risk exposure include: - staff who were not wearing airborne precautions (P2/N95 respirators, eye protection) where aerosol generating behaviours or procedures have been involved. - have had at least 15 minutes face to face contact where both mask and eyewear were not worn by exposed person and the case was without a mask; or - greater than 2 hours within the same room with a case with inadequate PPE. • If a worker has been exposed to COVID-19 in the community follow the advice for people exposed to COVID-19 factsheet. **Management** Review affected staff to assess risk of exposure. If staff furloughing is not an option and staff must continue to work the following risk mitigation strategies should be in place: ➢ Monitor for symptoms, test (RAT initially, if negative proceed to PCR if available), and isolate immediately if symptomatic. ➢ Daily RATs (until day 7). ➢ Avoid staff redeployment to unaffected areas to minimise risk of potential spread. ➢ Do not enter shared space or meal rooms. ➢ Work in P2/N95 masks for the first 7 days following exposure.
Requirements for residents	Where a resident has had transient, limited contact that - Does not meet the high-risk contact definition; or - Based on facility and/or PHU risk assessment is not assessed as a high-risk contact. **Management** - Close monitoring for symptoms. If symptoms develop, isolate immediately and test. - Regular RAT testing in the first 7 days if deemed appropriate by facility and/or PHU. - Other risk mitigation strategies deemed appropriate.	Where a resident has been exposed to a COVID-19 case: - in a shared defined area (e.g., prolonged contact during activity, co-located in a wing of a facility); and/or - who have had household-like exposure with a case during their infectious period; or - outbreak-related contact (e.g., cases in the same ward / wing / shared area with unknown exposure). **Management** - Isolate for 7 days. - Test (PCR or RAT) day 2 and day 6. OR - Consider allowing residents to leave room after risk assessment, wearing a mask and with ➢ Baseline and day 6 PCR, or ➢ RAT at least every second day from day 0-7. - If symptoms develop, do a RAT and, if negative, do a PCR test. - Release from isolation: ➢ After day 7 with a day 6 negative result and asymptomatic.
Requirements for visitors	• Follow Information for people exposed to COVID-19 factsheet.	• Follow Information for people exposed to COVID-19 factsheet.

This risk matrix does not replace the CEC Application of PPE Guide https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0018/644004/COVID-19-IPAC-manual.pdf

Appendix 3 – Glossary of terms

Acronym	Abbreviation
ARI	Acute Respiratory Infections
ATAGI	Australian Technical Advisory Group on Immunisation
CHO	Chief Health Officer, NSW
COVID-19	Novel Coronavirus 2019
IPAC	Infection Prevention and Control Measures
OMP	Outbreak Management Plan
OMT	Outbreak Management Team
PCR	Polymerase Chain Reaction
PHU	Public Health Unit
PPE	Personal Protective Equipment
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
RDCF	Residential disability care facility
RAT	COVID-19 Rapid Antigen Test