Public Health & Infection Prevention & Control Guidelines on Prevention and Management of Cases and Outbreaks of COVID-19, Influenza & other Respiratory Infections in Residential Care Facilities

V1.12 17.07.2023.

Note: If you have any queries on this guidance please contact the AMRIC team at hcai.amrteam@hse.ie

Ver.	Date	Changes from previous version
1.12	17.07.23	Changes to the duration of isolation, recommendation for use of masks and appropriate use of PPE as part of standard and transmission based precautions. Editorial updates and changes made
1.11	04.04.23	Removal of universal use of masks for healthcare workers outside of periods of high levels of community transmission Recommendation for use of masks and appropriate use of PPE as part of transmission based precautions Updated reference to ECDC and WHO guidance on mask use by HCW Recommendation to facilitate mask use by those residents who wish to use them Remove recommendations for testing of asymptomatic contacts Updated to link to public health recommendations on duration of self-isolation for general public

Ver.	Date	Changes from previous version
		Amendments to detail on vaccination against COVID19 and inclusion of link to NIAC guidance Links to resources on techniques for respiratory virus sample collection Removal of posters and resources in the appendices, included links to these resources Removal of elements of standard precautions and transmission based precautions in main body of guidance, included a link to NCEC draft guidance for this section Influenza outbreak closure guide added to section 5.6 Some editorial changes to the guidance document Deletion of records of changes in previous versions prior to 1.10
1.10	20.12.22	Corrections to version 1.9 to include the following: Updated to include updated reference and links to Guidance on testing for Acute Respiratory Infection (ARI) in Residential Care Facilities (RCF) – Winter 2022/2023 V1.2 17/11//2022 with updated EU/ECDC case definition for acute respiratory infection (ARI) Corrections to table on duration of transmission based precautions on Transfer/admission of a resident to a LTRCF General editorial corrections

Note; the term "respirator mask" is generally used in this document. In most circumstances, this will be an FFP2 mask but respirator masks that meet or exceed the filtration standards of FFP2 masks are also appropriate. Powered Air Purifying Respirators (PAPRs) also meet the requirement for respiratory protection.

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 Organization; 2020
HIQA-Rapid Review of Public Health guidance on infection prevention and control measures for residential care facilities in the context of COVID-19 30/3/20

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1 Introduction

This document replaces version 1.11 of this document. Co-circulation of influenza virus with SARS-Cov-2 is likely to continue to be a feature of management of viral respiratory infections at certain times of the year. The clinical features caused by infection with respiratory viruses are often difficult to differentiate and the public health and infection prevention and control management is very similar. For these reasons, this document is framed as general guidance for this group of infections.

Managing the risk of COVID-19, influenza and other respiratory viruses in a residential care setting can be thought of as three elements.

The first is to take all practical measures to reduce unintended introduction of the virus into the residential care facility. If the virus is not introduced by a person with infection, then it cannot spread.

Even when all practical precautions are taken it is still possible that the virus will be introduced unintentionally, therefore the second element is to take all practical measures to reduce the risk of the virus spreading if introduced.

The third element is having processes in place to minimise the risk of harm to residents and staff if both other elements fail and the virus is introduced and spreads. This includes the administration of specific antivirals against COVID-19 or influenza when appropriate.

This guideline addresses measures needed to achieve all of the above elements. Controlling the risk of introduction, spread and harm from COVID-19 and Influenza is challenging particularly as there is a need to balance the management of risk with respect for the autonomy and rights of residents. Vaccination of residents, staff and visitors, including booster vaccination, plays a central part in managing all aspects of the risk.

This document should be used in association with the NCEC National Clinical Guideline No. 30 Infection Prevention and Control, which is available at the following link http://health.gov.ie/national-patient-safety-office/ncec/.

1.1 Residential Care Facility

This guidance applies to residential care facilities (RCF) where residents are provided with overnight accommodation. The anticipated duration of such accommodation may vary within and between different types of RCF. For example, some RCFs for older persons may offer a blend of long-term nursing home and shorter-term respite and convalescence care.

This guidance was developed primarily for congregated care settings providing care for relatively large numbers of residents. Experience shows that spread of COVID-19 in these settings had profound consequences prior to the vaccination campaign and continues to impact some residents severely. Influenza virus can also cause severe illness in residents.

While the principles of this guidance can be applied in all residential care settings, the risks are lower in the context of residential care provided in the setting of community housing for groups of five to six people or fewer. The approach to prevention of infection and the management of outbreaks of infection in those community-housing units requires a more nuanced approach. For example, restricting people to their room for extended periods is likely to be impractical. Likewise, outbreak management needs to take account of the specific needs, interpersonal dynamics and number of people potentially at risk in such settings.

Facilities providing acute inpatient rehabilitation services are advised to refer to the 'Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting':

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/

The primary responsibility for managing the risk of infection with COVID-19 and influenza and for control of outbreaks lies with the RCF, within their responsibilities for resident care and infection prevention and control (IPC). This responsibility is referred to in the 2016 National Standards for Residential Care Settings for Older People in Ireland. The 2018 National Standards for infection prevention and control in community services are

also relevant. All RCFs should have in-house IPC expertise and should have outbreak management plans in place.

Congregated care settings, such as nursing homes, should have at a minimum one designated on-site IPC link practitioner who has protected time and the support of management to promote good IPC practice within the facility. An IPC link practitioner generally does not have a formal IPC qualification but should be supported in participating in link practitioner training at the earliest opportunity and avail of ongoing training as much as possible. The IPC link-practitioner should provide ongoing training to staff with a particular emphasis on standard precautions, hand hygiene and PPE donning and doffing techniques. The IPC link practitioner can signpost staff to additional training resources available on standard and transmission based precautions, such as AMRIC online e-learning courses provided through HSeLanD https://www.hseland.ie and from community IPC nurses.

Under the Infectious Diseases Regulations 1981, Amendment February 2020, any medical practitioner who is aware of a case of COVID-19 or an outbreak of any infectious disease including influenza, 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 three working days, (Statutory Notifications Guidance for registered providers and persons in charge of designated centres. January 2016).

Nominated Support Person

- Each resident should have the opportunity to identify a nominated support person. The nominated support person should normally have unrestricted access to the resident for most of the day. If it is considered necessary to limit access in the morning or evening when staff and residents are occupied with getting up or

preparing for bed, then at a minimum the nominated support person should have access from at least mid-morning to late afternoon.

- The above is in addition to and not instead of visitor access as outlined below. The nominated support person should comply with the infection prevention and control measures that apply to a visitor when they attend the long-tern residential care facility (LTRCF).

The nominated support partner is a partner in care. Access of the nominated support partner to the resident they support, should only be more limited than outlined above if:

1) The nominated support person is subject to self-isolation or restricted movement or otherwise represents an infection risk to staff or residents
2) There is a written recommendation from a public health or infection prevention and control practitioner to limit access for nominated support people for a defined period in a specific context.

1.2 Regional Department of Public Health

The Regional Departments of Public Health are responsible for investigating cases and outbreaks of COVID-19, influenza or other infectious disease and providing overall leadership and oversight for outbreak management. The IPC link practitioner is a key resource in supporting the Public Health Department in fulfilling its role.

2 COVID-19 Background information

2.1 Sources of Infection with COVID-19

COVID-19 and influenza virus infection is acquired as a result of exposure to a person shedding infectious virus. It is generally accepted that the highest risk of transmission occurs at about the time an infected person develops symptoms. Spread from **symptomatic people** is generally considered the greatest risk.

With respect to COVID-19, infection can be transmitted from people with minimal symptoms, from people before they develop symptoms (**pre-symptomatic transmission**) and from people who never develop symptoms (**asymptomatic**

transmission). However, symptomatic people are generally more infectious. HIQA have provided a useful summary of the evidence related to asymptomatic transmission at:

https://www.hiqa.ie/reports-and-publications/health-technology-assessment/evidence-summary-asymptomatic-transmission

Transmission in the Healthcare Setting

The spread of COVID-19 and influenza in the healthcare setting is a specific concern. Experience in Ireland and elsewhere indicates that transmission in residential care facilities and hospitals can occur readily when the virus is introduced from the community into the healthcare setting. Even with high levels of vaccination the virus can spread rapidly, particularly if IPC precautions are suboptimal. Transmission typically occurs when an unrecognised infectious person enters the facility. Control of entry to minimise risk of unrecognised introduction is therefore a key priority in preventing outbreaks. This requires a particular focus when rates of infection in the community served are high. In the context of long-term residential care facilities, a key group of people who move regularly between community and the facility is staff. Visitors also represent a risk of introduction of COVID-19 and influenza. Principles to support the management of risk associated with visiting is provided in section 2.14.4.

Outbreaks of infection involving both residents and healthcare workers (HCW) have been frequent in RCFs during the major community surges in COVID-19. This has also been observed previously with influenza. The control of spread of the SARS-CoV-2 virus, the cause of COVID-19, in RCFs in this context continues to be challenging even after vaccination. The emergence of SARS-CoV-2 variants with higher transmissibility or that are less effectively prevented by vaccination add to the challenge of effective control.

Vaccination, including booster vaccination, of a high proportion of residents and staff in RCFs against COVID-19 has had a major impact on reducing the impact of COVID-19 in RCFs. In this context, it is possible to manage the risk of spread of COVID-19 effectively with less restriction on the lives of residents. There is however, a continuing

need for vigilance to prevent infectious staff members or other people from entering the RCF. It remains important to ensure that residents with symptoms of COVID-19 and influenza are detected promptly and that transmission-based IPC precautions, including appropriate use of PPE are implemented in the care of infectious residents to further reduce the risk of spread. RCFs must have systems in place to ensure that, to the greatest extent possible, residents with COVID-19 and influenza are rapidly identified and are cared for with appropriate transmission-based IPC precautions.

Use of appropriate PPE remains an important part of the controls within healthcare and requires risk assessment by the healthcare worker regarding the symptoms of the resident, and the task they plan to undertake during the episode/s of care.

At a minimum, for interaction with residents with respiratory viral symptoms, healthcare workers should use a surgical mask or respirator mask. For longer episodes of care, for care within the bed space, or while performing higher risk procedures, a respirator mask and eye protection are recommended. In addition, respirator masks or surgical masks should be offered to residents, following a risk assessment, in open or multi-bed healthcare settings who are exposed to other symptomatic residents. The following link to a point of care risk assessment tool provides helpful advice on appropriate selection of PPE.
https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/A3%20Poster%20Resist.final%20online%20version.pdf

2.2 Routes of Transmission

The transmission of COVID-19 and influenza occurs mainly as a result of scattering of liquid respiratory particles into the air from an infectious person. Respiratory particles are generated from the nose and mouth by actions such as breathing, coughing, sneezing, talking or laughing. Transmission to others may result from direct impact of infectious droplets on the mucosa of persons nearby and through contact with surfaces contaminated

with infectious respiratory droplets and subsequent transfer of infectious material to the mucous membranes (droplet transmission).

Advice from the World Health Organisation (WHO) regarding the use of masks by health workers providing care to residents with suspected or confirmed COVID-19 is available on the following link:

https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC_Masks-Health_Workers-Omicron_variant-2021.1

Updated ECDC guidance can be found as follows: https://www.ecdc.europa.eu/en/publications-data/considerations-infection-prevention-and-control-practices-relation-respiratory

2.3 Control of Transmission

Control of transmission of respiratory viral infections can be achieved by:

- Vaccination (See section 2.4)
- Standard and transmission based precautions (see Section 2.20
- Environmental controls such as ventilation. (See section 2.25).

2.4 Vaccination

Vaccination against SARS-CoV-2 (including booster vaccination) reduces the risk of transmission in addition to reducing severity of disease in those vaccinated. This serves to emphasise the importance of vaccination, including booster vaccination, of healthcare workers not only to protect themselves but also in protecting the people that they care for. Current recommendations for vaccination and booster vaccination are available here: Chapter 5a of NIAC Immunisation Guidance NIAC Immunisation Guidelines. Chapter 05 a. COVID-19 | Royal College of Physicians of Ireland (preservica.com)

The majority of residents and staff in RCFs have been vaccinated and have had booster vaccination.

Vaccination against influenza is also important for protection of the healthcare worker and the people they care for. Influenza vaccine is recommended to and offered to

residents of RCFs and to all healthcare workers before winter each year. Vaccine protection is not perfect and the vaccine may not work so well in people who have certain conditions or who are on a treatment that interferes with their immune system. Healthcare workers and residents are advised to continue to adhere to all IPC measures in this guideline after vaccination including booster.

2.5 Incubation period for COVID-19

The time interval between exposure to the virus and developing symptoms (incubation period) has been considered five to six days for most people. Some consider that incubation period is shorter with the Omicron variant. The incubation period can be up to 14 days. Individuals are usually considered most infectious to others around the time they develop symptoms.

2.6 Survival of Respiratory Virus in the environment

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 time. Common household cleaning products and many disinfectants, including bleach, easily kill SARS-CoV-2 and influenza virus. Based on experience through the pandemic, infection as a result of persistence of viable virus on surfaces for long periods appears to be very uncommon.

2.7 Clinical features of COVID-19 and Influenza

Most otherwise healthy people with COVID-19 or influenza will have mild disease and will recover. A minority will develop an illness that is more serious.

The HSE has defined categories of people who are considered very high risk for COVID-19 (also known as extremely medically vulnerable) and those at high risk for severe

disease. See the following link https://www2.hse.ie/conditions/coronavirus/people-at-higher-risk.html

For more information on symptoms and signs of COVID-19, refer to the latest case definition

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casedefinitions/

And on https://www2.hse.ie/conditions/covid19/symptoms/overview/

It is important to remember that older people with COVID-19 very often do not have fever and respiratory symptoms and may only have symptoms such as:

1. **lethargy;**
2. **increased confusion;**
3. **change in baseline condition;**
4. **loss of appetite.**

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

It is important to note that people who are vaccinated and who become infected may have very mild symptoms but be infectious. This poses a risk in particular for residents who are not vaccinated or who may not have had a good response to vaccine.

RCF residents with influenza virus infection may have very similar clinical features to residents with COVID-19. It is important to consider and test for both viruses when clinically relevant.

2.8 Testing

Note that testing of asymptomatic residents on transfer or admission is generally not required.

See also Guidance on testing for Acute Respiratory Infection in Residential Care Facilities – Winter 2022/2023

https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/guidance/residentialcarefacilitiesguidance/Guidance%20for%20ARI.pdf

This guidance contains the updated EU/ECDC case definition for acute respiratory infection (ARI).

1. Testing is necessary to confirm a diagnosis of COVID-19 or influenza infection;
2. Testing is performed in a similar way for both viruses. Note that if a resident has symptoms of viral respiratory tract infection and testing is performed they should generally be tested for both SARS-CoV-2 and influenza virus;
3. Check with the laboratory who provides the service in advance of any requirement to test that you have the correct type of swab required by that laboratory;
4. The viral swab collected may be deep nasal/mid-turbinate swab or a nasopharyngeal swab. A deep nasal swab is often less distressing for people and is almost equally likely to detect the virus if it is present. Deep nasal sampling is particularly useful where people are undergoing repeated testing or are distressed by nasopharyngeal sampling. Please note HSE videos demonstrating sample collection techniques are available at the following link https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/sampling/
5. Anterior nasal swabs are not a good sample and should not be submitted;
6. When testing is performed, ensure the correct swab type is taken (viral swab), sealed tightly to prevent leakage and is appropriately labelled with two matching resident identifiers on both the swab and request form, to include the resident's name and date-of-birth (DOB). Ensure that the name and contact details for the resident's doctor are on the request form, together with the address of the RCF and any other contact details required. These should include the name and mobile telephone number for the designated person who will receive the laboratory result by text clearly visible on the request form. Deliver the sample to the testing

laboratory as soon as possible. Confirm in advance that you are sending the sample to the designated laboratory to perform the test for your RCF and that samples taken from residents of RCF are prioritised for testing, particularly in a suspected outbreak. Indicate clearly if testing for influenza virus is also required;

7. Current polymerase chain reaction (PCR) based laboratory tests are accurate, but no diagnostic test is perfect. If a test result comes back as “SARS-CoV-2 not detected” and “influenza virus not detected” and the resident remains unwell with no alternative diagnosis, then a diagnosis of COVID-19 or influenza is still possible. If there is any concern, the resident’s condition should be discussed with their doctor;
8. Testing for SARS-CoV-2 by another method called **antigen testing** is also used in some situations. Antigen testing is generally less likely to detect virus at low levels than PCR testing;
9. When there is an outbreak of a respiratory tract infection in a long term RCF, a Public Health Risk Assessment (PHRA) will be undertaken. This PHRA will direct the management of the outbreak. It is recommended that up to approximately five symptomatic residents are tested for both COVID-19 and Influenza in the first instance to determine if the outbreak is related to COVID-19 or Influenza;
10. In some other circumstances e.g. when infection with more than one respiratory pathogen is suspected in the facility, additional testing of symptomatic individuals may be required to assist in outbreak management following a risk assessment. This will be assessed on a case-by-case basis;
11. Additional testing may be required to guide clinical decisions for example, if required to determine eligibility to be considered for targeted treatment for COVID-19, or antiviral treatment or prophylaxis against influenza;
12. If COVID-19 is detected, following public health risk assessment and where appropriate, PCR testing is recommended only for **symptomatic** residents and staff;
13. In the context of influenza, testing of asymptomatic residents is not appropriate, as there is no reason to believe that testing of those who are asymptomatic will assist in managing the outbreak;

14. For further information, please see “Guidance on testing for Acute Respiratory Infection (ARI) in Residential Care Facilities* (RCF) – Winter 2022/2023 V1.2 17/11//2022”
    https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/guidance/residentialcarefacilitiesguidance/Guidance%20for%20ARI.pdf

2.9 COVID-19 and Immunity after Recovery

There is still limited experience with immunity after recovery and therefore caution is required in interpretation. In general, people who have recovered from COVID-19 have evidence of an immune response and that offers them significant protection. However, the protection afforded by the immune response to previous variants of the virus (Alpha or Delta) to the current dominant variants (Omicron) is uncertain. People who have had infection since December 1st 2021 are more likely to have had Omicron infection and are therefore more likely to have more protection against reinfection with Omicron. Healthcare workers who have recovered from COVID-19 should continue to follow the same IPC precautions as all other HCWs when in contact with residents to reduce the risk of transmission of COVID-19. Currently, antibody testing is not recommended for routine use to assess immunity to infection.

2.10 Planning

1. Identify a lead for COVID-19 and influenza preparedness and response in the RCF. The lead should be a person with sufficient authority to ensure that appropriate action is taken and requires at a minimum the support of one designated on-site IPC link practitioner (see above). In some smaller RCFs the lead may also fulfil the role of the IPC link practitioner. In larger RCFs there may be a requirement for a liaison person on each unit in the RCF in addition to lead and link IPC practitioner roles;
2. RCF settings must have COVID-19 and influenza preparedness plans in place to include planning for cohorting of potentially infectious residents separately from

non-infectious residents, enhanced IPC, staff training, establishing surge capacity and promoting resident and family communication;

3. All RCFs should consider the available COVID-19 therapeutics as part of the COVID-19 preparedness plan. Up to date guidance relating to community prescribing of currently available agents is available on the COVID page on www.antibioticprescribing.ie
4. Maintain an up-to-date line list of all residents in the RCF and all staff working in the RCF, along with contact telephone numbers;
5. Each RCF should have an area identified where a resident with suspected or confirmed COVID-19 or influenza can isolate from other residents. In many cases this will be the resident's room if they have a room exclusively for their own use;
6. Where possible, each ward or floor should try to operate as a discrete unit or zone, meaning that staff and equipment are designated to a specific area and are not rotated from other areas (this includes night duty). This practice may reduce exposure to risk for staff and residents in the event COVID-19 or influenza is introduced into the facility. This may also allow outbreak response measures to be targeted in zones, rather than having to be implemented facility-wide;
7. The risk associated with movement or rotation of staff is lower if staff are vaccinated and have had booster vaccine against COVID-19 and influenza or have recently recovered from COVID-19;
8. Facilities should ensure the availability of supplies, including tissues, alcohol-based hand rub (ABHR), hand wipes, cleaning products, disinfectants and personal protective equipment (PPE) and liaise with relevant supply lines if there is difficulty in obtaining such supplies;
9. Supplies of PPE should be sufficient to ensure that single-use items of PPE, including visors and goggles, are used only once and then disposed of safely;
10. Note: the Health and Safety Authority indicate that where a risk assessment indicates that workers need to use a close-fitting respirator mask for their protection that every effort should be made to comply with the requirement for fit testing of the workers, as far as is reasonably practicable. When fit testing of all staff is not immediately possible, then fit testing should be prioritised for those at greatest risk;

11. A summary table of key interventions for the prevention and management of a COVID-19 or Influenza outbreak can be found in Appendix A.

2.11 Education

2.11.1 Staff

1. All staff should be aware of the early signs and symptoms of COVID-19 and influenza. They should know 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;
2. All staff should have training in standard precautions, in particular hand hygiene, respiratory hygiene and cough etiquette, along with training in transmission-based precautions (contact, droplet and airborne), including the appropriate use of PPE for each situation;
3. RCFs should ensure that one or more staff members are trained to collect a viral swab sample for testing for SARS-CoV-2 and Influenza virus. Please refer to guidelines and video in relation to same available HERE.

2.11.2 Residents

1. Residents should be consulted on and kept informed of the measures being taken and the reason for these measures during this time;
2. Residents should be encouraged and facilitated to clean their hands and actively assisted with this practice where necessary;
3. Key messages around cough etiquette (where appropriate) include:
    a. Cover your mouth and nose with a disposable tissue when coughing and sneezing to contain respiratory secretions;
    b. Discard used tissues after use and clean your hands;
    c. If you don’t have a tissue, cough into your forearm or the crook of your elbow;
    d. Clean your hands.

4. Where possible and appropriate, residents should be made aware of the need to report any new symptoms of illness to staff members;
5. Residents who may leave a RCF should be made aware of the general principles of staying well, details of which can be found https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/peopleatincreasedriskofsevereillness/othersatincreasedriskofsevereillness/Guidance%20For%20Older%20People%20and%20Others-Reducing%20COVID-19%20Exposure%20Risk.pdf ;
6. Residents who are in the high risk or the very high risk groups for severe disease with COVID-19 should be supported in taking additional measures to reduce their risk of infection over and above any general measures applied in the RCF if they wish to do so;
7. Residents whether they are vaccinated or unvaccinated may prefer to wear a mask in certain places or at certain times in the LTRCF. In that case they should have access to a surgical mask or respirator mask according to their preference.
8. Residents who are not vaccinated or are immunocompromised should be facilitated to wear a mask (surgical mask or respirator mask) in busy areas of the RCF or during transport to and from the facility if they wish to do so.

2.12 Social activity

1. Social activity is an essential part of community life within the LTRCF.
2. Social activity between residents should no longer be limited on infection prevention and control grounds other than for individual residents when they are infectious or when temporary limits are required to manage an outbreak of infection; this too applies for involvement of family or visitors whom the resident wishes to join social activity;
3. Residents with symptoms of COVID-19, influenza or other viral respiratory tract infection should be asked not to join in social activities until they are no longer infectious. **This continues to apply to people who have been vaccinated including booster;**

4. Residents and others engaged in social activity should be encouraged to practice hand hygiene and cough etiquette;
5. In the context of social interaction it is appropriate, with due regard to the weather and comfort, to use well-ventilated indoor space or outdoor space where available;
6. Staff members should be encouraged to maintain physical distancing measures during their break and meal times in the workplace.

2.13 Group Activities

1. Before any group activity, confirm on that day that participants have no symptoms that suggest viral infection (COVID-19 or influenza);
2. Weather permitting, outdoor group activities are likely to be lower risk than indoor activities;
3. Ensure adequate supplies of hand sanitiser and appropriate cleaning products (for example detergent wipes) are available in each activity room/area;
4. Ensure staff and volunteers know that they should be vaccinated including booster and follow good infection prevention and control practice.

2.14 Group Controls to minimise risk of inadvertent introduction of virus

2.14.1 Staff

1. Vaccination of staff against SARS-CoV-2, including booster vaccination, and influenza is expected to play a key part in reducing the risk of inadvertent introduction virus. LTRCFs should do all that is practical to encourage high level of vaccine uptake in staff;
2. External contractors should ensure that their staff who may enter clinical areas are also vaccinated;
3. Symptomatic staff should stay away from work and should follow current public health advice about PCR testing.

2.14.2 Movement across facilities

1. See Appendix E

2.14.3 Staff occupational health & workforce planning

1. Staff working in a facility that is experiencing an outbreak of COVID-19 or influenza should not work in any other facility;
2. Staff should be informed that they must not attend work if they have fever, cough, shortness of breath, or any kind of new respiratory symptoms. **This continues to apply to staff after vaccination.** They should be aware of their local policy for reporting illness to their manager;
3. In addition, at the start of each shift, all staff should confirm with their line manager that they do not have any symptoms of respiratory illness, such as fever, cough, shortness-of-breath or myalgia. **This continues to apply to staff after vaccination.** Where relevant, staff should be asked to confirm that they are not currently working in a facility where there is an outbreak;
4. Staff members who become unwell at work should immediately report to their line manager and should be sent home and advised to follow current public health guidance with respect to testing for healthcare workers. If they cannot go home immediately, they should be isolated in a separate room until they can go home;
5. Occupational health guidance for healthcare workers is available at: https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/covid-19-guidance/ :
    a. Staff members who test positive for COVID-19 may return to work after the end of the isolation period as defined in current public health guidance. Repeat testing at the end of the illness is generally not appropriate;
    b. Staff members who test positive for influenza may return to work 5 days after onset of respiratory symptoms if they are well enough to return;
    c. There is no requirement for contact tracing including the identification of

close contacts of a confirmed case of COVID-19 in an RCF.

2.14.4 Visitors and Access

Separate guidance on access to LTRCF has been retired. The following principles to support access and visiting are recommended:

1. RCFs must strike a balance between the need to manage the risk of introduction of COVID-19 or other communicable infectious diseases by people accessing the RCF and their responsibility for ensuring the right of residents to meaningful contact is respected in line with regulatory obligations
2. Full access should be facilitated to the greatest degree practical for all residents. Access may be very limited for a period of time in the early stages of dealing with an outbreak but a total withdrawal of access is not appropriate. If limitations on access are considered necessary, this should be based on a risk assessment that is reviewed regularly in view of the prevailing public health circumstances in the population served by the RCF. Risk assessments that underpin decisions regarding restricted visiting should be documented. Visits should not be restricted unless there is an identified risk
3. A RCF should have a policy on access and should have the capacity and relevant skill sets within its staffing complement to manage access appropriately. The RCF should provide information on access that is clear, up to date and consistent across website, leaflets and when talking to staff and residents. This should make it clear how access is facilitated, any limitations that apply, the reasons for those limitations and the expected duration of limitations. Residents and others should be provided with a clearly defined pathway to appeal against limitations on access that they consider as being unreasonable.
4. Other than a resident transferring or returning to an RCF, no one should access a RCF who has symptoms of COVID-19 or other communicable infectious disease. Very rare exceptions to this may need to be considered on compassionate grounds. In that case, careful risk assessment and planning is required.

5. Everyone who accesses a RCF must adhere to directions on essential infection prevention and control practices including maintaining physical distance (in so far as appropriate to their purpose), mask use, respiratory hygiene and cough etiquette and hand hygiene. RCFs may be obliged to refuse access to a person who is unwilling or unable to comply with reasonable measures to protect themselves and all residents and staff or if the person has not complied with reasonable measures during previous access.

An information leaflet for residents and their visitors is available at the following link: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Normalising%20visiting%20in%20nursing%20homes%20%20and%20residential%20care%20facilities.pdf

2.14.5 Resident transfers

1. Guidance on resident transfers related to COVID-19 is addressed as an appendix to this document. (**Appendix E)**;
2. For guidance on admission to facilities such as community hospitals and acute rehabilitation units please refer to the document - Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting located here;
3. Guidance on admission to RCF applies to residents who routinely use ventilatory support such as CPAP or BiPAP. Use of CPAP or BiPAP may be associated with risk of spread of virus from infectious people (see the following link https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/);
4. Particular attention to infection prevention and control precautions and a high level of awareness for features of COVID-19 infection is required in those requiring

respiratory support (CPAP/BIPAP) and particularly in residents who are not vaccinated, including booster vaccination if eligible;

5. Such residents should be admitted to single rooms with a window that can be opened to improve ventilation (subject to weather and security; the goal is gentle air circulation rather than strong air movements) and the door should remain closed as much as possible when ventilatory support is in use;
6. Testing of asymptomatic residents who use CPAP or BiPAP is not generally required;
7. If a local risk assessment indicates that testing of newly admitted residents on CPAP or BiPAP remains appropriate, then the residents should remain in their room with the door closed all of the time until the result of the test taken is available;
8. If a resident has any new clinical features to suggest viral infection, any care delivered by staff during the use of CPAP or BiPAP should be delivered with airborne precautions (minimise numbers and time in the room, maximise ventilation as far as is practical and use appropriate PPE); please refer to the relevant section in the "NCEC National Clinical Guideline No. 30 Infection Prevention and Control" , http://health.gov.ie/national-patient-safety-office/ncec/If there are no clinical features to suggest viral infection, care provided by staff should be delivered with Standard Precautions and, if indicated by Point of Care Risk assessment, appropriate PPE;
9. Newly admitted residents, including those on ventilatory support such as CPAP or BiPAP, can move around outside their room and participate in activities, subject to confirming each day that there is no deterioration in their condition that could suggest COVID-19 or other viral respiratory tract infection;.
10. If at any point during admission to the RCF a person including those who use CPAP or BiPAP develops symptoms consistent with COVID 19 or influenza, appropriate transmission-based precautions should be introduced immediately while arrangements are made for assessment by their doctor.

2.15 Increased surveillance and early identification of cases of COVID-19 infection

1. Surveillance (monitoring for illness) is an essential component of any effective infection prevention and control programme;
2. RCFs should ensure that they have means in place to identify a new case of COVID-19 or influenza and control transmission, through active monitoring of residents and staff for new symptoms of infection, rapid application of transmission-based precautions to those with suspected COVID-19, prompt testing of symptomatic residents and referral of symptomatic staff for evaluation. Current case definition for COVID-19 can be found here;
3. The RCF 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);
4. There should be early identification of staff absence/s, which may be due to COVID-19 or influenza infection.

2.16 Management of a possible or confirmed case of COVID-19 or Influenza

1. The initial assessment of the resident should be performed by their doctor;
2. If the resident is eligible for consideration for specific antiviral treatment they should be referred appropriately for assessment;
3. If the clinical condition does not require hospitalisation, the resident should not be transferred from the facility on infection prevention and control grounds;
4. Where it is appropriate to their overall care needs, a resident with possible or confirmed COVID-19 or influenza should be placed in a single room with transmission-based precautions and appropriate use of PPE by staff (See Appendices);
5. Staff assigned to care of a resident in these circumstances should be staff who have been vaccinated (including booster vaccination);
6. Room doors should be kept closed where possible and safe to do so;
7. Practical measures to increase ventilation should be taken consistent with

comfort and weather. Note: the intention is to achieve gentle air circulation rather than strong air movements;

8. When this is not possible, ensure the resident's bed is moved to the furthest safe point in the room to try and achieve at least 1 m distance to the door;
9. Display signage to reduce entry into the room, but confidentiality must be maintained;
10. 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;
11. Ideally, the resident's single room should have ensuite facilities;
12. If ensuite facilities are not available, try to designate a commode or toilet facility for the resident's use;
13. In the event of a commode being used, the HCW should exit the resident's room while wearing appropriate PPE, transport the commode directly to the nearest sluice (dirty utility) and place the contents directly into the bed pan washer or pulp disposal unit; PPE can then be removed and disposed of in the dirty utility. A second person should be available to assist with opening and closing doors to the single room and dirty utility. If a second person is not available, change gloves and perform hand hygiene and put on a clean pair of disposable gloves;
14. If the resident must use a communal toilet, ensure it is cleaned and disinfected after every use;
15. Listen and respond to any concerns residents may have to ensure support and optimal adherence is achieved during their care;
16. If well enough, a resident who has infection should be facilitated in going outside alone if appropriate, or accompanied by a staff member maintaining adequate distance from both staff and other residents. If the staff member can maintain this distance, they do not need to wear PPE;
17. 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;
18. Residents with confirmed COVID-19 or influenza will require appropriate

healthcare and social support, including access to their doctor or GP for medical management and on -site support;

19. Residents with confirmed COVID-19 or influenza should continue to have some access each day in their room to their nominated support person if that person acknowledges and accepts the associated risk and complies with all infection prevention and control guidance;
20. Residents with influenza or who are exposed to influenza may require treatment with antiviral medication; this may also be a consideration with respect to COVID-19;
21. A care planning approach that reflects regular monitoring of residents with COVID- 19 or influenza infection for daily observations, clinical symptoms and deterioration should be put in place. Where appropriate there should be advance planning in place with residents and / or advocates reflecting preferences for end of life care and / or transfer to hospital in event of deterioration. Staffing levels / surge capacity planning should reflect the need for an anticipated increase in care needs during an outbreak;
22. **The duration of transmission based precautions/ period of isolation in current conditions should in general be as for the general public. This is influenced by current vaccine uptake in RCF settings, and the features of the current variants of SARS-CoV-2, and the fact that these are generally controlled environments. Residents with confirmed COVID-19 infection** should remain in isolation with contact and droplet precautions in place for 5 days from onset of symptoms or date of positive result (whichever first), and have had complete or substantial resolution of symptoms for at least the last 2 days of the period. Note if the resident is eligible for booster vaccination but has not had booster vaccination the period of transmission-based precautions is extended at least to 7 days but to no longer than 10 days. Please refer to 'Duration of Transmission based precautions' section;
23. **At a minimum, for interaction with residents with respiratory viral symptoms, healthcare workers should use a surgical mask or respirator mask. For longer episodes of care, for care within the bed space, or while performing**

higher risk procedures, a respirator mask and eye protection are recommended;

24. **Refer to this algorithm for further advice https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/guidance/residentialcarefacilitiesguidance/Algorithm%20for%20testing%20for%20ARI%20in%20RCF.pdf**
25. There is no requirement for repeat testing after a person has a test confirming COVID-19 infection; in particular, there is no general requirement for a PCR or antigen as a 'clearance test' at the end of the period of isolation. However, in some circumstances, antigen testing may be used to support decision making around the end of the period of isolation, only to offer an additional level of confidence where this is sought by a resident or a family or an organisation;
26. Antiviral treatment for residents with influenza and, where appropriate, COVID-19 should be discussed promptly with the resident's doctor or with Public Health. Treatment is likely to be more effective if started early;

    Residents with confirmed influenza virus infection should remain in isolation for 5 days from the onset of symptoms. This may be extended to 7 days for residents who are immunosuppressed following consultation with their doctor;
27. Healthcare workers with confirmed influenza should remain off work for 5 days from the onset of symptoms and until they are well enough to return;
28. Staff should be mindful that prolonged isolation is stressful for most residents. Access to a nominated support person who is willing to attend may greatly relieve that stress;
29. If residents need to see people other than the nominated support person, for example because they are distressed or approaching end of life, this should be facilitated if the person they wish to see understands that there is a risk of infection and can follow recommendations to lower the risk of infection.
30.

2.17 Cohorting residents with possible or confirmed COVID-19 or Influenza

1. Placement of residents with possible or confirmed COVID-19 or influenza in a designated zone, with designated staffing to facilitate care and minimise further spread is known as cohorting.

2. In a RCF, cohorting can be a useful approach to managing a highly infectious disease with associated serious morbidity and mortality when a number of residents are affected at the same time. Cohorting is not required in the management of every outbreak. It is appropriate to balance the potential benefits of cohorting with the disruption and stress for residents associated with moving from the room or space that they are accustomed.
3. If cohorting is necessary it requires an individual facility risk assessment approach including planning for each facility, and the zoned area might be a floor, a wing or a separate annex. In these zoned areas, heightened infection prevention and control measures are critical.
4. Ensure adequate ventilation in the cohort area in so far as practical, consistent with comfort and safety; the goal is gentle air circulation rather than strong air movements.
5. Cohorting includes residents who are placed in single rooms close together, or in multi-occupancy areas within the building or section of a ward/unit;
6. Where possible, residents with probable or confirmed COVID-19 or influenza should be isolated in single rooms with ensuite facilities. If there are multiple residents and if it is necessary to cohort, 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;
7. Where single room capacity is exceeded and it is necessary to cohort residents in a multi-occupancy room:
    a. Residents with **a confirmed diagnosis of COVID-19** can be cohorted together
    b. Residents with **a confirmed diagnosis of influenza** can be cohorted together
    c. Residents with suspected COVID-19 or influenza should not be cohorted with those who are confirmed positive
    d. The risk of cohorting **suspected cases** in multi-occupancy areas is much greater than that of cohorting confirmed positive residents together, as the suspected cohort is likely to include residents with and without the specific

virus infection.

8. Where residents are cohorted in multi-occupancy rooms, every effort should be made to minimise cross-transmission risk:
    a. Maintain as much physical distance as practical between beds (minimum of 1m); if possible reduce the number of residents/beds in the area to facilitate physical distancing
    b. Close privacy curtains if available between the beds to minimise opportunities for close contact.
9. There should be clear signage indicating that the area is a designated zone to alert staff about a cohorting location in the RCF. A cohort zone may have multi-occupancy rooms or a series of single rooms;
10. A designated cohort area should ideally be separated from non-cohort areas by closed doors;
11. In the rare event of outbreak of two viral infections, do not cohort people with COVID-19 and those with influenza together;
12. Minimise unnecessary movement of staff in cohort areas and ensure that the number of staff entering the cohort area is kept to a minimum;
13. Staff working in cohort areas should be vaccinated (including booster vaccination if eligible) and should not be assigned also to work in non-outbreak areas, where possible;
14. In so far as is possible, the cohort 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.

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

There is no requirement for contact tracing including the identification of close contacts of a confirmed case of COVID-19 in an RCF. PCR testing is recommended for symptomatic contacts.

2.19 Management of close contacts of a possible or confirmed case of Influenza

1. Residents who are close contacts of a confirmed case of influenza should be accommodated in a single room with their own bathing and toilet facilities. If this is not possible, cohorting in small groups (two to four) with other close contacts is acceptable;
2. Antiviral prophylaxis may be appropriate for contacts as per advice from Public Health;
3. Testing of asymptomatic close contacts of influenza cases is not generally required.

2.20 Infection prevention and control measures

2.20.1 Standard precautions

Standard Precautions applied to all people cared for in all settings at all times plays a key role in managing the risk of infection for residents and for healthcare workers. For further information on Standard Precautions please refer to the relevant section in the "NCEC National Clinical Guideline No. 30 Infection Prevention and Control" http://health.gov.ie/national-patient-safety-office/ncec/.

Links to the standard precautions poster and explainer are available on the following link: https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/HSE%20West%20Standard%20Precautions%20Poster%20A3.pdf

Healthcare workers are no longer required to wear a facemask for all healthcare interactions. Standard Precautions continue to apply.

As part of Standard Precautions, it is the responsibility of every HCW to undertake a point of care risk assessment prior to performing a clinical care task; this will inform the level of IPC precautions needed, including the choice of appropriate PPE.
For further information on PCRA, and how to use a PCRA please see links

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/
AND
https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/how-to-use-a-point-of-care-risk-assessment-pcra-for-infection-prevention-and-control-copy.pdf

For further information on Standard Precautions and the chain of infection, refer to HSEland (www.hseland.ie) online learning or www.hpsc.ie.

2.20.2 Hand hygiene

1. Hand hygiene is the single most important action to reduce the spread of infection, including but not limited to respiratory viral infections, in health and other social care settings and is a critical element of standard precautions;
2. Facilities must provide ready access for staff, residents and visitors to hand hygiene facilities and alcohol-based hand rub (ABHR);
3. Staff should adhere to the WHO five moments for hand hygiene:
    a. 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.
4. Residents should be encouraged and facilitated to clean their hands after toileting, after blowing their nose, before, after eating, and when leaving their room. If the resident's cognitive state is impaired, staff must help with this activity;
5. **Gloves should not be used in routine care of residents.** They are appropriate when contact with blood or body fluids (other than sweat), non-intact skin or mucous membranes is anticipated. When gloves are required, they are not a substitute for hand hygiene. Hand hygiene is required before putting on gloves and immediately after they have been removed.

Hand hygiene information posters are available here.

2.20.3 Respiratory hygiene and cough etiquette

1. Respiratory hygiene and cough etiquette refer to measures taken to reduce the spread of viruses via liquid respiratory particles produced when a person coughs or sneezes;
2. Disposable single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose;
3. Used tissues should be disposed of promptly in the nearest foot operated waste bin;
4. Some residents may need assistance with containment of respiratory secretions. Those who are immobile will need a waste bag at hand for immediate disposal of the tissue. Hands should be cleaned with either soap and water or ABHR after coughing, sneezing, using tissues or after contact with respiratory secretions and contaminated objects;
5. Staff and residents should be advised to try to avoid touching their eyes, mouth and nose.

   Please see eLearning resources that are available on www.hseland.ie

2.20.4 Transmission-based Precautions for COVID-19 and Influenza virus

Transmission-based Precautions are measures taken in addition to Standard Precautions to manage risk of transmission of infection when caring for people with known or suspected infectious disease for which Standard Precautions alone are not sufficient. Transmission-based Precautions include Contact, Droplet and Airborne Precautions. For details on Transmission-based precautions please see please refer to the relevant section in the "NCEC National Clinical Guideline No. 30 Infection Prevention and Control". http://health.gov.ie/national-patient-safety-office/ncec/

2.20.5 Personal Protective Equipment (PPE)

The guidance on PPE is available on the following link: https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/.

Updated Guidance on the use of masks by Healthcare workers

1. Surgical masks or respirator masks should to be worn by healthcare workers in all settings where they are caring for residents with suspected or confirmed COVID-19.
2. Surgical masks or respirator masks should also be worn in settings where the infection prevention and control team advice indicates that there is a high risk that residents with unsuspected COVID-19 are likely to be present.
3. Healthcare workers in low-risk settings, when caring for those who do not have suspected or confirmed COVID-19, can revert to standard precautions, which includes risk assessment for whether wearing a surgical mask or other PPE is required.
4. Recognising that health care workers' preferences are an important consideration, surgical and respirator masks should continue to be available to healthcare workers in all settings, although they are not required for most healthcare interactions outside of periods of increased community transmission of respiratory viral infections.
5. Care staff who live and work with residents in health and social care settings should, when caring for those who do not have suspected or confirmed COVID-19, revert to standard precautions and risk assessment as to whether wearing a surgical mask is required.
6. Surgical masks are no longer required to be worn for all healthcare interactions.
7. HCWs in non-clinical settings where residents are not cared for are not required to wear a surgical mask, although may choose to do so.

8. The IPC team should review any new items of PPE for suitability and consider if existing guidance for staff requires updating, to ensure it is compatible with the new item of PPE.
9. Where visors were being worn by staff in place of masks when providing care for certain categories of resident for example, residents who may need to lip-read, this is no longer routinely required.
10. PPE should be readily available outside the resident's room or cohort area;
11. Have a colleague observe donning and doffing of PPE where practical.

Educational videos are also available on www.hpsc.ie at https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/videoresourcesforipc/

A suite of resources including posters, videos and webinars relating to the safe donning and doffing of PPE is accessible at https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/

The Health and Safety Authority indicates that where a risk assessment indicates that workers need to use a close-fitting respirator mask for their protection that every effort should be made to comply with the requirement for fit testing of the workers, as far as is reasonably practicable. When fit testing of all staff is not immediately possible, then fit testing should be prioritised for those at greatest risk.

2.21 Duration of transmission based precautions

1. The duration of isolation for cases of COVID-19 in the general public is part of Public Health guidance. https://www.gov.ie/en/publication/3361b-public-health-updates/

   In general, the period of isolation/ transmission based precautions for a resident with COVID-19 in an RCF is 5 days as long as major symptoms, such as fever,

have completely or substantially resolved. This is in the context in which the majority of residents are up to date with vaccination and booster, and the burden of prolonged isolation on residents is considerable. Please see this link for further informationhttps://www2.hse.ie/conditions/coronavirus/people-at-higher-risk.html

2. There is no requirement for repeat testing after a person has a test confirming COVID-19 infection; in particular, there is no general requirement for a PCR or antigen as a 'clearance test' at the end of the period of isolation. However, in some circumstances, antigen testing may be used to support decision making around the end of the period of isolation, only to offer an additional level of confidence where this is sought by a resident or a family or an organisation
3. This duration also applies to residents who have had primary vaccination and for whom booster vaccination has been deferred because of recent COVID-19 infection.
4. The duration of transmission-based precautions should be extended to at least 7 days, but to no more than 10 days for those who have not had booster vaccination and not had recent COVID-19 infection (including those who have had no vaccine, have started but not completed primary vaccination or have completed primary vaccination but have not had booster).
5. There is an exception for people on respiratory support devices that are aerosol generating. For residents who are on respiratory support devices that are aerosol generating the period should be extended to 21 days in consultation with their doctor and IPC advisors. Extension beyond 21 days is rarely if ever appropriate;
6. Some people that meet the criteria for release from isolation may have a persistent cough. There is no evidence that such people pose a specific infection risk, or that transmission-based precautions should be continued.
7. For influenza, transmission based precautions can be discontinued after 5 days from onset of symptoms. This may be extended to 7 days for residents who are immunosuppressed following consultation with their doctor.
8. In small community housing units the duration of isolation for cases of COVID-

19 should generally be as for the general population.

2.22 Care Equipment

Please refer to the relevant section in the ""NCEC National Clinical Guideline No. 30 Infection Prevention and Control". http://health.gov.ie/national-patient-safety-office/ncec/

Where possible, use single-use equipment for the resident and dispose of it as healthcare risk waste into a designated healthcare risk waste bin inside the room;

1. Where single use equipment is not possible, use designated care equipment in the resident's room or cohort area. In a cohort area, the equipment must be decontaminated immediately after use and before use on any other resident following routine cleaning protocols.
2. If it is not possible to designate 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 and disinfection protocols.
3. There is no need to use disposable plates or cutlery. Wash crockery and cutlery after use either in a dishwasher or by handwashing, using household detergent and hand-hot water.

2.23 Management of waste

1. Dispose of all waste from residents with confirmed or suspected COVID-19 or influenza virus as healthcare risk waste during the period when transmission based precautions applies (also referred to as clinical risk waste).
2. When removing waste, it should be handled as per usual precautions for healthcare risk waste;
3. The external surfaces of the bags/containers do not need to be disinfected;
4. All those handling waste should wear appropriate PPE and clean their hands after removing PPE;
5. Hands-free healthcare risk waste bins should be provided in single rooms and cohort areas;

6. Bodily 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.

2.24 Safe management of linen

1. 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;
2. 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;
3. Disposable gloves and an apron should be worn when handling linen;
4. 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;
5. When handling linen, the HCW should not:
    a. rinse, shake or sort linen on removal from beds/trolleys;
    b. place used/infectious linen on the floor or any other surfaces (e.g., a bedside locker/table top);
    c. handle used/infectious linen once bagged;
    d. overfill laundry receptacles; or
    e. Place inappropriate items in the laundry receptacle (e.g., used equipment/needles).
6. When managing infectious linen, the HCW should:
    a. Place linen directly into a water-soluble/alginate bag and secure;
    b. Place the alginate/water-soluble bag into the appropriately coloured linen bag (as per local policy);
    c. Store all used/infectious linen in a designated, safe area pending collection by a laundry service;
    d. If there is no laundry service, laundry should be washed using the hottest temperature that the fabric can withstand and standard laundry detergent;
    e. Laundry may be dried in a dryer on a hot setting.

2.25 Environment

1. 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 and they are likely to want to personalise their space with objects of significance to them;
2. Ventilation should be maintained in so far as practical taking account of comfort and weather. Note that the goal is to achieve reasonable air exchange with gentle air movement. Strong airflow into the room from outside that is readily felt and causes discomfort is not required and may contribute to airflow out of the room.
3. Some healthcare settings have found it helpful to use carbon dioxide (CO_2) monitors, mobile or fixed, to identify areas of poor ventilation and or to monitor ventilation. The deployment of monitors may help to identify specific areas where ventilation is poor and where particular efforts to increase ventilation are required.
4. When appropriately selected, deployed and maintained, single-space air cleaners with HEPA filters (either ceiling mounted or portable) can be effective in reducing/lowering concentrations of infectious aerosols in a single space however, they have not been shown to reduce the risk of residents acquiring infection with COVID-19 in a healthcare setting. They may have a role in settings where ventilation is not adequate based on institutional risk assessment;
5. Residents' observation charts, medication prescription and administration records (drug kardexes) and healthcare records should not be taken into the resident's room, to limit the risk of contamination.

2.26 Cleaning

1. Decontamination of equipment and the care environment must be performed using either:
   a. A combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.); or;
   b. A general-purpose neutral detergent in a solution of warm

water, followed by a disinfectant solution of 1,000 ppm av.cl;

   c. Only cleaning (detergent) and disinfectant products supplied by employers meet specification for their intended use and are approved for use. Products must be prepared and used according to the manufacturer's instructions and recommended product "contact times" must be followed.

2. Vacuuming of carpet floor in a resident's room should be avoided during an outbreak and while the person is infectious. When the resident is recovered the carpet should be steam cleaned;
3. All shared spaces should be cleaned with detergent and disinfectant;
4. 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;
5. Household and care staff should be trained in the appropriate use and removal of PPE;
6. In practical terms, staff who are also providing care to the resident while in the single room may undertake single room cleaning.

2.26.1 Frequency of cleaning in the context of COVID-19 and Influenza

1. All surfaces in the resident room/zone of people who have infectious COVID-19 or influenza should be cleaned and disinfected at least daily, and when visibly contaminated. These include high-touch items; bedrails, bedside tables, light switches, remote controls, commodes, doorknobs, sinks, surfaces and equipment close to the resident (e.g., walking frames, sticks, phone or other mobile device);
2. Handrails and table tops in facility communal areas, along with nurses' station counter tops and equipment require regular cleaning;
3. Cohort areas and clinical rooms must be cleaned and disinfected at least daily, and when visibly contaminated and a documented cleaning schedule should be available to confirm this.

2.26.2 Cleaning after a resident with COVID-19 has vacated a room

1. The room should be thoroughly cleaned, with particular emphasis on surfaces and fabrics that are touched regularly. Contact surfaces should be disinfected.
2. The use of novel technologies for room disinfection have not been shown to add value beyond standard cleaning and disinfection and are not recommended. If they are used, they must be used in addition to and not as a substitute for cleaning.

2.26.3 Staff uniforms/clothing

1. Staff uniforms are not considered to be personal protective equipment.
2. The appropriate use of PPE will protect staff uniforms from contamination in most circumstances.
3. Uniforms should be laundered:
    a. separately from other household linen;
    b. in a load not more than half the machine capacity;
    c. at the maximum temperature the fabric can tolerate.
4. The risk of virus transmission from contaminated footwear is likely to be extremely low. Shoe covers should not be used. However, HCW could consider designating a pair of comfortable, closed, cleanable shoes for wearing in a COVID-19 care area.
5. Staff should avoid bringing personal items, including mobile phones into isolation or cohort areas.

3 Care of the person with suspected or confirmed COVID-19 who is dying

1. A compassionate, pragmatic and proportionate approach is required in the care of those who are dying;
2. The presence of a person close to the resident should be facilitated (see above re nominated support person). They should be aware of the potential infection risk.

3. If the person who wants to be with the resident is vaccinated, including booster vaccination if eligible, the risk is much reduced.
4. Pastoral care team where requested by the person or their family and who are willing to attend should have access to the facility.
5. All persons in attendance should be advised to wear a surgical or respirator mask but it is important to accept that at such a time some people may prefer not to wear mask or other PPE. A respirator mask should be available to those who wish to use them although it is unlikely that it will be practical to train most people in their correct use in this context. Gloves and apron are not essential. If it is necessary to wear additional PPE for the provision of care, visitors should be supported and advised on how to put on and take off the PPE and how to perform hand hygiene.
6. The use of PPE is less important if the person accompanying the dying person is vaccinated including booster vaccination if eligible.
7. Visitors should avoid interacting with residents other than the person they are accompanying.

4 Care of the recently deceased

4.1 Hygienic preparation

1. Any IPC precautions that have been advised before death must be continued in handling the deceased person after death. In relation to COVID-19 specifically, if transmission based precautions have been discontinued before death, then they are not required after death – see section on duration of transmission based precautions;
2. Hygienic preparation includes; washing of the face and hands, closing the mouth and eyes, tidying the hair and in some cases, shaving the face;
3. Washing or preparing the body for religious reasons is acceptable if those carrying out the task wear long-sleeved gowns, gloves, a surgical facemask and eye protection, if there is a risk of splashing.

4.2 Handling personal possessions of the deceased

1. It highly unlikely that handling the personal possessions of the deceased contributes materially to the risk of infection for the individual or society. Items should be clean and free of visible blood or body fluid contamination before handled.

4.3 Transport to the mortuary

1. An inner lining is not required in terms of COVID-19 risk or influenza risk, but may be required for other practical reasons such as maintaining dignity or preventing leakage affecting the mortuary environment;
2. A surgical face mask or similar should be placed over the mouth of the deceased before lifting the remains into the inner lining;
3. Those physically handling the body and placing the body into the coffin or the inner lining should wear, at a minimum, the following PPE:
    a. Gloves;
    b. Long sleeved gown;
    c. Surgical facemask.
4. Play close attention to hand hygiene after removal of PPE;
5. There is no Infection Prevention and Control concern with viewing the remains of a person who died with COVID-19. The family should be advised not to kiss the deceased and should clean their hands with alcohol hand rub or soap and water after touching the deceased.

PPE is not required for transfer, once the body has been placed in the coffin. Viewing the remains at any time is not a significant infection prevention and control risk.

5 Management of an outbreak of COVID-19 or Influenza

When there is a suspicion of cases of COVID-19, influenza or other acute respiratory virus infection the MOH should be informed so that they can perform a risk assessment

to determine the scale of the risk and whether there is either possible or confirmed active transmission in the facility.

Community housing units with small number of younger, mainly vaccinated residents are generally lower risk settings for respiratory tract infection outbreaks than are large congregated settings for older people. In terms of size and function, they are in many ways similar to a private house. One or a small number of cases of respiratory tract infection in these settings can generally be managed by pointing staff in the facility to this guidance and general public health advice. The formal process of an outbreak control team is generally unnecessary but may be appropriate in some cases based on knowledge of specific risks associated with a particular facility.

The following content on outbreak management is primarily intended to address larger congregated settings but the principles are applicable also to community housing units in the even that a formal outbreak management process is required based on the assessed risk.

An isolated positive result of SARS-CoV-2 or influenza in a resident or staff member is not in itself proof of current active transmission.

When an outbreak is suspected laboratory testing should be arranged as quickly as possible. However, it is not appropriate to wait for laboratory test results before beginning initial investigation, contacting Public Health or implementing control measures. There should be heightened awareness among staff, so that other residents with symptoms are quickly identified.

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

This group should:

1. Try and establish whether it is likely that an outbreak is occurring, taking in to account the following:

a. Could onward transmission have already occurred? (e.g., resident had widespread contact with others in the 48 hours before symptom onset):
    i. Are they in a single room or sharing?
    ii. Is the resident ambulatory?
    iii. Have they spent time with others in communal areas or group activities?
    iv. Are there behavioural characteristics, which might be increased risk of transmission?
    v. Are all or most residents vaccinated against COVID-19 and influenza?

2. Identify if any other residents are symptomatic and if so, what are their symptoms?
3. Identify are any staff symptomatic or has there been an increase in staff absence?
4. For an outbreak of influenza, identify residents and staff who were in close contact with the symptomatic resident/s and monitor for symptoms and signs of infections. Follow public health recommendations for antiviral chemoprophylaxis.

5.1 Declaring an outbreak

The declaration of an outbreak in a LTRCF is made by the Medical Officer of Health, guided by general principles and taking account of all the circumstances. The key question is if there is reason to believe that transmission of virus is occurring in the LTRCF.

The declaration of an outbreak is considered when two or more cases of infection with the same pathogen (COVID-19, Influenza or other respiratory virus) are confirmed by an appropriate method and there is reason to consider that they may be epidemiologically linked in place and time.

<u>OR</u>

A cluster/outbreak, with two or more cases of illness with symptoms consistent with the same pattern of infection related illness, and at least one person is laboratory confirmed

and there is reason to consider that they may be epidemiologically linked in place and time.

It is important to detect outbreaks in Nursing Homes early and to manage the risk to residents and staff. If it is possible to identify a likely source of infection for the index case this may assist in determining if an outbreak should be declared. It is also important to consider that declaring an outbreak in a Nursing Home may have profound consequences for residents of that Nursing Home in relation to their access to visitors and their care and social activity within the Nursing Home. It may also result in temporary denial of access to the Nursing Home for potential new residents who would receive better and safer care in the Nursing Home than in their current location. It is therefore important to avoid declaring an outbreak in the absence of reasonable evidence of transmission within the Nursing Home. In forming a judgement regarding the declaration of an outbreak in a LTRCF it is important to consider the incidence of the infection in the community. When the incidence of infection in the community is high the detection of three or more cases of current infection in one LTRCF, particularly among staff may be a chance finding (particularly in a very large nursing home).

5.2 Outbreak Control Team (OCT)

All outbreaks of infectious disease, including COVID-19 or influenza, in a RCF must be reported to the regional Medical Officer of Health (MOH) at the Department of Public Health (DPH) at the earliest opportunity.

Following public health risk assessment and where appropriate:

- The RCF should lead and manage the outbreak locally in line with national guidance, however, they should continue to have access to their local DPH for advice and guidance if required.
- Public Health should continue to engage in active decision-making in relation to nursing home outbreaks i.e. when activities / transfers can resume and declaring an outbreak over.
- RCFs should keep a record of the numbers of cases and provide this information to their local Departments of Public Health if requested.
- An Outbreak Control Team may be convened.

If an outbreak is declared, Public Health doctors from the Regional Department of Public Health will provide overall leadership for the management of the 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 membership should be decided at local level and will depend on available expertise.

An OCT Chairperson 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:

1. Specialist in Public Health Medicine and/or Public Health Department Communicable Disease Control Nurse Specialist;
2. GP/Medical officer/Consultant to RCF (dependent on nature of RCF);
3. Director of Nursing or Nurse Manager from RCF;
4. Management representative from the RCF i.e. manager or CEO;
5. Community Infection Prevention and Control Nurse (CIPCN) where available;
6. Administration support.

Other members who may need to be included, particularly if it is an extensive or prolonged outbreak include:

1. Community Services General Manager;
2. Administrative support;
3. Occupational Medicine Physician;
4. Consultant Clinical Microbiologist;
5. Representative from HPSC;
6. Communications officer.

Every member involved should have a clear understanding of their role and responsibility.

The frequency required for the OCT meeting should be decided. The RCF should inform HIQA or Mental Health Commission, as appropriate and the local CHO as per usual protocols.

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

1. A line list of all residents and staff. Template can be found in Appendix C;
2. The vaccination history (COVID-19 and influenza) of all residents and staff;
3. Identify the total number of people ill (residents & staff), dates of illness onset and the spectrum of symptoms;
4. Identify staff and residents who have recently recovered, developed complications, been transferred to acute hospitals and those who have died;
5. Information on laboratory tests including the number of tests taken to date and the date sent to the laboratory, along with the tests requested and reported results;
6. Determine if the number of symptomatic residents/staff involves more than one unit/floor/ward or if the outbreak is confined to one area only;
7. A checklist for outbreak management can be found in Appendix D.

5.3 Communication

1. Good communication is essential for residents, family and staff members;
2. Provide regular information sessions and education on measures required for staff members and assign someone to do these.

5.4 Support services for staff and residents

1. The effect on staff and residents during outbreak events should not be underestimated especially where there have been deaths in the RCF. Every effort should be made to support those who are impacted by outbreak events;
2. Some social activity in “pods” of up to 6 people may help to support residents in an outbreak setting. Social activity in defined pods is expected to be lower risk than activities that bring large numbers together

3. One of the key supports to staff is to promote vaccination. It is important that staff with questions about the benefits and risks of vaccination have access to appropriate support.

5.5 Monitoring outbreak progress

1. Monitoring the outbreak will include ongoing surveillance for symptoms in residents and staff to identify new cases and to update the status of ill residents and staff;
2. 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;
3. The review of this information should examine issues of ongoing transmission and the effectiveness of control measures;
4. Institute active twice-daily surveillance for respiratory symptoms, including fever, cough and other symptoms suggestive of COVID-19 or influenza, in residents and staff until the outbreak is declared over.

5.6 Declaring the outbreak over

In order to formally declare that the outbreak is over, the RCF should not have experienced any new cases of infection (resident or staff) considered as likely to have been acquired in the RCF which meet the case definition for a period of two incubation periods, 14 days (2 x 7 day incubation period).

COVID-19 outbreaks in RCFs may be declared closed once 14 days have elapsed since the last confirmed case of COVID-19 in the facility. In practical terms, the RCF can resume normal function once there is reasonable confidence that active transmission has ceased. Seven to ten days after the most recent case was detected is a reasonable general guide. There should be a high level of vigilance regarding symptoms of infection until the outbreak is formally closed.

Please note for influenza outbreaks they can be declared over 8 days after the last positive case linked with the outbreak.

As above, an isolated positive result of SARS-CoV-2 in a resident or staff member is not of itself evidence of ongoing transmission.

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

	Domain	Action	Comment
Pre-Outbreak Measures	Planning and Administration	Written Policies	Vaccination policies Standard and 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 – Standard and Transmission-based Precautions, PPE Measures to improve compliance
		Provision of supplies	Hand hygiene supplies, PPE, cleaning and disinfection materials, viral swabs, request forms and arrangements for prioritised testing of samples
		Vaccination	Regularly review the uptake of vaccination in residents and staff.
	Standard Precautions	Standard infection control procedures	Standard Precautions should be practised by all staff at all times
	Surveillance	Awareness of signs and symptoms of COVID	Formal process to record any new symptomatic residents twice daily
	Case Definition	As per HPSC guidance	Case definition may change as pandemic progresses
	Outbreak Definition	Action threshold for outbreak control measures	See section 6
	Communication of suspected outbreak	Notification of senior management, medical and	Ensure residents and other relevant people are informed

	Domain	Action	Comment
Early recognition		public health staff, CHO and NH lead and infection prevention and control team, as appropriate	
	Formation of outbreak control team (OCT)	OCT may be convened following risk assessment	Important to consider the nature of the facility and associated risks
	Testing	Viral swab	Prompt testing of symptomatic residents
During an Outbreak	Initial Actions	Daily Case list	
		Activate Daily surveillance	
		Appropriate IPC precautions in place	Contact and Droplet precautions in the cohorted area/zone. Note should wear a surgical/respirator mask
		Resident placement	Single rooms Cohorting or zone allocation if appropriate following risk assessment
		Respiratory etiquette	
	Infection Control Measures	Hand Hygiene	As per WHO 5 moments: • Before patient contact • Before an aseptic procedure • After body fluid exposure • After patient contact • After contact with patient surroundings Hand hygiene after PPE removal
		PPE	Gloves (as required) Mask (surgical/respirator mask)

	Domain	Action	Comment
			Aprons / Gowns (as required)
		Aerosol Generating Procedure associated with increased risk of infection (AGP)	See HPSC guidance document. Ventilation, closed door, respirator mask , gown, eye protection and gloves
	Environmental control measures		Resident environmental cleaning and disinfection Residential care equipment Laundry Eating utensils and crockery Practical measures to ensure adequate ventilation consistent with comfort and weather (gentle movement of air rather than strong airflow is the objective)
	Containment Measures Note in most cases these measures can cease 7 to 10 days after most recent case		New admissions restricted Transfers restricted Assess need for restriction of communal activities Staffing precautions Managed access for nominated support person and visitors
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: 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. Sex;
7. Status i.e., resident, staff member, volunteer, visitor;
8. Vaccination status of resident, staff member, volunteer, visitor; vaccine protection;
9. Date of onset of symptoms;
10. Date of notification of symptoms;
11. Clinical symptoms (outline dependent on case definition) e.g., fever, cough, myalgia, headache, other;
12. Samples taken and dates;
13. Laboratory results including test type e.g., RT-PCR;
14. Date when isolation of resident was started;
15. Date of recovery;
16. Duration of illness;
17. Outcomes: recovery, pneumonia, other, hospitalisation, death;
18. Also include work assignments of staff and last day of work of ill staff member;
19. 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 First name	Location (unit/ section)	Vaccinated (COVID-19 and influenza) including booster if eligible Y/N	Sex	DOB	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	Laboratory 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	Vaccinated (COVID-19 & Influenza) including booster if eligible/N	Sex	DOB	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; Note column 6 is only applicable for COVID-19 outbreaks**

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	Consider if the criteria for declaring an outbreak are met		
2	Decide if an OCT is required		
3	Agree the chair		
4	Formulate an outbreak code and working case definition		
5	Define the population at risk		
6	Active case finding, request line listing of residents and staff from the RCF		
7	Discuss whether it is a facility-wide outbreak or unit-specific		
8	Confirm how and when communications will take place between the RCF, CIPCN, CHO NH lead, Public Health and the laboratory		
9	Review the control measures (infection prevention and 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		
10	Review vaccination status of all residents and staff		
11	Discuss which specimens have been collected. Notify the laboratory of the investigation.		
12	Confirm the type and number of further laboratory specimens to be taken. Clarify which residents and staff should be tested.		
13	Confirm with the laboratory that it 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.		
14	Liaise with the RCF and laboratory regarding specimen collection and transport		

	Discussion point	Decision/action to be taken (date completed)	Person responsible
15	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		
16	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	Link with Community Support Team		
20	Discuss communication arrangements with HSE management ± HSE crisis management team		
21	Discuss communication arrangements with local GPs and Emergency Departments		
22	Decide how frequently the OCT should meet and agree criteria to declare outbreak over		
23	Prepare/circulate an incident report/set date for review meeting		

Appendix E: Admissions, transfers and discharges to and from residential care facilities

Note that testing of asymptomatic residents regardless of vaccine status on transfer or admission, is generally not required.

Testing of asymptomatic residents on admission/transfer may remain appropriate based on local risk assessment for those on non-invasive respiratory support.

There is no requirement to limit the movement of a resident within the LTRCF after return from an outing or hospital attendance regardless of the duration of the absence unless some significant and unanticipated exposure risk occurred or there is a specific public health or IPC recommendation that requires limitation of movement.

Introduction

Long-term residential care facilities (LTRCF) are a critical part of health and social care services.

LTRCFs should put in place clear processes that facilitate the return of residents from an acute setting and the admission of new residents, where it is clinically safe to do so.

It is recognised that accepting admission or transfer of residents poses a risk of introducing COVID-19. However, at this stage of the pandemic response, the level of immunity among staff and residents is high, from vaccination, booster vaccination and from COVID-19 infection and as a result, the risk of harm from introduction of COVID-19 is greatly reduced.

Given the uptake of vaccination in the population, most residents transferring to a LTRCF are likely to have had booster vaccine. If an unvaccinated person is transferring from an acute hospital, they should be offered the first dose of vaccine before transfer. While the vaccine should ideally be administered as long as possible in advance of transfer, there is no requirement to delay transfer of a person who is otherwise ready for discharge to allow time for an immune response to the vaccine. Arrangements to complete the vaccination in the LTRCF are essential.

In all instances, careful attention to standard precautions will assist in minimising risk of infection to residents and staff. Key elements include; hand hygiene, respiratory hygiene and cough etiquette, use of personal protective equipment (PPE), for example wearing disposable gloves when in contact with blood or other body fluids (other than sweat), non-intact skin or mucus membranes and regular environmental cleaning.

It is essential that residents, clients, and their significant persons are informed of the issues and risks of decisions related to their care and that their preferences are taken into account in applying this guidance.

Background on testing for COVID-19

> **The key point about testing is that interpretation is not straightforward**
>
> 1. **A test result that says not-detected or “negative” does not prove the person is not infectious to others**
> 2. **A test result that says a virus is detected does not prove the person is still infectious to others**

Over the course of the COVID-19 pandemic, there has been significant learning about the role of testing for COVID-19 and its role in determining levels of asymptomatic infection and tracking spread of infection, especially in congregated settings, such as LTRCF.

A single test may be reported as not detected or “negative” in a substantial proportion of people with infection. The test is more likely to miss infection in people with pre-symptomatic or asymptomatic infection. Therefore, a not-detected or “negative” test makes COVID-19 infection less likely, but it does not prove the person is not infected.

Equally, for those who have been infected and infectious with COVID-19, a continued positive test result does not mean they are still infectious to others. Some people have a positive test for weeks after onset of symptoms, but latest evidence shows they are very unlikely to spread infection.

Note that if a person is detected by testing and subsequently develops symptoms the period of isolation is counted from the date of symptom onset (not the sample date); however, if they do not develop symptoms the isolation period begins on the sample date.

The period of isolation continues to apply in this setting although the infectious period may differ for the general public. Note that repeat testing at the end of the isolation period is generally not appropriate though exceptions may arise in the context of discussion with Microbiology, Infectious Diseases or Public Health Clinician.

The role of COVID-19 testing in assisting with decision-making regarding transfers to congregated settings

1. Testing of asymptomatic residents regardless of vaccine status on transfer or admission, is not required.
2. Irrespective of testing, all residents should be assessed before admission to determine if they have clinical symptoms suggestive of COVID-19
3. People may have been identified as COVID-19 contacts in other settings, such as in hospitals. Such people may transfer to an LTRCF if they have been tested by PCR and SARS-CoV-2 virus has not been detected. No restriction of movement is required as long as they remain asymptomatic.
4. For residents who decline or are clearly distressed by collection of a nasopharyngeal sample a deep nasal sample (also known as a mid-turbinate swab) is often less uncomfortable and they may consent to that. Deep nasals swabs should generally be used if repeated testing is needed, and for those in whom a nasopharyngeal sample collection is difficult or distressing. An anterior nasal swab is NOT a suitable sample. Some residents may decline testing, or may find the process too distressing and that testing may not be appropriate in every situation (Refer to DOH guidance document, 'Ethical Considerations Relating to Long-Term Residential Care Facilities in the context of COVID-19').

Procedure for Testing of People Pre-transfer/ Admission to a LTRCF, if required

1. Routine testing prior to transfer from an acute hospital to a LTRCF is not required; if required, the hospital should arrange for the person to be swabbed in the three days before transfer.
2. If a person being admitted to the LTRCF from home, testing is not routinely required; if required, the GP should arrange for the person to be swabbed within the three days before admission. This can be done using Healthlink. If the person cannot travel to the testing location, a home test can be ordered by clicking on the 'no transport available' option as shown on the screenshot below (Figure 1).
3. If a test pre-admission is required and cannot be arranged, including for urgent admissions, the person should be admitted as planned.The facility can arrange swabbing after admission. This can be done by the person's own GP or the GP/Medical Officer who provides medical care for the residents in the facility.

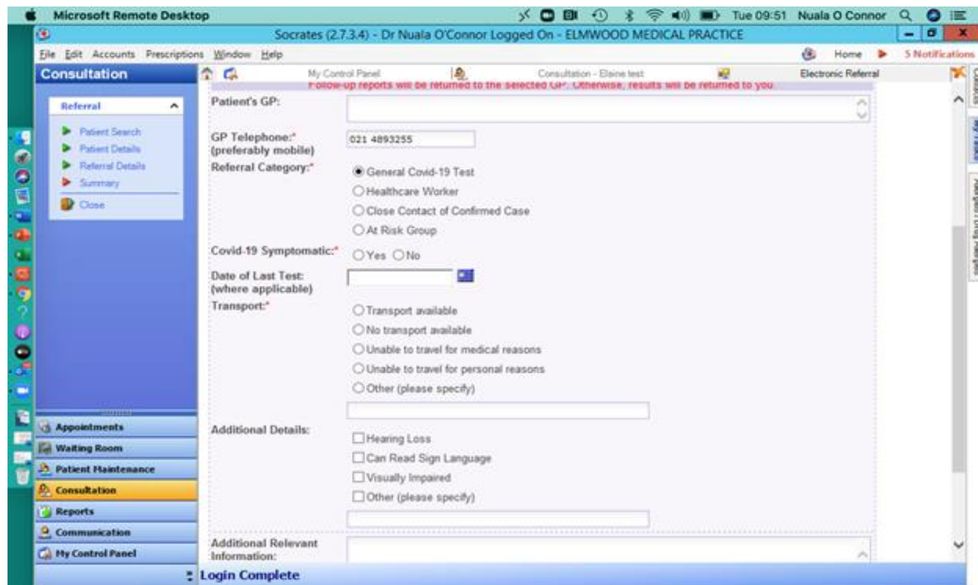

Figure 1. Snapshot of Health link web page **Requirements for placement of the person as part of transfer protocols**

Planning

1. The LTRCF should undertake a risk assessment ahead of all transfers or new admissions to ensure sufficient resources are available within the LTRCF to support physical distancing and placement of residents.
2. Where possible the use of single rooms in LTRCFs should be prioritised for symptomatic residents.
3. For those LTRCFs providing a blend of longer-term nursing home and short-term respite or convalescence care, it is advised to consider where the longer and shorter-term residents will be accommodated and where it is feasible, to try and place residents for shorter-term accommodation in an area separate to those for longer-term accommodation.
4. Existing residents should generally not be required to move from their room / accommodation in order to facilitate the creation of new areas to facilitate transfers.
5. Careful consideration should also be given to the consequences of closing facilities/rooms within a service for the purpose of having an isolation area should a need arise – the potential harms of such decisions should be balanced against the likely requirement.
6. Public Health may recommend that a person who is transferring from a particular congregated healthcare setting (a hospital or RCF) where there is evidence of ongoing transmission of COVID-19 (one or more open outbreaks) is monitored for symptoms as a COVID-19 Contact after transfer based on risk assessment – see below. Public Health may also advise on timing of any testing if required.

Transfer of people with COVID-19

1. Any resident transferred to a LTRCF before they have finished their period of transmission-based precautions in the hospital must complete their period of transmission-based precautions after transfer. Such transfer should not proceed if the receiving LTRCF has no other residents with infectious COVID-19 at the time.
2. In particular, existing residents from a LTRCF who require transfer to hospital from the LTRCF for assessment or care related to COVID-19 acquired in the LTRCF should be allowed to transfer back to that LTRCF following assessment / admission, if clinically fit for discharge, and risk assessment with the facility determines there is capacity for them to be cared for there, with appropriate isolation and where that transfer represents the most appropriate place of care for the resident (e.g. ongoing need for palliative care).
3. If the resident in an LTRCF has been diagnosed with COVID-19 while in hospital, it is important to assess if the person was infected in the LTRCF before transfer to the hospital or if this is a hospital-acquired infection. If it is likely that infection was acquired in hospital and there are no other known cases of COVID-19 in the LTRCF, transfer back to the LTRCF can take place if the resident can be managed safely in a single isolation room.
4. The public health team should be notified immediately where newly diagnosed COVID-19 is assessed as acquired within a LTRCF.
5. In all instances the discharging hospital should provide the LTRCF with the following information on the arrival of the resident:

    a. The date and results of any COVID-19 tests (including dates of tests reported as not-detected)
    b. The date of onset of any symptoms of COVID-19
    c. Date of last documented fever while in hospital (particularly important where resident is being transferred to RCF before the period of transmission based precautions is complete)
    d. Details of any treatment or monitoring required

Residents who become symptomatic during their stay in the LTRCF

1. Following transfer/ admission to a LTRCF, the resident should be evaluated by their doctor if they become symptomatic, including changes in the resident's overall clinical condition and a viral swab for SARS-CoV-2 sent for testing. **They may also require testing for other viruses, in particular influenza virus.**
2. The rationale for this recommendation is that there may have been contact between the resident and HCW or other people who may have had COVID-19 infection, but who may have been in the pre-symptomatic incubation period or have had minimal or no symptoms at the time. In that case, there would be an associated risk of unrecognised

onward transmission to the resident. They may also have been exposed to other respiratory viruses.

Cessation of new admissions to a facility during an outbreak of COVID-19 in a LTRCF

1. Following the declaration of an outbreak within a LTRCF, admissions of new residents to the facility (i.e. residents not previously living in the LTRCF) should generally be suspended.
2. In practical terms, the RCF can resume normal function once there is reasonable confidence that active transmission has ceased. Seven to ten days after the most recent case was detected is a reasonable general guide.
3. Residents normally cared for in the LTRCF, who are admitted to hospital while an outbreak is ongoing in the LTRCF, may have their discharge to the same LTRCF facilitated if it is deemed to be clinically appropriate, and a risk assessment has been carried out which identifies that the resident can be isolated, and the facility has capacity to manage their care needs, and where that transfer represents the most appropriate place of care for the resident (e.g. ongoing need for palliative care).

Transfers from LTRCF to an acute hospital

1. COVID-19 positive status must not significantly delay transfer to an acute hospital, where it is deemed clinically appropriate. The national ambulance service (NAS) and the local receiving hospital must be informed by the LTRCF, in advance of transfer of any COVID-19 positive or suspected COVID-19 resident AND where there is a suspected or confirmed COVID-19 outbreak in the LTRCF.
2. People with COVID-19 do not require to be hospitalised for the full period when transmission based precautions is required if they are clinically fit for discharge, if infection was acquired in the LTRCF or if the LTRCF already has cases of COVID-19 and the LTRCF has appropriate facilities and capacity for isolation and can support care.
3. Residents do not require isolation on return to their LTRCF following hospital transfer to facilitate short investigations (e.g., diagnostics, haemodialysis, radiology, outpatient appointment).

Table Transfer/admission of a resident to a LTRCF

CLINICAL SCENARIO	RECOMMENDED PRECAUTIONS ON ARRIVAL TO LTRCF	PRE-ADMISSION TEST FOR SARS-CoV-2 (COVID-19)	TIMING OF TRANSFER TO LTRCF	DAY OF TRANSFER
CONFIRMED COVID-19 & will be still infectious to others on planned date of transfer	Transmission-based precautions for the appropriate duration of time from date of onset of symptoms and with minimal symptoms or symptoms resolved for the last 2 of those days. The period is extended to no longer, than 10 days if they are eligible for booster and have not had booster.	Not required, as already confirmed COVID-19	**LTRCF has other resident(s) with COVID-19:** Transfer when fit for discharge to LTRCF AND provided LTRCF can meet care needs **LTRCF has no other resident with COVID-19 -** Remain in hospital until no longer infectious to others	Confirm date of onset/first positive test result Confirm date last febrile
CONFIRMED COVID-19 & no longer infectious to others (no longer subject to transmission based precautions)	No requirement for transmission based precautions or restricted movement	Testing not required as already confirmed COVID-19	When fit for discharge to LTRCF	Confirm date of onset/first positive test result
ASYMPTOMATIC Transfer/ new admission	No requirement for transmission based precautions or restricted movement **[may be exceptions based on risk assessment]**	Testing generally not required	When fit for discharge to LTRCF	Confirm details of vaccination Ensure no new symptoms