Community and Aged Care Services
Greater Newcastle Sector

WALLSEND AGED CARE FACILITY

COVID-19 PANDEMIC PLAN & OUTBREAK MANAGEMENT PLAN

March 2020
Revised August 2020
Revised September 2020
Revised January 2021
Revised March 2021

NSW GOVERNMENT
Health
Hunter New England
Local Health District

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Acknowledgement

Wallsend Aged Care Facility, Community and Aged Care Services-Greater Newcastle acknowledge the following resource was used to compile this supporting plan:

The National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia

This guideline was developed by the Communicable Diseases Network Australia (CDNA), in consultation with the Aged Care Sector, and noted by the Australian Health Protection Principal Committee (AHPPC).

Endorsement

ENDORSED Virginia Tideswell
Service Manager/ Director of Nursing
Wallsend Aged Care Facility

Dated: 23 March 2020

ENDORSED Louise Lazic
Acting General Manager
Community and Aged Care Services –
Greater Newcastle Sector

Dated: 23 March 2020

ENDORSED Karen Kelly
Executive Director
Greater Metropolitan Health Services

Dated:

Amendments

Suggested amendments or additions to the content of this plan are to be forwarded in writing to:

Service Manager/Director of Nursing
Wallsend Aged Care Facility
Longworth Avenue
WALLSEND NSW 2287

Amendments promulgated are to be certified in the following table when entered.

AMENDMENT		**ENTERED**	
Number	Date	Signature	Date
1	March 2020		23.03.2020
2	May 2020		21.05.2020
3	June 2020		25.06.2020
4	August 2020		03.08.2020
5	September 2020		29.09.2020
6	January 2021		07.01.2021
7	March 2021		09.03.2021

Currency

This plan is to be reviewed and / or updated by the Service Manager/Director of Nursing on the following occasions:

- On the conclusion of an emergency in which this plan was or could have been activated
- Annually, or as required during ongoing/extended community transmission or outbreak

Introduction

This guide will assist Wallsend Aged Care Facility (WACF) to manage all types of respiratory outbreaks, but the focus is predominantly on COVID-19. Additional guidance for investigation and management of COVID-19 outbreaks in high-risk settings via CDNA National Guideline CDNA COVID-19 National Guidelines for Public Health Units

COVID-19 Outbreaks

It can be difficult to tell the difference between a respiratory illness such as COVID-19 and a respiratory illness caused by other viruses based on symptoms alone. Suspected COVID-19 cases are referred to as a 'suspect case' until a causative pathogen is identified through diagnostic testing. If the COVID-19 virus (SARS-CoV-2) is detected during an outbreak this is referred to as a COVID-19 outbreak.

While all respiratory viruses can cause outbreaks and significant morbidity and mortality, COVID-19 is acknowledged as a significant health risk particularly for the elderly and individuals with co-morbidities or low immunity.

Legal Framework

COVID -19 is a notifiable condition under the Australian National Notifiable Diseases List. It is the responsibility of WACF to identify and comply with relevant legislation and regulations. WACF must fulfil their legal responsibilities in relation to infection control by adopting standard and transmission-based precautions as directed in the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019) and by state/territory public health authorities. WACF are also required to operate under the Aged Care Act 1997 to be accredited and be eligible for funding. Accreditation requires adherence to infection control standards. WACF is expected to comply with the Aged Care Quality and Safety Commission Aged Care Quality Standards.

Roles and Responsibilities

Residential Care Facility

The primary responsibility of managing COVID-19 outbreaks lies with WACF, with responsibilities for resident care and infection control. WACF have via HNEHLHD Infection Control expertise, and a service specific outbreak management plan in place.

WACF is are required to:

- Detect, declare and notify outbreaks to HNELHD Population Health, Commonwealth Department of Health
- Self-manage outbreaks in accordance with this guideline, the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019), and the Australian Health Sector Emergency Response Plan for Novel Coronavirus (2020)
- Provide advice on infection control measures and use of PPE
- Declare an outbreak at onset and when an outbreak is over

The State/Territory Department of Health and Human Services

HNEHealth Public Health Unit will act in an advisory role to assist WACF detect, characterise and manage COVID-19 outbreaks.
This includes:

- Assisting in confirming outbreaks by applying the case definition correctly and providing advice on obtaining testing samples
- Providing guidance on outbreak management
- Monitoring for severity of illness (record deaths and hospitalisations)
- Informing relevant stakeholders of outbreaks
- Monitoring the number of COVID-19 outbreaks occurring as the epidemic progresses
- Contributing to national surveillance

UNDERSTANDING COVID-19

Recognising COVID-19

COVID-19 is a contagious viral infection that generally causes respiratory illness in humans. Presentation can range from no symptoms (asymptomatic) to severe illness with potentially life-threatening complications, including pneumonia.

The most common signs and symptoms include:

- fever (though this may be absent in the elderly)
- dry cough

Other symptoms can include:

- shortness of breath
- fatigue
- sore throat
- diarrhoea
- sputum production
- diarrhoea
- loss of taste and or smell
- nausea or vomiting

Less common symptoms include:

- headache
- chills
- nasal congestion
- conjunctival congestion
- myalgia/arthralgia
- nausea or vomiting
- haemoptysis

Older people may also have the following symptoms:

- confusion or behavioural changes
- worsening chronic conditions of the lungs
- loss of appetite

Staff should be cognisant of these symptoms and note that the majority of cases experience mild symptoms. If any staff member (including casual, domestic, hospitality and volunteer workers) develops any symptoms, they must isolate and get tested to prevent transmitting the virus to other staff members or residents.

Elderly residents often have non-classic respiratory symptoms including behaviour change, and may not develop a fever. Ideally, staff should know residents well so that they can detect changes in behaviour. Staff should consider testing any resident with any new respiratory symptom, even if they are not typical of COVID-19.

Asymptomatic COVID-19 infections are relatively common and may occur in residents. Public Health Units may consider testing asymptomatic contacts to inform management of the outbreak.

Incubation Period

People with COVID-19 generally develop signs and symptoms, including mild respiratory symptoms and fever, on an average of 5-6 days after exposure to the virus (mean incubation period 5-6 days, range 1-14 days). In rare cases the incubation period may exceed 14 days.

Routes of Transmission

The virus that causes COVID-19 most commonly spreads through:

- Direct contact with droplets from an infected person's cough or sneeze. This can be minimised by cough etiquette and physical distancing.
- Close contact with an infectious person.
- Touching objects or surfaces (e.g. bed rails, doorknobs or tables) that have been contaminated with respiratory droplets from an infected person and then touching the face, especially mouth, nose or eyes.

Faecal shedding of the virus has been demonstrated in some patients, and viable virus has been identified in some cases. Although the faecal-oral route does not appear to be a driver of COVID-19 transmission, if diarrhoea is a feature of the COVID-19 illness it may become important in RCF; as such, cases with ongoing diarrhoea or uncontained faecal incontinence who may have limited capacity to maintain standards of personal hygiene should continue to be isolated until 48 hours after the resolution of these symptoms.

Airborne spread may occur during certain aerosol-generating procedures conducted in health care settings.

People at risk of complications from COVID-19

People at or are likely to be, at higher risk of serious illness from COVID-19:

- People 70 years and older
- People 65 years and older with chronic medical conditions
- Aboriginal and Torres Strait Islander people 50 years and older with one or more chronic conditions (see below)
- People with a compromised immune system

Complications of COVID-19

Most people with COVID-19 have mild disease and will recover. Some people can develop complications which may be life-threatening and can result in death.
Complications include:

- pneumonia (interstitial pneumonitis, secondary bacterial infection)
- respiratory failure
- septic shock
- multi-organ dysfunction/failure

Elderly residents may experience a worsening of chronic health problems such as congestive heart failure, asthma and diabetes.

PREPAREDNESS AND PREVENTION

Preparation

WACF will complete a risk assessment and implement strategies to ensure preparation is in place for outbreaks of COVID-19 including for the occurrence for a first case of COVID-19. WACF Infection Prevention Control (IPC) program working with Work, Health & Safety program, is the basis for an effective IPC response during a COVID-19 pandemic.

Planning Assumptions

It is important to note that assumptions about the epidemiology and impact of COVID-19 may change as knowledge emerges.

The following public health assumptions are relevant to Infection Prevention Control and outbreak management planning:

- A COVID-19 pandemic will affect the entire health care system and the community. Hospitals, local public health units and other services may have limited capacity. WACF may not be able to rely on the same level of support they receive now from other parts of the health care system or from other community services during an outbreak.
- Pandemic COVID-19 plan developed by WACF is:
  - coordinated and consistent with the HNELHD Pandemic Plan
  - Facility will have to rely on traditional infection prevention and control practices (e.g., hand hygiene, appropriate personal protective equipment, and isolating sick individuals) as the main line of defence.

- To meet needs during a pandemic, resources – including staff, supplies and equipment – may have to be reassigned or shifted.
- WACF to ensure documentation of visitors and patients, staffing, locations of work to assist with contact tracing. All staff and visitors to supply up to date contact details.

Communication

Education for staff, residents and their families is vital to inform their behaviour and help manage the potential occurrence for ongoing transmission in an outbreak setting.

WACF will provide prompt and clear information to residents and families regarding the outbreak including respiratory hygiene and cough etiquette, hand hygiene and restrictions on visitation if they have any symptoms of COVID-19.

Staff to be informed, and supported, to exclude themselves from work when they have any kind of respiratory illness and to notify the facility if they were confirmed to have COVID-19.

Family members of residents and other visitors (including visiting workers) can potentially transmit COVID-19 to residents. The following actions will be taken:

- Advise all regular visitors to be vigilant with hygiene measures including social distancing, and to monitor for symptoms of COVID-19, specifically fever and acute respiratory illness. They will be instructed to stay away when unwell, for their own and residents' protection, and to observe any self-quarantine requirements.

Signage and other forms of communication (i.e. information and factsheets) will be used to convey key messages including what actions the facility is taking to protect them, and explaining what they can do to protect themselves and residents. WACF will display current signage with update entry to facility information.

Workforce Management

WACF will work with CACS-GNS Executive to develop a staff contingency plan in the event of an outbreak where unwell staff members need to be excluded from work for a prolonged period until cleared to return to work.

WACF maintains a contact list for casual staff members or external nursing agencies to activate of a surge workforce should an outbreak occur. Leave will be suspended during the pandemic. Staff may be deployed to WACF from community based services where services have been closed during pandemic. Staff to provide support in resident care as well as leisure and lifestyle activities.

Health care workers and other members of staff who develop symptoms of respiratory illness should immediately be excluded from the facility and remain away whilst a diagnosis is sought. If COVID-19 is excluded, the staff member may be able to return to work once well and as guided by the infections period for their condition. If a diagnosis of COVID-19 is confirmed, the staff member must be excluded until they meet the criteria for release from isolation.

Management of vulnerable staff who are at higher risk of serious illness if infected will require a risk assessment. The risks will be assessed and mitigated with consideration of the characteristics of the worker, the workplace and the work. This includes ensuring vulnerable people are redeployed to other suitable roles where possible. Where risk cannot be appropriately mitigated, WACF will liaise with Human Resources and may consider alternate arrangements.

Staff Education and Training

WACF is responsible for ensuring staff are adequately trained and competent in all aspects of outbreak management prior to an outbreak. Education aim is for staff knowledge of the signs and symptoms of COVID-19 in order to identify and respond quickly to a potential outbreak. All staff need to understand the infection control guidelines and be competent in implementing these measures during an outbreak.

Topics for staff education and training will include:

- symptoms and signs of COVID-19
- exposure risk levels for COVID-19, including being aware of Geographical Areas of Risk and the importance of travel history
- hand hygiene, sneeze and cough etiquette
- appropriate use of PPE such as gloves, gowns, eye protection and masks, including how to don and doff PPE correctly
- handling and disposal of clinical waste
- processing of reusable equipment
- environmental cleaning
- safe handling and laundering of linen
- food handling and cleaning of used food utensils
- collection and handling of respiratory swabs, where appropriate and in alignment with the staff's prior training and skillset.

Hand Hygiene

Staff should be made aware of the proper hand hygiene technique and rationale. There must be adequate access for staff, residents and visitors to hand hygiene stations (alcohol based hand rub or hand basins with liquid soap, water and paper towel) that should be adequately stocked and maintained.

Cough and Sneeze Etiquette

Cough and sneeze etiquette relates to precautions taken to reduce the spread of virus via droplets produced during coughing and sneezing. Residents, staff and visitors encouraged to practice good cough and sneeze etiquette, which includes coughing or sneezing into the elbow or a tissue, and disposing of the tissue then cleansing the hands. Useful educational and promotional material can be found at Appendix 3. Specific advice should be given to any resident with ARI as a reminder.

Consumable Stocks

WACF to ensure adequate stock levels of all consumable materials required during an outbreak are maintained, including:

- personal protective equipment (gloves, gowns, masks, eyewear)
- hand hygiene products (alcohol based hand rub, liquid soap, hand towel)
- diagnostic materials (swabs)
- cleaning supplies (detergent and disinfectant products)

WACF requirements:

- undertake regular stocktake (counting stock)
- provision of respiratory kits well stocked
- ensure PPE, including facemasks, eye protection, gowns, and gloves, is available immediately outside of the resident room.
- position a disposal receptacle near the exit inside any resident room to make it easy for employees to discard PPE.
- position signs on the door or wall outside of the resident room clearly describing the type of precautions needed and required PPE.

Prevention

Avoidance of exposure is the single most important measure for preventing COVID-19. WACF will aim to be vigilant in implementing, effective infection control procedures.

The general strategies recommended to prevent the spread of COVID-19 are the same Infection Prevention Control strategies used every day to detect and prevent the spread of other respiratory viruses like influenza. During a COVID-19 pandemic, or when local community transmission of the disease is identified, WACF will focus on preventing introduction of the disease into the facility.

Exposure Prevention

Exposure prevention actions include:

- Following advice and directives from MoH, Public Health units, LHSD on use of PPE.
- Screening for staff, volunteers and visitors (including visiting workers)
  - WACF will instruct all staff to self-screen for symptoms, and staff should be made aware of early signs and symptoms of COVID-19. Staff must not come to work if symptomatic and must report their symptoms to WACF.
  - WACF to have signage at entrance and screening station to inform visitors to self-identify if they have relevant symptoms, travel history or exposure. Visitors must be instructed not to enter the facility until any symptoms have completely resolved.
- Monitor residents and employees for fever or acute respiratory symptoms
  - Restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated).
  - In general, for care of residents with undiagnosed respiratory infection use Standard, Contact, and Droplet Precautions with eye protection unless a procedure requires Airborne Precautions.
  - Nebulisers generate aerosols of medicine, only some of this is absorbed with large amounts being widely dispersed into the environment for a period of time. This exhaled vapour can contain large numbers of infectious viruses. These aerosols will remain suspended for a short period before falling (30 minutes). (Appendix 4)
- Active screening for resident admissions or re-admissions/returning residents
  - Assess residents for symptoms of COVID-19 upon admission to the facility and implement appropriate infection prevention practices for incoming symptomatic residents.
- Implementation of non-pharmaceutical measures, which include:
  - Hand hygiene and cough and sneeze etiquette
  - Use of appropriate personal protective equipment
  - Environmental cleaning measures
  - Isolation and cohorting
  - Social distancing
- Ensure that adequate hand washing facilities and alcohol based hand rub, as well as tissues and lined disposal receptacles are available for visitors to use; at the entrance of the facility and in each resident's room.
- Notify facilities and transport service providers prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19; or transferring to a higher level of care.
- If an outbreak occurs in a facility, staff should not work at another facility until the outbreak is over.

IDENTIFYING COVID-19

Identification

Prevention and management of influenza outbreaks have been built around surveillance of influenza-like illness (ILI). Monitoring of staff and residents for COVID-19 with a high level of vigilance and have a low threshold for investigation must be undertaken. Surveillance for fever or acute respiratory illness[1] (ARI, with or without fever), rather than ILI, is very sensitive for detecting possible cases of COVID-19 in the context of confirmed local transmission of COVID-19.

The aim of surveillance is to ensure early identification of symptoms in residents and staff that may precede, or indicate early stages of, an outbreak. Identification of a resident or staff member with ARI should be followed by prompt testing for a causative agent. While confirmation of infection is pending, immediate and appropriate infection control management of the person with ARI may prevent further spread of the disease. WACF will maintain a record of residents with ARI, including screened and positive for COVID-19.

Testing for COVID-19

Step 1: Isolate

- Provide resident with a mask, instruct them to wash their hands, and isolate them immediately if medical attention required. If a single room is not available, cohorting of pandemic positive patients may occur following risk assessment to ensure transmission is minimised.

Step 2: Assess/Manage

- Continue subsequent assessment and management of the resident with suspected pandemic illness in a single room. If the patient requires immediate medical intervention, this should be performed in the single room wherever possible.
- Collect Specimens as documented in the current COVID19 Testing Flowchart. (Appendix 5)

Step 3: Send Specimens

- The viral specimens should reach the laboratory within 8 hours of specimen collection.
- Specimens are to be labelled 'URGENT'
- For Wallsend Aged Care Facility, the designated pathology lab is PathNorth at John Hunter Hospital.
- Specimens are to be packaged and transported in accordance with the National Pathology Accreditation Advisory Council guidelines can be found at NPAAC Guidelines Packaging and transport of Specimens.

Notification

WACF must be prepared to provide the following information to the PHU using a line listing template:

- Information on the setup of the facility
- total number of residents and/or staff with fever and/or ARI
- date of onset of illness of each person
- symptoms of each person
- number of people admitted to hospital with fever and/or ARI (if applicable)
- number of people with influenza-like symptoms who have died
- total number of staff that work in the facility and in the affected area
- total number of residents in the facility and in the affected area
- whether appropriate respiratory specimens have been collected
- results of any respiratory specimens already tested

The PHU will advise and assist with the following:

- defining the outbreak setting
- confirming and declaring a COVID-19 outbreak
- arranging diagnostic testing for COVID-19 for all staff and residents in the outbreak
- ensuring that the facility notify other staff, residents and visitors where relevant, that cases of COVID-19 have occurred
- advising staff about enhanced implementation of infection control measures
- ensuring that staff who have worked at any other aged care facility or provided in home care in the last 14 days are identified by the facility
- collating information onto a line list
- ensuring staff form an outbreak management team
- identifying and informing relevant internal and external stakeholders
- isolating and treating people who test positive. Quarantining people who test negative and monitoring for illness
- where feasible, commencing a program of repeat tests for those who may be susceptible or incubating who are in quarantine
- identifying suitable sites where individuals may be cohorted together into either isolation of the sick OR quarantine of the exposed.

Unwell residents must be reviewed by their GP regardless of whether an outbreak is present or not. If a COVID-19 outbreak is present, all visiting GPs should be informed at the start of the outbreak. Refer to Appendix 2 for copy of GP letter.

If the resident requires transfer to another facility, including hospital, advise the hospital and transport provider in advance that the resident is being transferred from a facility where there is potential or confirmed COVID-19.

Declaring an Outbreak

A COVID-19 outbreak is defined as a single confirmed case of COVID-19 in a resident, staff member or frequent attendee of a RCF.

This definition does not include a single case in an infrequent visitor of the facility. A determination of whether someone is a frequent or infrequent visitor may be based on frequency of visits, time spent in the setting, and number of contacts within the setting

HNELHD PHU will assist WACF in deciding whether to declare an outbreak. Families are to be notified ASAP. Refer to Appendix 1 for copy of Families letter.

If any deaths occur during an outbreak, HNELHD must be notified within 24 hours. Hospitalisation of residents should be noted on the case list and sent to Population Health daily.

State/Territory Public Health Unit Contact Details

State	Contact Details
New South Wales	1300 066 055

High-risk settings – steps in investigation

There are several initial steps that public health unit staff need to take when responding to an outbreak of COVID-19 in high-risk settings. Further details for each step are provided below.

1. Define the setting.
2. Confirm and declare a COVID-19 outbreak with one confirmed case.
3. Identify those most at risk of severe disease.
4. Arrange diagnostic testing for COVID-19 for all members of the setting. If available, consider additional serological tests. If other members of the setting are symptomatic, test these individuals for other respiratory pathogens such as influenza as well as COVID-19.
5. Ensure that the facility managers have notified ALL staff, residents (where applicable) and visitors as relevant, that cases of COVID-19 have occurred in the setting.
6. Advise staff about enhanced implementation of infection control measures. Determine if staff have worked at any other aged care facility or provided in home care in the last 14 days.
7. Collate information onto a line list that describes people infected in terms of time, place and person.
8. In a residential facility, ensure the staff form an outbreak management team that meets within hours of the identification of a case. The team should not be part of day-to-day facility management.
9. Identify and inform relevant internal and external stakeholders.
10. Isolate and treat individuals who test positive. Quarantine, as best as possible, those individuals who test negative and monitor for illness – persons in this group are considered to be susceptible or incubating.
11. Where feasible, commence a program of repeat tests for those (who may be) susceptible or incubating who are in quarantine. This will identify those who are pre-symptomatic to enable rapid removal from the environment.
12. Identify suitable sites where individuals may be cohorted together into either: isolation of the sick OR quarantine the exposed.

Establish Outbreak Team

WACF is responsible for managing the outbreak and to take leadership role with support from the PHU. An outbreak management team (OMT) should be established to direct, monitor and oversee the outbreak. Refer to First 24 hours – managing COVID-19 in a residential aged care facility Residential aged care facilities should follow these steps in order, following the identification of a COVID-19 positive case.

Implementing Infection Prevention and Control Measures

Isolation and Cohorting

ICEG IPC guidelines state residents with **suspected or confirmed COVID-19 should be isolated and cared for in single rooms where possible**. When managing an isolated resident, the following applies:

- Residents should be isolated while they remain infectious (as determined by the PHU)
    - If residents must leave their room while infectious they should wear a surgical mask
- Staff in contact with ill residents should observe contact and droplet precautions
- Supplies of PPE should be available immediately outside the room.
- Special arrangements may be needed for care of residents with dementia who need to be isolated on a case-by-case basis.

If a single room is not available, the following principles can guide resident placement:

- Residents with the same virus[2] who are assessed as suitable roommates, can be cohorted together in the same room within a section of the facility.
- Ill residents sharing a room should be physically separated (more than 1.5 metre apart) with privacy curtain between them drawn to minimise the risk of droplet transmission.
- Staff in direct contact with ill residents should observe contact and droplet precautions
- Staff caring for residents who have COVID-19 should be cohorted as far as possible to avoid potential exposure of additional staff and residents.

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

- Any resident who has been in close contact with someone who has confirmed COVID-19 (another resident, staff member or visitor), in the 24 hours before the onset of symptoms, but remains well, should be quarantined in a single room for 14 days.
- They should be monitored for symptoms of COVID-19 (at least daily).

Once resident isolation or cohorting measures are in place, to further reduce the risk of transmission, it is preferable to allocate specific staff to the care of residents in isolation, and must ensure that staff members:

- do not move between their allocated room/ section and other areas of the facility, or care for other residents.
- self-monitor for signs and symptoms of acute respiratory illness and self-exclude from work if unwell.

Hand Hygiene

COVID-19 can be spread by contaminated hands, hence frequent hand hygiene is important. Hand hygiene refers to any action of hand cleansing, such as hand washing with soap and water or hand rubbing with an alcohol based hand rub. Alcohol based hand rubs are the gold standard for hand hygiene practice in healthcare settings when hands are not visibly soiled. However, if hands are visibly soiled or have had direct contact with body fluids they should be washed with liquid soap and running water then dried thoroughly with disposable paper towel. Refer to Appendix 6 for detailed information on hand hygiene.

Residents should wash their hands after toileting, after blowing their nose, before and after eating and when leaving their room. If the resident's cognitive state is impaired, staff caring for them must be responsible for helping residents with this activity. Visitors should be reminded to perform hand hygiene on entering and leaving the facility, and before and after visiting any resident. The use of gloves should never be considered an alternative to hand hygiene. Hand hygiene is required before putting on gloves and immediately after they have been removed.

Personal Protective Equipment (PPE)

Staff must wear appropriate PPE when caring for infected residents requiring contact and droplet or airborne precautions. A gown, eye protection, mask and gloves may be required depending on the level of precaution required. PPE requirements for caring with patients with suspected or confirmed COVID-19 are outlined in Appendix 7.

WACF staff must be trained and deemed competent in the proper use of PPE, including donning and doffing procedures. Refresher training is recommended for all existing staff, including non-clinical support staff, and as required for new staff. PPE should be removed in a manner that prevents contamination of the HCW's clothing, hands and the environment. Useful educational and promotional material for the proper use of PPE can be found at Appendix 8.

Environmental Cleaning and Disinfection

Regular, scheduled cleaning of all resident care areas is essential during an outbreak. Frequently touched surfaces are those closest to the resident, and should be cleaned more often. During a suspected or confirmed COVID-19 outbreak, an increase in the frequency of cleaning with a neutral detergent is recommended.

Environmental Services staff required to:

- observe contact and droplet precautions. Wear appropriate PPE, including impermeable disposable gloves and a surgical mask plus eye protection or a face shield while cleaning
- adhere to the cleaning product manufacturer's recommended dilution instructions and contact time use.

Refer to **COVID-19 HealthShare Response Plan 2020** for outbreak management procedures and processes. Detailed information on environmental cleaning and disinfection is available in the Commonwealth Department of Health factsheet – COVID-19 Environmental cleaning and disinfection principles for Health and Residential Care Facilities

Visitors and Communal Activities

During a COVID-19 outbreak, the movement of visitors into and within the facility will be restricted.

WACF will follow the Industry Code for Visiting Residential Aged Care Homes during COVID-19 regarding visitors to the facility while minimising the risk of spreading COVID-19
In line with the CDNA National Guidelines, WACF will:

- Suspend all group activities, particularly those that involve visitors (e.g. musicians).
- Postpone visits from non-essential external providers (e.g. Hairdressers and allied health professionals).
- Follow the 'Tiered Escalation' model to determine and continually assess the level of visitation to aged care residents and additional restrictions required to protect residents against the ongoing risk of COVID-19.

Ensure Ongoing Social Support

Staff are to monitor the effects of social isolation for residents on an ongoing basis. A change of focus for the Lifestyle & Leisure program will be required to ensure the needs of residents are being met, with the aim to ensure resident's social supports are maintained. Social interactions be supported with families and friends via alternate methods e.g. Facetime, Zoom etc.

Re-admissions of confirmed cases

The re-admission of residents who met the case definition and have been hospitalised for their illness is permitted, provided appropriate accommodation and infection prevention and control requirements can be met.

Re-admission of non-cases

The re-admission of residents that have not been on the COVID-19 outbreak case lists (i.e. they are not a known case) should be avoided during the outbreak period if possible. If non-cases are re-admitted, the resident and their family must be informed about the current outbreak and adequate outbreak control measures must be in place. Families may wish to make alternative arrangements (e.g. family care) until the outbreak is over.

Transfers

If transfer to hospital is required, the ambulance service and receiving hospital must be notified of the outbreak/suspected outbreak verbally and through using the HNE Transport Form.

Unaffected residents

In some circumstances, it may be feasible to transfer residents who are not symptomatic, to other settings (e.g. family care) for the duration of the outbreak. The family or receiving facility should be made aware that the resident may have been exposed and is at risk of developing disease. They should be provided with information regarding the symptoms of COVID-19 and the use of appropriate personal protective measures.

Note: In Residential Aged Care settings, security of tenure provisions of the Aged Care Act 1997 will need to be considered.

Management of the deceased resident

- Confirmation with family of preferred documented funeral provider
- Communication with family (identified role for communications team member)
- Supply of body bags maintained on each unit
- Staff handling deceased body to wear PPE gown, gloves, mask, eyewear
- Avoid unnecessary manipulation of the body that may expel air or fluid from the lungs
- On contacting funeral directors, staff to advise body is COVID-19 positive
- Deceased body to be placed in 2 body bags with Infection Control sticker on bag, stating ‘COVID-19 – Handle with care’
- Family viewing of the deceased to take place at the funeral director’s facility
- Planning around returning of belongings to family
- Terminal clean to be attended of the room

Declare Outbreak Over

In most circumstances, a COVID-19 outbreak can be declared over if no new cases occur within 14 days (maximum incubation period) following the date of isolation of the last case. The Outbreak Management team should declare the outbreak over in consultation with the PHU. Once the outbreak is over, provide reports of the relevant stakeholders and ensure that data is appropriately summarised.

Reviewing Outbreak Management

Following a declaration that an outbreak is over in consultation with the PHU, it is important for all parties to reflect on what worked well during the outbreak and which policies, practices or procedures need to be modified to improve responses for future outbreaks. A debrief provides the opportunity to identify strengths and weaknesses in outbreak response and investigation processes, and provide information to help improve the management of similar outbreaks in the future.

Key Contact Details

WACF Command Centre – Outbreak Management Team

Virginia Tideswell	Director of Nursing	0428 727 250
Melina Psychas	Deputy Director of Nursing	0477 341 156
Scott Gregory	Nursing Unit Manager	0458 494 875
Mark Scott	Nursing Unit Manager	0423 057 340
Sheena Biju	Nursing Unit Manager/ IPC Lead	0405 194 978
Anne Hardwick	Educator	0412 928 727
Jemma Alex	HealthShare Manager	0428 272 972
Jodie Thomas	Admin Officer	0403 296 347

Key Reporting Contacts

NSW Public Health Unit	1300 066 055
Department of Health	agedcarecovidcases@health.gov.au
NSW Ministry of Health	1800 852 649

Key Local Contacts

Louise Lazic	CACS GNS General Manager	0437 361 485
Elizabeth Grist	HNEHealth HSFAC Coordinator	492 13000 (request HSFAC)
John Hunter Hospital	Main Switch	492 13000
Calvary Mater Hospital	Main Switch	492 11211
Dr John Ferguson Director	Infection Prevention Service (IPS)	0428 885 573
Jeff Deane, Nurse Manger	Infection Prevention Service (IPS)	0423 296 486
IPS On-Call Service	Infection Prevention Service (IPS)	0477 339 193
Terry White Chemmart	Pharmacy provider	4932 5155
Eric Huber	Facility Management	0408 680 726
JHH Pharmacy	HNEHealth	498 53152
Human Resources	HNEHealth	498 53152
Douglas Hanley Moir	Pathology	1800 570 573
Pathology North	HNEHealth	Ext 42550 Fax 42560
Air Liquide	O2 Supplier	1300 360 202
ACE Service	Hunter Primary Care	1300 223 555
Patient Transport	HNEHealth	1300 233 500
Ambulance Transport	NSW Ambulance	131233
Communications Unit	HNEHealth	498 55522
Interpreter Service	HNEHealth	492 46285

WACF Visiting GPs

Dr Miriam Paquet	General Practitioner	0425 840 966
Dr Praful Patel	General Practitioner	0421 506 633
Dr Herath Palipana	General Practitioner	0435 327 953
Dr Indrika Palipana	General Practitioner	0435 326 753
Dr Shahul Mujahid	General Practitioner	4967 6755
Dr Shahid Sarki	General Practitioner	0435 198 458
Dr Andrew Pratt	General Practitioner (does not visit)	4961 3017

Staffing

AllStaff Nursing Agency	Nursing Agency	4964 5555
North Shore Nurses	Nursing Agency	9009 5120
Triple CN Agency	Nursing Agency	0413 446 912
Nurses at Call	Nursing Agency	0426 984 071

First 24 Hours - Managing Covid-19 in a Residential Aged Care Facility Outbreak Management Plan

Outbreak Management Team Roles

Incident Controller	Director of Nursing
Planning	Deputy Director of Nursing
➢ **Communications**	Admin Officer
➢ **Education**	Educator
Operations	Buchanan NUM
Logistics	Firkin NUM & Health Share Manager
Establish Outbreak Unit	Henry NUM

Refer to Red folder- 'WACF Outbreak Management' for all information, copies of forms/templates and USB stick (kept in DDON office)
Refer to Department of Health Resource Tool – **First 24 hours – managing COVID-19 in a residential aged care facility**

Timeframe	Tasks	Responsibility
First 30 minutes	Identify confirmed, probable or suspected case/s **Inform and isolate the COVID-19 positive case(s)**	**NUM of unit** or RN IC if after hrs
	COVID-19 positive person is a staff member • They must apply a surgical mask, leave the premises immediately • Advise positive staff member they must isolate at home as directed by the Public Health Unit • Advise positive staff member they are unable to work until cleared to do so by the PHU	**NUM of unit** or RN IC if after hrs

	If the COVID-19 positive case is a resident, RACFs must:
	• Inform resident of their diagnosis
	• Immediately isolate the resident in a single room with an ensuite, if possible
	• Discuss other accommodation options with the resident e.g. hospital transfer if it:
	  ○ is required for clinical care; or
	  ○ as per local public health requirements
		NUM of unit or RN IC if after hrs

	Following identification of a suspected or positive case
	• Use personal protective equipment (PPE) when interacting with any residents until confirmation of initial test results
	• Place all of the following outside all affected residents' rooms –
	  ○ contact and droplet precaution signs (Red Folder Section 7)
	  ○ signs to avoid aerosol generating procedures
	  ○ alcohol-based hand sanitiser
	  ○ appropriate PPE and hands-free bins for use inside and outside rooms
	  ○ PPE supplies- gloves, surgical masks, long-sleeved impermeable gowns, eye/face protection)
		NUM of unit or RN IC if after hrs

Timeframe	Tasks	Responsibility
	Check resident identification accessible/correct • Wristbands • Current photographs on file	**NUM of unit** or RN IC if after hrs
	Contact local Public Health Unit 1300 066 055 Provide following information: • Current situation • Listings of all staff and residents (Red Folder: Section 3) • Facility floor plans (Red Folder: Section 4)	**Incident Controller/DON**
	Notify the Commonwealth Department of Health at agedcareCOVIDcases@health.gov.au of any resident or staff COVID-19 cases **Notify CACS General Manager** who will notify HSFAC Coordinator	**Incident Controller/DON**
	Lockdown the facility • Display outbreak signage at entrances to facility (Red Folder: Section 7)	**Incident Controller/DON** in consultation with PHU
	Review the visitor log to determine who is on site • Evacuate non-essential people from the residential aged care facility.	**Operations/** NUM 1
	Inform residents of the reason for the lockdown and that the facility • Ask all residents to remain in their rooms. • Avoid resident movements, consult the PHU prior to a transfer	**Incident Controller/DON**
	Reinforce standard precautions • Hand hygiene • Cough etiquette • PPE donning and doffing protocols • Staying 1.5m away from other people	**Operations/** NUM 1
Minutes 30-60	**Activate outbreak management plan**	**Incident Controller/DON**
	Convene outbreak management team to meet within hours • Notify and distribute OMP to all stakeholders • Establish 'Command Centre'- Conference Room • Set up white board with residents names, COVID status – Neg, waiting for result, positive, current location, if transferred to acute sector (name of ward), and unit maps (Red Folder: Section 5 and 7) • Set up daily briefing sessions for outbreak management team (Red Folder: Section 5)	**Planning/DDON** **Communications/Admin**

	• **On confirmation of a COVID-19 diagnosis,** inform
	  ○ Residents on other units
	  ○ Staff not currently on site
	  ○ Primary family contacts
		Planning/DDON

Timeframe	Tasks	Responsibility
	○ Other key stakeholders – GPs, Maintenance, Allied Health, NDIS workers, volunteer • Inform staff that they should not work at any other facility during the outbreak	
Hours 2-3	**Contact tracing and monitoring of residents to begin** • The local PHU will lead contact tracing • Follow up on record keeping of visitors to site, staff rosters etc	**PHU** **Operations/NUM**
	Increase monitoring of all residents for any symptoms of COVID-19 • Take clinical observations day • Obs to be taken as indicated by GP e.g. TDS • Environmental controls for COVID-19 residents ○ Air conditioning restriction ○ Aerosolised therapy restrictions e.g. CPAP, Nebulisers	**NUM of unit**
	Prepare key documents for PHU & Commonwealth • Detailed floor plan - confirm location of positive cases • Up-to-date list of residents	**Incident Controller/DON**
	Commence Line Listing sheet of residents with COVID like symptoms, and includes • Onset date • Testing status • Location within the facility • Whether the residents have had contact with confirmed case and/or staff contacts • Residents with higher risk profiles highlighted (wandering, behaviours of concerns, aerosol generating behaviours, requiring clinical interventions e.g. Nebuliser) • List of the respiratory specimens collected and the results of any recent tests or investigations	**Operations/NUM-** overall collection of data **NUM of unit -** for compiling of line list on unit
	Review list of all staff employed by the facility Including people providing primary care or allied health services List includes- • Full names, contact details, dates of birth • Review of staff roster for period of infectivity • Determine shifts worked during period of infectivity (48 hours prior to onset of symptoms) Signs and symptoms and date of onset • Possible source of transmission • Number of residents cared for during the period - names collected **Staff who work across multiple facilities** • Refer to list of staff who have self-declared secondary employment • Determine if there is a transmission risk if staff work across multiple facilities or has secondary employment	**PHU** **Operations/NUM**

Timeframe	Tasks	Responsibility
	Visitors • QR Code and paper based Register –names, contact details, date/time and who they visited. Master Register in **WACF Drive / Common / COVID**	
	PPE Stocktake • Check PPE and hand sanitiser stock levels • Estimate stock required for a fortnight • Ensure access to adequate supply of hand soap, paper towels Access to National Medical Stockpile https://consultations.health.gov.au/health-grants-and-network/18d6cd12.	**Logistics/NUM** **HealthShare**
	Communication • Contact Strategic Communications unit re media response plan • Inform all staff currently off-site of outbreak • Establish single point of contact- Admin Officer • Access to an Interpreter Service 4924 6285 • Establish Acute Sector contact list for any residents transferred to hospital • Email templates of letter to families in Red Folder: Section 5	**Planning** **Communications**
Hours 4-6	**Establish first meeting of the PHU Outbreak Management Team** (To be held daily)	**Incident Controller/DON**
	Planning re Staffing and Rosters • Review current rosters • Determine the estimated number of staff that may be unable to work • Confirm staff who will continue to work in an outbreak setting • Implement workforce mitigation arrangements, i.e. contacting workforce suppliers, and/or moving to an adjusted roster (12 hour shifts) • Assess need for higher proportion of clinically experienced staff including Registered Nurses during outbreak • Review for 24 hour coverage of staff with required skill sets • Review orientation process for any surge workforce and ensure there is a clinical handover of all residents' assessed care plan • Review access for temp staff e.g. keys, policies and procedures.	**Logistics/NUM** **Planning/ Educator**
	Conduct Testing • In collaboration with the PHU, urgently arrange COVID-19 testing for all residents and staff • Ensure staff request that all samples for COVID-19 testing from both residents and staff are marked ***"Urgent – Aged Care Facility" or "Urgent – Health Care Worker"***	**PHU** **Operations/NUM**

Timeframe	Tasks	Responsibility

	Clinical management of COVID-positive resident cases
	• Assess each COVID-19 positive resident to determine whether the resident's condition warrants a transfer to hospital – in consultation with the resident, their carer and GP
	• If requirement to transfer resident quickly
	  ○ Bag packed
	  ○ Medications available
	  ○ Medical documents accessible
	• Facilitate GP and relevant visits for unwell residents
	• Inform all visiting GPs and allied health workers, other visitors of COVID-19 status prior to attending the facility
		NUM of unit

Hours 6-12	**Cohorting / zoning and relocation**
	• Floor plans available with occupied beds and set up of COVID specific unit with designated red/amber and green zones identified. A3 size plans on white board in WACF Conference Room with magnetic resident names/per room in place
	• Establish designated COVID-19 isolation unit- Henry Unit
	  ○ Temporary move of residents to other units during pandemic, with resident/family notification. Template letter in Red Folder Section 5
	
	• **Allocation of COVID-19 residents or Positive or awaiting results**
	  ○ Red zone set up for COVID-19+ residents
	  ○ Amber zone set up for residents waiting for results
	  ○ Only cohort with other COVID-19 patients if no single room available.
	  ○ In cohort area, draw the curtain between adjacent occupied beds to the bed-end
	  ○ Ensure a minimum of one metre of resident separation when cohorting patients
	  ○ Donning and Doffing stations set up
	  ○ Allocate bathrooms near lift for staff to change
	  ○ Allocate equipment e.g. commode to be utilised only by COVID-19 positive residents
	
	• Liaise with PHU on residents who attend outpatient regular services
	  ○ Dialysis
	  ○ ECT
	• Allocate designated staff member/s to provide resident care on unit
	• Restrict number of staff entering unit during this period
	• Shared items must undergo a sufficient cleaning processes between residents
	  ○ Red and Green Clinell wipes available
		NUM of unit

Timeframe	Tasks	Responsibility
	Workforce • Increase staff numbers for the positive, suspected positive zones and close contacts zone to account for time required to don and doff PPE • Ensure staff work in a single zone and do not cross into other zones • Establish separate staff break areas in each zones to ensure staff do not cross into another zone to take breaks	**NUM of unit**

	• Establish separate PPE storage and waste removal areas in each zone to reduce PPE contamination
	• Provide cleaning (detergent/disinfectant wipes) available for cleaning of shared equipment
	  ○ Oxygen supply
	  ○ Emergency supplies of urgent Pharmacy medication
	  ○ Infusion pumps
	  ○ Blood pressure machines
	  ○ Pulse oximeters
	  ○ Thermometers
		Logistics/NUM
		HealthShare

	Move to a command-based governance structure
	• Communicate the command and governance structure, including who is in charge for every shift
	• All staff to be aware of who will be in charge, at all points in time, at the facility.
	• Communicate each shift
	  ○ Everyone's roles and responsibilities
	  ○ What to do if there is a problem
	  ○ What the escalation processes are.
	• Ensure thorough briefing and orientation of new staff each shift, including infection prevention and control education, and PPE usage
	• Ensure handovers for all staff at the start of a new shift including clinical and care needs
		Planning
		Communications

	Rapid PPE supply • Staff need to know how to identify clinical waste and how and where to dispose of it safely • Review of clinical waste removal due to increased usage	**Logistics/HealthShare**
	Infection control • Implement transmission-based precautions immediately • The nominated infection control lead must ensure infection control processes and practices are in place. • Conduct checks of correct donning and doffing of PPE and disposal of used stock. • Clinical staff must have had P92 fit testing completed and be aware of the recommended P92 mask. Staff List in Red Folder Section 10 • Reinforce/re-educate standard precautions throughout facility immediately • Designate one lift for COVID use only, with signs in Red Folder Section 7	**Operations/IPC Lead** **Logistics/HealthShare**

Timeframe	Tasks	Responsibility

	• Review the systems and processes to minimise risk of material, surfaces or equipment moving between areas
	  ○ ensuring there is sufficient medical equipment
	  ○ Allocate individual thermometer for each resident
	  ○ no entertainment materials, i.e. books, puzzles, toys, computers, phones, etc, moving between zones in the facility. If sharing between zones necessary appropriate decontamination and cleaning practices need to be implemented
	• Review laundry arrangements
	• Review environmental cleaning processes
	  ○ Refer to HealthShare COVID-19 Response Plan (Page 29)	

Hours 12-24	**Clinical First Responder assessment** • Liaise with Commonwealth Clinical First Responder • Advise Commonwealth case manager of potential need to facilitate access to a temporary surge workforce	**Incident Controller/DON**
	Review advance care directives • Clinical staff should familiarise themselves with any positive residents' advance care directives	**NUM of unit**

	Establish strong induction and control processes
	• Determine who will be the on-the-ground infection control lead. Identify this role on the roster for each shift.
	• The responsible person must ensure:
	  ○ Screening processes are reviewed and any required changes implemented
	  ○ Robust induction process for all new agency and surge workforce staff coming onsite
	  ○ All staff working are competent using PPE
	  ○ Infection prevention and control practices are maintained i.e. Hand hygiene, correct donning and doffing and physical distancing
	  ○ Consider having workforce competency reviews for all staff.
		Operations/IPC Lead

	Maintaining social contact • Implement social contact procedures • Where possible, IT equipment should be assigned to a single resident's room. Clean and decontaminate shared IT equipment after each use. • Ensure IT support contact information is readily available to staff • Review extra staff to assist residents with communications/use of technology	**Planning** **Communications**
	Follow up communications • Establish and maintain a clear and consistent pattern of daily communication for residents, families, staff and other stake holders	**Planning** **Communications**

Timeframe	Tasks	Responsibility
	Continue primary health care • Ensure there is strong ongoing maintenance of "routine" care • Review to maintain and monitor normal activities and limit deconditioning. Suspend non-essential group activities e.g. excursions, concerts, art and craft activities • Ensure residents have adequate supply of medication and an up-to-date clinical summary and plan.	**Logistics/NUM**
	Support staff • Closely monitor the health of staff via screening • Continue to exclude symptomatic staff until test results available • Start establishing fatigue management plans • Ensure Employee Assistance Program (EAP) information is readily available • Establish pathways to maintain contact with staff who are isolating or quarantining • Consider implementing a "buddy" system for peer support during the outbreak period	**Planning/ Educator**

Other Priorities	Tasks	Responsibility

Workforce	• Clarify GPs capacity for clinical care in an outbreak
	• COVID-19 HNE Care at Home RN to provide telephone monitoring of RACF COVID-19 residents 0428 112 384.
	• COVID-19 Care at Home Advanced Trainee to link with general practitioner 0428 112 384
	• Plan for management presence on site 24/7
	• Review staffing requirements
	  ○ MA and Physio- assist with meals, continence care and PI management
	  ○ AOs- assist with meals, maintain communication between residents and families
	  ○ Admin Officers- Communications
	• Plan for potential workforce needs with HNE Workforce, and other staffing agencies (Red Folder: Section 10)
	• Vulnerable Persons identified and plan in place re leave options- Resident COVID-19 Outing Risk Ax to be utilised (Red Folder: Section 6)
	• Clinical Handover conducted each shift
	• Include Safety Huddle with staff at commencement of each shift (Red Folder: Section 5)
	  ○ Clarify roles and responsibilities
	  ○ Confirm communication process
	  ○ Update on residents care needs
	  ○ Update on screening results for the day
	• In event of surge workforce, allocation of lead to conduct orientation each shift (Red Folder: Section 10)
	• Provide orientation for surge workforce (see Orientation checklist), including "just in time training" and competency in:
		Operations/NUM
		Planning/ Educator

	○ PPE ○ Infusion pumps ○ Oxygen ○ Resident care plans ○ End of life • Clinical handover of resident care needs to surge staff. • Surge Workforce to access Evacuation folder (red folder held on each unit). This folder contains ID photo, relevant 2 page information regarding the resident, their care needs with pictorial care plan • Clear workforce procedures to activate of a surge workforce in event of outbreak ○ Staff contingency plan process for staff sick leave ○ Maintain current contact list for casual staff ○ Access to HNE Health rapid recruitment of university nursing students for additional staff ○ Utilise external nursing agencies ○ Access to MoH Residential Aged Care Rapid Response team and resources ○ Leave requests review for the next six months ○ Liaise with GM re community based service support • Ensuring staff are adequately trained and competent in all aspects of outbreak management • Staff Education/training on ○ Infection Control ○ Donning & Doffing ○ Hand Hygiene ○ PPE • Promote mental health & wellbeing awareness to staff ○ Support services e.g. Hunter Primary Health Care Staff self-care handout EAP resources	
Medication Mgt	• Liaison with Amcal Pharmacist re potential increase requirements for Midazolam, Morphine and Hyoscine (in GP consultation) • Pall Care Stat box in place and stock maintained • GPs to chart EOL medications via phone order and attend within 12 hrs to document order • Avoid use of nebulisers and CPAP for COVID-19 residents • GPs to chart EOL medications via phone order and attend within 12 hrs to document order • Oxygen ○ Air Liquide will supply additional 0^2 cylinders and regulators as required ○ Deliver to site x2 week on designated days ○ Maintain current 0^2 stock levels • Niki pumps ○ 3 pumps available in facility for use ○ Additional butterfly needles ordered	**Logistics/NUM**
Education	**Ensure staff competent in** • Infection prevention and control, including PPE. • Recognising signs and symptoms of COVID-19. • Using infusion pumps. • Giving oxygen	**Planning/ Educator**

	• End of life care	
Exit strategy	**Exit strategy for the outbreak – declare the outbreak over** • Easing of protocols • Transition back to usual operations	**PHU** **Incident Controller/DON**
End of Outbreak	**Communication at the completion of the outbreak** • Communicate with staff face to face and/or via phone calls • Communicate with residents face to face. Ensure residents are aware of supports available to them, and encourage feedback. • Communicate via family preferred method e.g. phone, email as per Representative list • Plan for residents who have gone to stay with family during outbreak to return to facility **Debriefing with staff post outbreak** • Ensure staff are aware of mental health and any other, supports available to them. • Encourage staff to provide feedback on experience **Ongoing Planning** • Ongoing surveillance for relevant illnesses • Ongoing IC processes and practices, e.g. education for donning and doffing	**Incident Controller/DON**

WACF COVID-19 Potential Risks Identification & Planned Actions

Potential transmission of COVID-19 within WACF

- Development and implementation of WACF Pandemic Response Plan (Red Folder: Section 2)
- Refer to Department of Health Resource Tool - First 24 hours – managing COVID-19 in a residential aged care facility (Red Folder: Section 1) in event of COVID-19 outbreak
- Follow MoH advice re transmission risk e.g. Amber Alert (moderate transmission)
- Restrictions on access into the facility- lockdown of site during pandemic, follow MoH advice
- Screening procedures in place for anyone accessing the site
- Annual Flu Vaccination program for residents and staff, visitors
- COVID-19 Vaccination program roll out for residents and staff
- Vaccination records maintained for compliance

Reduced access to resources & equipment during Pandemic

- Report to CACS GNS Logistics Coordinator re stock levels
- Use disposable equipment or dedicated equipment in event of outbreak, if unable then utilise appropriate cleaning of equipment e.g. Clinell
- Respiratory kits available on each unit for use
- HNEHealth District Procurement Service overseeing the coordination of resources e.g. PPE
- Pandemic stock kept in secure cupboards (located in ground floor link-way, opposite pad trolleys). Key kept in Red folder with green key ring. Spare set of keys are kept in Educators office desk drawer

Clinical Care consideration

- Implementation of COVID -19 Care plans
  - Infection Control care Plan (Red Folder: Section 8)
  - COVID-19 Symptom Mgt Care Plan (Red Folder: Section 8)
- GP engagement/communication during outbreak
- Notify Acute Sector and Transport prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19; or transferring to a higher level of care
  - In event time limited- send copy of Resident Evacuation form with resident with MOLST

Communication & Information

- Staff update their personal information on StaffLink
- Phone lists and email contacts for resident's families updated and spreadsheet maintained
- Ongoing regular updates for residents and families via
  - Information/Update flyers, Face time, Zoom, phone, email, mail out
  - DON/incident Controller to complete in event of outbreak (Red Folder: Section 5)
  - COVID-19 Critical Incident brief for the Exec in the event of an exposure or outbreak
  - HSFAC Incident Review for COVID-19 in a Residential Aged Care facility in HNELHD

Catering and cleaning service provision

- Ensure staff are competent with donning and doffing PPE including masks
- Minimise equipment and items in the resident rooms
- Refer to COVID-19 HealthShare Action Plan 2020 for additional information (Red Folder: Section 1)

NSW HealthShare

ACTION DESCRIPTIONS	PERSON RESPONSIBLE	RESOURCES AVAILABLE	OUTCOME
Training and Education **Check identified staff have completed training:** - **SWP training** - **Hand hygiene** - **Donning & Doffing** - **PPE use** - **Environmental Cleaning** - **IP&C**	- HS Site Supervisor	- My Health Learning - Training records - Business Processes / SWP's	- All HS staff fully compliant to access Hot Unit Area.
Vaccination - **All relevant vaccinations are complete**	- HS Site Supervisor	- Staff Health	- All HS staff accessing Hot Unit are fully compliant
Staffing - **Staff allocated to Hot Unit must be compliant to above** - **Staff welfare check to occur each morning** - **Staff rostering**	- HS Site Supervisor	- Draft standalone roster	- Staff allocated to Hot Unit are the only staff accessing and entering Hot Unit. - Staff must be briefed about processes and workflow (provision of all services in Hot Unit) - Staff welfare check to be conducted each shift prior to entering Hot Unit - Staff rostering will rotate weekly/fortnightly
Cleaning - **Staff to be allocated to Hot Unit daily on rotational roster (roster to be set separately) as per requirements** - **Infectious trolley allocated to Hot Unit** - **Required consumables provided daily or as needed**	- HS Site Supervisor	- Standalone infectious trolley - Sanitiser wipes for sanitising trolleys - Donning & Doffing stations located at set locations on unit - PPE stations located outside COVID-19 rooms	- Staffing will provide full service within Hot Unit (cleaning, food service, waste collection, stores) - Staff to clean within IP&C processes. - One lift will be designated as COVID only lift for staff to use. - Services will be delivered to entrance of the Hot Unit and placed in designated clean area outside of lift (meal service, linen, stores). Hot Unit HS staff will retrieve and distribute as required. - Soiled / dirty equipment and trolleys will be removed from Hot Unit and placed in designated dirty area outside of lift for immediate collection. - Linen to be placed in plastic bag with alginate bag. Plastic bags to be placed over soiled linen trolleys for collection.

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- **Relevant PPE as per IP&C guidelines**			- Waste to be placed in sealed waste bag, double bagged for placement in a dedicated sulo bin. - All food service operations will be completed by HS staff within the Hot Unit – tray delivery, collection and meals) - Consumables are to be rung through to the HS supervisor when required for ordering and picking and delivery to Unit.
Food Service - **Plated meal service to continue and service on trays.** - **List of meal made up on the unit** - **PPM provide to staff in Hot Unit** - **Collection of Meal Service**	- HS Site Supervisor	- Mid meal trolley based in Unit.	- All meals to be plated as standard plating service - Mid meal delivered with meal services on either patient trays or separate tray. - Selection of PPM to be provided for staff within the Hot Unit. - Meal trolleys to be delivered to the Hot Unit for collection at lift by HS Hot Unit staff. - Resident menu selection taken by HS Hot Unit staff will be telephoned through to HS Supervisor. - When meal service is collected trolley is to be left in designated dirty area to be collected and returned to the kitchen and put through the ware washing process (last trolley to be washed up) - Availability of disposable plates/cutlery in event of staffing/resources shortages
Stores - **Stores delivery Clinical and non-clinical**	- HS Site Supervisor	- Dedicated Stores trolley	- Dedicated stores trolleys to be used to take stores to Hot Unit. - Trolley to be placed in the designated clean area at lift for the HS Hot Unit staff to collect. - HS Hot Unit staff will decant and pack stores away within Unit, exiting the Hot Unit HS staff will sanitise the trolley and park in the designated dirty area for collection. - Stores orders can be processed as normal
Linen Services - **Clean linen** - **Soiled Linen**	- HS Site Supervisor	-	- Clean linen will be delivered to the Hot Unit and parked in the designated clean area outside the lift– HS Hot Unit staff will collect clean linen and restock the Hot Unit linen supply. - Soiled Linen will be removed from the Hot Unit by the HS staff and placed in the designated dirty area (soiled linen trolley will be covered by plastic linen covering)

			- Clothing will double washed in designated washing machine
Waste **Collection of:** - **Clinical Waste,** - **Sharps** - **General Waste** - **Cardboard**	- HS Site Supervisor	-	- Waste bins (general and clinical bins) are to be placed in the designated dirty area for immediate collection - Sharps containers will be collected using the same processes and replaced when bin replacements are provided. - Cardboard collected using the same processes as above and replaced - No other waste streams (apart from specific clinical streams) will be segregated from COVID Unit to reduce contamination. PPEs used for Covid19 will be treated as general waste and not to be segregated - Foot pedal bins are NOT to be in use on COVID unit due to risk of aerosolisation by force when using foot pedal
Terminal cleaning of rooms	- HS Site Supervisor		- Cleaning should be followed by, or combined with, a disinfectant process (2-in-1 step clean below). - Reusable cleaning equipment must be bagged and sent for laundering after each cleaning activity (e.g. after cleaning each resident's room or shared communal area). Metal items (e.g. mop handles), must be disinfected after each use. - Wear PPE – surgical mask, protective eyewear, gloves and gown. - Bed privacy curtains, and window curtains (if fitted), are to be removed and sent for laundering, or disposed of if disposable versions. - Clean/disinfect all surfaces, furniture (including all surfaces of the bed and mattress) and fittings. - 2-in-1 clean using a combined detergent and TGA-listed hospital-grade disinfectant with activity against viruses (according to label/product information) or a chlorine-based product such as sodium hypochlorite, i.e. a combined detergent/disinfectant wipe or solution.
WH&S - **Staff welfare checks** **Anxiety** **Symptoms** **Mental Health**	- HS Site Supervisor	-	- Daily staff welfare check prior to shift commencement: Checking on mental health / anxiety Symptoms and fatigue - Staff allocation will group allocated staff together and rotate selected staff within roster.

- **Staff allocation / roster rotation** - **Limited staff access to Hot Unit**			- Only allocated staff to HS Hot Unit will be entering the Hot Unit all other services will provide services to external entry of the Hot Unit.
	ADDITIONAL NOTES		
	- HS Hot unit staff will be allocated after discussions with staff - All services from HealthShare (Food Service, Linen, Stores, Waste) will be provided to entry point of the Hot unit only - Documentation of all services and rosters will be maintained centrally at HS Office - Weekly review of service provisions to Hot unit will be conducted each Friday - Documentation of all resource for Hot unit will be documented centrally at HS Office		

Response Plan adapted from Maitland Hospital HealthShare COVID-19 Response Plan

Appendix 1: Letter to Families –Outbreak of COVID-19

COVID-19 outbreak at Wallsend Aged Care Facility

Dear residents, relatives and friends,

A resident who resides at Wallsend Aged Care Facility has tested positive to COVID-19.

While all types of respiratory viruses can cause sickness in the elderly, COVID-19 is a particularly contagious infection that can cause severe illness and death for vulnerable people.

The following actions have been taken in response to this confirmed case of COVID-19.

- The WACF COVID-19 Pandemic Plan has been implemented
- Within the plan Henry unit has been identified as the COVID- 19 unit with a red zone for COVID-19 positive residents and an Amber zone for those displaying symptoms waiting for results of testing
- Identified pathology service with a COVID-19 collection team has been contacted and will be testing all residents and staff for COVID-19
- Henry Unit has been activated as COVID-19 unit which means that all residents within this unit have been transferred to one of the other units during the outbreak and impacted families have been notified
- The resident with confirmed COVID-19 has been isolated in this unit and family have been notified
- The NSW Ministry of Health have been notified and a COVID-19 Outbreak has been declared
- WACF will work closely with Hunter New England Local Health District (HNEHealth), NSW Ministry of Health as well as the Commonwealth Department of Health, to minimise the spread of infection
- Staff caring for the affected resident will take additional precautions and wear a mask, eyewear, gown and gloves at all times
- The local Public Health Unit are conducting contact tracing to identify all staff, residents and visitors who would have had recent contact with this resident
- All staff, residents and visitors who are identified as having recent contact with this resident will be tested for COVID-19
- Anyone identified as having had close contact with someone diagnosed with COVID-19 must quarantine for 14 days after last contact with this person.
- All staff suspected to have COVID-19 will be excluded from work until cleared by the Public Health Unit
- All residents suspected to have COVID-19 will be moved to the COVID unit waiting results in the Amber zone until cleared by the Public Health Unit
- All visitors suspected to have COVID-19 will be instructed to call the Coronavirus hotline on 1800 020 080
- Surveillance for further cases of COVID-19 continues, including increasing our current practice of daily vital sign observations on residents to twice a day
- Increased cleaning includes twice daily touch point cleaning for frequently used surfaces such as handrails and door knobs
- All group Lifestyle group activities have been suspended
- All visitors restricted from entering the facility including non-essential staff

WACF is committed to keeping the safety and wellbeing of our residents and staff as the focus of our decisions and we appreciate your assistance and support.

We will keep you informed on the progress of the outbreak and notify you when there are updates to the restriction of visitors.

If you have any queries or concerns please contact WACF Administration 4924 6320. We ask that you contact this central number rather than contact the units due to the demand on staffing and resources during this time. We will be utilising our Activity Officers to assist with maintaining communications with families.

Should you require further information regarding COVID-19, please refer to the NSWHealth COVID Update website.

Appendix 2: Letter to GPs – COVID-19 Outbreak

COVID-19 Outbreak at Wallsend Aged Care Facility

Dear Doctor,

There is an outbreak of acute respiratory illness affecting residents at the Wallsend Aged Care Facility. The outbreak may involve some of your patients who may require review.

It is important to establish if the outbreak is caused by **SARS-CoV-2**. Coronavirus Disease 2019 (COVID-19), caused by SARS-CoV-2, is a notifiable condition.

We recommend that you:

- Establish if any of your patients are affected
- Help determine if the outbreak is caused by SARS-CoV-2:
  - Obtain/order appropriate respiratory samples from residents who meet the case definition, for respiratory PCR testing.
- Ensure that your patients are vaccinated against influenza, if there are no contraindications
- Ensure that you observe hand hygiene procedures and use appropriate PPE when visiting your patients.

Limit the use of antibiotics to patients with evidence of bacterial superinfection, which is uncommon. There is significant evidence that antibiotics are over-prescribed during the institutional respiratory illness outbreaks.

Control measures that the facility has been directed to implement include:

- Isolation of symptomatic residents
- Use of appropriate PPE when providing care to ill residents
- Exclusion of symptomatic staff from the facility
- Restriction/limitation of visitors to the facility until the outbreak has resolved
- Promotion of thorough hand washing and cough and sneeze etiquette.

Should you require further information regarding COVID-19, please refer to the Commonwealth Department of Health website:
https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert

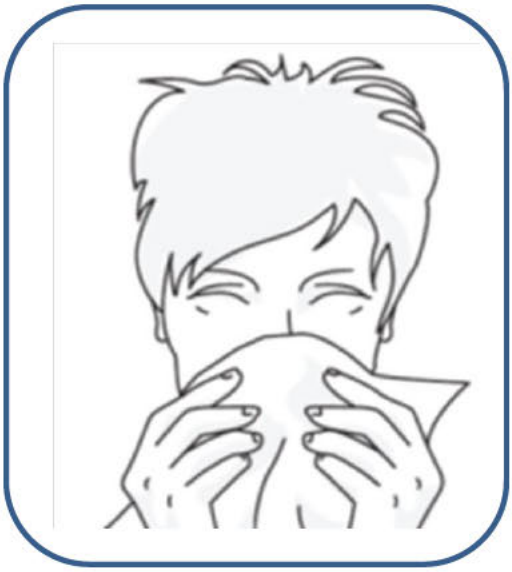
If you require any further information or advice please contact 492 46320

Yours sincerely,

Virginia Tideswell]
Director of Nursing
Wallsend Aged Care Facility

Appendix 3: Cough and Sneeze Etiquette

Cough and Sneeze Etiquette



- When coughing or sneezing, use a tissue to cover your nose and mouth
- Dispose of the tissue afterwards
- If you don't have a tissue, cough or sneeze into your elbow

- After coughing, sneezing or blowing your nose, wash your hands with soap and water
- Use an alcohol-based hand cleanser if you do not have access to soap and water

Remember:

Hand hygiene is the single most effective way to reduce the spread of germs that cause respiratory disease!

Anyone with signs and symptoms of respiratory infection:

- should be instructed to cover their nose/mouth when coughing or sneezing;
- use tissues to contain respiratory secretions;
- dispose of tissues in the nearest waste receptacle after use; and

Appendix 4 Aerosol Generating Procedure – Safety Alert

NSW Health
Hunter New England
Local Health District

Internal Safety Alert 002/2020

19th March 2020

Distributed to;
- General Managers
- Health Service Managers
- Directors of Nursing
- Directors of Medical Services
- Clinical Network Manager
- Policy, Procedure, Guideline Directory
- District Pharmacy Services

Action required by;
- Operational Managers
- Clinicians

Consultation and Approval Procedures;
- Executive Director Clinical Governance
- District QUM
- Clinical Network Manager
- IPC Nurse Manager HNE
- Director Paediatric JHH ICU

Deadline for completion of action;

20th March 2020

Contact:
Clinical Risk Manager,
Clinical Governance

Tel: 02 498 55820

Elizabeth.Newham@health.nsw.gov.au

Safe use of Nebulisers and COVID-19 Pandemic

Situation:
We must ensure the safe use of nebulisers as they can generate potentially infectious aerosols that place health care workers and other patients at risk.

Background:
Nebulisers generate aerosols of medicine, only some of this is absorbed with large amounts being widely dispersed into the environment for a period of time. This exhaled vapour can contain large numbers of infectious viruses. These aerosols will remain suspended for a short period before falling (30 minutes).

These treatments may be necessary, but precautions need to be taken.

Assessment:
- Some treatments may have to be given via a nebuliser, this should be critically reviewed and based on clinical need.
- Some patients require urgent nebuliser treatment (e.g. Children with croup)
- If a nebuliser is necessary then the patient will need to be isolated, if possible, and airborne infection control precautions implemented for 30 minutes after the end of the nebuliser.
- Evidence demonstrates that **bronchodilators** delivered via "Puffer (Metered-Dose Inhalers (**MDI**)) with Spacer" can often be effective, if the patient's condition and capacity is suitable.
- Use of MDI with spacer needs to consider current supplies in the unit.
- If a patient requires a **bronchodilator**, alternatives to a nebuliser need to be considered if possible, and the patient can achieve technique. Alternatives include:
  1. Use patient's own puffers and spacers if appropriate
  2. Possible cascade of MDI's could include:
     - Salbutamol MDI or autohaler
     - Terbutaline (Bricanyl) Dry Powder Inhaler (DPI)
     - Ipratropium (Atrovent) MDI
     - Formoterol (eformeterol – Oxis)

Recommendation:
1. **Airborne infection control precautions** (i.e. P2/95 masks and eyewear, gowns and gloves) must be used by staff whenever a nebuliser is used and up to 30 minutes afterwards. See Airborne Precautions
2. **Aerosol generating procedures, unless in an emergency,** are to be carried out in a single room with the door closed at all times (preferably negative pressure room). They should not occur in shared patient accommodation unless in an emergency (See PD2017_013:PCP 11 for bed management details)
3. **Limit unnecessary access to nebulisers** so that use can be monitored by senior staff (including out-of-hours).
4. **Optimise current stock of 'Puffers'** (Pharmacy) and Spacers (Stores).
5. **Ask patients to bring their puffers and spacers with them and follow procedure** PD2013_043: PCP 32.
6. **Circulate this Safety Alert** to all clinicians, and display where nebulisers are stored.
7. See HNELHD PD2017_013: PCP 11 for details regarding airborne precautions and Infection Prevention Control Practice Handbook for additional information

Prepared for HNE Health Local Health District by 18/03/2020

Appendix 5: Swab Collection Procedure

Swab Collection Procedures

Guidance on the collection of upper respiratory specimens from the Public Health Laboratory Network (PHLN) is available on the Department of Health website.

Detailed guidance on laboratory testing for SARS-CoV-2 (the virus that causes COVID-19) from the PHLN is available on the Department of Health website.

1. Before performing swab

IMPORTANT NOTES:

- Contact your laboratory provider for current local advice about swabs.
- Do not use bacterial swabs for specimen collection. If in doubt, check!
- To conserve swabs, the same swab that has been used to sample the oropharynx should be utilised for nasopharynx/deep nasal sampling.

Obtain required materials:

- Personal protective equipment (PPE) for the health care worker taking the swab, including, gloves, eye protection (goggles or face shield), surgical mask, and gown, if necessary.
- One dry, sterile, flocked swab or one viral culture swab with viral culture medium.
- Tongue depressor.

Performing the swabs

IMPORTANT NOTES:

- *Choose an area for the procedure where the patient can rest their head against a wall or on a high-backed chair with room for you to stand beside (not in front of) the patient.*
- *Ensure the area is well lit, with hand washing and infectious waste disposal facilities.*
- *Remember to **WASH AND DRY HANDS** before and after the procedure!*
- *Gloves, surgical mask and eye protection **MUST** be worn when collecting nose and throat swabs. The need for a gown or apron is based on risk assessment.*[3]
- *Masks should **NOT** be touched during wear and should **NOT** be worn around the neck at any time. When removed, handle the mask by the ties of the mask only.*

Preparation:

1. Perform hand hygiene.
2. Don PPE in the order of gown, surgical mask, eye protection, and gloves.
3. Explain the procedure to the patient and obtain consent.
4. Place patient standing or sitting with head tilted at 70^0, supported against a bed, chair or wall.

After performing the swab

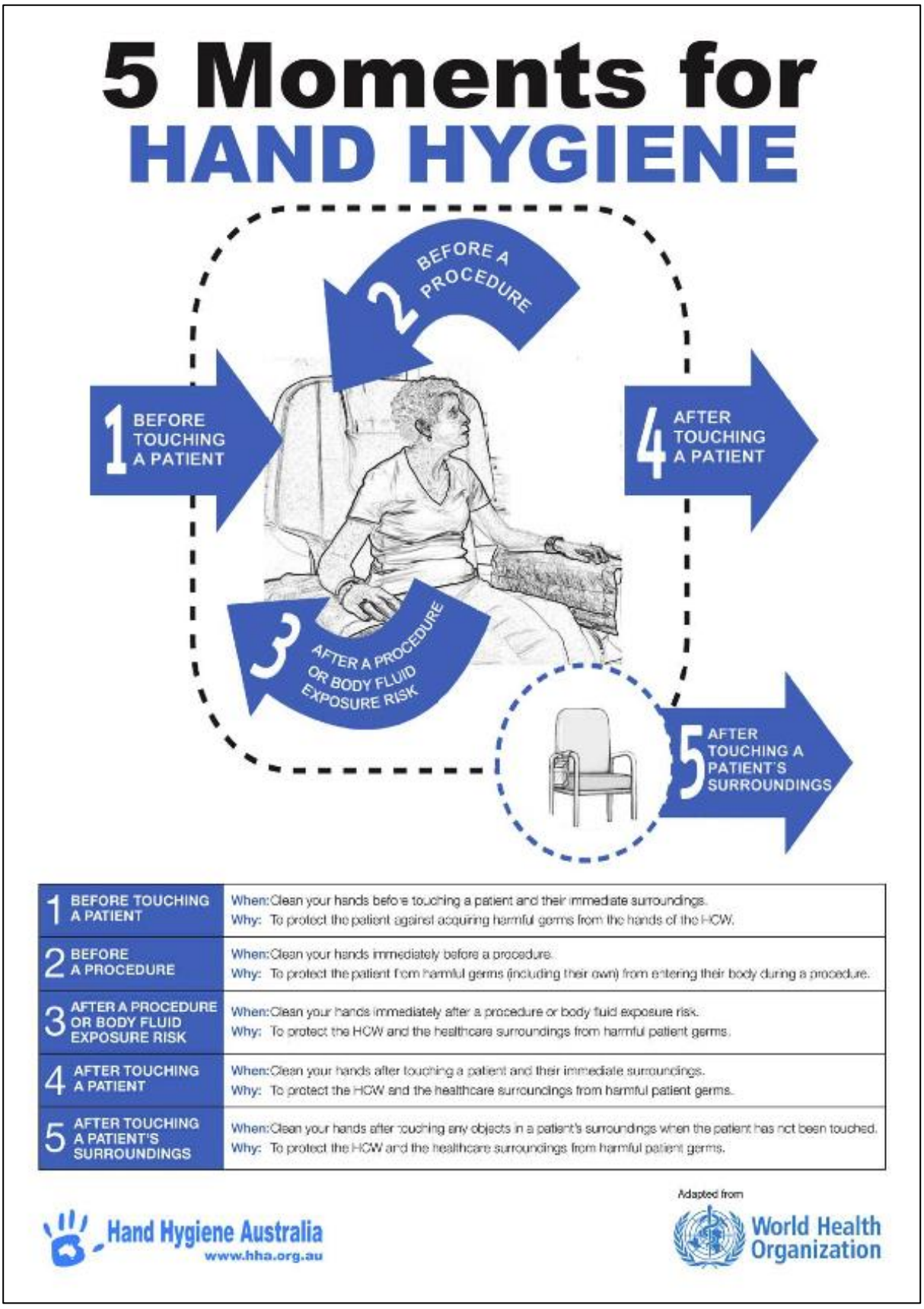
Labelling and storage of specimen:

1. Label the tube or bottle containing the swabs with the patient's full name, date of birth, specimen type and date of collection. The accompanying request form should include the RCF facility name.
2. Remove PPE safely (remove gloves, perform hand hygiene, remove goggles or face shield, gown and mask and perform hand hygiene again).
3. Specimens should be ***sent on the day of collection***. Refrigerate the specimen until it is sent to the laboratory (do NOT freeze the specimen). Specimens should be packaged in a small insulated bag/box (with ice bricks) for transport to the pathology laboratory.

IMPORTANT NOTE: Dispose of gloves, gowns and masks in an infectious (biohazard) waste bag.

[3] See the *ICEG guidance on use of PPE in non-inpatient health care settings during the COVID-19 outbreak* for additional information on PPE during specimen collection.

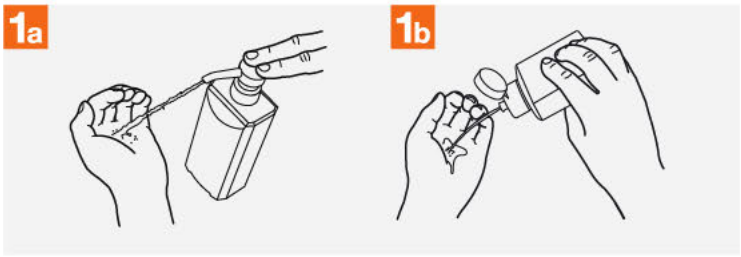
Appendix 6: Hand Hygiene



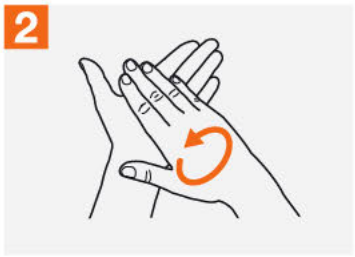
How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

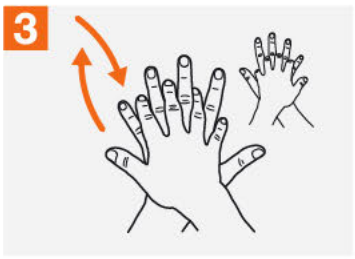
Duration of the entire procedure: 20-30 seconds



Apply a palmful of the product in a cupped hand, covering all surfaces;

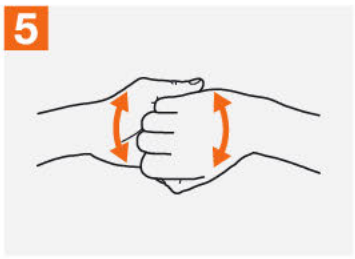


Rub hands palm to palm;



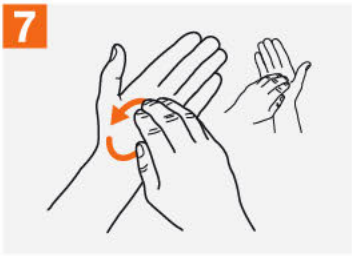
Right palm over left dorsum with interlaced fingers and vice versa;

Palm to palm with fingers interlaced;

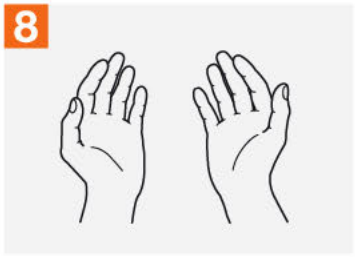


Backs of fingers to opposing palms with fingers interlocked;

Rotational rubbing of left thumb clasped in right palm and vice versa;



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Once dry, your hands are safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

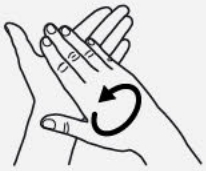
0

Wet hands with water;

1

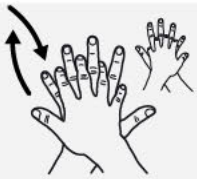
Apply enough soap to cover all hand surfaces;

2



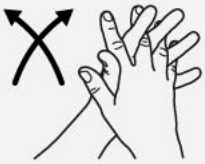
Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4

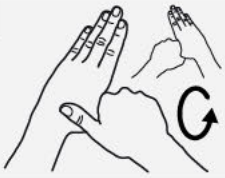


Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

6



Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

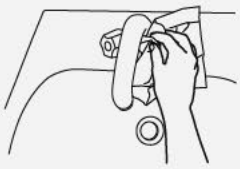
8

Rinse hands with water;

9

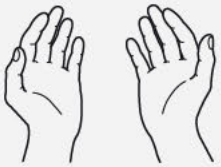
Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11



Your hands are now safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

May 2009

Source: Hand Hygiene Australia, adapted from '5 Moments for Hand Hygiene', 'How to Handwash', and 'How to Handrub' © World Health Organization 2009. All rights reserved.

Appendix 7: Personal Protective Equipment (PPE) for patient care during the COVID-19 Pandemic

AREA	PATIENT CHARACTERISTICS		PRECAUTIONS[1]	Type of PPE required: Frequent Hand Hygiene	Surgical mask[3]	P2/N95 mask[3]	Eye protection	Impervious Gown	Gloves
All non COVID-19 (green) patient zones, inpatient, outpatient, including emergency departments	**All patient care**	STANDARD PRECAUTIONS FOR ALL[1]	STANDARD[1]	✓	✗	✗	✓	✗	✗
	Taking respiratory samples for COVID19 testing[2] **Aerosol generating procedure (AGP)[4]** for patient without COVID-19 or influenza-like illness risk factors (based on history).		CONTACT + DROPLET	✓	✓	✗	✓	✓	✓
COVID-19 zones, ED red/amber zones, OT, recovery, imaging and inpatient zones	**Non-ICU patient care of suspected (test status awaited) or confirmed COVID-19 case (unless AGP required)** Patient transport included.		CONTACT + DROPLET	✓	✓	✗	✓	✓	✓
	Intensive care COVID-19 zones or rooms **Aerosol generating procedure (AGP)[4]**		CONTACT + AIRBORNE[5]	✓	✗	✓	✓	✓	✓

Notes:

1. Standard precautions: use eye protection always (wrap-round glasses and/or face shield), risk assess the need for PPE: i.e. surgical mask when examining ENT or patient with respiratory symptoms, gloves when doing wound dressing, apron to protect clothing from splashes.
2. For current case definitions and testing advice, see the NSW Health website: https://www.health.nsw.gov.au/Infectious/diseases/Pages/2019-ncov-case-definition.aspx
3. For extended use, masks can be worn for up to 4 hours. Eye protection can also remain on between patients. Masks and eye protection should be discarded (or reprocessed in the case of reusable eye protection) if they are moist or contaminated with blood or bodily fluids, following aerosol generating procedures and after removal. Replace mask if it becomes hard to breathe through or if it loses its shape.
4. High risk AGP – consult the HNE Intranet for the specified list of high risk AGP. NB. Confirmed non-COVID respiratory viral infections (e.g. influenza or RSV) who require an AGP must be isolated under airborne precautions in single room with door closed.
5. P2/N95 masks – it is recommended that staff who have to use airborne precautions and who have not been fit tested, receive specific training in optimal mask donning, fit checking and doffing.
6. Shoe and head covers are not registered and do not function as PPE.

Issue date 16/04/2020 **Issued by: Infection Prevention Service** **Authorised: Dr J. Ferguson** **Expires: 16/4/2021** **Document: IPS-046-FACT-2.0**

Appendix 8: Proper Use of Personal Protective Equipment (PPE)

- Gloves should be changed and hand hygiene performed between patients; change or remove gloves when clinically indicated, if contaminated, or moving from dirty to clean site on the same patient or when damaged or torn
- Perform hand hygiene immediately after removing gloves and other PPE if there is risk of contamination between steps
- Gown/apron should be removed and discarded appropriately upon completion of care (session) and /or on leaving the room/zone
- Reusable eye protection should be cleaned/disinfected between use
- Clean and disinfect reusable shared patient equipment and high touch points

CONTACT + DROPLET

CONTACT + DROPLET

CONTACT + DROPLET

CONTACT + DROPLET + AIRBORNE - AGP

Appendix 9: Use of Personal Protective (PPE) in Correct Order

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

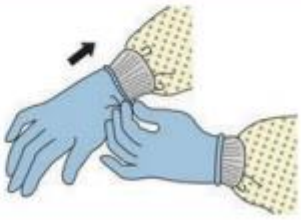
NHMRC

Sequence for putting on and removing PPE

To reduce the risk of transmission of infectious agents, PPE must be used appropriately. The following table outlines sequences and procedures for putting on and removing PPE.

Table 14. Putting on and removing PPE

SEQUENCE FOR PUTTING ON PPE
Put on PPE before patient contact and generally before entering the patient room
HAND HYGIENE • Wash hands or use an alcohol based hand rub.
GOWN • Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back. • Fasten at the back of neck and waist.
MASK • Secure ties or elastic bands at middle of head and neck.
PROTECTIVE EYEWEAR OR FACE SHIELD • Place over face and eyes and adjust to fit.
GLOVES • Extend to cover wrist of isolation gown.



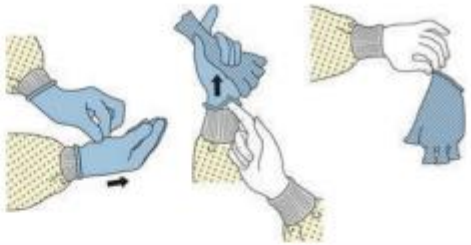
Australian Guidelines for the Prevention and Control of Infection in Healthcare

SEQUENCE FOR REMOVING PPE

Remove PPE at doorway or in anteroom

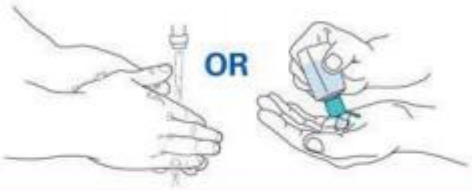
GLOVES

- Outside of gloves is contaminated!
- Grasp outside of glove with opposite gloved hand; peel off.
- Hold removed glove in gloved hand.
- Slide fingers of ungloved hand under remaining glove at wrist.
- Peel glove off over first glove.
- Discard gloves in waste container.



HAND HYGIENE

- Wash hands or use an alcohol based hand rub.



PROTECTIVE EYEWEAR OR FACE SHIELD

- Outside of eye protection or face shield is contaminated!
- To remove, handle by head band or ear pieces.
- Place in designated receptacle for reprocessing or in waste container.

GOWN

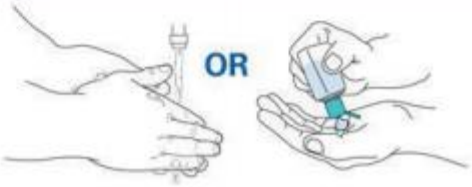
- Gown front and sleeves are contaminated!
- Unfasten ties.
- Pull away from neck and shoulders, touching inside of gown only.
- Turn gown inside out.
- Fold or roll into a bundle and discard.

MASK

- Front of mask is contaminated—DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove.
- Discard in waste container.

HAND HYGIENE

- Wash hands or use an alcohol based hand rub immediately after removing all PPE.



safetyandquality.gov.au

Adapted from CDC Guideline for Isolation Precautions[203].

REFERENCES

Aged Care Act 1997

Aged Care Quality Standards

Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019),

Australian Health Sector Emergency Response Plan for Novel Coronavirus (2020).

BMC Public Health – Structured Framework for Improving Outbreak Investigation Audits

CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia

Centres for Disease Control and Prevention

Commonwealth Department of Health Contact Details

Environmental cleaning and disinfection principles for COVID-19

HNELHD Pandemic Plan for Influenza and other Respiratory Infections, March 2020

Infection Prevention and Control COVID-19 (SARS-CoV-2) – Residential & Aged Care Facilities

Therapeutic Goods Administration