Management of acute respiratory infection outbreaks, including COVID-19 and influenza, in residential care facilities

Version 4

Community and Public Health Division | Department of Health

OFFICIAL

Version History

Version number	Comment	Date of approval
Version 1.0	Original document. Replaces: • Management of influenza-like-illness and influenza outbreaks in residential and aged care facilities • Management of COVID-19, influenza, and influenza-like-illness outbreaks in residential and aged care facilities • Respiratory illness in residential and aged care facilities – guidelines and information • Managing COVID-19 exposures and outbreaks: actions for residential aged care facilities (RACFs)	15 September 2022
Version 2.0	Updated to reflect cessation of the Pandemic Orders from October 13, 2022. Updates to isolation, testing, mask and sensitive settings recommendations.	13 October 2022
Version 2.1	Minor content updates to advice for COVID-19 vaccination and infection prevention and control, and references. Integration of advice for management of visitors to facilities.	7 March 2023
Version 3.0	• Mask and respirator wearing, testing and return to work advice updated to reflect the recommendations of the COVID-19 Management Expert Advisory Group. • RSV vaccines update. • Links to staff testing and visitor restriction guiding principles resources included.	February 2024
Version 3.1	• Corrected return to work advice. • Updated advice re sourcing PPE and RATs. • Updated resource links.	April 2024

Version 4	• Updated to align outbreak measures with CDNA's *National Outbreak Management Guideline for Acute Respiratory Infection (including COVID-19, influenza and RSV) in Residential Aged Care Homes.* Key changes in recommendations include:
	  - Release from isolation
	  - Staff return to work
	  - Testing advice
	• Simplified contact definition
	• Streamlining outbreak closures for all ARIs
		May 2025

Created: May 2025

Date valid to: May 2028 (Standard: 36 Months after last update)

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Contents

Executive Summary

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), influenza and other viruses including respiratory syncytial virus (RSV) are very infectious causes of acute respiratory infections (ARIs) and can cause serious illness and death. Residential care facilities (RCFs) are considered high risk environments due to communal living arrangements of many people at high risk of illness. The elderly are particularly vulnerable due to immune weakness related to ageing and co-morbidities.

Early public health response can have a significant positive impact to reduce transmission and improve health outcomes. Coronavirus disease 2019 (COVID-19), influenza and RSV are notifiable conditions in Victoria. Vaccines are available for COVID-19, influenza and RSV that reduce disease severity and likelihood of infection. Treatment is available for both influenza and COVID-19, and prophylaxis is available for influenza, and in limited circumstances for COVID-19.

The purpose of this guideline is to provide state-wide public health advice to support exposure and outbreak management of ARI in RCFs. It is intended to be used in conjunction with the Outbreak Management Plans (OMPs) developed by the RCF.

The guidelines also recognise the key role the Local Public Health Units (LPHUs) have in outbreak management and are intended to support the provision of consistent and practical advice to RCFs.

RCFs, LPHUs and the Victorian Department of Health (the department) must balance their responsibilities to reduce the risk of COVID-19 and other respiratory infections within RCFs against their responsibilities for meeting the physical, social, and emotional needs of residents, and supporting choice and quality of life.

RCF outbreak preparedness and prevention activities continue to be paramount with the emergence of COVID-19 variants, continued community transmission of seasonal influenza and RSV, in addition to other viruses causing outbreaks in residential care.

A checklist <https://www.health.vic.gov.au/infectious-diseases/acute-respiratory-infection-management-rcf> is available to assist RCFs to assess that they have performed key actions in responding to cases and outbreaks of ARI. Further details of actions in the checklist are available in this guideline.

Key acronyms and abbreviations

ARI	acute respiratory infection
ATAGI	Australian Technical Advisory Group on Immunisation
CDNA	Communicable Disease Network Australia
COVID-19	Coronavirus disease 2019
EPA	Environment Protection Authority
GP	General Practitioner
HCW	healthcare worker
HIV	human immunodeficiency virus
IPC	infection prevention and control
LPHU	local public health unit
NAAT	nucleic acid amplification testing
NDIS	National Disability Insurance Scheme
NMP	National Medical Stockpile
OMP	outbreak management plan
OMT	Outbreak Management Team
PCR	polymerase chain reaction
PPE	personal protective equipment
RACF	residential aged care facilities
RAT	rapid antigen test
RCF	residential care facility
RICPRAC	rural infection control practice group
RSV	respiratory syncytial virus
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
the department	Victorian Department of Health

1. Introduction

Purpose

The purpose of this guideline is to provide state-wide and consistent public health advice and direction to RCFs and LPHUs in support of their response to respiratory outbreaks.

This guideline outlines key prevention and preparedness measures, noting that outbreak preparedness continues to be paramount with the emergence of variants of COVID-19, together with widespread community transmission of influenza, RSV and other viruses.

While this document is primarily intended to apply to RCFs (see scope) many principles are applicable to other settings such as hospitals, cruise ships, military barracks, and boarding schools.

This guidance is designed to supplement any obligation an employer may have under the [Occupational Health and Safety Act 2004](https://www.legislation.vic.gov.au/in-force/acts/occupational-health-and-safety-act-2004/038) <https://www.legislation.vic.gov.au/in-force/acts/occupational-health-and-safety-act-2004/038> and is not intended to derogate from any such obligations.

This guideline will be regularly updated to reflect changes in public health policy and advice.

Scope

In this guideline, use of the term RCF includes the following settings:

- Residential Aged Care Facilities (RACF)
- group accommodation where Supported Independent Living (SIL) is provided
- Specialist Disability Accommodation (SDA) facilities
- forensic residential disability settings
- Short Term Accommodation and Assistance (STAA) or respite facilities
- Supported Residential Services (SRS)

Why are we concerned about respiratory outbreaks in RCFs?

RCFs are identified as high-risk settings for transmission of respiratory pathogens due to the proximity of residents who are at risk of severe disease or death from respiratory infections with public health measures available to limit their spread.

Vaccines are available for COVID-19, influenza and RSV that reduce disease severity and likelihood of infection. Early therapies (antivirals) are available for both COVID-19 and influenza Early public health response can have a significant positive impact to reduce transmission and improve health outcomes for residents living in RCFs.

To detect outbreaks as early as possible, staff working in RCFs should monitor residents for symptoms of ARI. This will facilitate early identification and testing, and timely implementation of prevention and control measures within facilities. It will also assist with monitoring morbidity and mortality from respiratory infections.

Objectives of the public health response

The objectives of the public health response are to:

- reduce transmission of COVID-19, influenza, RSV and other respiratory pathogens
- enable early detection of respiratory outbreaks
- reduce morbidity and mortality in vulnerable populations (for example, the elderly, those living with a disability)
- protect residents at risk of severe disease
- optimise care for residents
- minimise the harm of extended isolation on residents
- effectively communicate with all involved
- contribute to state and national surveillance of COVID-19, influenza and RSV outbreaks, the associated morbidity and mortality of respiratory pathogens in residential care, the severity and geographical spread of outbreaks, and type/subtyping of SARS-CoV-2, influenza, and RSV viruses.

Key principles

These guidelines are based on the following key principles:

- All people in Victoria should be able to access healthcare and live well and with dignity, regardless of their age and where they live.
- RCFs provide a home to thousands of vulnerable people across Victoria and Australia. Delivery of person-centred care is necessary, and any restrictions must be proportionate.
- It is acknowledged that risk cannot be eliminated and that exposures to infections will occur. Providers of residential care are expected to balance their responsibilities to reduce the risk of respiratory pathogens entering RCFs with their responsibilities for meeting the physical, social, and emotional needs of residents and supporting choice and quality of life.
- Reduce the risk of severe outcomes of respiratory infection, especially amongst older people, those with medical comorbidities or who are immunosuppressed and those who are unvaccinated/partially vaccinated.
- Continue to ensure health equity by supporting those people in our community with higher risk of disease transmission and where access to health care may be reduced, such as experiencing socioeconomic or geographical disadvantage, Aboriginal and Torres Strait Islander people and those in culturally and linguistically diverse communities.

Legal

It is the responsibility of residential care approved providers to identify and comply with relevant legislation and regulations.

Whilst reporting respiratory outbreaks is currently not a legislative requirement in Victoria, RCFs are recommended to report outbreaks to their respective LPHU. This allows the LPHU to provide support in managing the outbreak.

RCFs must fulfil their legal responsibilities in relation to managing organisational infection risk by adopting standard and transmission-based precautions for infection control as directed by the department and Commonwealth Public Health authorities as outlined throughout this document and in Australian Guidelines for the Prevention and Control in Healthcare (2019) <https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-

infection-healthcare-2019>. Residential **aged** care facilities 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.

2.   Prevention and preparedness

When there is widespread community transmission, it is expected that there will be exposure to respiratory viruses, and cases within RCFs. RCFs are responsible for ensuring they are prepared to carry out public health measures in response to COVID-19, influenza and RSV cases in their facility. RCFs should consider plans that balance the risk of infection with the health and wellbeing of residents. Additionally, facilities should implement controls to reduce the risk of respiratory viruses entering the facility.

Facilities should have COVIDSafe plans (or equivalent policies) to manage positive cases who are patients or residents, employees, and visitors and to promote isolation of cases.

This section will provide practical guidance to support RCFs. The blue text boxes are prompts for RCFs to help prevent and prepare for an outbreak.

Developing the Outbreak Management Plan

Preparing an OMP is essential in ensuring RCFs can rapidly respond to and manage exposures to respiratory viruses and outbreaks within their setting.

The plan should describe how residents, staff and contractors will be kept safe, actions that will be taken, and pre-established processes intended to limit the severity and duration of an outbreak. It should identify dedicated staff members to plan and coordinate activities in response to an exposure or outbreak, as well as communicate with the relevant LPHU or the department. Larger sites should consider whether a separate plan for each area is more appropriate.

Facilities should regularly review and update their plan to ensure it reflects business practices, staffing and current COVIDSafe settings. Learnings from previous outbreaks should be reviewed and improvements made where necessary. The following should be kept up to date:

- detailed floor plan
- list of residents and family contact details where appropriate
- list of all staff employed by the facility, including agency staff
- staff and resident vaccine registers
- contingency staffing plans.

The prevention strategies discussed in this section should be included in the facility OMP. Key questions should be posed for consideration and prompt in the design of the OMP.

The OMP should, at a minimum, include the following:

- isolation of unwell residents
- contact assessment and management
- identification of a designated infection prevention and control (IPC) lead
- enhanced IPC activities
- appropriate use of personal protective equipment (PPE)
- activating RCF Communication Plan
- activating screening/testing program
- clinical care of residents, including use of antivirals
- declaring an outbreak over.

Vaccination

COVID-19, influenza and RSV vaccines are highly effective in reducing severe illness, hospitalisation, and death. It is strongly recommended that staff and residents are up to date with COVID-19 and influenza vaccinations unless an exemption applies.

Vaccination is highly recommended annually for influenza. Influenza viruses change frequently so new influenza vaccines are formulated each year to match the influenza viruses predicted to predominate in the coming winter influenza season. Elderly people may have a weaker immune response to vaccination, but the vaccine can still reduce the duration and severity of symptoms if infection occurs. The Influenza vaccine can be co-administered with a scheduled dose of COVID-19 vaccine.

COVID-19 vaccination recommendations are updated frequently. For employees who express hesitancy relating to mRNA vaccines, ensure information is available about non-mRNA vaccines such as now readily available protein-conjugate-based vaccines for COVID-19. It is strongly recommended that workers are up to date with COVID-19 vaccinations. Some workers may be required to meet vaccination requirements. Workplaces may continue to implement their own vaccination mandates. Employers are responsible for ensuring staff comply with any requirements that apply to their workplace.

RSV vaccines are now available for persons aged over 60 years. This vaccine is not currently funded under the National Immunisation Program but is available via private script.

Information on the vaccination requirements or recommendations is available at:

- ATAGI clinical guidance for COVID-19 vaccine providers <https://www.health.gov.au/our-work/covid-19-vaccines/advice-for-providers/clinical-guidance>
- Seasonal Influenza and COVID-19 - vaccination for healthcare workers in Victoria <https://www.health.vic.gov.au/immunisation/vaccination-for-healthcare-workers>. This includes residential aged care services operated by public health services.
- Information for residential aged care workers <https://www.health.gov.au/our-work/covid-19-vaccines/information-for-aged-care-providers-workers-and-residents-about-covid-19-vaccines/residential-aged-care-workers>

- Is there a plan to offer all residents vaccination against COVID-19 and influenza in accordance with the current vaccination schedule?
- Are all staff aware of vaccination recommendations or requirements?
- Have you recorded the vaccination status of all staff, residents, participants contractors, volunteers?

Air quality and ventilation

- The risk of airborne transmission of COVID-19 and other airborne pathogens is higher in inadequately ventilated indoor areas. Indoor air ventilation should be maximised to reduce the concentration of any airborne pathogens.
- Ventilation consultants can be used to identify at risk areas to prioritise for ventilation improvements.
- Ventilation strategies to reduce COVID-19 airborne transmission is available at: Infection prevention control resources <https://www.health.vic.gov.au/covid-19/infection-prevention-control-resources-covid-19>.

Type of ventilation	Instructions
Natural ventilation	- Open windows and external doors as much as practicable – provide education to staff and residents - Have a break time between the use of a space or room between two groups of people. During this time, windows and doors should be opened. - Some evaporative coolers may be able to be run in 'fan only' mode to increase natural ventilation when cooling is not required - Consider minor capital works to replace fixed with openable windows or install security/fly doors
Mechanical ventilation	- Set centralised air handling ventilation systems to provide the maximum amount of outdoor air possible, up to 100%, considering thermal comfort. A ventilation professional may be required to assess this. - Ensure the installation of sufficient grade of filter in air handling systems - Ensure ventilation systems are regularly maintained for compliance and optimum functioning - Have a break time between the use of a space or room between two groups of people. This will allow the mechanical system to "purge" in between sessions.
Other advice	- Electric fans, whirlybirds, or extractor fans can be installed to enhance air flow and circulation - Move meetings and activities outdoors when possible
Augmented ventilation (air recirculation and filtration)	- Use portable high-efficiency particle air (HEPA) filter units (also called air cleaners, purifiers, or air scrubbers) to increase equivalent clean air exchange in areas where there is inadequate ventilation or unacceptable risk of airborne virus transmission - HEPA filters are not a replacement for natural or mechanical ventilation but can be used in conjunction with them when optimum ventilation cannot be achieved. - Ensure air cleaners are positioned where the designed ventilation is least effective or in dead spots. They should not be placed next to openable windows, extract grilles or open doors

Masks and respirators

Face masks can stop or slow viruses spreading in the air when you talk, cough, sneeze and laugh. Masks lower an individual's chance of catching and spreading both COVID-19, influenza and other respiratory infections.

Staff - Facilities should employ risk assessment in determining mask requirements in public facing areas.

Facilities may consider not employing mask requirements during periods of low community COVID-19 transmission risk. In periods of high community COVID-19 transmission risk facilities should require public facing staff to wear masks, with the choice of mask at the individual's or facility's discretion and in accordance with their fit test profile.

Individual staff choice to wear a mask should be maintained in other non-resident, non-public facing areas, for example, corporate support offices. Masks (both surgical masks and P2/N95 respirators) should be made available to all staff to support staff choice and risk (for example, contacts attending the workplace). Cloth face masks are not recommended for staff working in residential care settings and should only be worn by staff when arriving or leaving the facility.

Visitors - Surgical masks may be adequate for most areas however health services may consider P2/N95 respirators for visitors in higher-risk areas (that is, areas with immunocompromised residents) as determined by the facility or during periods of increased transmission risks.

Facility operators should ensure staff wearing surgical masks and respirator masks, do so in line with departmental guidance available at Personal protective equipment (PPE) <https://www.health.vic.gov.au/covid-19-infection-prevention-control-guidelines/personal-protective-equipment-ppe> and ensure there is adequate signage and staff training regarding mask usage.

Further resources about the use of masks can be found in:

- Infection prevention and Control guidelines - COVID-19 <https://www.health.vic.gov.au/covid-19-infection-prevention-control-guidelines>
- IPC Expert Group (ICEG) – endorsed resources for IPC <https://www.health.gov.au/resources/collections/iceg-endorsed-resources-for-infection-prevention-and-control>

- Have you undertaken a risk assessment to identifying risk of respiratory hazards?
- Do you have a policy that includes wearing of masks by staff, visitors and for cases and contacts?
- Do you have signage encouraging staff to wear recommended masks?
- Do you have a fit testing program for staff who wear respirators?
- Do staff know how to correctly fit their masks?

Antiviral treatment and prophylaxis

Facility operators should have pathways in place to ensure rapid access to medication, when indicated, for COVID-19 (early therapy only) or influenza (prophylaxis or early therapy).

To facilitate access and best practice, facilities are encouraged to engage with residents' General Practitioners (GPs) to pre-assess any potentially eligible residents which should include:

- discussing consent options for potential treatment with the resident and relevant decision-maker
- identifying eligible residents
- discussing potential antiviral administration with prescriber (medical or nurse practitioner) to enable assessment
- ensuring a dispensing pathway is established with community pharmacy.

Oral medications for COVID-19 and influenza are available on the PBS. More information is available at:

- Medications for patients with COVID-19 <https://www.health.vic.gov.au/covid-19/vaccines-and-medications-in-patients-with-covid-19>
- Better Health Channel: COVID-19 antiviral medicine <https://www.betterhealth.vic.gov.au/covid-19/covid-19-antiviral-medicine>
- CDNA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection in Residential Aged Care Homes <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities>
- Letter to GP pre-season with FluVax antiviral planning tool <https://www.health.vic.gov.au/infectious-diseases/respiratory-illness-management-in-aged-care-facilities>

> - Have residents been assessed by their medical practitioner for eligibility for antiviral treatment and where applicable prophylaxis therapy for COVID-19 and influenza?
> - Are medications available onsite or are pathways in place to ensure rapid supply?

Testing

All Victorians should get tested at the first sign of symptoms for COVID-19, influenza, RSV and other respiratory pathogens. Facility operators should ensure they have communication plans in place for staff, testing capacity available for residents, staff, and participants, and mechanisms in place to report results to the department and LPHU.

Asymptomatic staff testing is not recommended during periods of low COVID-19 transmission risk unless required for staff working in higher-risk areas as determined by the facility.

Asymptomatic staff testing should be considered in specific circumstances, such as during an outbreak, during periods of high COVID-19 transmission risk or for those working in higher-risk areas as determined by the facility. The frequency of testing should be determined by the facility in accordance with the risk posed to patients and other staff. See section 5 for further information regarding testing people with respiratory symptoms and reporting COVID-19 and influenza cases.

- Do residents know to report symptoms of acute respiratory infection?
- Do your staff know they should not attend work if they are unwell?
- Do your staff know how to get tested at the first sign of symptoms?
- Do you have a testing policy for visitors visiting the facility, staff or residents visiting other sensitive settings and for cases and contacts?
- Do staff know who to tell if they return a positive COVID-19 or influenza test result?
- Do staff know how to notify workplace contacts and advise them on actions to follow?
- Do you have testing equipment available? Are staff trained to collect tests?

Education and practice

It is the responsibility of all RCFs to ensure staff regularly refresh their IPC training and skills, including hand hygiene, appropriate use of PPE and cleaning practices. Staff should be aware of the signs and symptoms of respiratory illnesses and monitor themselves and those under their care, to identify and respond quickly to a potential exposure.

Staff and contractors also need to understand the facility infection prevention and control guidelines, ventilation recommendations, and workplace health and safety requirements that apply to their setting.

Facilities should practice using their OMP and make sure staff are aware of the actions in the COVIDSafe Plan. This could include running exercises that include prevention, identification, and management activities of acute respiratory infections, including COVID-19. Facilities must adequately train staff to implement this plan and identify development opportunities.

Training resources can be found at COVID-19 Infection prevention and control guidelines <https://www.health.vic.gov.au/covid-19/infection-prevention-control-resources-covid-19>.

- Does the facility have an IPC Lead, and have they completed the necessary education?
- Does facility management support the IPC lead and ensure they have adequate time and resources to oversee IPC capability across the service?
- Have staff undertaken education and training in relevant aspects of outbreak identification and management?
- Have staff completed a donning and doffing competency assessment demonstrating safe PPE use?
- Are staff familiar with, and adhere to, infection prevention and control activities and the appropriate use of personal protective equipment (PPE)?
- Do staff, residents, participants, and visitors to your facility know how they can help stop the spread of COVID-19 and influenza?
- Do your staff understand the policy for visitors entering facility, including masks and pre-entry testing?

Workforce planning

RCFs should have a contingency plan to replace staff on sick leave or furlough during outbreaks. The plan should cover a staff absentee rate of 20–50%. This should incorporate staff across all categories of workers/areas of the facility. Consideration should also be given to ability to cohort or zone staff, and minimise staff working across multiple sites/ services, and in non-public facing roles. Consider expected peaks in transmission, such as influenza transmission during winter, when planning staff leave.

Ensure only staff essential to the delivery of care are entering areas designated for the care of suspected or confirmed of cases of COVID-19 and influenza. Consider decreasing the potential exposure of each staff member to others (including residents and colleagues) through stable allocation of residents. Where reasonably practicable, provide separate break areas for separate teams and consider staggering staff breaks where ventilation is limited.

For further information on zoning see Managing staff, visitors and outbreaks <https://www.health.vic.gov.au/covid-19-infection-prevention-control-guidelines/ipc-control-strategies>.

- Do you have a workforce plan, and is it up to date?
- Have you identified which staff have essential roles?
- Have you identified back-up staff in case essential staff are unable to work?
- Who do you contact to source additional staff?
- Have you developed a plan for cohorting/zoning staff in an outbreak?
- Do you know which staff work across multiple residential care services and which site may become their primary site if this is limited?

Visitors to Residential Care Facilities

It is an essential part of resident's wellbeing that they can receive visitors to help to reduce the impacts of social isolation and mental health impacts. Visitations should be conducted in a manner that minimises the risk of introducing and spreading COVID-19 or other infections into the facility or protecting visitors from infections in residents.

During periods of low transmission risk, visitor restrictions may not be necessary.

All visitors should have access to face masks upon entry to a facility. Surgical masks may be adequate for most areas however health services should consider P2/N95 respirators for visitors in higher-risk areas as determined by the facility.

Facilities should advise that people with symptoms of an ARI or who have been diagnosed with COVID-19 should not visit, except in exceptional circumstances (see below).

During periods of high transmission risk or in areas of elevated clinical risk, to reduce COVID-19 transmission facilities should consider implementing visitor restrictions (for example, up to 2 visitors per resident), requiring visitors to wear a P2/N95 respirator during their visit and limiting the location of visitation – such as to within the resident's room only or in outdoor spaces where feasible, avoiding indoor common areas.

The decision to allow visitors to a resident suspected or confirmed to have COVID-19 or another respiratory virus should be managed on a case-by-case basis in conjunction with the treating medical team and under guidance of the LPHU as needed. If the resident is suspected or confirmed

to have COVID-19, appropriate personal protective equipment (PPE) must be used by the resident and their visitors and additional mitigations put in place to reduce the risk of transmission: see Infection prevention and control resources.

Facilities may request that individuals should not visit, if they:

- have been diagnosed with COVID-19 within the last seven days
- have been diagnosed with influenza in the past five days
- have had known contact with a person who has COVID-19 in the previous seven days
- have symptoms of an ARI such as:
    - a temperature higher than 37.5 degrees
    - breathing difficulties such as breathlessness
    - cough
    - sore throat
    - runny nose.

In exceptional circumstances visitation may be permitted, such as to support end-of-life visitation or to care for a child or dependent, additional mitigations should be in place to minimise the risk of transmission to staff and residents (incl. wearing a face mask – preferably an N95/P2 respirator and avoiding indoor communal areas).

All visits during an outbreak should be based on a local risk assessment, under guidance of the LPHU as needed.

Useful resources include:

- Aged Care Quality Standards <https://www.agedcarequality.gov.au/providers/standards>
- Ensuring safe visitor access to residential aged care <https://www.agedcarequality.gov.au/resource-library/ensuring-safe-visitor-access-residential-aged-care>
- Coronavirus (COVID-19) – National aged care guidance – aged care visitation guidelines <https://www.health.gov.au/resources/publications/coronavirus-covid-19-national-aged-care-guidance-aged-care-visitation-guidelines>
- Industry Code for Visiting in Aged Care Homes <https://www.cota.org.au/policy/aged-care-reform/agedcarevisitors/>
- Partnerships in care <https://www.agedcarequality.gov.au/providers/clinical-governance/infection-prevention-control/partnerships-care>
- Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Disability Residential Services <https://www.health.gov.au/resources/publications/control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-disability-residential-services>

- Do you have a system to check that visitors are well, and are not a COVID19 case or contact?
- Do you have policies that recommend strategies to reduce risk, such as use of masks, and visits to occur in a resident's room, outdoors or in well-ventilated areas, rather than communal areas with other residents?
- Do you have policies to support end-of-life visits, urgent support for a resident's immediate physical, cognitive or emotional wellbeing, or providing professional patient care as an emergency, healthcare, or an ambulance worker?

> - For residential aged care facilities, do you have a procedure for the implementation of partnership in care model?

Communication

Education and communication to staff, visitors, residents and their families is critical both prior to and during an outbreak. Staff residents and visitors should be encouraged to wear masks when recommended, and both staff and residents should monitor for symptoms and undertake testing as recommended. Staff should be supported to not attend work while unwell. The same principles apply to visitors to facilities.

Staff and visitors should be aware to not enter the facility if they have respiratory symptoms, irrespective of their vaccination status.

Some residents will benefit from the use of Easy Read documents and/or story-based learning. However, not all will be capable of implementing actions aimed at infection control and this will need to be reflected in provider planning.

Easy Read resources on COVID-19 can be accessed via:

- Coronavirus (COVID-19) Victoria <https://www.betterhealth.vic.gov.au/coronavirus-covid-19-victoria?redirectSrc=coronavirus.vic.gov.au>
- Coronavirus (COVID-19) Easy Read collection <https://www.health.gov.au/resources/collections/coronavirus-covid-19-easy-read-resources>
- Better Health Channel: COVID-19 information for people with disability <https://www.betterhealth.vic.gov.au/covid-19/covid-19-information-people-disability>
- Disability Advocacy Network of Australia <https://www.dana.org.au/> has resources available to assist communications with residents and families.

Workplaces should have COVIDSafe plans (or equivalent policies) to manage positive cases who are patients or residents, employees and visitors and promote isolation of cases. This plan should include communication of cases within the facility. Prompt and active communication to facility residents and families is also necessary to reinforce preventative behaviours.

> - Do you have a plan for communicating with staff, residents, volunteers, family members and other service providers (for example, cleaners) during an outbreak?
> - Are the contact details for resident nominated representatives up to date?
> - Do you have a plan to restrict unwell visitors entering the facility? Will you limit all other visitors during an outbreak to reduce risk of transmission?
> - Will you promote/support alternate means of access to visitors (for example, telephone/video calls, outdoor meetings)?
> - Can your current screening practices cope with high visitor numbers?

Stock levels

RCFs should ensure adequate supply of test kits, PPE, and other outbreak related consumables are available in an outbreak response kit prior to and during an outbreak. Essential stock includes:

- test kits including rapid antigen tests (RATs) and swabs for laboratory tests for respiratory viruses
- PPE (N95 or P2 masks, gloves, gowns, eyewear)
- hand hygiene products (alcohol-based hand rubs, soap, paper towels)
- cleaning supplies (detergent and disinfectants)
- waste disposal capacity (access to additional clinical waste bins).

Expiry dates should be checked, and stock rotated to ensure use before expiry and that stock held remains within the expiry date.

The required amount of on-site PPE will differ for each facility. RCFs should undertake regular stocktakes of supplies, and ensure they have enough supplies stored onsite for an immediate facility-wide outbreak response using full PPE. This supply should be always available and be sufficient to cover weekends and public holidays. Additional supplies should be ordered if a case occurs in the facility.

Information regarding support to Australian Government-funded aged care services (residential and in-home care) in managing COVID-19 outbreaks, including sourcing PPE and RATs can be found on the Department of Health and Aged Care website <https://www.health.gov.au/topics/aged-care/managing-covid-19/government-support>.

Rough guide to estimate required PPE:

- Count the number of times staff members (including cleaners) access a resident's room (for example, 20 times per day)
- Add in the number of times this access needs to be by 2 carers (for example, +3 times per day)
- Multiply this total by the number of residents in the facility.

So, a 100 resident facility would need to have onsite (20+3) multiplied by 100 = 2,300 sets of PPE (mask or PFR, gloves and gowns) for one day.

- Do you have enough PPE, hand hygiene products, testing kits, and cleaning supplies?
- Do you know where you can order more PPE?
- Do you know where you can order RA testing kits or swabs?
- Do you have enough storage and access if the facility and staff are cohorted?

Cleaning

The frequency of environmental cleaning and disinfection during a respiratory outbreak should be increased to at least twice daily, particularly of frequently touched surfaces such as door handles, light switches, trays, rails, equipment for personal or clinical care, chair arms, and in shared bathrooms, dining and lounge areas.

- Does the OMP identify who is responsible for overseeing increased frequency of cleaning and waste disposal, liaison with contractors or hiring extra cleaners as necessary?
- Does the OMP identify the cleaning and disinfection agents that are to be used?
- Do you have adequate supply for an outbreak?

Waste management

COVID-19

Studies into the known modes of transmission of COVID-19 indicate that PPE from patients does not routinely need to be considered clinical waste and can therefore be placed in a general waste bin (provided it is not soiled with blood or bodily fluids). All waste from an isolation room should be contained in a closed bag for transport to the waste storage area for disposal. Staff handling waste should wear gloves and ensure the waste is not carried in contact with clothing.

All used RATs from aged care facilities and acute care services must be disposed into clinical waste bins, whether the result is positive or negative (body fluids). Other residential care settings should follow the advice for correct disposal of RATs and PPE as set out in Managing coronavirus waste from a workplace | Environment Protection Authority Victoria <https://www.epa.vic.gov.au/about-epa/news-media-and-updates/coronavirus/managing-coronavirus-waste-from-a-workplace>.

Influenza

All gloves, masks, protective eyewear, or gowns used whilst caring for a resident with influenza should be disposed of into clinical waste (yellow bin or bag).

For more information refer to the EPA Victoria's How to manage clinical and related waste <https://www.epa.vic.gov.au/for-business/find-a-topic/manage-clinical-and-related-waste>.

- Have you reviewed waste management requirements relevant to your workplace?

Review other IPC measures

RCFs should ensure that sufficient IPC measures to prevent the transmission of COVID-19, influenza and other respiratory pathogens are in place, such as:

- Using consistent signs in multiple sites of the facility, in graphic and text, to remind all people to maintain COVIDSafe behaviours.
- Provide adequate hygiene resources, such as masks, hand hygiene supplies, paper towel and lined disposal bins are available for visitors to use.
- Promote physical distancing:
  - For enclosed rooms:
    - o limit the number of people present, maintain 1.5 metres distance from other people when feasible
    - o if 1.5 metres distance cannot be maintained, minimise time in close proximity
    - o a mask should be worn by both staff and visitors. Masks should also be worn by residents when recommended if they are a case or contact

- o   position waiting room chairs 1.5 metres apart where possible or block out interval chairs
- o   rearrange furniture to limit staff congregation in staff communal areas.
- – Direct interactions between staff to be conducted at a distance:
  - o   for example (but not limited to): during ward rounds, shift handovers and meal breaks
  - o   for meal breaks, consider staggering break times to limit levels of staff congregation and encourage breaks outdoors when possible. Staff should wear masks, and minimise the time when masks are removed while eating and drinking in shared tea rooms.
- – Staff and residents to remain at least 1.5 meters apart except for the provision of direct care.
- – In residential care settings, communal activities may still proceed if physical distancing is maintained. This may mean smaller groups are offered more frequently.

All RCFs are recommended to designate specific workers, for example, an IPC lead, with the responsibility of reviewing IPC measures to ensure facilities remain up to date with current advice. Residential aged care facilities should be aware of requirements for their services.

Additionally, learnings from previous outbreaks should be reviewed and improvements made where necessary.

Further resources:

- COVID-19 Infection Prevention and Control Guidelines <https://www.health.vic.gov.au/covid-19-infection-control-guidelines>
- The Aged Care Infection Prevention and Control Guide <https://www.safetyandquality.gov.au/sites/default/files/2024-08/The-Aged-Care-Infection-Prevention-and-Control-Guide.pdf>.

- Do you know where you will place residents or participants in different exposure or outbreak scenarios, considering the layout of your facility and the implications for staff and equipment?
- Do you have consistent signs across the facility and policies that support physical distancing?

3. Understanding ARI, COVID-19 and influenza

In Australia, viral respiratory outbreaks commonly occur during the months of March through to September but can occur at any time throughout the year.

It can be difficult to tell the difference between a respiratory illness caused by COVID-19, influenza, RSV, or other viruses based on symptoms alone. Severity can vary from case to case, and from one season to the next. For example, severity can be affected by pre-existing illness, the type of strains circulating, vaccine coverage of the population and how well the vaccine matches the circulating strains. Undertaking testing to determine the cause of respiratory illnesses is important for surveillance of respiratory virus activity in the community, case-finding in outbreaks, and to ensure clinical diagnosis and appropriate treatment of respiratory illnesses.

Clinical presentation of ARI

Infections with COVID-19, influenza, RSV, and other respiratory viruses have similar and overlapping clinical presentations. It is important that staff of RCFs are aware of signs and symptoms of acute respiratory illness to prompt early testing of unwell residents.

> ### ARI definition
>
> Recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion, with or without the following symptoms:
>
> - Headache, muscle aches, fatigue, loss of appetite, nausea or vomiting, diarrhoea, loss of smell and taste can also occur with COVID-19
> - Fever (≥37.5°C) can occur (less common in the elderly)
>
>   In the elderly, other symptoms to consider include new onset or increase in confusion, change in baseline behaviour, falling, or exacerbation of underlying illness

People at increased risk for severe disease

Several factors may contribute to an increased risk of developing severe disease or dying from a respiratory viral infection. There are a number of common risk factors.

People at increased risk for severe disease or death include:

- people aged 65 years and above
- residents of aged care or disability care facilities
- people with severe immunocompromise
- Aboriginal and Torres Strait Islander people aged 50 years or above
- individuals with chronic or other medical conditions including:
  - asthma
  - neurological and neurodevelopmental conditions including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury
  - chronic lung disease (such as chronic obstructive pulmonary disease)

- heart disease (such as congestive heart failure and coronary artery disease)
- blood disorders (such as sickle cell disease)
- endocrine disorders (such as diabetes mellitus)
- kidney disorders
- liver disorders
- metabolic disorders (such as inherited metabolic disorders and mitochondrial disorders)
- immunosuppression due to disease (such as, HIV or AIDS, cancer) or medications (such as, chemotherapy, some anti-rheumatic medications, and long-term steroid treatment)
- morbid obesity (Body Mass Index ≥ 40 kg/m2)
- severe underweight (Body Mass Index < 16.5 kg/m2).

4. Contact, exposure, and outbreak definitions

Contact definition (COVID-19 only)	Description
Resident contact	Where a resident has been exposed to a COVID-19 case: • In a shared defined area (e.g. prolonged contact during activity or shared living space) and/or • Outbreak-related contact (e.g., co-located in the same ward/wing/shared area with unknown exposure).
Staff contact	Where a worker has been exposed to a COVID-19 case within or outside the RCF with: • No effective PPE (N95/P2 masks, eye protection) during aerosol generating behaviours or procedures • At least 15 minutes face to face contact where both mask and protective eyewear were not worn by exposed person and the case was without a mask, or • Greater than 2 hours in the same room as a case with inadequate PPE.
Exposure definition (COVID-19 only)	**Description**
Exposure	**People have had contact with a case in a situation that does not meet the outbreak definition.**
Outbreak definition	**Description**
Respiratory outbreak	A respiratory outbreak in a residential care setting is defined as: **Three or more resident** cases of **ARI** in the facility within a 72-hour period
Influenza outbreak	An **influenza** outbreak in a residential care setting is defined as: **Two or more residents** in the facility test positive for **influenza** within a **72-hour period**
COVID-19 outbreak	A **COVID-19** outbreak in a residential care setting is defined as: **Two or more residents** in the facility test positive to **COVID-19** within a **72-hour period**
RSV outbreak	An RSV outbreak in a residential care setting is defined as: **Two or more residents** in the facility test positive to **RSV** within a **72-hour period**

5. Detecting and notifying cases and outbreaks

Monitor for symptoms

To detect respiratory illnesses and outbreaks early, all residents should be routinely monitored for respiratory symptoms. All staff working at the facility should self-monitor for symptoms. Symptomatic staff and residents should follow testing recommendations.

In the elderly, other symptoms to consider include new onset or increase in confusion, change in baseline behaviour, falling, or exacerbation of underlying illness

Conduct appropriate testing

All symptomatic residents should isolate and be tested immediately. Any staff with respiratory symptoms should not enter the workplace, should isolate, and undergo testing. This should occur during an outbreak and when there is no outbreak declared.

This means a resident (or staff member) who has respiratory or other relevant symptoms should receive:

- A RAT for COVID-19 (or a combination RAT including influenza and RSV, if available)
    - If positive, no further testing required
    - If negative proceed to:
- A throat and nasal swab for multiplex respiratory PCR (includes SARS-CoV-2, influenza A/B, other respiratory viruses including RSV)

OR if timely results will not be available for multiplex PCR, testing should include:

- A throat and nasal swab for influenza A/B PCR AND a throat and nasal swab for SARS-CoV-2 PCR.

RCFs that are unable to organise tests to be taken on-site should facilitate testing via testing GPs/health services where possible.

Notifying cases and outbreaks

Individual cases of COVID-19

- WorkSafe must be notified if a staff member contracts COVID-19 at a workplace and requires immediate in-patient care or dies as a result.
- All RCFs should remain up to date with their sector specific notification requirements and notify positive COVID-19 cases to the relevant agencies accordingly.
- RCFs do not need to notify individual cases of COVID-19 to the department but should report outbreaks as below.

Individual cases of influenza or RSV

- RCFs do not need to notify individual cases of influenza or RSV to the department but should report outbreaks as below.

Outbreak notification

Acute respiratory infections – respiratory outbreak

To detect and respond to outbreaks early, all RCFs are strongly recommended to notify the LPHU and department as below when they have a respiratory outbreak at their facility. Respiratory outbreaks should be reported promptly – there is no need to wait for test results prior to reporting.

Confirmed COVID-19, influenza, or RSV outbreak

All RCFs should report outbreaks of COVID-19, influenza, or RSV so that LPHUs can provide support managing the outbreak.

How to notify outbreaks

RCFs can notify LPHUs and the department of an outbreak via the following channels:

1. Local Public Health Units <https://www.health.vic.gov.au/local-public-health-units> - notify the relevant LPHU for your location directly.

2. Facilities can also phone through the notification to 1300 651 160.

3. Outbreak Notification Form <https://dhvicgovau.powerappsportals.com/outbreak-notification/>: Facility completes online notification form for the department which is then emailed directly to the appropriate LPHU. **This form is currently unavailable while undergoing review.**

Notifying resident and facility GPs

Unwell residents require medical review by their GP regardless of whether an outbreak is present or not. If a respiratory outbreak is present, all visiting GPs should be informed at the start of the outbreak. This will facilitate swabs being obtained, early treatment for symptomatic residents and consideration of provision of post-exposure prophylaxis (influenza only). It is important to speak with the LPHU to confirm the presence of an outbreak before issuing the outbreak letters to visiting GPs.

6.   Influenza outbreak and respiratory outbreak management

This section provides information on the recommended actions to be implemented for initial management of a respiratory outbreak while waiting for test results to be available, and for confirmed influenza outbreaks. Further information is included in section 9 for ongoing management of ARI outbreaks including RSV outbreaks, if COVID-19 and influenza have been excluded. See section 4 for outbreak definitions.

Facilities should refer to the Acute respiratory infections - outbreak management checklist online <https://www.health.vic.gov.au/infectious-diseases/acute-respiratory-infection-management-rcf> during an outbreak.

If a facility has concurrent cases of influenza or another respiratory infection <u>and</u> COVID-19, IPC practices – including the use of PPE – should default to COVID-19 outbreak measures. The department recommends facilities engage an infection control consultant or contact the residential in-reach service at their local health service or LPHU IPC team should they require additional support during an outbreak.

- The Rural Infection Control Practice Group (RICPRAC) is a collaborative network of rural infection control consultants who may be able to offer advice in relation to IPC issues in a residential **aged** care facility outbreak in regional Victoria. Further information and contact details for RICPRAC can be found here Rural infection control centres <https://www.health.vic.gov.au/quality-safety-service/rural-infection-control-centres>.

- Residential in-reach services are run by Victorian public hospitals and provide tertiary care. They may be available to assist residential **aged** care services to avoid the transfer of residents to hospital where possible. RCFs can contact the LPHU should they require support from these services. Details about Residential In-Reach services in Victoria can be found at the Better Health Channel Residential in-reach services <https://www.betterhealth.vic.gov.au/health/servicesandsupport/residential-in-reach-services>.

Actions	Instructions
Establishing an outbreak management team (OMT)	RCFs are responsible for managing the outbreak. An internal OMT should be established to: • direct, monitor and oversee the outbreak • confirm roles and responsibilities • liaise with the LPHU.
Implementing IPC measures	A number of key measures should be employed during a respiratory outbreak in an RCF, including: • standard precautions: – hand hygiene

Actions	Instructions
	– use of PPE
	– respiratory hygiene/cough etiquette
	– cleaning shared equipment
	– enhanced environmental cleaning.
	• transmission-based precautions:
	– dedicated equipment where possible
	– single room isolation
	– cohorting/zoning of staff and residents where possible
	– using staff vaccinated against influenza to care for influenza cases
	– ventilation/air handling
	– increased cleaning of frequently touched surfaces
	– minimising the movement of visitors into and within the facility
	– only conduct communal activities if physical distancing can be maintained, this may mean smaller groups offered more frequently. Where appropriate, activities should be moved outdoors to ensure optimal ventilation.
	– taking a risk-based approach to manage risk related to admissions and transfers
	– displaying appropriate signage.
	• Use of appropriate PPE
	– N95/P2 mask and face shield recommended for care of diagnosed influenza cases and for respiratory outbreak cases while waiting further test results.
	o At a minimum, droplet precautions should be used for care of diagnosed influenza cases (single use face mask).
	• All staff working in RCFs should have good understanding of IPC measures required throughout an influenza or other respiratory virus outbreak at their workplace.
	• COVID IPC resources may also be useful: COVID-19 Infection Prevention and Control Guidelines <https://www.health.vic.gov.au/covid-19-infection-prevention-control-guidelines>.
Release from isolation	Residents diagnosed with influenza should be released from isolation:
	• After 5 days (on day 6) from symptom onset, or until acute symptoms resolved, whichever is longer
	OR

Actions	Instructions
	• 72 hours after antivirals commenced regardless of symptoms. No testing required. For information on residents with other respiratory infections (excluding COVID-19), see section 9.
Staff – return to work	Staff diagnosed with influenza can return to work: • After 5 days (return day 6) from symptom onset, or until acute symptoms resolved, whichever is longer **OR** • 72 hours after antivirals commenced regardless of symptoms. No testing required. Staff with respiratory illnesses (other than influenza and COVID-19) should be excluded from work, and can return once acute symptoms have resolved.
For influenza cases and outbreaks, arrange antiviral treatment and prophylaxis with residents' GPs	Early initiation of antiviral treatment (within 48 hours of symptoms) in adults with confirmed influenza reduces the risk of secondary complications requiring antibiotic therapy or hospitalisation[1]. • Prescribing antiviral medications and treating residents in a confirmed influenza outbreak is the responsibility of the GP. • LPHUs can assist by providing a letter to RCFs to supply to visiting GPs, recommending treatment of confirmed cases and prophylaxis (where appropriate) once the outbreak has been notified. • This letter should be sent to all facility GPs at the start of an influenza outbreak. • The department/LPHU does not provide or cover the cost of treatments – costs are to be covered by the resident and/or their families. • RCFs should liaise with local pharmacies to ensure there is adequate availability of antiviral medication. • RCFs should inform LPHU if they are having difficulty sourcing medications.
Offer vaccination	Review vaccination records of all residents and staff. Unvaccinated and asymptomatic staff, residents and visitors should be offered or recommended vaccination.
Movement of staff, residents and visitors	**Staff movements** • Staff should not move between wings of the facility where possible.

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[1] Dobson J, Whitley RJ, Pocock S, Monto AS. oseltamivir treatment for influenza in adults: a meta-analysis of randomised controlled trials. Lancet. 2015;385(9979):1729-37.

Actions	Instructions
during influenza outbreaks. *Also recommended for other respiratory outbreaks*	• Staff should be allocated to the care of residents in an outbreak affected wing, and should avoid working in unaffected wings, to further reduce the risk of transmission. • Only vaccinated staff should care for affected residents in suspected or confirmed outbreaks. • For influenza, unvaccinated staff are recommended to attend work only if they are asymptomatic and are wearing appropriate PPE and/or taking appropriate antiviral prophylaxis in influenza confirmed outbreaks. They should also be offered immediate vaccination. Vaccination may not prevent illness if already incubating. A protective immune response takes approximately two weeks to develop. • All staff members should self-monitor for signs and symptoms of respiratory illness and self-exclude if unwell. **Resident movements** • Movement of affected residents (cases) outside the isolation room should be limited to medically necessary/essential procedures or activities including transfer to other facilities. • Affected residents who must be transported outside of the room should wear a mask if tolerated and follow respiratory hygiene/cough etiquette. • When transferred to another health care facility, the outbreak and infection status of the resident must be communicated to the accepting facility. **New admissions** • Admission of new residents to the affected unit during the outbreak is not recommended. If new admissions are unavoidable, new residents and their families must be informed about the current outbreak and adequate outbreak prevention and control measures must be in place. **Re-admission of residents** • Re-admission of residents who are active cases of influenza is permitted, provided appropriate accommodation including any infection control requirements can be met. • Re-admission of non-case residents (that is, are not a known case) should be avoided to protect them 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 prevention and control measures must be in place. Families may wish to make alternative arrangements. **Visitors** • Visitors should be kept to a minimum where possible. • Signage must be present at the entrance of facility to inform visitors of outbreak.

Actions	Instructions
	• Visitors with influenza should not visit the facility until after 5 days from symptom onset or until their symptoms have resolved, whichever is longer, or until 72 hours after the commencement of antivirals.
	• Visitors with other (non-COVID) respiratory illnesses should not visit the facility while symptomatic.
	• Visitors should be instructed and supervised on the use of PPE (donning and removing masks) and hand hygiene.
Monitor outbreak progress	Increased and active observation of all residents for ARI is essential in outbreak management to identify possible ongoing transmission and potential gaps in infection control measures.
	• Facilities should have the capacity to monitor or count residents and staff displaying signs and symptoms of ARI daily to ensure swift infection control measures are implemented or strengthened to reduce transmission and the duration of the outbreak.
	• Once the outbreak is notified, a case-list of ill residents/staff should be provided to the LPHU on the same day of notification.
	• Update the case-list daily.
	• Send a copy to the LPHU twice weekly, ensuring all relevant details are captured.
	If influenza is NOT detected in residents or staff:
	• When nose and throat swabs are found to be negative for influenza (and COVID-19), or a different virus has been detected (for example, RSV), contact the LPHU to inform and seek advice.
	• The LPHU will encourage the RCF to manage the remainder of the outbreak themselves (see section 9) and will not continue to actively follow up or request ongoing case lists for other respiratory pathogens. It is recommended to request a final case list for RSV outbreaks from the RCF.
Escalation criteria	If any deaths occur during an outbreak, the LPHU should be notified within 24 hours.
	Hospitalisation of residents may be noted on the case list and sent to the LPHU twice weekly.
	During an outbreak, contact the LPHU for advice as required.
Declaring the outbreak over	All respiratory outbreaks, including influenza, can be declared over 7 days after the last case tests positive or the date of isolation of the last case in a resident, whichever is longer; or later at LPHU discretion.
	In the instance of an influenza outbreak, contact LPHU for final approval when this time frame has occurred to ensure the outbreak can be formally declared over.
Review outbreak management	After the outbreak is declared over, it is important to reflect on strengths and weaknesses of the outbreak response and investigation process within the facility. This can occur through formal or informal debriefs with the aim to improve processes for future outbreaks.

7. COVID-19 exposure – initiating management and identifying COVID-19 contacts

The following section outlines the steps that RCFs should follow to identify contacts when there has been exposure to COVID-19 at the facility. The RCF is responsible for coordinating this response. Some actions may need to occur concurrently. See section 8 on outbreak management for more details on additional specific actions including IPC measures and clinical management of resident cases.

See also the checklist available online <https://www.health.vic.gov.au/infectious-diseases/acute-respiratory-infection-management-rcf>. Also useful is the Commonwealth Department of Health checklist <https://www.health.gov.au/resources/publications/first-24-hours-checklist-management-of-acute-respiratory-infections-or-outbreaks-in-residential-aged-care-homes>.

Contact definitions can be found in section 4 'Contact, exposure and outbreak definitions'.

It is important to note that:

- If the case is an asymptomatic resident identified via RAT (and is not a contact of a case), the result should be confirmed with a PCR test as soon as possible and recommended to be within 48 hours of the positive RAT. Confirmatory testing should however not delay the first round of testing in the facility, but rather occur concurrently.
- If the COVID outbreak definition is met – refer outbreak management in section 8.
- If the outbreak definition is not met – continue with the appropriate management including identifying contacts as outlined below, testing of resident and staff contacts, and implement IPC measures as described in outbreak management in section 8.
- RCFs should be aware of additional reporting requirements relevant to their sector.

COVID exposure pathway: single resident case – identifying contacts

Steps RCFs should follow when there has been COVID-19 exposure in the facility. The RCF is responsible for coordinating this response and some actions may need to occur concurrently. RCF should contact their LPHU if they have any questions.

1. Isolate the resident with COVID-19 diagnosis

A resident with a COVID-19 diagnosis should be immediately isolated in a single room with an ensuite bathroom, if possible.

2. Notify the case according to sector requirements

All RCFs are required to report a COVID-19 case in a resident, worker or visitor according to sector requirements found in section 5 'Detecting and notifying cases and outbreaks'.

3. Activate the internal OMT

Activate the internal OMT to initiate the facility OMP, ensuring the plan is current and all staff are clear about roles and responsibilities.

4. Test all residents in the affected zones and other contacts (i.e. exposed in a shared defined area, such as prolonged contact during an activity or shared living space)

This round of testing will help to determine if there is an outbreak. This testing should ideally occur on the same day that the positive case was identified. Review the first round of COVID-19 test results.

5. Management of residents who are considered contacts

Residents who are contacts who choose **not to self-quarantine** in their rooms should:

- If RAT negative, enable socialisation by choice of resident with others who have a similar exposure level
- Undertake a RAT at least every second day up to day 7 after being identified as a contact.
- Isolate if they become unwell and take a test.
- Wear a face mask when leaving their home for 7 days; the wing/area where the resident lives is considered their home.
- Not visit hospitals and other care facilities, except for essential care
- Resume normal activities after day 7 with a day 6 negative result and asymptomatic.

Residents who are contacts who choose to **self-quarantine in their rooms for 7 days** should:

- Undertake RAT on Day 2 and 6 of self-quarantine.
- Isolate if they become unwell and take a test. .
- Wear a face mask when leaving their home for 7 days.

5b. Management of residents who are not considered contacts

Other residents in the facility may also have been exposed to COVID-19, but do not meet the criteria for being managed as a contact. These residents should limit their movement within the facility and be monitored for symptoms. If they become unwell, they should take a COVID-19 test (PCR or RAT), and isolate while awaiting test result.

6. Management of staff working in the same area/wing

Identifying staff contacts:

Where a staff member has been exposed to COVID-19 within the facility with:

- no effective PPE (N95/P2 masks, eye protection) during aerosol generating behaviours or procedures
- At least 15 minutes face to face contact where both mask and protective eyewear were not worn by the staff member and the case was without a mask, or
- Greater than 2 hours in the same room as a case with inadequate PPE

They **are** considered a contact. The following mitigation strategies should be implemented if the staff member is returning to work:

- Test (RAT initially, if negative proceed to PCR if available), followed by daily RATS (until day 7)
- Isolate immediately if symptoms develop at any time or upon testing positive (even if asymptomatic)
- Work in P2/N95 masks for the first 7 days following exposure
- Avoid staff redeployment to unaffected areas to minimise risk of potential spread
- Avoid shared spaces or meal rooms.

COVID exposure pathway - staff or visitor case - identifying contacts

Steps RCFs should follow when there has been COVID-19 exposure in the facility. The RCF is responsible for coordinating this response and some actions may need to occur concurrently. RCF should contact their LPHU if they have any questions.

1. Determine if the staff or visitor were on site during their infectious period

- Review staff records and visitor logs.
- Interview the staff or visitor for each interaction.
- If there are concerns that the RCF was the source of infection, arrange appropriate testing of possible sources. The LPHU can provide advice in this situation.

Interview Questions

- How long they spent in each area and with each person?
- Were they were wearing PPE throughout their interactions?
- If yes, what type of PPE was worn (for example, surgical mask, N95).
- Whether there were any PPE breaches about their movements whilst on-site (for example resident's room, a communal area, a bathroom).

2. Notify the case according to sector requirements

All RCFs are required to report a COVID-19 case in a resident, worker, or visitor according to sector requirements found in section 5 'Detecting and notifying cases and outbreaks'.

3. Activate the internal OMT

Activate the internal OMT to initiate the facility OMP, ensuring the plan is current and all staff are clear about roles and responsibilities.

4. Identify and manage any resident contacts and monitor for symptoms

N95 worn and No PPE Breaches

- Staff or visitor wore an N95 respirator throughout interactions with residents, and
- No PPE breaches

Residents **are not** considered a contact. **There is no further action required.**

N95 not worn or PPE Breaches

- Determine if affected residents meet the contact definition (see section 4).
- Manage residents as per the 'single resident case' exposure pathway above.

5. Identify and manage any staff contacts and monitor for symptoms

N95 worn and No PPE Breaches

- Staff or visitor wore an N95 respirator throughout interactions, and
- No PPE breaches.

Staff **are not** considered a contact. **There is no further action required.**

N95 not worn or PPE Breaches

- Determine if the staff member meets the contact definition (see section 4).
- Manage staff as per the 'single resident case' exposure pathway above.

8. COVID-19 outbreak management

Many of the actions required for outbreak management are also recommended for management of exposure to isolated cases. It is important that all actions are completed where necessary. Some actions may need to occur concurrently. Refer to section 7 - exposure management section for additional considerations.

If it has been established that there is an outbreak of COVID-19 within an RCF, the following actions outlined below should be conducted.

Actions	Instructions
Notify the outbreak	Refer to section 5 for information about which agencies/organisations to notify
Initiate the OMP	Ensure the OMP is current, and staff are clear of roles and responsibilities

Implement IPC measures	A number of key measures should be employed during a COVID-19 exposure or outbreak in an RCF, including:
	• standard precautions:
	  – hand hygiene
	  – use of PPE
	  – respiratory hygiene/cough etiquette
	  – cleaning shared equipment
	  – routine environmental cleaning.
	• transmission/airborne based precautions:
	  – N95/P2 respiratory protection
	  – single room isolation
	  – dedicated equipment where possible
	  – physical distancing should be maintained where feasible
	  – cohorting/zoning of staff and residents where possible
	  – ventilation/air handling

Actions	Instructions
	– increased cleaning of frequently touched surfaces – minimising the movement of visitors into and within the facility – taking a risk-based approach to minimise risk related to admissions and transfers – displaying appropriate signage. • All staff working in RCFs should have good understanding of IPC measures required throughout a COVID-19 exposure or outbreak at their workplace. • See the following resource for further information: COVID-19 Infection Prevention and Control Guidelines <https://www.health.vic.gov.au/covid-19-infection-prevention-control-guidelines>.
Clinical care of residents with COVID-19, including the use of antivirals	All residents should continue to receive their usual ongoing medical care, including essential allied health and mental health care. Services that maintain the physical and emotional wellbeing of residents should continue to be provided as much as possible. Where possible, the use of nebulisers, continuous positive airway pressure (CPAP) and suction should be avoided. If continuation of this therapy is necessary, a hospital transfer may be required. This should be discussed with your LPHU. Clinical supports include existing health providers (ensure GP and other key health providers are notified as appropriate), and support from the LPHUs, and in-reach teams. **Antivirals** Facility operators providing care to those at high risk of severe disease should ensure timely access to treatment including clinical assessment, prescription, and dispensing, as these are most effective in the early phase of COVID-19 infection. There is no recommendation for prophylactic (preventative) use of antiviral treatments during COVID-19 outbreaks. For more information, please see section 2 – antiviral treatment and prophylaxis.
Management of residents who are considered contacts (see section 4 for contact definition)	A contact with COVID-19 symptoms should undertake a COVID-19 test (RAT or PCR). There are two options for managing contacts. Discuss these options with residents and where applicable this decision should involve the resident's family, guardian and/or enduring power of attorney to understand whether, in the next 7 days, they would usually attend activities outside their home , for example in another part of the facility or off-site. If leaving the RCF to go on an outing, contacts should be strongly recommended to avoid visiting people who are elderly or medically at-risk of severe illness from COVID. **Option 1:** Choose not to self-quarantine in their room: • If RAT negative, enable socialisation by choice of resident with others who have similar exposure level

Actions	Instructions
	• Undertake a RAT at least every second day up to day 7. – The 7-day period commences on the date the person became a contact (date the case/ outbreak was identified) and ends on the date the contact's period of self-quarantine would have ended (7 days later). For example, if self-quarantine starts on a Monday, the 7-day period ends the following Monday. • Wear a face mask when leaving their home for 7 days (the wing/area where the resident lives is considered their home). However, RCFs should <u>recommend</u> the use of masks within communal indoor areas. • Do not visit sensitive settings including hospitals and other care facilities for 7 days except for essential care. • It is strongly recommended that they do not visit other areas/wings within the facility. **Option 2:** Choose to quarantine in their room: • Residents can choose to remain in room, away from others, for up to 7 days. • Test (PCR if available, or RAT) on day 2 and day 6 of self-quarantine. • They may exercise outdoors, however should wear a face mask and maintain physically distancing.
Difficulties with testing some residents	Testing can be difficult in some circumstances, for example there may be an inability to understand the process or reason for testing. All options to facilitate testing of residents should be explored, for example: • leaving a swab for familiar staff members to use later (this may not be possible if the specimen is critical to diagnosis) • supervised self-testing • alternative modes of testing such as saliva testing. If the resident has symptoms of COVID-19 and no test can be undertaken due to lack of consent, resistance or distress, the resident should be treated as though they had tested positive. Whilst in isolation, the resident should have care provided with COVID airborne precautions (N95 respirator and eye protection) and gloves and gowns/apron as per standard precautions, when risk of contact with blood/body fluids including respiratory secretions. until a test can be undertaken or an appropriate period of isolation has been completed. If the resident is recommended to have a test for screening purposes only (that is, the resident does not have any symptoms) and no test can be undertaken due to lack of consent, resistance or distress, explore all the options to facilitate testing, and determine whether there is any need to consider quarantine based on the risk assessment, noting that quarantine is not mandatory. Continue to monitor for symptoms and if any develop, the resident should be isolated.
Management of staff working in the same area/wing as the case	Any staff members with symptoms of COVID-19 should not enter the facility, should isolate, and undergo testing.

Actions	Instructions

	• Staff are to follow COVID airborne precautions (N95 respirator and eye protection) and gloves and gowns/apron as per standard precautions when risk of contact with blood/body fluids including respiratory secretions. Please note that gloves are never a substitute for hand hygiene.
	
	 • Staff in the wing/area caring for residents who are contacts without symptoms of COVID-19 and who have returned a negative COVID-19 test result should wear an N95 respirator.
	
	 • If the staff member wore an N95 respirator throughout their interactions with the positive case(s) (and there were no PPE breaches), the staff member is not considered a contact.
	
	 • A staff member should be considered a contact if:
	   - They wore no effective PPR (N95/P2 masks, eye protection) during aerosol generating behaviours or procedures
	   - They had at least 15 minutes face to face contact where both mask and protective eyewear were not worn by exposed person and the case was without a mask, or
	   - They spent more than 2 hours in the same room as a case with inadequate PPE.
	
	 • Staff contacts should:
	   - Test (RAT initially, if negative proceed to PCR if available), followed by daily RATS (until day 7)
	   - Isolate immediately if symptoms develop at any time or upon testing positive (even if asymptomatic)
	   - Work in P2/N95 masks for the first 7 days following exposure
	   - Ensure they work in P2/N95 masks for at least 7 days following exposure, and for the duration of the outbreak, whichever is longer
	   - Avoid staff redeployment to unaffected areas to minimise risk of potential spread
	   - Avoid shared spaces or meal rooms.
	
	 • Staff who may have been exposed to COVID-19, but are not considered contacts should still monitor for symptoms. If they become unwell, they should immediately get tested and be excluded from work.
	
	 During an outbreak of ARI in an RCF where testing for COVID-19 is negative, consideration should be given to performing viral multiplex PCR testing to detect influenza and other respiratory pathogens.
	
	 For documentation, prepare a line list to be sent to the LPHU daily (or as directed). See suggested line list fields in the appendix.

Actions	Instructions
Management of residents who are not considered contacts	Residents who are not contacts: • should immediately undertake a COVID-19 test should they develop symptoms and should isolate pending the results • avoid the affected areas/wings where there are active cases • be encouraged to wear a mask in communal indoor areas • be supported with a transfer out of the facility if feasible, after a risk-assessment has taken place (that is, understanding family circumstance and health status prior to transfer) – the LPHU may provide advice where required. It is strongly recommended that contacts do not visit other areas/wings within the facility. During an outbreak, careful consideration should be taken during organisation of communal activities that may usually include contacts from affected wings, and residents from unaffected wings. To reduce the risk of transmission, where possible, groups should be separated, and activities should be conducted outdoors.
LPHU risk assessment during an outbreak	Upon notification, the LPHU will undertake a risk assessment to determine their level of involvement and the need for further enhanced public health interventions. They will take into consideration factors such as: • resident and staff case numbers • staff numbers and ability to provide safe care to residents, cases across multiple wings/areas • ongoing transmission • numbers of hospitalisations and/or deaths • cases with challenging behaviours • vaccination rates • RCF outbreak management experience, resources, including being a stand-alone facility.
Review staffing levels	Staffing levels should be reviewed in line with the facility OMP. This should consider the following: • review current rosters • determine the estimated number of staff that may be unable to work • implement workforce mitigation arrangements (for example, contacting workforce suppliers and/or moving to an adjusted roster of 12-hour shifts) • cohort all staff and contractors to work consistently in one area of the facility (for example, one wing or floor) where practicable.

Actions	Instructions
	Residential care workers who are contacts (and do not have any symptoms of COVID-19) may attend work at a care facility, however, are strongly recommended to take daily RATs for the first 7 days following exposure. They should not attend work if they return a positive RAT.
	It is important that facility managers monitor and ensure staff health and wellbeing.
Case and contact management	Follow exposure management pathways for staff, residents, and visitors (see section 7). Ensure timely access to the use of antivirals (see section 2 – antiviral therapy) for those at high risk of severe disease, as these are most effective in the early phase of COVID-19 infection.
Release from isolation	**For residents with COVID-19:**
	• After 5 days (on day 6) since symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved and COVID-19 RAT is negative
	OR
	• After day 7 if acute symptoms resolved and no fever for 24 hours. No testing required.
	Residents should not leave isolation if they are experiencing the common symptoms of COVID-19: runny nose, sore throat, cough, shortness of breath, fever, chills, or sweats. People may be infectious for up to 10 days after testing positive, and sometimes longer.
	Additional recommendations:
	• If residents have ongoing symptoms or are severely immunocompromised, they should seek advice from the medical practitioner or LPHU before leaving isolation.
	• They should wear masks for at least 7 days after the positive test when they are needing to leave home, and they are indoors or unable to physically distance.
	• A negative RAT result is a helpful tool to determine if a case is likely to be no longer infectious. Additional testing to determine release from isolation may be considered for those severely unwell in hospital or RCFs, or those with severe immunocompromise, and may also be considered for other cases in residential care settings with residents at high risk from COVID-19 infection, depending on the risk assessment of the situation.
Staff diagnosed with COVID-19 – return to work	Staff diagnosed with COVID-19 can return to work:
	• After 5 days (return day 6) since symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved and COVID-19 RAT is negative

Actions	Instructions
	OR
	• After 7 days (return day 8 onwards) if acute symptoms resolved for 24 hours, no testing required. If symptoms continue, return when acute symptoms resolved and no fever for 24 hours.
	On the worker's return, and until 10 days following the onset of symptoms (or date of first positive test if asymptomatic), additional mitigations should be required by facilities. This includes the worker being required to use a P2/N95 respirator and have separate breakout areas, where possible.
	Facilities can consider allowing an earlier return to work in circumstances where a worker's attendance at work is required to prevent a significant risk to safe service delivery. In these situations, a local risk assessment should be undertaken, and additional mitigations should be in place including the worker:
	• wears a P2/N95 respirator
	• is asymptomatic (or all acute symptoms having resolved)
	• returns a negative COVID-19 RAT
	• uses separate breakout areas.
	Staff must never be compelled to return to work when unwell.
	• Workers with ongoing symptoms or who are severely immunocompromised should seek advice from the medical practitioner or LPHU before attending work.
Monitor outbreak progress	After the initial notification, the LPHU will maintain communication with the RCF by arrangement. This may include daily check-in if required, or less frequent contact as deemed appropriate by the LPHU.
	LPHUs may choose to offer an onsite assessment of a RCF to support infection control measures and ensure an adequate outbreak response is underway.
	• Update case lists each shift/daily.
	• Once the outbreak is notified, a case-list of ill residents/staff should be provided to the LPHU on the same day of notification.
	• Update the case-list daily.
	• Send a copy to the LPHU twice weekly, ensuring all relevant details are captured.
Escalation criteria	If any deaths occur during an outbreak, the LPHU must be notified within 24 hours. Hospitalisation of residents should be noted on the case list and sent to the LPHU twice weekly.

Actions	Instructions
Communicate and notify through internal pathways as per the OMP and communication plan	Staff, residents, families, and others as required (for example, other nominated next of kin for residents, contractors) should remain informed of any updates while the exposure remains active.
Organise urgent access to vaccines for staff/residents who require COVID-19 vaccination	Follow current advice on vaccination including primary course and boosters and timing of vaccination following COVID-19 infection. See section 2 - vaccination for more details. Boosters can be provided in the event of an outbreak if they can be provided safely on site.
Visitors	Visitor access should continue to be facilitated by RCFs, to mitigate the adverse effects of social isolation on residents. Visitors to the facility must be notified of exposure and potential risk. Visitors should be reminded about safety measures such as: • hand hygiene • wearing masks properly (both by directly reminding visitors and indirectly, such as vis signs in the facility reminding visitors of these measures) • social distancing should be practiced where possible and appropriate • all visitors to RCFs should have a negative RAT taken on the same day that they attend the care facility • visitors should visit residents in their rooms or private space, preferably in a well-ventilated room or outdoors. **Visitors diagnosed with COVID-19** Visitors who have had COVID-19 can return to visiting a RCF after day 7 (on day 8) if their acute symptoms have resolved and no fever for 24 hours. No testing is required. **Visitors to residents with COVID-19** Residents with COVID-19 should always have access to at least one essential visitor and follow a risk-based approach. This is particularly important in compassionate circumstances such as end-of-life care. The RCF should consult with the LPHU to determine appropriate mitigations to support families, carers, and pastoral supports (emotional and spiritual support) to visit cases. For further information refer to the following resources:

Actions	Instructions
	• CDNA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities> • Coronavirus (COVID-19) – National aged care guidance – aged care visitation guidelines <https://www.health.gov.au/resources/publications/coronavirus-covid-19-national-aged-care-guidance-aged-care-visitation-guidelines> • Industry Code for Visiting RAC Homes during COVID-19 https://www.cota.org.au/policy/aged-care-reform/agedcarevisitors/ • Older Persons Advocacy Network: COVID-19 and visitor access <https://opan.org.au/information/covid-19-information-and-visitor-access-information/>
Admissions and transfers	CDNA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities> describe a risk-based approach to manage admissions and transfers during an outbreak: • residents attending medical or procedural appointments • new admissions • re-admission of residents confirmed to have COVID-19 • re-admission of residents without COVID-19 • moving unaffected residents out of the facility • transfers to hospital. The risk assessment undertaken by the LPHU will also assist in guiding this risk-based approach.
Cleaning	A deep clean is not routinely required, but the LPHU will advise of any additional cleaning requirements required to manage an outbreak case-by-case. Review cleaning schedules to ensure cleaning of high (frequently) touched surfaces in communal areas is occurring twice daily. High-touch points in communal spaces such as kitchens and staffrooms, should be included in a cleaning schedule. These are areas where staff take off their masks (when worn) and network with their colleagues. High-touch surfaces include equipment, door handles, trays, tables, handrails, chair arms, light switches, patient care equipment (for example, commodes, lifter slings).

Actions	Instructions
	Facilities should increase the number of sites for hand sanitizer and ensure that one is available at each bed space.
	Detailed information on environmental cleaning and disinfection is in COVID-19 Environmental cleaning and disinfection principles for health and residential care facilities <https://www.health.gov.au/resources/publications/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities>.
	Disinfectants registered with the TGA as effective against the virus (SARS-CoV-2) are listed at Disinfectants for use against COVID-19 in the ARTG for legal supply in Australia <https://www.tga.gov.au/products/covid-19/covid-19-personal-protection-products/disinfectants-use-against-covid-19-artg-legal-supply-australia>.
	Additional requirements for cleaning include:
	• a system to clean and disinfect reusable PPE and shared equipment
	• an increase in the number of cleaning staff to:
	– support enhanced cleaning schedules
	– provide daily cleaning and disinfection of individuals' rooms and communal areas.
	For further information please refer to: Standard and transmission-based precautions <https://www.health.vic.gov.au/covid-19-infection-prevention-control-guidelines/standard-and-transmission-based-precautions>.
Ventilation strategies to reduce COVID-19 transmission in RCFs	Staff can implement ventilation strategies where appropriate, including opening windows and conducting activities outdoors.
	Optimal ventilation via heating, ventilating, and air-conditioning (HVAC) systems is one of a suite of controls to reduce COVID-19 transmission. These work by removing infectious aerosol particles in enclosed spaces.
	For information on ventilation refer to section 2 - air quality and vaccination . Further information on ventilation strategies that are recommended to reduce the risk of COVID-19 aerosol transmission can be found in the department's COVID-19 Infection Prevention and Control Guidelines <https://www.health.vic.gov.au/covid-19-infection-prevention-control-guidelines>.
	These strategies should be implemented in consultation with an occupational physician or ventilation professional.
Waste management	Studies into the known modes of transmission of COVID-19 indicate that PPE from patients does not need to be considered clinical waste, see Managing coronavirus waste from a workplace | Environment Protection Authority Victoria <https://www.epa.vic.gov.au/about-epa/news-media-and-updates/coronavirus/managing-coronavirus-waste-from-a-workplace>.
	See section 2 - Waste management for further information.
Declaring the outbreak over	An outbreak can be declared over 7 days after the last case tests positive or the date of isolation of the last case in a resident, whichever is longer; or later at LPHU discretion.
	If a further case is diagnosed after the outbreak has been closed and is within 14-days of when the most recent case returned a positive test and was diagnosed with COVID (and entered isolation), the outbreak is re-opened.

Actions	Instructions
	New cases diagnosed at the RCF after this 14-day period are considered a new outbreak (if meeting the outbreak definition).
Review the outbreak	After the outbreak is declared over, the OMT should reflect on: • strengths and weaknesses in the response and investigation • policies, practices, or procedures to improve responses for future outbreaks. It may be useful to complete an audit to assess the outbreak response against best practice, using a tool such as A structured framework for improving outbreak investigation audits <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-9-472>. Consider providing a document outlining lessons learned to the LPHU and the Australian Government to enable ongoing quality improvement in the management of outbreaks.

9. Non-influenza, non-COVID-19 outbreaks in RCFs including RSV

It is strongly recommended that RCFs report all respiratory outbreaks to the LPHU or the department. If tests are negative for both COVID-19 and influenza, or another pathogen such as RSV is detected, RCFs would usually then self-manage the outbreak.

As a general guide the following actions should be undertaken by RCFs:

- Continue to monitor the outbreak by using daily case lists, however there is no need for case lists to be communicated to LPHU regularly. It is recommended that case lists are sent to the LPHU at the end of an RSV outbreak.
- Continue to test all symptomatic residents: a RAT to test for COVID-19 (or a combination RAT, if available), and if negative, test (or arrange testing) for multiplex respiratory PCR (includes COVID-19, influenza A/B, RSV, and other respiratory viruses).
- Any symptomatic person should isolate for the duration of their symptoms.
- Continue with IPC measures as referenced to in section 6 – Influenza Outbreak Management. Viruses such as human metapneumovirus or RSV can also cause significant morbidity in the elderly.
- These outbreaks can be declared over 7 days after the last case tests positive or the date of isolation of the last case in a resident.
- Contact the LPHU if there are any concerns with the outbreak or if more guidance is required (for example, case numbers not decreasing, deaths).
- If the facility identifies a case of COVID-19 or influenza they should notify the LPHU, and the appropriate actions must occur, as outlined in the relevant sections above.

10. Appendices

Appendix A: Key documents

Key supporting documents

Note that advice in national guidelines may at times differ from the requirements set out in the in the Victorian guidelines. Local guidelines have been developed specific to the Victorian context.

- CDNA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities>

- Information relating to SARS-CoV-2 and COVID-19 has been sourced from the CDNA Coronavirus (COVID-19) National guidelines for public health units <https://www.health.gov.au/resources/publications/coronavirus-covid-19-cdna-national-guidelines-for-public-health-units?language=en>

- Pre-season letter i to GP with FluVax Antiviral planning tool <https://www.health.vic.gov.au/infectious-diseases/acute-respiratory-infection-management-rcf>

- COVID-19 Infection Prevention and Control Guidelines <https://www.health.vic.gov.au/covid-19-infection-prevention-control-guidelines>

- Personal Protective Equipment (PPE) specific recommendations for COVID-19) <https://www.health.vic.gov.au/covid-19-infection-prevention-control-guidelines/personal-protective-equipment-ppe>

- How to do a nasal rapid antigen test (available in English and other languages) <https://www.health.gov.au/resources/videos/coronavirus-covid-19-video-how-to-do-a-nasal-rapid-antigen-test?language=en>

- Information about COVID-19 for the public <https://www.betterhealth.vic.gov.au/coronavirus-covid-19-victoria>

- COVID-19 information for people with disability <https://www.betterhealth.vic.gov.au/covid-19/covid-19-information-people-disability>

Australian Department of Health and other sources

- Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Disability Residential Services <https://www.health.gov.au/resources/publications/control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-disability-residential-services>

- Government support for providers and workers <https://www.health.gov.au/topics/aged-care/managing-covid-19/government-support>

- Prevent and prepare for COVID-19 in residential aged care <https://www.health.gov.au/node/18602/prevent-and-prepare-for-covid-19-in-residential-aged-care> covers measures that RACFs should always have in place to prevent and prepare for an outbreak.

- Managing a COVID-19 outbreak in residential aged care
  <https://www.health.gov.au/topics/aged-care/managing-covid-19/prevent-and-prepare-in-residential-aged-care/managing-a-covid-19-outbreak>

- First 24 hours checklist – Managing COVID-19 in a residential aged care facility
  <https://www.health.gov.au/sites/default/files/2023-04/first-24-hours-managing-covid-19-in-a-residential-aged-care-facility.pdf>

- COVID-19 advice for people in residential aged care homes and visitors
  <https://www.health.gov.au/topics/aged-care/managing-covid-19/for-older-people-and-carers/for-people-in-residential-aged-care-homes-and-visitors>

- COVID-19 advice for disability support services <https://www.health.gov.au/topics/covid-19/health-sector/disability>

- Coronavirus (COVID-19) Easy Read resources
  <https://www.health.gov.au/resources/collections/coronavirus-covid-19-easy-read-resources>

- Aged Care Quality Standards <https://www.agedcarequality.gov.au/providers/standards>

- Visitor access <https://www.agedcarequality.gov.au/providers/clinical-governance/dealing-infectious-outbreaks/visitor-access>

- Ensuring safe visitor access to residential aged care
  <https://www.agedcarequality.gov.au/resource-library/ensuring-safe-visitor-access-residential-aged-care>

- Coronavirus (COVID-19) – National aged care guidance – aged care visitation guidelines
  <https://www.health.gov.au/resources/publications/coronavirus-covid-19-national-aged-care-guidance-aged-care-visitation-guidelines>

- Industry Code for Visiting in Aged Care Homes <https://www.cota.org.au/policy/aged-care-reform/agedcarevisitors/>

- Partnerships in care <https://www.agedcarequality.gov.au/resource-library/partnerships-care>

Appendix B: Department of Health and LPHU contact details

Organisation Name	Phone/email
Communicable Diseases, Victorian Department of Health	1300 651 160 Infectious.diseases@health.vic.gov.au <infectious.diseases@health.vic.gov.au>
Barwon Southwest PHU	phu@barwonhealth.org.au <phu@barwonhealth.org.au>
Gippsland Region PHU	grphu.cd@lrh.com.au <grphu.cd@lrh.com.au>
Goulbourn Valley PHU	phu@gvhealth.org.au <phu@gvhealth.org.au>
Grampians PHU	phu@bhs.org.au <phu@bhs.org.au>
Loddon Mallee PHU	LMPHU@bendigohealth.org.au <LMPHU@bendigohealth.org.au.
North Eastern PHU (NEPHU)	healthprotection.nephu@austin.org.au <healthprotection.nephu@austin.org.au.
Ovens Murray PHU	omphu@awh.org.au <omphu@awh.org.au>
South East PHU (SEPHU)	sephu.trace@monashhealth.org <sephu.trace@monashhealth.org>
Western PHU (WPHU)	wphu@wh.org.au <wphu@wh.org.au>