Policy and Infection Control Plan for The Village Residence . September 2023

Policy Name	**Policy and Infection Control Plan for The Village Residences**
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Authors:	Adapted with permission for DSOP from - Nursing Matters and Associates.
Adapted for local use by:	Michael McCaul The following guidance documents were referred to in developing this Plan: 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. May 2023 Infection Prevention and Control (IPC) National Clinical Guideline No. 30 Volume 1 1. Infection Control Guiding Principles for Buildings Acute Hospitals and Community Healthcare Settings. July 2023 2. Guidance on testing for Acute Respiratory Infection (ARI) in Residential Care Facilities* (RCF) Winter 2022/2023 3. Guidance on testing for Acute Respiratory Infection (ARI) in Residential Care Facilities* (RCF) – Winter 2022/2023 V1.2 17/11//2022 4. Guidance on provision of day services in the context of COVID-19/ respiratory viral infection V. 1.7 01.08.2023 5. The impact of COVID-19 on nursing homes in Ireland July 2020. Health Information and Quality Authority. 6. National Standards of healthcare cleanliness, specifications, methodology and good practice. (National Health Service. U.K. 2019). 7. Guide and framework to infection control inspections in rehabilitation and community healthcare. (HIQA, July 2020). 8. Covid 19 An assurance framework for registered providers – preparedness planning and Infection prevention and control measures (HIQA 2020). 9. COVID-19 Preparedness Plan CHO Area 8. (HSE, CHO8,

	September 9 2020). 10. HSE Interim Guidance for the Pharmacological Management of Patients with COVID-19. August 2022. 12.Public health advice for the management of COVID-19 cases and contacts V1.2 Publication Date: 18/04/2023
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Authorised by:	Michael McCaul,

1.0 Policy Statement.

The Village Residence has a responsibility for the safety and welfare of all stakeholders affected by its activities. Emergency preparedness and planning is an integral part of our culture of safety and is implemented through a risk management approach. The following infection control plan is aimed at responding to the threat of a all infections at national or local level.

2.0 Purpose.

The purpose of this plan is to outline the specific protocols and procedures to be followed by staff of The Village Residence in the following circumstances.

1. The serious and potentially fatal consequences of influenza and COVID 19.
2. One or more residents are suspected of having an infection on the presence of symptoms.
3. One or more residents are diagnosed as having an infection which could potentially harm others.
4. The Village Residence has an outbreak of a transmissible infection.

3.0 Objectives.

3.1.1 To ensure that The Village Residence has a preparedness plan in place to address the threat of an outbreak, that is based on best evidence and statutory guidance. (See separate contingency preparedness plan and guidelines on cleaning plan).

3.1.2 To ensure that staff are aware of the protocols and procedures to be followed in the event of the occurrence of an outbreak or a transmissible infection.

3.1.3 To ensure that an evidence-based approach is used to caring for our residents in the event of the occurrence any of any infection.

4.0 Scope.

This policy applies to all staff employed by or contracted by The Village Residence.

NB: This policy may need to be updated in the event of changing guidance received from the Health Services Executive and the Health Surveillance Protection Centre.

5.0 Definitions.

Covid 19: Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness. There is currently no vaccine or treatments for available for COVID-19.

Managing the risk of COVID-19 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 guideline addresses measures needed to achieve all of the above elements. Controlling the risk of introduction, spread and harm from COVID-19 is challenging, particularly as there is a need to balance the management of risk with respect for the autonomy and rights of residents.

Methicillin-resistant Staphylococcus aureus is a group of gram-positive bacteria that are genetically distinct from other strains of Staphylococcus aureus. MRSA is responsible for several difficult-to-treat infections in humans.

Escherichia coli is a Gram-negative, facultative anaerobic, rod-shaped, coliform bacterium of the genus Escherichia that is commonly found in the lower intestine of warm-blooded organisms

ESBL stands for Extended Spectrum Beta-Lactamase. Beta-lactamases are enzymes produced by some bacteria that may make them resistant to some antibiotics. ESBL production is associated with a bacteria usually found in the bowel.

Vancomycin-resistant Enterococcus, or vancomycin-resistant enterococci, are bacterial strains of the genus Enterococcus that are resistant to the antibiotic vancomycin.

Carbapenemase Producing Enterobacterales (**CPE**) is the newest in a long line of 'superbugs' (bacteria that are hard to kill with antibiotics).

Infection: the term infection is used to refer to the deposition and multiplication of bacteria and other micro-organisms in tissues or on the surfaces of the body with an associated host reaction.

Infectious Disease: a disease caused by a microorganism that can be passed from a person, animal or the environment to another susceptible individual.

Sources of Infection Infectious diseases are illnesses caused by harmful organisms (pathogens) that get into your body from the outside. Pathogens that cause infectious diseases are viruses, bacteria, fungi, parasites and, rarely, prions. You can get infectious diseases from other people, bug bites and contaminated food, water or soil.

Healthcare Associated Infection: A healthcare-associated infection is an infection that is acquired after contact with the healthcare services. This is most frequently after treatment in a hospital, but can also happen after treatment in outpatient clinics, nursing homes and other healthcare settings (HPSC, 2009).

Standard Precautions are evidence based clinical work practices published by The Centre of Disease Control (CDC) in 1996 and updated in 2007 that prevent transmission of infectious agents in healthcare settings (HPSC, 2009).

Transmission Based Precautions are designed for residents known or suspected to be colonised or infected by highly transmissible microorganisms for which additional precautions beyond Standard Precautions are required to interrupt their transmission. Infection or colonisation of pathogens are spread by the following routes:

- Contact
- Airborne
- Droplet

(HSE, 2011).

Contact Precautions are designed to reduce the risk of transmitting microorganisms by direct or indirect contact. Direct contact transmission involves skin-to-skin contact e.g. hands of healthcare HCWs. Indirect contact involves contact with contaminated equipment or environment. Examples of infection spread by the contact route include: MRSA, and Rotavirus (HSE, 2011).

Airborne Precautions are designed to reduce the risk of either airborne droplet nuclei or small particles containing infectious agents that remain infectious over time and distances. Examples include: Mycobacteria Tuberculosis, Varicella and Measles (HSE, 2011).

Droplet Precautions are designed to reduce the risk of droplet transmission of infectious agents including respiratory droplets which are generated within a 3 foot (1 meter) proximity when an infected person coughs, sneezes, talks or during aerosol generating procedures such as suctioning and CPR. Examples of infections spread by droplets include Neisseria Meningitides, Mumps, Rubella and Influenza (HSE, 2011).

Decontamination: the process of removing or neutralizing contaminants that have accumulated on personnel and equipment. It includes cleaning, disinfecting and sterilisation.

Cleaning: A process which physically removes contamination but does not necessarily destroy germs. Cleaning removes germs and the organic material on which they thrive (Ayliffe et al, 2000).

Disinfection: A process used to reduce the number of viable germs to a level where they are unlikely to be a danger to health but which may not necessarily inactivate some agents, such as certain viruses and bacterial spores (Ayliffe et al, 2000).

Sterilisation: A process which achieves the complete killing or removal of all types of germs, including viruses and spores. Disinfection may not achieve the same reduction in microbial contamination level as sterilisation (Ayliffe et al, 2000).

Multiple variants of the virus that causes COVID-19 are circulating globally:

Spread from symptomatic people is generally considered to be the primary driver of the

pandemic.

It is accepted that 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/healthtechnology-assessment/evidence-summary-asymptomatic-transmission.

Outbreak of COVID-19 Infection (HPSC 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**,).**

Under the Infectious Diseases Regulations 1981, Amendment February 2020, any medical practitioner who is aware of a case of COVID-19 or an outbreak, is obliged to notify the Medical Officer of Health (MOH) at the regional Department of Public Health. Contact details can be found here on the HPSC website.

When there is a suspicion of cases of COVID-19, the MOH should perform a risk assessment to determine whether there is either possible or confirmed active transmission in the facility. An isolated positive result of SARS-CoV-2 in a resident or staff member is not in itself proof of current active transmission. It is appropriate to consider if the test result may reflect a persistent positive result related to a remote infection and if the person may have become infected outside of the RCF.

When an outbreak is suspected, laboratory testing should be arranged as quickly as possible.

Michael McCaul PIC will facilitate this with Maura Ward, and arrangements will be made for tests to be analysed within The National Virus Reference Laboratory at UCD, Dublin. Enda White will be contacted and will transport any specimens there. However, it is not necessary to wait for laboratory test results before beginning initial investigation, contacting Public Health and implementing control measures. There should be heightened awareness among staff, so that other residents with symptoms are quickly identified.

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

All staff will meet in dining room and an action plan will be devised immediately

This group should:

Was there any breaches of PPE.

Ensure staff are allowed to speak off and report breaches

Establish what residents worked with what staff and what staff worked with residents.

Examine the entry and exit documents and allocation for each room and each resident.

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

o Could onward transmission have already occurred? (e.g., resident had widespread contact with others in the 48 hours before symptom onset)

▪ Are they in a single room or sharing? ▪ Is the resident ambulatory?

▪ Have they spent time with others in communal areas or group activities? ▪ Are there behavioural characteristics which might be increased risk of transmission?

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

Identify are any staff symptomatic, or has there been an increase in staff absence?

• Identify residents and staff who were in close contact with the symptomatic resident in the 48 hours before symptom onset or before isolation and transmission-based precautions were implemented and assess what staff worked with that resident.

For the **purposes of public health action, the threshold for an outbreak of any transmissible respiratory or other infection** is defined

As TWO OR MORE

Declaring an outbreak

For surveillance purposes, the following outbreak definition applies: HSE Health Protection Surveillance Centre. www.hpsc.ie Page 26 of 73 Confirmed

A cluster/outbreak, with two or more cases of laboratory confirmed infection regardless of symptom status. This includes cases with symptoms and cases who are asymptomatic.

OR

A cluster/outbreak, with two or more cases of illness with symptoms consistent with infection, and at least one person is a confirmed case of a transmissible infection.

Suspected A cluster/outbreak, with two or more cases of illness with symptoms consistent with infection

Outbreak Control Team (OCT) • All outbreaks of COVID-19 in a RCF must be reported to the regional Medical Officer of Health (MOH) at the Department of Public Health at the earliest opportunity. This will be done in consultation with Dr. John Mulroy and the Person in Charge.

Michael McCaul will issue a report to the Public Health Department

The Person in Charge will contact relevant HSE managers. Noeleen Hallahan, Infection Control Nurse Specialist, and the Occupational Health Deaprtment.

• Public Health doctors from the Regional Department of Public Health will provide overall leadership for the management of transmissible outbreak in the RCF and the PIC will co-operate with all recommendations and provide factual up to date information on a daily basis.

• 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 but will include membership from all staff

• An OCT Chairperson should be agreed as well as involvement from the Lead Worker Representatives.

• Members of the OCT may include any of the following. However, in many settings it may not be possible to include all the expertise referred to below:

• Specialist in Public Health Medicine and/or Public Health Department Communicable Disease Control Nurse Specialist • GP/Medical officer/Consultant to RCF (dependent on nature of RCF) • Director of Nursing or Nurse Manager from RCF.

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

• The frequency required for the OCT meeting should be decided and they should be carried out in consideration of social distancing requirements via teleconference/videoconference facilities

• Public Health will formulate a case definition, assign an outbreak code and decide as to whether an on-site visit is required or not

• The Person in Charge will inform HIQA and the local CHO as per usual protocols.

A line list of all residents and staff.

• Identify the total number of people ill (residents & staff), dates of illness onset and the spectrum of symptoms

• Identify staff and residents who have recently recovered, developed complications, been transferred to acute hospitals and those who have died . Data base is kept on DSOP Drive under Folder Coronavirus if COVID related or any other pathogen identified.

• 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 Data base is kept on DSOP Drive under Folder Coronavirus.

Use the case definitions for possible, probable and confirmed infections available on the HPSC website

A checklist for outbreak management.

Management of a possible or confirmed case of transmissible infection

• The initial assessment of the resident should be performed by their doctor by telephone

• If a transmissible based infection is suspected, the doctor will arrange testing

• If the clinical condition does not require hospitalisation, the resident should not be transferred from the facility on infection prevention and control grounds

• Where there is capacity and it is appropriate to their care needs, a resident with possible or confirmed transmissible infection should be placed in a single room with transmission-based precautions and appropriate use of PPE by staff

• Room doors should be kept closed where possible and safe to do so

• When this is not possible, ensure the resident's bed is moved to the furthest safe point in the room to try and achieve a 2m physical distance to the door

• Display signage to reduce entry into the room, but confidentiality must be maintained

• Take time to explain to the resident the importance of the precautions that are being put in place to manage their care and advise them against leaving their room

• Ideally, the resident's single room should have ensuite facilities

• If an ensuite is not available, try to designate a commode or toilet facility for the resident's use

• 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 remove the PPE in the sluice after placing the contents directly into the bed pan washer or pulp disposal unit. A second person should be available to assist with opening and closing doors to the single room and sluice room. If a second person is not available, change gloves and perform hand hygiene and put on a clean pair of disposable gloves.

• If the resident must use a communal toilet ensure it is cleaned after every use

• Listen and respond to any concerns residents may have, to ensure support and optimal adherence is achieved during their care

• If well enough, a resident may go outside alone if appropriate or accompanied by a staff member maintaining adequate distance from both staff and other residents. If the staff member can maintain this distance, they do not need to wear PPE

• If the resident passes briefly through a hallway or other unoccupied space to go outside, there is no requirement for any additional cleaning of that area beyond normal good practice

• Residents with confirmed transmissible infections will require appropriate healthcare and social support, including access to their doctor or GP for medical management and on-site support

• A care planning approach that reflects regular monitoring of residents with transmissible 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 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.

• Residents with confirmed transmissible infection should remain in isolation on Contact and Droplet precautions until 14 days after the first date of onset of symptoms and they are fever free for the last five days.

Staff should be mindful that prolonged isolation may be stressful for some residents and should encourage relatives and other residents where practical to communicate with them regularly via phone or video calls and where possible window visits.

Cohorting residents with possible or confirmed transmissible infections

• Placement of residents with possible or confirmed transmissible infections in a designated zone, with designated staffing (where staffing levels permit) to facilitate care and minimise further spread is known as cohorting. As the lay-out of Sunnyside and Meadowview is comprised of single rooms and multi occupied rooms an immediate plan will be drawn up. In line with HPSC guidelines, a

resident will be placed in a single room or within the two bedded unit within Sunnyside beside the fire exit doors and used and staffed as a separate wing or a separate annex. In this zoned areas, heightened infection prevention and control measures are critical

Within The Butterfly Cottage, Red Robin Cottage and Forget me Not Cottage, all bedrooms have ensuite facilities and are all single rooms

• Cohorting includes residents who are placed in single rooms close together, or in multioccupancy areas within the building or section of a ward/unit if they are available.

• Where possible, residents with probable or confirmed transmissible infections should be isolated in single rooms with ensuite facilities. If there are multiple residents and if it is practical to do so, these single rooms should be located in close proximity to one another in one zone, for example on a particular floor or area within the facility

• Where single room capacity is exceeded and it is necessary to cohort residents in a multioccupancy room:

Residents should not be moved out of their rooms in order to care for another infected resident.

o **Only residents with a confirmed diagnosis of a transmissible infection can be cohorted together**;

o **Residents with suspected transmissible organisms should not be cohorted with those who are are.**

o 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 a transmissible organism.

• Where residents are cohorted in multi-occupancy rooms, every effort should be made to minimise cross-transmission risk:

o Maintain as much physical distance as possible between beds; if possible reduce the number of residents/beds in the area to facilitate social distancing

o Close privacy screens if available between the beds to minimise opportunities for close contact • There should be clear signage indicating that the area is a designated zone to alert staff about cohorting location in the RCF. A zone may have multi-occupancy rooms or a series of single rooms • A designated cohort area should ideally be separated from non-cohort areas by closed doors • Minimise unnecessary movement of staff in cohort areas and ensure that the number of staff entering the cohort area is kept to a minimum.

Staff working in cohort areas should not be assigned to work in non-infectious transmissible areas,

• **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.**

Management of close contacts of a possible or confirmed case of transmissible infections

• Residents who are close contacts of a confirmed case 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

• Residents who are close contacts should be advised to avoid communal areas and stay in their room where it is practical to do so.

• Residents who are close contacts may go outside if appropriate, alone or accompanied by a staff member maintaining adequate distance. An accompanying staff member in this situation is not required to wear PPE if distance can be maintained

• If the resident transits 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

• It is understood that some residents may, due to underlying conditions (e.g. dementia with wandering behaviours) have significant difficulties with isolation and/or restricted movement. In these instances, the creation of a ‘safe zone’ may be the most appropriate support to prevent distress arising from confinement. Separate access to outdoor spaces or communal rooms not used by other residents may be appropriately used when followed by environmental cleaning and disinfection if required

6.0 Current Measures in Place to Reduce the Risk of Accidental Introduction of transmissible infections into The Village Residence.

Standard precautions

Strict hand hygiene is offered

Standard Precautions are the minimum infection prevention practices that apply to the care of all people, regardless of suspected or confirmed infection status of the person, in any setting where health care is delivered. For further information on Standard Precautions and the chain of infection refer to HSEland online learning or www.hpsc.ie . For most recent HSE guidance on IPC refer here: **Infection Prevention and Control (IPC) National Clinical Guideline No. 30 Volume 1 May 2023**

Hand hygiene

• Hand hygiene is the single most important action to reduce the spread of infection in health and other social care settings and is a critical element of standard precautions

• Facilities must provide ready access for staff, residents and visitors to hand hygiene facilities and alcohol-based hand rub (ABHR)

• Staff should adhere to the WHO five moments for hand hygiene

o Hand hygiene must be performed immediately before every episode of direct resident care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of PPE, equipment decontamination, handling of waste and laundry

• Residents should be encouraged and facilitated to clean their hands after toileting, after blowing their nose, before and after eating and when leaving their room. If the resident's cognitive state is impaired, staff must help with this activity.

Gloves should not be used in routine care of residents to whom Standard Precautions apply unless 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

• HSE land hand hygiene training is available online and staff should be encouraged to do refresher training at www.hseland.ie Refer to hand hygiene information posters.

Respiratory hygiene and cough etiquette

• Respiratory hygiene and cough etiquette refer to measures taken to reduce the spread of viruses via respiratory droplets produced when a person coughs or sneezes

• Disposable single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose

• Used tissue should be disposed of promptly in the nearest foot operated waste bin

• Some residents may need assistance with containment of respiratory 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

• Staff and residents should be advised to try to avoid touching their eyes, mouth and nose.

Personal Protective Equipment (PPE)

• As part of Standard Precautions, it is the responsibility of every HCW to undertake a risk assessment PRIOR to performing a clinical care task, as this will inform the level of IPC precautions needed, including the choice of appropriate PPE for those who need to be present

• Full guidelines on the appropriate selection and use of PPE **Z:\HIQA SCHEDULE 5 THE VILLAGE\14. Schedule 5 Health and safety of residents , staff and visitors (including infection control and food safety)\The Village Residence Lead Worker Guidance**

Transmission-based Precautions for respiratory associated transmissible infections

• Transmission-based Precautions are IPC measures which are implemented in addition to Standard Precautions when Standard Precautions alone are insufficient to prevent the onward transmission of specific infectious diseases..

They include contact, droplet and airborne precautions. In general, transmissible respiratory infections is spread by respiratory droplets – transmission may be direct, through contact with the respiratory secretions of someone with an infection, or indirect, through contact with a contaminated surface/object. Less commonly, airborne spread may occur for example during aerosol generating procedures (AGP). Z:\HIQA SCHEDULE 5 THE VILLAGE\14. Schedule 5 Health and safety of residents , staff and visitors (including infection control and food safety)\The Village Residence Lead Worker Guidance

Transmission-based Precautions should be applied immediately to all suspected cases of respiratory infection

o It is recognised however that there can be significant challenges in applying transmission-based precautions in residential settings, which resemble household settings more than acute hospitals.

Transmission-based Precautions may need to be modified to take into account that the setting is also the resident's home. A pragmatic, compassionate and proportionate approach may be necessary when considering the care needs of the resident balanced against the risk to others.

Duration of transmission-based precautions

• A test of clearance is not appropriate for residents who have been diagnosed with a transmissible infection. Transmission based precautions can be discontinued 48 hours after the resident ceases to have synptoms.

• In exceptional circumstances where a physician is concerned on clinical grounds that there may be an ongoing risk of transmission repeat testing may be considered in advance of ending Transmission-based Precautions.

• Note: some people who meet the above 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. An

extended period of Contact and Droplet precautions may be considered in some such cases if there is clinical concern. In such cases the period of Contact and Droplet precautions should not be extended.

Management of waste • Dispose of all waste from residents with confirmed or suspected transmissible respiratory infections as healthcare risk waste (also referred to as clinical risk waste).

• When removing waste, it should be handled as per usual precautions for healthcare risk waste. • The external surfaces of the bags/containers do not need to be disinfected.

• All those handling waste should wear appropriate PPE and clean their hands after removing PPE. • Hands-free healthcare risk waste bins should be provided in single rooms and cohort areas.

• If a healthcare risk waste service is not available in the RCF, then all consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, tie the bag, place in a second bag and leave for 72 hours. This should be put in a secure location prior to usual waste collection.

• Bodily waste, such as urine or faeces from individuals with possible or confirmed COVID19 does not require special treatment and can be discharged into the sewage system. Safe management of linen (laundry)

• All towels, clothing or other laundry used in the direct care of residents with suspected and confirmed transmissible infections should be managed as ‘infectious’ linen and placed in alginate bags.

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

Shower curtains should be changed when visibly soiled or every three months Z:\HIQA SCHEDULE 5 THE VILLAGE\14. Schedule 5 Health and safety of residents , staff and visitors (including infection control and food safety)\The Village Residence Lead Worker Guidance

• Disposable gloves and an apron should be worn when handling linen

• All linen should be handled inside the resident room/cohort area. A laundry skip/trolley should be available as close as possible to the point-of-use for linen deposit, for example immediately outside the cohort area/isolation room

• When handling linen, the HCW should not: o rinse, shake or sort linen on removal from beds/trolleys; o place used/infectious linen on the floor or any other surfaces (e.g., a bedside locker/table top); o handle used/infectious linen once bagged; o overfill laundry receptacles; or o place inappropriate items in the laundry receptacle (e.g., used equipment/needles)

• When managing infectious linen, the HCW should: o Place linen directly into a water-soluble/alginate bag and secure;

- **Place the alginate/water-soluble bag into the appropriately-coloured linen bag (as per local policy)**
- **Store all used/infectious linen in a designated, safe area pending collection by a laundry service**
- Laundry may be dried in a dryer on a hot setting

Recommend routine cleaning frequencies

Level of Risk

Risk rating	Settings
Very high risk	Outbreak in high-risk area.
High risk	Intensive care unit, high dependency unit, burns unit, renal units, operating suite, emergency departments.
Significant risk	General wards.
Low risk	Rehabilitation, long-term care, primary care, office-based, homecare services.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Alcohol based hand rub dispenser, bedside	Clean daily.	Clean daily.	Clean daily.	Clean weekly.	Detergent.
Alcohol based hand rub dispenser, not in Patient/treatment rooms	Clean daily.	Clean daily.	Clean daily.	Clean weekly.	Detergent.
Bath	Clean daily and spot/ check clean once daily. If used by more than one person must be cleaned after each use.	Clean daily and spot/check clean once daily. If used by more than one person must be cleaned after each use..	Clean daily and spot/check clean once daily. If used by more than one person must be cleaned after each use.	Clean daily and spot/check clean once daily. If used by more than one person must be cleaned after each use.	Detergent. Detergent plus disinfectant for MDRO and specific infections.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Bed	Clean frame daily. Clean underneath weekly. Clean whole on discharge.	Clean frame daily. Clean underneath weekly. Clean whole on discharge.	Clean frame daily. Clean underneath weekly. Clean whole on discharge.	Clean frame weekly and when visibly soiled. Clean whole on discharge.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Bedrails	Clean twice daily and after discharge.	Clean twice daily and after discharge.	Clean twice daily and after discharge.	Clean daily and after discharge.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Bedside table	Clean twice daily and after use.	Clean twice daily and after use.	Clean daily.	Clean weekly and when visibly soiled.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Bidet	Clean three times daily and after each patient use.	Clean three times daily and after each patient use.	Clean daily assuming single person use.	Clean daily assuming single person use.	Detergent and disinfectant.
Blood pressure cuff (note disposable cuffs may be preferred in some settings)	Clean after each patient use if used on multiple patients. If dedicated to one patient clean daily and after discharge.	Clean after each patient use if used on multiple patients. If dedicated to one patient clean daily and after discharge.	Clean after each patient use if used on multiple patients. If dedicated to one patient clean daily and after discharge.	Clean after each patient use if used on multiple patients. If dedicated to one patient clean daily and after discharge.	Detergent. Detergent plus disinfectant for MDRO and specific infections. Note: if a disposable sleeve or other barrier is used between the cuff and skin this reduces the requirement for cleaning.
Call bell	Clean Daily. Clean after discharge.	Clean Daily. Clean after discharge.	Clean Daily. Clean after discharge.	Clean Daily. Clean after discharge.	Detergent. Detergent plus disinfectant for MDRO and specific infections.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Carpet (soft floor) (should generally be avoided in clinical areas but may be appropriate in special areas within clinical facilities for family /bereavement rooms)	Vacuum clean twice daily. Steam clean 6-monthly.	Vacuum clean daily. Steam clean 6-monthly.	Vacuum clean daily. Steam clean annually.	Vacuum clean weekly. More frequent cleaning may be required in high use communal areas. Steam clean annually.	Vacuum with high efficiency particulate air filter. Steam clean (or shampoo).
Catheter stand/ bracket	Clean daily and after use.	Clean daily and after use.	Clean before initial use, after use and weekly.	Clean before initial use, after use and weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Ceiling	Spot clean daily and wash yearly.	Spot clean daily and wash yearly.	Spot clean weekly and wash yearly.	Spot clean monthly and wash every 3 years.	Detergent/ Damp dust.
Chair	Clean twice daily.	Clean twice daily.	Clean daily.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Chair, dental and surrounds	N/A	N/A	N/A	Clean daily and between patient use.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Cleaning equipment	Clean after use.	Clean after use.	Clean after use.	Clean after use.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Clipboard	Clean daily and between patient use.	Clean daily and between patient use.	Clean daily and between patient use.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Commode	Clean contact points after use. Clean whole daily.	Clean contact points after use. Clean whole daily.	Clean contact points after use. Clean whole daily.	Clean contact points after use. Clean whole weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Computer and keyboard; used and/or located in close proximity to patient for example patient bay or room	Clean twice daily and anytime when visibly soiled.	Clean twice daily and anytime when visibly soiled.	Clean daily and anytime when visibly soiled.	Clean daily and anytime when visibly soiled.	Manufacturers recommend-ations. Install keyboard covers or washable keyboards where feasible. Detergent. Detergent plus disinfectant for MDRO and specific infections.
Computer & keyboard; general ward use, non-mobile, located outside patient area	Clean twice daily and anytime when visibly soiled. Clean between patients. Clean after discharge.	Clean daily and anytime when visibly soiled. Clean between patients. Clean after discharge.	Clean daily and anytime when visibly soiled. Clean between patients. Clean after discharge.	Clean weekly and anytime when visibly soiled. Clean between patients. Clean after discharge.	Manufacturers recommend-ations. Install keyboard covers or washable keyboards. Detergent. Detergent plus disinfectant for MDRO and specific infections.
Curtains and blinds	Bed curtains – change or clean weekly and upon discharge. Patient with MDRO or other infectious disease – change bed curtains or clean upon discharge.	Bed curtains – change or clean monthly. Patient with MDRO change bed curtains or clean upon discharge.	Bed curtains – change or clean biannually. Patient with MDRO change bed curtains or clean upon discharge.	Bed curtains – change or clean biannually. Patient with MDRO change bed curtains or clean upon discharge.	Replace with laundered curtains. Blinds can generally be steam cleaned. Follow manufacturers recommend-ations.
Door knob/handle general	Clean twice daily.	Clean daily.	Clean daily.	Clean weekly.	Detergent.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Door knob/handle patient room	Clean twice daily.	Clean daily.	Clean daily.	Clean daily.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Drip/ intravenous stands	Clean daily and after use.	Clean daily and after use.	Clean before initial use, after use and weekly.	Clean before initial use, after use and weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Floor, non-slip	Damp mop twice daily.	Damp mop twice daily.	Damp mop daily.	Damp mop daily.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Floor, polished	Dust removal and clean twice daily.	Dust removal and clean daily.	Dust removal and clean daily.	Dust removal and clean weekly.	Detergent for routine. Consider electrostatic mops. Detergent and disinfectant for MDRO and specific infections.
Fridges	Weekly and defrost as required. Three times daily spot check-clean when necessary.	Weekly and defrost as required. Daily spot check-clean when necessary.	Monthly defrost as required. Daily spot check-clean when necessary.	Monthly defrost as required. Daily spot check-clean when necessary.	Detergent.
Fridge (drug)	Clean weekly.	Clean weekly.	Clean weekly.	Clean weekly.	Detergent.
Glazing, internal (including partitions)	Spot clean daily and full clean weekly.	Spot clean daily and full clean weekly.	Spot clean daily and full clean weekly.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Hoist, bathroom	Clean weekly and contact points after use.	Clean weekly and contact points after use.	Clean weekly and contact points after use.	Clean weekly and contact points after use.	Detergent. Detergent and disinfectant for MDRO and specific infections.
Drip/IV stand and poles	Clean daily and clean contact points after use.	Clean daily and clean contact points after use.	Clean weekly and contact points after use.	Clean weekly contact points after use.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Light switch	Clean daily.	Clean daily.	Clean weekly.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Locker – bedside	Clean contact points twice daily.	Clean contact points twice daily.	Clean contact points daily.	Clean contact points weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Manual handling (such as hoist)	Clean weekly and contact points after use.	Clean weekly and contact points after use.	Clean weekly and contact points after use.	Clean weekly and contact points after use.	Detergent. Detergent plus disinfectant for MDRO and specific infections Note: hoist slings may be disposable or reusable. Assign sling to an individual patient/ service user. If reusable clean/ disinfect as per manufacturer's instructions before assigned for use on another person.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Mattress (entire mattress should have a waterproof cover)	Clean when visibly soiled/ bodily substances and after discharge.	Clean when visibly soiled/ bodily substances and after discharge.	Clean when visibly soiled/ bodily substances and after discharge.	Clean when visibly soiled/ bodily substances and after discharge.	Detergent. Detergent plus disinfectant for MDRO and specific infections. Note: monthly check of mattress cover for integrity and inside the cover for soiling.
Medical equipment (such as IV infusion pumps, pulse oximeters) NOT connected to a patient	Clean daily (when in use) and between patient use.	Clean daily (when in use) and between patient use.	Clean daily (when in use) and between patient use.	Clean daily (when in use) and between patient use.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Medical gas equipment	Clean daily.	Clean daily.	Clean daily.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Microwave	Clean daily and leave clean after each use.	Clean daily and leave clean after each use.	Clean daily and leave clean after each use.	Clean daily and leave clean after each use.	Detergent.
Nebuliser, portable (when in use)	Clean daily and after use.	Clean daily and after use.	Clean monthly and after use and before initial use.	Clean every 2 months and after use and before initial use.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Notes folder	Clean daily.	Clean daily.	Clean weekly.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections if taken into patient zone.
Over bed tray table (overway table)	Twice daily.	Daily.	Daily.	Weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections

Element	Very high risk	High risk	Significant risk	Low risk	Method
Oxygen equipment	Clean daily and after use.	Clean daily and after use.	Clean monthly and after discharge and before initial use.	Clean monthly and after discharge and before initial use.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Patient slide/ board	Clean daily and after use.	Clean daily and after use.	Clean monthly and after use.	Clean monthly and after use.	Detergent. Detergent plus disinfectant for MDRO.
Pillow (waterproof cover)	Clean when visibly soiled/ bodily substances and after discharge.	Clean when visibly soiled/ bodily substances and after discharge.	Clean when visibly soiled/ bodily substances and after discharge.	Clean when visibly soiled/ bodily substances and after discharge.	Detergent. Detergent plus disinfectant for MDRO and specific infections. Note: monthly check of pillow cover for integrity and inside the cover for soiling.
Sharps container trolley	Clean daily.	Clean twice weekly.	Clean weekly.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections if taken into patient zone.
Shower – In addition to cleaning there should be a daily check that water is draining freely with no pooling or backflow	Clean daily and one spot check clean daily. If used by more than one person clean after each use.	Clean daily and one spot check clean daily. If used by more than one person clean after each use.	Clean daily. If used by more than one person clean after each use.	Clean daily. If used by more than one person clean after each use.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Sink (hand washing) – in addition to cleaning there should be a daily check that water is draining freely with no pooling or backflow	Clean twice daily and after use.	Clean twice daily and after use.	Clean daily and after use.	Clean daily.	Detergent. Detergent plus disinfectant for MDRO and specific infections.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Stethoscope – surfaces in contact with skin	Clean after each patient use if used on multiple patients. If dedicated to one patient clean daily and after discharge.	Clean after each patient use if used on multiple patients. If dedicated to one patient clean daily and after discharge.	Clean after each patient use if used on multiple patients. If dedicated to one patient clean daily and after discharge.	Clean after each patient use if used on multiple patients. If dedicated to one patient clean daily and after discharge.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Surfaces (general horizontal) in patient room such as ledges	Clean twice daily and spot clean after use.	Clean twice daily and spot clean after use.	Clean daily and after discharge.	Clean weekly and after discharge.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Telephone	Clean daily.	Clean daily.	Clean daily.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections if taken into patient zone.
Toilet	Clean twice daily and spot clean after use.	Clean twice daily and spot clean after use.	Clean daily and spot clean after use.	Clean daily and spot clean after use.	Detergent and disinfectant.
Toilet seat, raised	Clean twice daily and spot clean after use.	Clean twice daily and spot clean after use.	Clean daily and spot clean after use.	Clean daily.	Detergent for routine. Detergent plus disinfectant for MDRO and specific infections.
Trolley, dressing	Clean utilised surfaces before and after use. Clean whole trolley weekly.	Clean utilised surfaces before and after use. Clean whole trolley weekly.	Clean utilised surfaces before and after use. Clean whole trolley weekly.	Clean utilised surfaces before and after use. Clean whole trolley weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Trolley, linen	Clean contact points daily. Clean whole trolley weekly.	Clean contact points daily. Clean whole trolley weekly.	Clean contact points daily. Clean whole trolley weekly.	Clean contact points weekly. Clean whole trolley monthly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Trolley, resuscitation	Clean daily.	Clean weekly.	Clean weekly.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
TV, fixed (out of patient reach)	Clean weekly.	Clean weekly.	Clean weekly.	Clean weekly.	Detergent.
TV, patient beside (mobile and within patient reach)	Clean daily and between patients.	Clean daily and between patients.	Clean daily and between patients.	Clean monthly and between patients.	Detergent / damp dust. Detergent plus disinfectant for MDRO and specific infections.
Walls	Spot clean daily and dust weekly and full clean yearly.	Spot clean daily and dust weekly and full clean yearly.	Spot clean weekly and full clean yearly.	Spot clean weekly.	Detergent / damp dust.
Washbowl, patient Each person should have their own washbowl	One full clean daily and between patient use.	One full clean daily and between patient use.	One full clean daily and between patient use.	One full clean daily and between patient use.	Detergent. Detergent plus disinfectant for MDRO specific infections or consider disposable lining.
Waste receptacle	Clean weekly and spot clean when visibly soiled /bodily substances.	Clean weekly and spot clean when visibly soiled /bodily substances.	Clean weekly and spot clean when visibly soiled /bodily substances.	Clean weekly and spot clean when visibly soiled /bodily substances.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Wheelchair	Clean daily and after use.	Clean daily and after use.	Clean monthly and after use.	Clean monthly and after use.	Detergent. Detergent plus disinfectant for MDRO specific infections.

Element	Very high risk	High risk	Significant risk	Low risk	Method
Trolley, resuscitation	Clean daily.	Clean weekly.	Clean weekly.	Clean weekly.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
TV, fixed (out of patient reach)	Clean weekly.	Clean weekly.	Clean weekly.	Clean weekly.	Detergent.
TV, patient beside (mobile and within patient reach)	Clean daily and between patients.	Clean daily and between patients.	Clean daily and between patients.	Clean monthly and between patients.	Detergent / damp dust. Detergent plus disinfectant for MDRO and specific infections.
Walls	Spot clean daily and dust weekly and full clean yearly.	Spot clean daily and dust weekly and full clean yearly.	Spot clean weekly and full clean yearly.	Spot clean weekly.	Detergent / damp dust.
Washbowl, patient Each person should have their own washbowl	One full clean daily and between patient use.	One full clean daily and between patient use.	One full clean daily and between patient use.	One full clean daily and between patient use.	Detergent. Detergent plus disinfectant for MDRO specific infections or consider disposable lining.
Waste receptacle	Clean weekly and spot clean when visibly soiled /bodily substances.	Clean weekly and spot clean when visibly soiled /bodily substances.	Clean weekly and spot clean when visibly soiled /bodily substances.	Clean weekly and spot clean when visibly soiled /bodily substances.	Detergent. Detergent plus disinfectant for MDRO and specific infections.
Wheelchair	Clean daily and after use.	Clean daily and after use.	Clean monthly and after use.	Clean monthly and after use.	Detergent. Detergent plus disinfectant for MDRO specific infections.

Environmental hygiene

See Policy on Hygiene and Cleaning

6.1.4 All staff have been provided with infection prevention and control training, including standard precautions, hand hygiene and the use of personal protective equipment.

6.1.5 All staff have received training on putting on and taking off personal protective equipment (Training video available on www.HSPC.ie)

6.1.6 The Village Residence has a policy and procedures for infection prevention and control based on National Guidelines.

6.1.7 Physical distancing measures are in place to include:

- Reducing the size of activity groups to ensure that a physical distance of two metres can be maintained between residents and activity staff.
- Staggering staff breaks and staff Covid 19 updates to ensure that physical distancing of two metres is maintained during these activities.
- Staff informed of the need for physical distancing measures when attending handovers.

7.0 Responsibilities.

These should be adapted to make them site specific, ensuring that a member of staff is nominated for each of the responsibilities outlined.

7.1 The Registered Provider.

7.1.1 The Registered provider is responsible for ensuring that emergency plans are in place to address all foreseeable emergencies in The Village Residence. This includes the threat of an outbreak.

7.1.2 The provider will ensure that an emergency response team is in place to respond to any threat of an outbreak in The Village Residence.

7.1.3 The provider is responsible for ensuring that supports and resources are provided to enable management and staff to initiate and implement this plan in response to the threat of an outbreak in The Village Residence.

7.1.4

7.2 Emergency Response Coordinator.

7.2.1 The *person in charge or specify* will assume the role of emergency response coordinator.

7.2.2 The emergency response coordinator will initiate the emergency plan as soon as a threat of an outbreak becomes known. This may be through information of a national or local epidemic.

7.2.3 The emergency response coordinator will set up the emergency response team and convene a meeting to ensure that all members of the team know their roles and responsibilities for implementing the emergency plan.

7.2.4 The emergency response team will comprise of the following:

- The registered provider representative (RPR)
- The person in charge (PIC)
- The assistant director of nursing (ADON).
- The Clinical Nurse Manager(s).
- A member of the administration staff.
- The head of maintenance (HM)
- The health and safety officer (HSO)
- The health and safety representative for The Village Residence.

7.2.5 The emergency response coordinator will ensure that the risk register is updated to reflect hazards and risks related to the accidental introduction of transmissible infections into The Village Residence. These should include:

- Corporate risks related to finance, reputation and business continuity. Information available at:https://dbei.gov.ie/en/Publications/Business-Continuity-Planning-A-checklist-of-Preparatory-Actions-in-Responding-to-the-COVID-19-Outbreak.html

- Risks to residents, which can be assessed with nursing staff.
- Occupational health risks to all categories of staff in The Village Residence which can be assessed with the heads of departments in collaboration with the health and safety officer/rep/ committee Risks related to staff shortages.
- Risks related to the spread of of a transmission based infection.
- Risks to quality improvement activities in The Village Residence.
- Risks related to data protection See ***European Data Protection Board, (2020) Statement on the processing of personal data in the context of the COVID-19 outbreak Adopted on 19 March 2020***

7.2.6 The emergency response coordinator has the following additional responsibilities in implementing the emergency plan for The Village Residence:

- Drawing up a letter for families and visitors to inform them of visitor restrictions in The Village Residence and contingency plans to facilitate on-going communication between residents and their families/visitors.
- Nominating a member of administration staff to develop a list of families/visitors who must be contacted and maintaining a record to ensure that the above letters are sent to all families/visitors to The Village Residence.
- Liaising with the head of household to ensure that preparations for hand hygiene resources and updated cleaning schedules are in place as per the emergency plan.
- Nominating a member of staff to source /print information posters to be available for display at strategic locations throughout The Village Residence.
- Arranging information sessions with staff to go through their concerns and provide information about the the transmissible pathogen and the emergency and contingency plans in place to manage the emergency.
- Ensuring that a succession plan for key management staff is in place in the event that any of these staff have to self-isolate during the period of the emergency.

- Ensuring that a contingency staffing plan is developed to include sourcing bank staff who will be on call in the event of staff shortages.

- Complete an inventory of personal protective equipment in place, make a list of additional personal protective equipment needed and ensure that same is ordered.

- Liaising with the **fire officer /local fire authority** to establish any changes required to evacuation plans in the event of a fire during an outbreak and **updating fire plans** to reflect same.

- Liaising with HR personnel/ external company re meeting the occupational needs of staff, such as stress, low morale, fatigue.

- Monitor adherence to and effectiveness of the emergency plan through the following indicators:

7.3 The Person in Charge (PIC)

7.3.1 The PIC will be responsible for making the necessary arrangements to facilitate the isolation of suspected and confirmed cases of a transmissible infection among residents and arrangements to address the need for cohorting as per the emergency plan.

7.3.2 The person in charge will identify staff need for training in infection prevention and control, including measures to be taken relating to suspected or confirmed cases of a transmissible infection and training in putting on and removing PPE. This will be done in collaboration with the heads of departments and human resources personnel.

7.3.3 The person in charge will act as the central communication person for communicating with:

- Residents general practitioners, specifically to discuss suspected cases and the need for testing.

- public health professionals, including the Chief Officer of the Community Health Office (CHO); and / or members of the community outbreak team to inform them of developments, receive advice and receive instructions about surveillance records that must be maintained.

- The coroner's office.The Coroner's Office must be contacted after all deaths.t

- General practitioners and locum services involved in The Village Residence to keep them updated with changes to arrangements and operations in The Village Residence during the emergency and to keep update with any changes to their arrangements and operations.

- Pharmacy services to keep them updated with changes to arrangements and operations in The Village Residence during the emergency and to keep update with any changes to their arrangements and operations.

- The social care (HIQA) inspectorate team to include reporting an outbreak and keeping them informed as required of how the emergency is being managed and receive any instructions from them regarding same.

- Funeral directors to report any deaths in The Village Residence and liaise with them regarding arrangements for their services during the emergency.

7.3.4 The person in charge will arrange for training to ensure that there are at least two nurses in The Village Residence who are trained to collect swabs for laboratory testing.

7.3.5 The person in charge will nominate

7.4 The Assistant Director of Nursing.

7.4.1 The ADON will deputise for the PIC in his absence and take on the responsibilities of the PIC outlined above during the emergency, including circumstances where the PIC cannot attend The Village Residence due to the need to self-isolate.

7.4.2 The ADON will act as the central communication person to communicate with:

- Family members/representatives to update them on the care of their loved ones during the emergency.

- Liaise with residents' general practitioners regarding the care and treatment of individual residents.

- Implement a system of additional monitoring of residents, through the clinical nurse manager(s) to detect any cases of transmissible infection. This includes checking residents vital signs and pulse oximetry twice daily and emphasizing the importance of reporting any change in a resident's condition the nurse on duty, who must report same to the (specify Michael McCaul and/or Jolly Varghese/Leenamma Varghese/Loretta Byrne.

- Informing the person in charge and emergency response coordinator of any resident with a change in condition suggestive of infection to arrange for testing.

- Delegate completion of surveillance records, and monitor surveillance records for The Village Residence and ensure that the PIC is kept up to date with same.

- Receiving handovers throughout the day from the clinical nurse managers about the care of individual residents in The Village Residence.

- Liaise with activities personnel about changing arrangements for activities provision in accordance with the emergency plan.

- Developing rosters for nurses, healthcare assistants and activities personnel.

7.5 Clinical Nurse Manager(s).

The clinical nurse manager(s) will be responsible for supervising and monitoring the care of residents at floor level during the emergency. He/she will also deputies for the PIC/ADON in the event that the PIC/ADON is absent due to illness and the need to self-isolate. Specific responsibilities of the clinical nurse manager during the emergency are:

- Ensuring that additional monitoring of residents is commenced at floor level.

- To monitor the care and condition of residents at floor level by meeting each nurse during their shift.

- Reporting to the ADON immediately of any changes in a resident's condition.

- Ensuring that incidents are responded to in accordance with the home's risk management policy.

- Provide clinical supervision to nursing and care staff at floor level.
- Identify residents whose condition is unstable and /or deteriorating; those residents who require additional observation and ensure that appropriate supervision and care is provided in accordance with their assessed needs.
- Attending morning and afternoon handovers in order to prioritise and plan daily care activities with the nursing team in accordance with each resident's current care and condition.
- Allocating PPE at floor level in accordance with staff and resident needs.
- Monitoring supplies of PPE and informing the emergency response coordinator of the need to replenish supplies.
- Advising staff at floor level on the use of infection prevention and control measures required for individual residents.
- Monitoring the needs of staff for support, stress management or issues related to morale and keeping the ADON and emergency response coordinator re same.
- Monitoring staff adherence to infection prevention and control measures and taking appropriate actions where there is a risk of non-adherence.
- Liaising with the chef on a daily basis to keep him/her updated on any changes to residents' food and nutrition needs.
- Keeping the PIC (and ADON) updated on individual residents' care and condition, with particular reference to residents with unstable and / or unpredictable conditions; new residents and those in the terminal phase of end of life care.
- Collecting surveillance data for the ADON to facilitate completion of surveillance records.
- Delegating responsibility to junior colleagues in accordance with their knowledge, skills, experience and the needs of residents.
- Nominating a nurse per shift who will take staff temperatures each day.

7.6 Senior Nurse.

7.6.6 A senior nurse will be nominated at floor level to deputise for the CNM in his/her absence and in the event that the CNM becomes ill and has to self-isolate.

7.6.7 The senior nurse will carry out responsibilities delegated to him/her as the need arises during the emergency.

7.7 Head of Household Services (Nursing Personnel in collaboration with Hygiene Staff).

7.7.6 The head of household will have the following responsibilities during the preparation phase of the emergency plan:

- Creating and inventory of current cleaning and disinfectant supplies and with the emergency plan coordinator developing an order for additional supplies that will be needed at all phases of the emergency.
- Ensuring that the order of supplies takes into account the need for additional cleaning, disinfection as well as additional hand hygiene points at entrances and exits to the home, both inside and outside the rooms of residents who are suspected of or have a diagnosis of infection; both at entrances and exits of areas where residents are cohorted in accordance with contingency plans for cohorting residents in the emergency plan.
- Ensuring that a supply of tissues and waste disposal bins are ordered and located in all communal areas.
- Ensuring that material safety data sheets are available to staff using cleaning and disinfectant products.
- Revising the cleaning schedules to facilitate additional cleaning and disinfection during the emergency.
- Liaising with suppliers to find out about any changes to ordering and delivering of supplies and any foreseeable difficulties with supply chains.

- Informing the emergency response coordinator of any changes to ordering, delivery of supplies and developing contingency plans to address these.
- Advising the emergency response manager on changes to rosters that may be required resulting from the change in cleaning schedules during the emergency.
- Nominating one member of the household team to check all hand hygiene points at scheduled intervals during the day to ensure that sufficient supplies of alcohol gel, liquid soap and disposable paper towels are in place.
- With the health and safety officer/rep/ committee assessing and potential exposure hazards and risks to staff during the course of their work, so that these are included in the risk register and identifying risk management measures to address these, including the use of PPE for environmental cleaning and disinfection and cleaning and disinfection of affected areas.
- Ensuring that household staff have information on COVID-19, including what to do if they are concerned that they may have been in close contact with a person suspected or confirmed as having a transmissible infection and/ or if they have any symptoms..
- Ensuring that information leaflets and posters are displayed for household staff in how to protect themselves from contracting an infection.
- Ensuring that laundry operatives have information about the handling of dirty and soiled linen during the emergency.
- Advising the emergency plan coordinator on training and support needs of household staff in infection prevention and control at preparation phase and throughout the emergency.
- Supervising household staff during the emergency to ensure that infection prevention control measures are being adhered to.

7.8 The Head Chef.

7.8.6 The head chef has the following responsibilities in preparation for and throughout the phases of the emergency:

- Developing contingency arrangements for mealtimes where residents can no longer attend communal dining areas. The head chef will work closely with the PIC.
- Liaising with suppliers to find out about any changes to ordering and delivering of supplies and any foreseeable difficulties with supply chains.
- Developing contingency plans where changes to ordering, delivery or supply of food may occur.
- With the health and safety officer/rep/ committee assessing and potential exposure hazards and risks to staff during the course of their work, so that these are included in the risk register and identifying risk management measures to address these, including the use of PPE when delivering trolleys to and collecting trolleys from affected resident areas.
- Updating cleaning schedules in kitchen and storage areas to include the need for increased cleaning and disinfection during the emergency.
- Ensuring that catering and kitchen staff have information on transmissible infections, including what to do if they are concerned that they may have been in close contact with a person suspected or confirmed as having a transmissible infection and/ or if they have any symptoms.
- Ensuring that information leaflets and posters are displayed for catering and kitchen staff in how to protect themselves from contracting a transmissible infection.
- Identifying additional PPE needs of staff and informing the emergency plan coordinator of these.

7.9 Human Resources Personnel.

7.9.6 Human Resources Personnel have the following responsibilities in preparation for and throughout the emergency:

- Ensuring that sick leave policies are current and reflect statutory and regulatory guidance related to transmissible infections.

- Assessing the information needs of staff and ensuring that information is available to all categories of staff to include information on the infection of concern, what to do if a staff member has concerns related to being in close contact with a confirmed person with a transmissible infection case or if the staff member develops any symptoms associated with the illness.

- Identifying any supports that staff will need during the emergency that may be related to anxiety, stress, family concerns, child care needs and / or accommodation needs and developing plans to address these support needs.

- Identifying the training needs of staff for infection prevention and control related to a transmissible infection and developing training plans to meet these needs, including alternative methods of training such as via remote access..

- Maintaining records of training and staff attendances at same.

- Assisting the emergency response coordinator with developing risk assessments of occupational hazards and risks related to infections.

- Identifying at risk staff, such as those who are pregnant or are immune-compromised and liaising with the emergency response coordinator to ensure these staff are not rostered to care for or to be in direct contact with residents who are suspected or confirmed as having a transmissible infection.

- Ensuring that record keeping related to staff records that contain personal health information in relation to infections comply with data protection legislation. *(See and European data Protection Board Statement on the processing of personal data in the context of the COVID-19 outbreak;).*

7.10 Head of Maintenance. Named Persons Alan McCartney, Christopher Woods and Michael McCaul. See Contiongency Plan.

7.10.10 The Head of maintenance will have the following specific responsibilities during an outbreak emergency:

- Making a list of all contractors who will need to be contacted regarding the infection emergency to inform them of increased infection prevention and control measures in The Village Residence.
- Contacting contractor who carry out essential maintenance and repairs to find out what arrangements are in place to address any essential maintenance and repairs during the emergency.
- Conducting a risk assessment of hazards and risks to essential contractors with the *(emergency response coordinator/health and safety officer, registered provider representative or external consultant).* The risk assessment should identify measures to mitigate the risks using the hierarchy of controls.
- Continuing with checking and maintenance responsibilities as needed while

7.11 Nominated Administrative Person. Alan McCartney Catherine Murphy.

The emergency response coordinator will nominate an member of administrative staff to be part of the emergency response tea. This person will have the following responsibilities:

- Make a list of posters and leaflets that need to be ordered /printed for The Village Residence. These include posters and information leaflets for staff, residents and non-essential visitors. These should also include droplet precaution posters for individual resident bedrooms.
- Type of letters to stakeholders as directed by the emergency response coordinator and PIC.
- Order and ensure a sufficient supply of surveillance forms are available for staff to use throughout the emergency.
- Drawing up forms to be placed in patient rooms for staff / essential visitors to record each time they have provided care to the resident and the length of time spent, with an emphasis on avoiding spending more than 15 mins at a time in close contact with a resident.

- Ensure that information posters are ordered/printed for display throughout The Village Residence. These include posters from both the HSE and National Bodies.
- Ordering supplies as directed by the emergency response coordinator/person in charge.
- Any other activities as directed by the emergency response coordinator/person in charge.

7.12 The Health and Safety Officer.

7.12.10 The health and safety officer is responsible for :

- Carrying out risk assessments in collaboration with the heads of department, the ERC and the PIC for additional environmental and occupation risks arising from the transmissible infection emergency.
- Updating the risk register to reflect the risk assessments carried out.
- Carrying out an inventory of PPE available, estimating supplies of same that will be needed and ordering same.
- Ensuring daily checks of PPE supplies and alerting the ERC of the need to order additional supplies.
- Liaising with staff to ensure all staff have received infection prevention and control training, including use of PPE.

7.13 The Health and Safety Representative.

The health and safety representative is responsible for:

- Representing staff at emergency response meetings and the development of risk assessments for occupational health and safety hazards and risks relating to the transmissible infection.
- Communicating with staff to ensure they are familiar with risk assessments carried out and to identify and concerns they have regarding health and safety and providing feedback to the ERC re same.

7.14 Registered Nurses.

7.14.1 Registered Nurses have the following specific responsibilities in the event of a threat of or outbreak of a transmissible infection in The Village Residence:

- Ensuring that they are familiar with this preparedness plan and policy.

- Maintaining their competence in infection prevention and control.
- Completing any additional training provided regarding prevention of infection into The Village Residence and responding to an outbreak of same.
- Monitoring residents for signs and symptoms of infection and changes in condition as outlined in this policy.
- Adhering to infection prevention and control requirements outlined in the policy.
- Assessment and care planning for all residents in accordance with this policy.
- Supervising care provided to residents in their designated area.
- Reporting any changes in a resident's condition to the *CNM/ADON/PIC).*
- Reporting any knowledge deficits related to infection prevention and control and the use of personal, protective equipment to the *CNM/ADON).*

7.15 Healthcare Assistants.

7.15.1 Healthcare assistants have the following specific responsibilities in the event of a threat of or outbreak of a transmissible infection in The Village Residence:

- Monitoring residents for any change in condition and reporting same to the nurse on duty in their area.
- Attending training provided on infection prevention and control in The Village Residence.
- Adherence to all infection prevention and control requirements outlined in this policy and in training.
- Reporting any knowledge deficits related to infection prevention and control and the use of personal, protective equipment to the *Person in Charge***.**

7.15.2 All staff in The Village Residence have the following specific responsibilities in the event of a threat of or outbreak of a transmissible infection in The Village Residence:

- Attending training provided on infection prevention and control in The Village Residence.
- Adherence to all infection prevention and control requirements outlined in this policy and in training.

- Reporting any knowledge deficits related to infection prevention and control and the use of personal, protective equipment to the
- Reporting to the PIC/ERC if they feel, because of any underlying condition that they may be particularly vulnerable to the transmissible infectionCovid-19.
- Take all reasonable precautions to prevent the accidental introduction of Covid 19 into The Village Residence through, for example, compliance with all public health advice issued.
- Inform their line manager without delay if they are feeling unwell or have respiratory symptoms.
- Refrain from coming into work if they are feeling unwell or have respiratory symptoms.
- Self isolate for the specified period if required.
- ***Any staff member who is working in another healthcare facility must ensure that they inform the person in charge of same.***

8.0 Assessment and Care Planning Protocol.

8.1.1 All residents have assessments and care plans developed on admission, where the resident's condition changes and formally on a four monthly basis. The following protocol outlines additional focused assessments and care planning specific to any infection.

8.1.2 Standard precautions must be adhered to by all staff to prevent infections in residents.

8.1.3 Nursing and healthcare staff will commence initiation of additional monitoring of residents to ensure prompt identification of cases of infection.

8.1.4 Residents should be educated in hand washing

8.1.5 Psychosocial needs resulting from visitor restrictions should be addressed both at communal and individual level. These for example may include the use of technology such as Skype or face time to assist residents in maintaining contact.

8.1.6 Continuation of group activities that allow for physical distancing of at least 2m for unaffected residents, unless there is an outbreak in The Village Residence.

8.1.4 Addressing fears and anxiety related to any infection through provision of information both in written form, erection of information posters, group information sessions and individual information as required through everyday contact with residents.

8.1.5 Addressing the information needs of family members and supporting families through visitor restrictions by facilitating phone calls, Skype and / or facetime.

8.1.6 Each resident should have an end of life care plan in place to include known wishes and preferences for measures to be taken in the event of a deterioration in condition that may require hospitalization, resuscitation, artificial nutrition. Where the resident has no known wishes and is unable to communicate their wishes, the views and observations of family members should be sought to inform decision making. The resident's general practitioner should be involved in decision making for the above interventions.

8.2 Surveillance and early identification of cases of infections.

8.2.4 **Once The Village Residence is informed or becomes aware of a threat of a local or national epidemic, increased monitoring of residents for signs and symptoms of infection will be commenced.**

8.2.5 Common signs and symptoms of possible infections are outlined in Figure 1.

Figure 1 Common Symptoms and Signs Indicative of possible Covid-19 illness, HSE, 17/03/2020

Common Symptoms and Signs indicative of possible Infection **illness:**

Most common:

Cough	Shortness of breath	Myalgia (Aches & Pains)
Fatigue	Fever>/=38°	

Less common:

Anorexia	Sputum production	Sore throat
Dizziness	Headache	Rhinorrhea
Conjunctival congestion	Chest pain	Haemoptysis
Diarrhea	Nausea/ vomiting	Abdominal pain

Risk factors for severe disease:

Ischaemic heart disease	Chronic heart failure	Hypertension
Diabetes	Chronic lung disease	1° or 2° immunosuppression
Cancer	Age > 75	Frailty

Red flags: Urgent Medical/Senior Clinician Review required

RR > 30breathes/min	Severe respiratory distress	New onset SpO2 < 90% on room air
New onset confusion	Hypotension	Oliguria > 12 hours

8.2.6 Nursing staff will record each resident's vital signs, including pulse oximetry twice daily.

Groups of people at very high risk are specified as those who:

• are over 70 years of age - even if you're fit and well

• have had an organ transplant • are undergoing active chemotherapy for cancer

• are having radical radiotherapy for lung cancer

• have cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment

• are having immunotherapy or other continuing antibody treatments for cancer

• are having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors

• have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs

• are on dialysis • have unstable or severe cystic fibrosis. This includes people awaiting a transplant

• severe respiratory conditions including Alpha-1 antitrypsin deficiency, severe asthma, pulmonary fibrosis, lung fibrosis, interstitial lung disease and severe COPD

• have a condition that means you have a very high risk of getting infections (such as SCID, homozygous sickle cell)

• are taking medicine that makes you much more likely to get infections (such as high doses of steroids or immunosuppression therapies)

• have a serious heart condition and you're pregnant

• have specific inborn errors of metabolism In the general population, the most common signs and symptoms include:

• fever (though this may be absent in the elderly)

• dry cough

• shortness of breath

• loss of sense of smell or taste.

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

• lethargy

• increased confusion

• change in baseline condition

• loss of appetite

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

8.2.7 Nursing and healthcare staff will observe for known signs of respiratory illness such as cough, complaining of aches and pains, shortness of breath, fatigue or fever.**of > 37.5 C or >1.5◦C from usual temperature, (Project Echo Webinar, 16/04/2020)**

8.2.8 ***Staff must also be vigilant in identifying symptoms in older people that may be suggestive of COVID-19, particularly the atypical presentations seen as outlined in Figure 2.***

8.2.9 The person in charge will nominate a staff member during the day and at night to measure and record the temperatures of oncoming staff.

8.2.10 All staff must have their temperatures measured and recorded at the start of their shift (HPSC, 18/04/2020)

8.2.11 All oncoming staff must report verbally to their line manager to confirm that they do not have any symptoms of respiratory illness, such as fever, cough, shortness of breath or myalgia. (HPSC, 18/04/2020)

- Typical symptoms of COVID-19 such as fever, cough, and dyspnoea may be absent in the elderly despite respiratory disease.
- Only 20-30% of geriatric patients with infection present with fever.
- Atypical COVID-19 symptoms include delirium, falls, generalized weakness, malaise, functional decline and conjunctivitis, anorexia, increased sputum production, dizziness, headache, rhinorrhoea, chest pain, haemoptysis, diarrhoea, nausea/vomiting, abdominal pain, nasal congestion, and anosmia.
- Tachypnoea, delirium, unexplained tachycardia, or decrease in blood pressure may be the presenting clinical presentation in older adults.
- Threshold for diagnosing fever should be lower, i.e. 37.5°C or an increase of >1.5°C from usual temperature
- Atypical presentation may be due to several factors, including physiologic changes with age, comorbidities, and inability to provide an accurate history
- Older age, frailty, and increasing number of comorbidities increase the probability of an atypical presentation.
- Older adults may present with mild symptoms that are disproportionate to the severity of their illness.

Solanki, T (14th April 2020 accessed at https://www.bgs.org.uk/blog/atypical-covid-19-presentations-in-older-people-–-the-need-for-continued-vigilance

8.2.12 Healthcare assistants who note a change in a resident's general condition or specific signs or symptoms outlined in Fig 2 must report this to the nurse on duty. The healthcare assistant must decontaminate their hands on leaving the resident's room using the nearest alcohol gel dispenser. The healthcare worker should then report same to the Nurse on duty in his/her area.

8.2.13 If the resident is not in their room, the healthcare assistant should assist the resident to their room and ask him/her to wait for the Nurse) and then decontaminate his/her hands as outlined in 8.2.2.

8.2.14 Nurse must put on personal protective equipment (Appendix 2) before entering the resident's room/area

8.2.15 The Nurse will assess the resident and check vital signs , including pulse oximetry and report same to the PIC

8.2.16 The Person in Charge must be informed of any resident who presents with respiratory illness and / or fever and / or influenza like illness, including cough

8.2.17 Once informed of a resident with symptoms the CNM 2 will contact the resident's general practitioner and following assessment, the general practitioner will make a decision about the need to refer the resident for Covid -19

8.2.18 In outbreak situations or other circumstances where extended use of one set of PPE (other than gloves) when moving between patients with a diagnosis of COVID-19, it is important to make every effort to avoid generalised use of PPE throughout the facility without considering the level of risk, (HPSC, 18/04/2020

8.2.19 In the event of extended use of PPE define clean and contaminated zones. PPE should be donned before entering the contaminated zone and doffed and hand hygiene before entering clean zones (HPSC, 18/04/2020

8.2.20 Where staff are having meals on a unit to minimise staff interaction, it is essential that the staff refreshment area is a clean zone. Corridors between units are designated clean zones. The Clinical Room is clean zone, (HPSC, 18/04/2020

8.2.21 Transiting through the hallway of a contaminated zone without providing resident care does not require use of PPE if the residents are in their rooms and there is no physical contact with staff wearing PPE. (HPSC, 18/04/2020

8.2.22 Staff with long hear should keep their hair tied up and off their face.

Please refer to Appendix 1 for HSE (18/04/2020) Guidance on use of PPE in specific situations.

8.2.23 Standard precautions should continue to be used in clean areas and units not affected by the outbreak. This includes

- Performing hand hygiene before and after every episode of resident contact **(5 moments),**

- The use of PPE (including gloves, gown, appropriate mask and eye protection) depending on the anticipated exposure,
- Good respiratory hygiene/cough etiquette and
- Regular cleaning of the environment and equipment.

8.2.24 Frequent hand hygiene should be carried out using alcohol based gels when hands or not soiled.

8.2.25 If hands are visibly soiled or have been in contact with bodily fluids, they should be washed with liquid soap and running water and then dried with a disposable paper towel.

8.2.26 Staff should be encouraged to do refresher infection control training.

8.2.27 Adequate hand hygiene facilities with either alcohol based gels or hand wash basins with liquid soap, water and paper towels. In particular, additional hand hygiene facilities should be located:

- In each resident bedroom.
- Outside each resident's bedroom so that's hands can be cleaned following removal of surgical masks.
- At entrances to and exits from areas where residents are being cohorted due to suspected or confirmed COVID-19.
- At entrance to The Village Residence.

8.2.28 Staff should encourage residents to wash their hands when leaving their room, before and after meals and after toileting. Residents who need assistance should be assisted with hand hygiene.

9.0 Environmental Cleaning (HPSD, 18/04/2020). Please see Policy on Cleaning.

1.1.1 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.

1.1.2 Residents observation charts, medication prescription and administration records (drug charts) and healthcare records should not be taken into the room to limit the risk of contamination.

9.2 Routine cleaning

9.2.1 Decontamination of equipment and the care environment must be performed using either:

- A combined detergent/disinfectant solution at a dilution of 1,000parts per million available chlorine (ppm available chlorine (av.cl.)); or
- A general-purpose neutral detergent in a solution of warm water,followed by a disinfectant solution of 1,000 ppm av.cl.
- Only cleaning (detergent) and disinfectant products supplied byemployers are to be used. Products must be prepared and used according to the manufacturer's instructions and recommended product "contact times" must be followed

9.2.2 Hoovering of carpet floor in a resident's room should be avoided during an outbreak and while the patient is infectious. When the resident is recovered the carpet should be steam cleaned.

9.2.3 All shared spaces should be cleaned with detergent and disinfectant.

9.2.4 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.

9.2.5 Household and care staff should be trained in the appropriate use and removal of PPE In practical terms isolation room cleaning may be undertaken by staff that are also providing care in the isolation room.

9.3 Frequency of cleaning

9.3.1 All surfaces in resident room/zone should be cleaned and disinfected twice daily and when contaminated. These include bedrails, bedside tables, light switches, remote controllers, commodes, doorknobs, sinks, surfaces and equipment close to the resident e.g. walking frames, sticks. Handrails and table tops in facility communal areas, and nurses station counter tops.

9.3.2 The resident rooms, cohort areas and clinical rooms must be cleaned and disinfected at least daily & a cleaning schedule should be available to confirm this.

9.4 Terminal cleaning

9.4.1 Terminal cleaning should always be performed after a resident has vacated the room and is not expected to return. In addition to the routine cleaning protocols, a terminal clean is needed, including:

- Removal of all detachable objects from a room or cohort area, including laundry and curtains; *
- Removal of waste;
- Cleaning (wiping) of lighting and ventilation components on the ceiling;
- Cleaning of the upper surfaces of hard-to-reach fixtures and fittings;
- Cleaning of all other sites and surfaces working from higher up to floor level.

9.4.2 The terminal clean checklist is good practice to support cleaning or household staff to effectively complete all environmental cleaning tasks, which should be signed off by the cleaning supervisor before the room reopens for occupancy.

9.5 Staff uniforms/clothing

9.5.1 Staff uniforms are not considered to be personal protective equipment.

9.5.2 Uniforms should be laundered daily and separately from other household linen; in a load not more than half the machine capacity at the maximum temperature the fabric can tolerate then ironed or tumble dried.

9.5.3 Staff should avoid bringing personal items, including mobile phones into isolation or cohort areas.

9.6 Resident Care Equipment.

See above

9.6.1 Where possible, single use, disposable equipment will be used and should be disposed of as healthcare risk waste inside the resident's room.

9.6.2 If re usable resident care equipment is in use, ideally it should be dedicated for the use of an individual resident. If this is not feasible, equipment should be cleaned and disinfected immediately following use between each resident use.

Linen. See above

9.7

9.7.1 All towels, clothing or other laundry used in the direct care of residents with suspected and confirmed COVID-19 must be treated as 'infectious' linen.

9.7.2 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.

9.7.3 Disposable gloves and an apron should be worn when handling linen.

9.7.4 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.

9.7.5 When handling linen, the staff should not:

- rinse, shake or sort linen on removal from beds/trolleys;

- place used/infectious linen on the floor or any other surfaces (e.g., a bedside locker/table top);
- handle used/infectious linen once bagged;
- overfill laundry receptacles; or
- place inappropriate items in the laundry receptacle (e.g., used equipment/needles)

9.7.6 When managing infectious linen, the staff should:

- Place linen directly into a water-soluble/alginate bag and secure;
- Place the alginate/water-soluble bag into the appropriately-coloured (red) linen bag
- Store all used/infectious linen in a designated, safe area pending collection.
- If there is no laundry service, laundry should be washed using the hottest temperature that the fabric can withstand and standard laundry detergent.
- Laundry should be dried in a dryer on a hot setting.

Crockery and Cutlery. See above

9.8

9.8.1 Crockery and cutlery from affected residents should be washed in a hot dishwasher.

9.8.2 There is no need to separate the crockery and cutlery being used by affected residents from that of other residents.

9.9 Signage.

9.9.1 Infection prevention and control signage should be placed at entrances and other strategic locations to alert staff, residents and essential visitors to provide information on the required infection prevention and control precautions.

9.9.2 Droplet precaution signs must be placed outside symptomatic residents' rooms to alert staff and essential visitors to the requirement for transmission based precautions.

10.0 Admissions and Transfers

11.0 Resident Transfer

In accordance with the resident's known wishes and preferences outlined in discussions with the resident or where the resident is unable with the resident's family/representative. Benefits and risks

associated with transfer to hospital should be discussed by the resident's general practitioner and recorded in the resident's healthcare record.

- For essential care that is deemed clinically appropriate and will provide a beneficial outcome for the resident.

11.1.1 Nursing staff must advise the hospital and transport provider in advance that the resident is being transferred from a facility where there is potential or confirmed transmissible infection.

11.1.2 Any resident requiring hospitalization who has suspected or confirmed transmissible respiratory infection should wear a surgical mask during transfer.

12.0 New admissions and Re admission UPDATE

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

12.1.1

Admission of patients from community / home settings

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.

13.0 Care of the Resident with Suspected or confirmed Transmissible infection.

13.1.1 As previously outlined, residents who have suspected or confirmed transmissible infection illness need to have additional infection prevention control measures in place .

13.1.2 The daily care of the resident will vary in accordance with individual needs resulting from any existing diagnoses and health conditions as well as the impact of the illness on the resident.

13.1.3 Vital signs should be monitored at least twice daily for residents with suspected respiratory infection to identify any changes in their clinical condition and progression of illness. This should be increased as required based on the resident's overall condition and as advised by the resident's GP. Vital signs should include checking of temperature, blood pressure, pulse, respiratory rate and pulse oximetry.

13.1.4 Care of a resident with a transmissible infection should be delivered by a single nominated healthcare assistant during each shift.

13.1.5 Nursing interventions should aim at

- Management of symptoms, including fever, shortness of breath, fatigue, generalized aches and pains. This includes administration of prescribed medications for symptoms.
- Identifying potential problems and risks specific to the illness itself and to its impact on the resident. These for example may include risks related to skin integrity/pressure ulcer risk, risks resulting from prolonged time spend in bed such as predisposition to deep vein thrombosis for those with circulatory problems, dehydration, delirium, constipation and so on.

- Recognising and managing delirium
- Optimizing the resident's fluid and nutritional intake. This may involve the use of subcutaneous fluid infusions.
- Addressing psychosocial needs arising from not being able to see family members, friends or being involved in group activities with other residents, such as loneliness, anxiety, boredom. Use of technology, such as Skype, facetime could assist with maintaining contact with family and friends outside of The Village Residence.
- Educating the resident on hand washing, maintaining distance of at least 1m from others if going outside, use of surgical mask and any other measures needed to maintain optimum health such as the need for fluids and nutrition.
- Recognising and responding appropriately to acute changes in condition.
- Palliative and end of life care where a resident reaches this stage of illness.

13.1.6 Acute changes in a resident's clinical status must be reported to the Nurse on Duty and or CNM and the PIC who will liaise with the resident general practitioner to determine what interventions are required.

13.2 Recognising and Responding to Sepsis.

13.2.1 Sepsis is a life-threatening condition triggered by infection that affects the function of the organs. It is treated most effectively if recognised early.

13.2.2 It can affect anyone but is more common in the very young, the elderly or those with a weakened immune system.

13.2.3 Sepsis and septic shock can result from an infection anywhere in the body, such as pneumonia, influenza, or urinary tract infections. Bacterial infections are the most common cause of sepsis.

13.2.4 Signs and symptoms of sepsis include:

- Fever> 38°C.
- Hypothermia ≤ 36
- Rigors/Shivering.
- Confusion

- Shortness of breath.
- Rapid breathing > 20 per minute.
- Rapid heart rate > 90 per minute.

Sepsis Alliance: Ageing accessed 31/03/2020.

13.2.5 Where a resident with an ionfection develops the above symptoms, the nurse should report these without delay to the ***CNM/ADON/PIC*** and the residents GP must be informed.

13.2.6 The GP and ***CNM/ADON/PIC*** will make a decision about the most appropriate intervention, including the need for hospital transfer, in accordance with the resident's known wishes and preference and / or the views and observations of the family where appropriate.

13.2.7 Hospital transfer of a resident during a transmission based outbreak is considered where the transfer is likely to provide benefit to the resident.

14.0 Recognising and Caring for Residents with Delirium.

14.1.1 Older people are at the greatest risk from infection. If infected they may present with or develop a delirium. Older people are at the greatest risk from respiratory infections. If infected they may present with or develop a delirium. The British Geriatrics Society, (2020) offer the following advice:

- Reduce the risk of delirium by avoiding or reducing known precipitants. Actions include: regular orientation, avoiding constipation, treating pain, identification and treatment of superadded infections early, maintaining oxygenation, avoiding urinary retention and medication review.
- With respect to behavioural disturbance, always look for and treat direct causes including pain, urinary retention, constipation, etc.
- Older adults, especially in isolation and those with cognitive decline/dementia, may become more anxious, angry, stressed, agitated, and withdrawn during the outbreak/while in quarantine. Provide practical and emotional support through informal networks (families via Skype) and health professionals.
- Share simple facts about what is going on and give clear information about how to reduce risk of infection in words older people with/without cognitive impairment can understand.

Repeat the information whenever necessary. Instructions need to be communicated in a clear, concise, respectful and patient way. and it may also be helpful for information to be displayed in writing or pictures. Engage their family and other support networks in providing information and helping them practice prevention measures (e.g. handwashing etc.)4 "

15.0 Management of Staff.

15.1.1 All staff receive education/training on infection prevention and control as part of the mandatory training programme for The Village Residence.

15.1.2 Updates will be provided to staff on infection prevention and control for cases of suspected or confirmed diagnosis of transmissible infections and management of outbreaks. This will include use of resources and videos available on both the HSE and HSPC websites. Training will include information on the use of PPE as well as instructions on how to put on and take off PPE.

15.1.3 Staff will be informed of the need to practice hand hygiene, cough and respiratory etiquette and the importance of not touching their face.

15.1.4 Staff will be informed of the importance of self-monitoring for signs and symptoms of respiratory illness, particularly, fever, cough, shortness of breath and / or fatigue.

16.0 Staff Members Identified as Close Contacts.

16.1.1 Staff members who meet the criteria below are considered close contacts:

- have a cumulative unprotected exposure during one work shift (i.e. any breach or omission of gloves, a gown, eye or respiratory protection) for more than 15 minutes face-to-face (< 1 meters distance) to a case
- OR have any unprotected exposure of their eyes or mouth or mucus membranes, to the bodily fluids (mainly respiratory secretions e.g. coughing, but also includes blood, stools, vomit, and urine) of the case. OR
- have any unprotected exposure (i.e. any breach in gloves, gown, eye or respiratory protection) while present in the same room when an aerosol generating procedure* is undertaken on the case.
- Staff members who have been identified as being close contacts of a confirmed case outside of the work environment.

(Any staff member who meets the above criteria as a close contact must inform the *person in charge/ADON/*

17.0 End of Life Care.

17.1.1 Residents at end of life stage should be cared for according to The Village Residence end of life policy.

17.1.2 Advance care plans should include decisions about whether hospital transfer would be considered (for oxygen therapy, intravenous fluid and antibiotics) for infection-related illness

17.1.3 Advance care plans should be shared with the primary care out-of-hours service. Primary care providers should consider how to respond in a timely fashion.

17.1.4 Where a resident is at the advanced stages of a life limiting condition and has already been moved to a palliative approach, care should continue in accordance with their end of life care plan and known wishes and preferences previously recorded.

17.1.5 Where the resident is at the palliative care stage of their illness, the ADON should liaise with the resident's GP or palliative care team about anticipatory prescribing for end of life symptoms.

17.1.6 Where a resident who is not at the advanced stages of a life limiting illness becomes very ill because of infection, their GP must be informed and decisions about interventions must be made by the resident's GP, involving the resident as far as he/she is able and the views and observations of family as appropriate.

17.1.7 Decisions about visitation during an end of life situation should be made on a case by case basis, but there should be no hindering of relatives being present

17.1.8 Symptom management for residents receiving end of life care should comply with The Village Residence End of Life Policy.

18.0 Death of a Resident and Last Rites.

18.1 This procedure must be followed in the event of the death of a resident *in Centre*, including last rights is outlined in The Village Residence End of Life Policy. The following additional measures are required for the death of a resident suspected or confirmed as having a transmissible infection.

18.2 Verification of the residents death

SCENARIO 1: Death where a resident was suspected as having a transmissible infection however this has not been confirmed as the resident was still awaiting testing.

- Report the death to the District Coroner
- Transfer the person who has died to mortuary if the Coroner so directs or in accordance with established out of hours procedures.
- Post mortem viral swabs may be taken at the direction of the Coroner.
- Whilst awaiting swab results, the body may be released by direction of the Coroner if the doctor confirms the cause of death as being due to natural causes and there are no other circumstances requiring further investigation or examination. The actual cause of death to be certified by the doctor on the Death Notification Form will need to be confirmed with the Coroner's office once the swab result is available.
- e) If positive, in most cases a postmortem examination will not be required unless other circumstances are present and the law mandates an autopsy to be directed by the Coroner.
- f) If negative and the body has not already been released by direction of the Coroner where the doctor has confirmed the cause of death as being due to natural causes and there are no other circumstances requiring further investigation or examination, the need for post mortem examination will only be required if the Coroner so directs based on the clinical and other circumstantial information applying the law accordingly.

SCENARIO 2: Death of a resident where there has been a previously confirmed outbreak of transmissible infection in The Village Residence.

- Report the death to the District Coroner.

- b) The Coroner may release the person who has died if he or she is satisfied that the cause of death is due to natural causes, and there are no other circumstances requiring further investigation or examination.
- The actual cause of death to be certified by the doctor will need to consider the preceding medical history and circumstances, and to be confirmed with the Coroner's office.

18.3 Preparation of Removal to the Funeral Home / Mortuary

18.3.1 The deceased resident should be wrapped loosely in a clean sheet and secured with tape.

18.4 Terminal Cleaning.

18.4.1 Following removal of the deceased resident from the room, the area will require terminal cleaning.

18.4.2 All equipment and surfaces should be cleaned using detergent and disinfected using disinfectant active against viruses or a 2 in 1 solution.

18.4.3 For equipment, staff should check manufacturer's instructions to ensure that the products in use are compatible with the instructions for cleaning and disinfecting the equipment.

18.4.4 Cleaning and disinfecting the room must include:

- Top, front and sides of the bed's headboard, mattress, bedframe, foot board and side rails, and between side rails
- TV remote
- Nurse-call device and cord
- All high-touch areas in the room including tabletops, bedside tabletop and inner drawer, phone and cradle, armchairs, door and cabinet handles, light switches, closet handles, etc.

18.4.5 In the bathroom, start with the highest surface and clean the toilet last; clean the sink and counter area, including sink fixtures, and if there is a shower, the support bars and shower fixtures and surfaces

18.4.6 Staff carrying out cleaning must wear PPE for contact precautions, that is nitrile gloves, plastic apron or the use of full sleeved gown and eye goggles where there is a risk of contact with body fluids from equipment.

18.5 Linen.

18.5.1 All linen should be placed into a water soluble or alginate bag. The bag must be sealed using the thread attached to the crease at the side of the bag.

18.5.2 The bag should be placed into a red canvass linen bag and transported for laundry.

18.5.3 Laundry staff must ensure water temperatures are > 65°C for more than 10 mins (HSE, 30/03/2020).

18.5.4 Staff handling laundry must use contact precautions, including gloves and plastic apron.

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Appendix 1: When to Use PPE

Putting on PPE

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

For FFP2

Fit Check

A. Place mask over nose, mouth and chin
B. Fit flexible nose piece over nose bridge
C. Secure on head with elastic
D. Adjust to fit
E. Inhale – mask should collapse
F. Exhale – check for leakage around face

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

Removing PPE

In patients' room

1. Remove gloves
   (avoid touching the outside of the gloves)
2. Decontaminate hands
3. Remove goggles
4. Remove gown or apron
   (avoid touching the front of the gown/apron)

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

5. Remove mask by breaking the ties.
   If ties are elastic grasp and lift ties from behind your head and pull off mask away from your face . Avoid touching the front of the mask & use ties to discard

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