COVID-19, Influenza, Respiratory Syncytial Virus, and Other Acute Respiratory Infection Outbreaks in Residential Aged Care Homes

Toolkit to support planning, preparedness, and response

Version 14 - July 2024

Department of Health

Tasmanian Government

We acknowledge and respect Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we work and live and pay respect to Elders past and present. For around 40 000 years, Aboriginal people have lived on lutruwita/Tasmania, within strong and resilient communities. We acknowledge that as we work to strengthen resilience against respiratory illness across Tasmania.

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Abbreviations

ABHR	Alcohol-based hand-rub
ARI	Acute Respiratory Infection
CDNA	Communicable Diseases Network of Australia
CDPU	Communicable Diseases Prevention Unit (PHS DoH)
DoH	Department of Health
GP	General practitioner
ICEG	Infection Control Expert Group
ILI	Influenza-like illness
IPC	Infection prevention and control
OMCT	Outbreak management coordination team
OMT	Outbreak management team
PCR	Polymerase chain reaction
PHEOC	Public Health Emergency Operations Centre
PHS	Public Health Services
PPE	Personal protective equipment
RACH	Residential aged care home
RAT	Rapid Antigen Test
RSV	Respiratory Syncytial Virus
TIPCU	Tasmanian infection prevention and control unit

Updates since earlier versions of this document

Content within this toolkit has been reviewed since version 12.0 to align with updated State and national guidance and CDNA guidelines.

Enquiries about this toolkit can be directed to Public Health Services by email, refer to below contacts.

Public Health contacts

Unit	Reasons to contact	Email
Public Health Services (PHS) Respiratory Outbreak – CNC Response Team	To notify outbreaks of COVID-19, influenza, respiratory syncytial virus (RSV), or other acute respiratory infections (ARI). To make general enquiries about ARI in RACH or the toolkit.	cdpuoncall@health.tas.gov.au PHS - CNC: 6166 0655 (8.30am to 5.00pm (Mon- Fri) On-call: (M) - 0408 532 708
Tasmanian Infection Prevention Control Unit (TIPCU)	To make general enquiries relating to infection prevention and control.	tipcu@health.tas.gov.au

Introduction

Scope and purpose of this document

The purpose of this toolkit is to assist aged care providers with the prevention, control, and public health management of COVID-19, influenza, respiratory syncytial virus (RSV), and other acute respiratory infection (ARI) outbreaks in residential aged care homes (RACH) in Tasmania. It has been adapted to the Tasmanian context from the following national guidelines:

- Communicable Diseases Network of Australia (CDNA) National Guideline for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection in Residential Aged Care Homes
- Australian Commission on Safety and Quality in Health Care (ACSQHC) Guideline Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019) (safetyandquality.gov.au)

The information about ARIs in this toolkit is purposely concise with links to key documents. It is recommended that staff involved in planning, preparing, and responding to ARI outbreaks in RACH review the linked documents above regularly.

This toolkit is primarily for RACHs but can also be used for disability residential care facilities and other residential settings.

Background

All respiratory viruses can cause outbreaks and significant morbidity and mortality for people aged over 65 years and people with co-morbidities or low immunity. Residential care facility residents are especially vulnerable, as communal living can facilitate the rapid spread of COVID-19, influenza, RSV and other ARIs.

COVID-19, influenza, RSV and other ARIs in residential aged care settings

Health services and RACHs have knowledge and skills to respond to the challenges posed by COVID- 19, influenza, RSV, and other respiratory viruses.

All respiratory viruses may present in a similar way, and robust systems for preventing, detecting, and managing ARI outbreaks safely are a key feature of any response in RACH. Additionally, influenza, RSV, and COVID-19 might occur together. Information for RACHs on preparing for ARI cases and outbreaks can be found in Appendix 1: Preparedness.

The management approach to COVID-19, influenza, RSV, and other ARI are similar, however there are key differences, as detailed in Table 1: Overview of Similarities and Differences – COVID-19, influenza, Respiratory Syncytial Virus (RSV), and other Acute Respiratory Infections.

Table 1: Overview of similarities and differences – COVID-19, influenza, Respiratory Syncytial Virus, and other Acute Respiratory Infections

	COVID-19	Influenza	RSV	Other ARIs
Vaccine available	Yes- 6-12 monthly boosters recommended	Yes, annual vaccine recommended	Yes- Vaccine available on private prescription for those aged 60 years and older	No vaccines available
Notifiable under the Public Health Act (1997)	Yes – laboratory confirmed case(s) *RAT identified case(s) no longer require notification as individual cases through the RAT portal, but should be included as part of an outbreak identification and notification in a RACH setting*	Yes – laboratory confirmed case(s)	Yes – laboratory confirmed case(s)	No
Notification process to Public Health	Individual cases: notified by laboratory (PCR) Outbreaks: RACH should notify Public Health of outbreaks by email cdpuoncall@health.tas.gov.au	Individual cases: notified by laboratory Outbreaks: RACH should notify Public Health of outbreaks by email cdpuoncall@health.tas.gov.au	Individual cases: notified by laboratory Outbreaks: RACH should notify Public Health of outbreaks by email cdpuoncall@health.tas.gov.au	Not routinely notified. Outbreaks: RACH are recommended to notify Public Health of outbreaks by email cdpuoncall@health.tas.gov.au
Outbreak definition	2 or more resident cases of COVID-19 within 72 hours	2 or more resident cases of influenza within 72 hours	2 or more resident cases of RSV within 72 hours	2 or more resident cases within 72 hours
Infection Control Precautions	Standard and Transmission based precautions. PPE as per Guidance on the use of personal protective equipment	Standard and Transmission based precautions. PPE as per Guidance on the use of personal protective equipment	Standard and Transmission based precautions. PPE as per Guidance on the use of personal protective equipment	Standard and Transmission based precautions. PPE as per Guidance on the use of personal protective equipment
Isolation of cases and suspected cases.	Yes, recommended	Yes, recommended	Yes, recommended	Yes, recommended
Outbreak stand down	No new resident cases within 7 days of the last resident case identified and in consultation with Public Health.	No new resident cases within 7 days of the last resident case identified and in consultation with Public Health	No new resident cases within 7 days of the last resident case identified and in consultation with Public Health	No new resident cases within 7 days of the last resident case identified

Prevention

Key strategies for preventing introduction of ARIs into the facility are outlined below.

Vaccination

Vaccination, along with other risk reduction measures, are essential to protecting residents, staff, and the wider community. Annual seasonal influenza planning and the latest recommendations for COVID-19 vaccination should be integrated into prevention strategies and planning for ARI outbreaks in RACH.

Immunisations for both influenza and COVID-19 are strongly encouraged for RACH staff and residents and are required in some instances following Work Health and Safety risk assessments.

See Australian Technical Advisory Group on Immunisation (ATAGI) and the Australian Government Department of Health and Aged Care for advice regarding 2024 vaccines

- ATAGI statement on the administration of seasonal influenza vaccines in 2024
- ATAGI statement on the administration of COVID-19 vaccines in 2024
- Information for aged care providers, workers, and residents about COVID-19 vaccines

Reinforce hygiene measures

The following measures can help prevent introduction and transmission of respiratory illness within the facility:

- require that staff and visitors do not enter the facility if unwell with respiratory symptoms,
- provide signage on hygiene promoting behaviours where staff, residents and visitors can see them,
- encourage appropriate use of personal protective equipment (PPE),
- support physical distancing where practicable,
- support and encourage hand and respiratory hygiene by residents, staff, and visitors,
- provide hand washing stations and alcohol-based hand rub throughout the facility,
- ensure liquid soap, paper towels and rubbish bins are available at all hand basins,
- provide tissues and rubbish bins throughout the facility.

Manage entry to your facility

Transfers and admissions into the RACH

All residents being transferred or admitted into the RACH should be screened for symptoms of respiratory illness. If any symptoms are identified, organise testing and manage the resident with transmission-based precautions in line with a risk assessment.

There is no requirement for asymptomatic residents being transferred into a RACH from an acute care facility to be routinely tested for respiratory illnesses.

Recommendations for visitors and staff entering the RACH

Public Health recommends facilities have a policy for risk mitigation measures for visitors and staff entering the facility, which considers the community risk for respiratory illness, cases of respiratory illness in staff and the local community, the likely interaction between visitors/ staff and residents and the individual preferences of residents. At a minimum all facilities should have messaging advising visitors to not enter if have any symptoms of respiratory illness or have had symptoms in the last 7 days. Broader general measures could be introduced for all visitors if respiratory illness is common in the community and may include mask wearing for staff and visitors.

Where visits cannot be deferred, facilities are recommended to have processes to enable visits with appropriate infection prevention and control measures in place (such as mask wearing, outdoor visitation, minimizing movement within the facility). This process is recommended for symptomatic visitors regardless of whether a visitor has tested positive to a particular respiratory pathogen, and for identified close contacts of COVID-19. Where possible visitors should **notify the facility prior to the visit. Advice can be sought from Public Health as required.**

Visitors with symptoms of respiratory illness

It is recommended that:

- visitors who have respiratory symptoms, or have had respiratory symptoms which commenced in the last 7 days, should not attend the facility,
- visitors who have tested positive for COVID-19, not attend the facility until 7 days after symptom onset if acute symptoms have resolved and no fever for 24 hours. No testing required,
- visitors who have tested positive for Influenza, not attend the facility until 5 days after symptom onset or until symptoms resolved, whichever is longer OR 72 hours after antivirals commenced.

Visitors who are identified close contacts of known respiratory pathogens

Asymptomatic household contacts and household like contacts of COVID-19 should avoid visiting high-risk setting for at least 7 days after their last contact with a COVID-19 case.

Visitors who have contact with a case of influenza, RSV or other respiratory pathogens are able to visit if they are well and do not have any symptoms. A mask should be worn for 7 days from last exposure if visiting the RACH.

Additional information regarding visitation to RACHs can be found here: Visiting high risk settings

Staff members with symptoms of respiratory illness

Facilities are recommended to have workplace policy for staff who have symptoms of respiratory illness to provide advice regarding testing, returning to work and mask wearing on returning to work. Where possible staff with respiratory symptoms should undertake testing for COVID-19. A RAT is an appropriate first test. If this RAT is negative, and symptoms persist, a PCR with respiratory panel should be sought were possible.

Staff members who have been sick with an ARI should only return to work when their acute symptoms have resolved.

If staff have tested positive for COVID-19, it is recommended they should not return to work until:

- After 5 days since symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved and COVID-19 RAT is negative, OR
- After 7 days if acute symptoms have resolved for 24 hours, no testing required. If symptoms continue, return when acute symptoms have resolved and no fever for 24 hours.

Staff returning after COVID-19 infection are recommended to wear a mask for up to 10 days.

Staff members who become unwell while at work should go home.

Staff members who are close contacts for known respiratory pathogens

Workplaces should have policies in place to manage close contacts of COVID-19 which may include wearing a mask in the workplace and undertaking RATs. If able, staff may be encouraged to work from home.

RACH staff who have contact with a case of influenza, RSV or other respiratory pathogens are not required to stay at home or avoid high-risk settings and can continue to work if they are well and do not have any symptoms. A mask should be worn for 7 days from the last exposure.

Identification of Acute Respiratory Infections in a RACH

Early identification of cases and rapid response is key to minimising transmission of ARIs within a RACH.

Transmission of respiratory viruses

The viruses that cause respiratory illness spread through:

- most common: inhalation of respiratory aerosols and droplets of various sizes from an infectious person
- less common (or rarely): touching objects or surfaces (like doorknobs, sink taps and tables) that have respiratory aerosols and droplets of various sizes (i.e., from coughing or sneezing) from an infectious person, and then touching your mouth or nose.

Signs and symptoms of acute respiratory infections

When residents develop symptoms of an ARI, it is not possible to know whether it is due to influenza, COVID-19, or another respiratory virus prior to testing.

The most common symptoms of any ARI are (in the absence of an alternative diagnosis that explains the clinical presentation):

- *fever (or symptoms of fever eg, chills, night sweats)
- acute respiratory infection symptoms (sore throat, shortness of breath, cough, runny nose), and/or
- tiredness or fatigue.

Other common symptoms include:

- muscle and joint pains,
- nausea, vomiting, and diarrhoea,
- headache,
- loss of smell or loss of taste (more frequent with COVID-19).

Older people may have mild or atypical presentations, such as:

- new or increased confusion,
- irritability,
- withdrawal from normal activities,
- worsening symptoms of chronic lung disease (e.g., increased sputum production),
- loss of appetite.

* fever may be absent in the elderly.

Management of residents with fever or acute respiratory illness

Unwell residents should be clinically assessed and managed by their GP or other treating medical practitioner. Maintaining the health and wellbeing of residents and ensuring their care needs are met is the responsibility of the RACH.

If a resident has fever or symptoms of acute respiratory illness:

- Isolate the resident (in a private/single room with ensuite if possible) and wear a P2/N95 and protective eyewear. Gown and gloves are required in line with standard precautions.
- Inform the resident's GP. Provide a comprehensive clinical history, current clinical observations, and facility details.

Tell the GP if there is a suspected or confirmed outbreak of influenza, COVID-19, or another ARI within the facility.

If it is after hours, contact the after-hours or locum service as per standard processes.

When to test residents for respiratory viral pathogens

If a resident has a fever or acute respiratory symptoms

- Test for COVID-19, influenza, and RSV.

  A PCR is recommended for all initial symptomatic resident cases and for all symptomatic residents with a negative RAT. A RAT for COVID-19 may be undertaken at the same time to support early access to antiviral therapy.

  Clinical decisions should be discussed with the resident's GP or other treating medical practitioner.

- While waiting for the test result, isolate the resident in a private room (with ensuite if possible) and use a P2/N95 mask and protective eyewear. Gown, and gloves are required in line with standard precautions.

How to arrange testing

Information on testing for COVID-19 and other respiratory viruses, including a flowchart for managing testing and notification of results, can be found in Appendix 2: Summary of PCR testing process for COVID-19, influenza, RSV, and other acute respiratory infections in RACH.

Clinical care of unwell residents

Decisions regarding the clinical care of unwell residents, including whether the resident(s) should be managed in the RACH or transferred to hospital, should be made on a case-by-case basis according to clinical need.

The needs of the resident(s) will be considered in consultation with the resident, their family, the facility, and clinicians.

Transfer of residents from hospital or another residence to the RACH should be facilitated once the resident is well enough.

Isolation

Clinical queries about isolation for individuals with unknown or another pathogen should be discussed with the managing clinician.

Additional information regarding isolation for COVID-19, influenza, and RSV can be found in the below sections.

Key initial actions for the RACH on identification of a symptomatic resident(s)

As soon as acute respiratory symptoms are first identified in a resident(s), the following initial actions are recommended:

Implement IPC measures

- Isolate the symptomatic resident(s). A single room with ensuite is recommended
- For direct care of symptomatic resident(s), wear a P2/N95 mask and eyewear
- Put on other PPE such as a long- sleeved gown or plastic apron, and/or gloves if you anticipate contact with blood or body fluids (i.e., as per Standard Precautions)
- Increase frequency of environmental cleaning and disinfection

Conduct testing

- Test the symptomatic resident(s) for COVID-19, influenza, and RSV via PCR
- Consider performing a RAT at the same time as completing a PCR to support early access to antiviral therapy
- A PCR is recommended for all initial symptomatic cases, regardless of RAT result and for all symptomatic residents with a negative RAT

Consider

- Reducing movement and group activities within the facility
- Cohorting staff and residents within the facility

Key general actions for the RACH in an outbreak

As soon as an outbreak of COVID-19, influenza, RSV, or other ARI is identified, the RACH should stand up the outbreak management team (see Appendix 1: Preparedness: Key Actions for Case and Outbreak Management) in accordance with their outbreak management plan. This team will be responsible for directing, monitoring, and overseeing the RACH outbreak response and management.

Scenarios may arise where a RACH is managing more than one respiratory virus within their facility. Where more than one pathogen is present, even when an outbreak definition is not met, the RACH should contact Public Health to discuss an appropriate facility- by-facility response. It is important that cohorting of residents occurs in such a way that residents with the same pathogen are cohorted together.

Action	Details
Isolate residents	Isolate all cases and symptomatic residents. Allocate specific staff to care for the confirmed or suspected case(s).
Notify outbreaks	Notify Public Health Notify the Australian Government Department of Health and Aged Care through the My Aged Care Portal (required for COVID-19 outbreaks but encouraged for other ARI outbreaks as well).
Activate outbreak management team	Activate the internal RACH outbreak management team. Appoint outbreak management coordinator. Meet and assign roles and responsibilities.
Ensure appropriate clinical management of case	Liaise with the treating GP/s and provide appropriate clinical care including antivirals where indicated. Arrange transfer if required for clinical care. Ensure all visiting health professionals are aware of outbreak. Review and communicate current Advanced Care Directives. Provide appropriate antiviral treatment in line with current national guidance for COVID-19 and influenza and in consultation with the patient's GP.
Activate communication plan	Provide information relating to the case and facility as requested by both Public Health and Australian Government Agencies to assist outbreak management. Allocate staff to manage communications.
Support contact tracing	Where indicated, identify contacts of cases, and manage in line with current Public Health guidance. Where required, provide a detailed site map and a line list of resident and staff cases to Public Health.

Action	Details
Enhance infection prevention and control	Ensure current infection prevention control and guidance is implemented and followed as per national guidelines Australian Guidelines for the Prevention and Control of Infection in Healthcare (2022) (safetyandquality.gov.au) and relevant disease specific national guidelines. Cohort residents where possible. Enhance hand hygiene, respiratory hygiene, and physical distancing. Wear PPE in line with PPE guidance as per Guidance on the use of personal protective equipment Increase frequency of environmental cleaning and disinfection.
Managing visitors	Visitors should comply with any RACH requirements (e.g., PPE requirements, screening etc). Admissions of new residents into the affected area(s) of the facility during an outbreak should be avoided where possible.
Conduct surveillance for additional cases	Monitor for ARI symptoms in staff and residents. Arrange testing for symptomatic staff and residents. Maintain an up-to-date line list with information regarding staff and resident cases and share line list with Public Health. Support any additional testing of staff and residents as per Public Health advice.
Manage staff	Allocate specific staff to care for residents in isolation. Cohort staff where possible. Actively screen staff for symptoms. If possible, recommend staff work at a single site only during an outbreak. Restrict staff close contacts who are returning to work with RACH approval to a single site only. Plan for staffing shortages where large numbers of staff may be furloughed.
Monitor and support health and wellbeing of residents and staff	Maintain primary and routine care. Support wellbeing of residents, including nutrition, physical activity, boredom, loneliness, and fear. Support residents with similar exposure or risk level to be cohorted together in an area away from other residents. Support morale and mental wellbeing of staff.
Standing down the outbreak	Liaise with Public Health about standing down the outbreak. Return to routine activities. Review and debrief on outbreak response. Review and revise the outbreak management plan as required.

Recommended key actions for **COVID-19** outbreaks

Notification	PCR confirmed cases are notified by laboratories to PHS. RAT identified cases should be included in RACH line list. RACH should notify Public Health of outbreaks by email **cdpuoncall@health.tas.gov.au**
Outbreak definition	2 or more resident cases within 72 hours
Testing	**Initial testing** Initial testing sweep of the affected area(s) via RAT once an outbreak is declared. For small facilities, a whole facility testing sweep may be recommended by Public Health on a facility-by-facility basis. **Ongoing testing** Ongoing testing of residents and staff as advised by Public Health. This should include testing of any symptomatic residents and staff, as well as RAT testing of residents in affected areas every 3 to 5 days.
Infection prevention and control	Isolate cases and cohort where possible. Wear a P2/N95 mask, and eyewear routinely. Wear other PPE (gown, gloves) when anticipating contact with blood or body fluids (as per Standard Precautions). Increase frequency of environmental cleaning and disinfection. Manage waste and linen as per usual processes.
Isolation of cases	**During isolation, cases can cohort with other COVID-19 positive residents.** **Resident cases should isolate away from other residents and implement appropriate IPC precautions for a minimum of 5 days. Release from isolation after 5 days from 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.** Staff cases should follow the general advice for community cases Tested positive? | Tasmanian Department of Health and **should not attend work for a minimum of 5 days. Return to work after 5 days from symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved and COVID-19 RAT is negative OR after 7 days if acute symptoms resolved for 24 hours, no testing required. If symptoms continue, return when acute symptoms resolved and no fever for 24 hours, no testing required.**

Close contacts	Identify contacts and ensure Public Health recommendations for close contacts are attended to e, g: monitored for symptoms.
Monitoring for cases	Monitor for fever and acute respiratory symptoms in residents and staff and test accordingly.
Antivirals	Case management: Provide in line with current national guidance Oral treatments for COVID-19 | Australian Government Department of Health and Aged Care and in consultation with the GP. Post-exposure prophylaxis: not currently recommended. Obtain pre-consent for the use of antivirals. For additional information about obtaining consent and procurement of antivirals for COVID-19 refer to Use of molnupiravir in residential aged care and Use of Paxlovid in residential aged care.
Other considerations	Plan to support visitors with appropriate use of PPE. Reduce resident movement within the facility. Cohort staff and residents within the facility where possible. Reduce or suspend group activities.
Stand down	**An outbreak may be stood down once:** • 7 days have passed with no new resident cases identified (where day zero is the date the last case tests positive or the date of isolation of the last case in a resident, whichever is longer). An outbreak may be declared over once: • 14 days after the last case tested positive. New staff cases where appropriate PPE has been worn and where there were no breaches, should not delay the standing down of an outbreak where the above criteria are otherwise met.

Recommended key actions for **influenza** outbreaks

Notification	PCR confirmed cases notified by laboratory. RACH should notify Public Health of outbreaks by emailing: **cdpuoncall@health.tas.gov.au**
Outbreak definition	2 or more resident cases within 72 hours.
Testing	Symptomatic residents and staff.
Infection prevention and control	Isolate cases and cohort where possible. Wear a P2/N95 mask, and eyewear routinely. Wear other PPE (gown, gloves) when anticipating contact with blood or body fluids (as per Standard Precautions). Increase frequency of environmental cleaning and disinfection. Manage waste and linen as per usual processes.
Isolation of cases	Isolate cases ideally in a single room with an ensuite. Cases can be released from isolation 5 days after symptom onset, or until acute symptoms have resolved (whichever is longer) or 72 hours after antivirals commenced. No testing required.
Close contacts	Not applicable.
Monitoring for cases	Monitor for new onset of acute respiratory symptoms in residents and test accordingly.
Antivirals	Case management: Provide in line with current national guidance and in consultation with the GP. Post-exposure prophylaxis: Provide in line with current national guidance 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 | Australian Government Department of Health and Aged Care and in consultation with the GP. Obtain pre-consent for the use of antivirals.
Other considerations	Plan to support visitors with appropriate use of PPE. Reduce resident movement within the facility. Cohort staff and residents within the facility where possible. Reduce or suspend group activities.
Stand down	A decision about standing down and closing an outbreak is made by the RACH in consultation with Public Health. An outbreak may be stood down once:

	No new resident cases within 7 days of last resident case identified. An outbreak may be declared over 14 days after the last case tested positive. New staff cases where appropriate PPE has been worn and where there were no breaches, should not delay the standing down of an outbreak where the above criteria are otherwise met.

Recommended key actions for **RSV and other respiratory viruses** outbreaks

Notification	PCR confirmed RSV cases notified by laboratory. Other ARIs are not routinely notified. RACH should notify Public Health of outbreaks by emailing: **cdpuoncall@health.tas.gov.au**
Outbreak definition	2 or more resident cases within 72 hours.
Testing	Symptomatic residents and staff only.
Infection, prevention, and control	Isolate cases and cohort where possible. Wear a P2/N95 mask, and eyewear routinely. Wear other PPE (gown, gloves) when anticipating contact with blood or body fluids (as per Standard Precautions). Increase frequency of environmental cleaning and disinfection. Manage waste and linen as per usual processes.
Isolation of cases	Isolate cases ideally in a single room with an ensuite. Cases can be released from isolation once symptoms have resolved or when a clinician has determined that the acute phase of illness is over. No testing required.
Close contacts	Not applicable.
Monitoring for cases	Monitor for new onset of acute respiratory symptoms in residents and test accordingly.
Antivirals	Not applicable.
Other considerations	Plan to support visitors with appropriate use of PPE. Reduce resident movement within the facility. Cohort staff and residents within the facility. Reduce or suspend group activities.
Stand down	A decision about standing down and closing an outbreak is made by the RACH in consultation with Public Health. An outbreak may be stood down once: No new resident cases within 7 days of the last resident case identified. An outbreak may be declared over 14 days after the last case tested positive. New staff cases where appropriate PPE has been worn and where there were no breaches, should not delay the standing down of an outbreak where the above criteria are otherwise met.

Declaring the outbreak over and transition to business as usual

The decision to ‘stand down’ an outbreak and wind back IPC precautions or declare an outbreak over **is guided by Public Health in conjunction with the facility.**

In general, an outbreak may be stood down once:

1. No new resident cases are identified *within 7 days* of the last resident case identified (see Key actions for the RACH for specific outbreaks for further details relating to individual pathogens).
2. Any required testing of close contacts and recommended testing regimens of other staff and residents have been completed.

Once an outbreak has been stood down a transition to business as usual requires a return to preventative and preparatory activities.

Guidance on the use of personal protective equipment (PPE)

PPE is required to protect staff, visitors, and residents when residents have, or are suspected to have, COVID-19, influenza, RSV, or another acute respiratory infection (ARI). The level of PPE required by staff and visitors is dependent on the known or suspected diagnosis of the resident and the activity being undertaken.

Staff should undertake all putting on (donning) and taking off (doffing) of PPE with a PPE buddy wherever possible to ensure PPE is worn correctly and that a fit check of the P2/N95 has been performed.

At designated PPE donning and doffing stations display signs outlining the:

- appropriate PPE needed for various roles and circumstances, and
- correct sequence of donning and doffing of PPE.

PPE used in RACHs are:

- Surgical mask – single use
- P2/N95 mask – single use
- Protective eyewear – single use or reusable
- Face shield – single use or reusable
- Plastic apron – single use
- Long-sleeved gown – single use
- Gloves – single use

The PPE required is task specific and is outlined in Table 2: PPE requirements for different activities.

The sequence for putting on and taking off PPE is outlined in Table 3: Sequence for putting on and taking off PPE.

Replace masks if they become damp, visibly soiled, accidently dislodged or have been in place for four hours. Do not touch the outside of the mask or leave the mask under the chin.

Staff who wear P2/N95 masks should ideally complete an initial fit test and must perform a fit check each and every time they don a P2/N95 mask. Where fit testing has not been performed and a P2/N95 mask is recommended for use, a fit-checked P2/N95 mask is preferred to a surgical mask.

To watch a fit check demonstration, refer to Personal Protective Equipment demonstration videos | Tasmanian Department of Health.

Visitors must be made aware of the risks of visiting during a declared outbreak and must be instructed and observed on the use of PPE and how to perform hand hygiene.

Residents who have a diagnosed viral respiratory illness should wear a surgical mask when possible, during face-to-face visiting.

Definitions

1. Direct care – where the resident is being physically touched by the carer. Most often occurs during assistance with activities of daily living.
    - Examples – assisting with bathing, dressing, toileting, ambulation, performing a procedure such as a wound dressing or catheterisation.
2. Indirect care – where care is provided but there is minimal physical touching of the resident by the carer. There is a low risk of blood or body fluid splashes.
    - Examples – dispensing medication, taking observations, putting a meal tray down in the resident's room, giving the resident an electronic device such as an iPad.
3. Direct contact with the physical environment.
    - Example – cleaning a resident's room, cleaning high-touch surfaces in common areas, cleaning bathrooms and waste removal.
4. Visiting/Visitors
    - Example – people not employed by the RACH such as friends or relatives or pastoral care.

Table 2: PPE requirements for different activities

Activity (work task or duty)	**Residents with diagnosed COVID-19, influenza, RSV, or other ARI** **Resident with symptomatic undiagnosed ARI**	**Residents negative and asymptomatic for a viral respiratory illness** **Close contacts of residents with COVID-19, influenza, RSV, or other ARI** **Residents who have ceased isolation following a diagnosed viral respiratory illness**
Direct care **Indirect care** **Direct contact with the physical environment**	P2/N95 mask Eye protection or face shield Other PPE as required as per Standard Precautions	Wear PPE as required as per Standard Precautions
Visiting	Visitor – N95/P2 mask and eyewear Resident - Surgical mask if able to be worn	Visitor – no PPE required Resident – no PPE required

Table 3: Sequence for putting on and taking off PPE

PPE	Putting on (donning) sequence	Taking off (doffing) sequence
Mask + protective eyewear/face shield	1. Hand hygiene using alcohol-based hand-rub (ABHR) 2. Put on mask 3. Hand hygiene using ABHR 4. Put on protective eyewear/face shield 5. Hand hygiene using ABHR	1. Hand hygiene using ABHR 2. Take off protective eyewear Dispose of disposable eyewear/face shield **OR** Clean reusable eyewear 3. Hand hygiene using ABHR 4. Take off mask 5. Hand hygiene using ABHR
Mask + protective eyewear + apron/gown + gloves	1. Hand hygiene using ABHR 2. Put on apron/gown 3. Hand hygiene using ABHR 4. Put on mask 5. Hand hygiene using ABHR 6. Put on protective eyewear/face shield 7. Hand hygiene using ABHR 8. Put on gloves	1. Take off gloves 2. Hand hygiene using ABHR 3. Take off apron/gown 4. Hand hygiene using ABHR 5. Take off protective eyewear/face shield Dispose of disposable eyewear/face shield **OR** 6. Clean reusable eyewear 7. Hand hygiene using ABHR 8. Take off mask 9. Hand hygiene using ABHR

Useful IPC resources

Australian Commission on Safety and Quality in Health Care

- Australian Commission on Safety and Quality in Health Care – hierarchy of control fact sheet
- Guideline Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019) (safetyandquality.gov.au)

Communicable Diseases Network Australia (CDNA)

- Coronavirus (COVID-19) – CDNA National Guidelines for Public Health Units

Tasmanian Infection Prevention and Control Unit (TIPCU) PPE video series

- Personal Protective Equipment demonstration videos | Tasmanian Department of Health

Information sharing

Notification to Public Health Services – Tasmania

For all notifications of respiratory virus outbreaks in RACH, please email the following information to **cdpuoncall@health.tas.gov.au:**

- name and address of the facility,
- contact details and role/position of person notifying,
- number of residents and staff in facility,
- number of residents and number of staff unwell,
- respiratory pathogen (if known),
- names and date of birth of all residents and staff cases,
- date of specimen collection.

COVID-19

COVID-19 is a notifiable disease in Australia.

Tasmanian Public Health is notified by laboratories of all positive PCR tests. RAT identified cases should be notified by the RACH on the PHS line list. In addition, the **RACH should notify Public Health of any outbreaks of COVID-19** by email to cdpuoncall@health.tas.gov.au.

If there is a case of COVID-19 identified at a RACH, all staff and residents should be made aware and should monitor for symptoms.

Notification to the Australian Government Department of Health and Aged Care

In the event of an outbreak of COVID-19, the RACH must notify the Australian Government Department of Health and Aged Care via the My Aged Care service provider portal | Australian Government Department of Health and Aged Care.

PHS may also liaise with the Australian Government Department of Health and Aged Care and/or the Aged Care Quality and Safety Commission so that additional support can be offered.

Other respiratory illnesses

Laboratory confirmed influenza and RSV are notifiable diseases in Tasmania.

Tasmanian Public Health is notified by the laboratory of all positive tests. **RACH should notify Public Health of any outbreaks of influenza, RSV, and other ARI outbreaks.** Notification should occur by email to cdpuoncall@health.tas.gov.au.

Notification to treating GPs and other healthcare workers

In addition to notifying Public Health, the RACH should notify all visiting GPs at the start of the outbreak. The RACH should also inform other healthcare providers (including transport/ambulance staff) before they attend the RACH.

Information sharing with Public Health – Tasmania

When a viral respiratory illness outbreak is suspected or confirmed and notified to Public Health, they will be in contact with the facility regularly. Public Health staff may request the following additional information from the RACH:

- resident and staff details, including total number of residents in the facility and in the affected area,
- description of the RACH in terms of size, buildings, layout, infrastructure, and staffing,
- total number of residents and staff with symptoms,
- date of onset and details of symptoms of each person,
- total number of staff that work in the facility and the affected area,
- capacity to isolate/cohort cases,
- whether respiratory specimens (nose and throat swabs) have been collected,
- number of people admitted to hospital with an acute respiratory illness,
- number of people with an acute respiratory illness who have died.
- **The death notification form *Notification of death related to COVID-19, influenza or RSV* is no longer required by Public Health.**

Line lists

- A line list will be provided to the RACH (in the form of an Excel spreadsheet) to record key information about cases.
- The RACH should update the line list and send it to Public Health by email to cdpuoncall@health.tas.gov.au. See Appendix 4 for an example of a line list.

Key resources

For additional and supporting information, please see:

- Coronavirus (COVID-19) CDNA National Guidelines for Public Health Units | Australian Department of Health and Aged Care.
- National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Homes | Australian Government Department of Health and Aged Care for additional guidance regarding influenza and ARI outbreaks.
- COVID-19 provider resources - Dealing with infectious Outbreaks – Aged Care Quality and Safety Commission | Aged Care Quality and Safety Commission.
- Tasmanian Infection Prevention and Control | Public Health (www.health.tas.gov.au/health-topics/infection-prevention-and-control).

Glossary

COVID-19 case

- An individual who has tested positive for SARS-CoV-2 on a polymerase chain reaction (PCR) or Rapid Antigen Test (RAT).

Close contact

- A person who has shared a defined area (e.g., a wing of a facility) and/or who has had a household like exposure with a case during their infectious period.

COVID-19 outbreak

- Two or more resident cases of SARS-CoV-2 within 72 hours.

Infectious period

- The infectious period begins 48 hours prior to when symptoms start or, where asymptomatic, before the positive test was taken, and may continue for up to 10 days after symptoms begin.

Reinfection

- Reinfection is a new COVID-19 infection in a person with a recent known history of COVID-19 that is determined to be separate to the previous infection based on epidemiological and/or laboratory findings. Automated surveillance systems will not routinely count positive results within 35 days of a case's previous positive test.

Appendix 1: Preparedness

RACH must prepare for respiratory illness cases and outbreaks. The following steps are key in ensuring preparedness. A useful checklist for RACH preparedness can be found at: COVID-19 outbreak management preparedness checklist | Tasmanian Department of Health.

Outbreak management plan	It is each service's responsibility to have an up-to-date **COVID-19, influenza, and ARI outbreak management plan.** **Talk with visiting GPs** and involve them in the planning process. See Appendix 3: Roles and responsibilities in a respiratory virus outbreak for the responsibilities of main organisations in COVID-19 outbreak management. Train staff in **activation** of your outbreak management plan. Include in your plan what will happen if a positive case is confirmed out-of-hours, such as arrangements for access to antivirals and primary care cover out-of-hours and contingency. Plans if usual GPs are unavailable.
Communication plan and resources	**Provide information** to residents and their families about infection control policies (including isolation protocols) and communicate restrictions and guidelines. Prepare a **communication plan** for communicating with staff, residents, volunteers, family members, GPs, and other service providers (e.g., cleaners) during an outbreak. Ensure appropriate IPC signage is readily available, see Best practice guidelines | Tasmanian Department of Health. Confirm you have the latest contact details for each resident's nominated representative. Ensure you have an **up-to-date list of your GPs** (with contact email and phone numbers) and develop an engagement process to support communication before, during and after an outbreak. Prepare **communication resources** that you may need in an outbreak (e.g., templates of letters to staff, residents, and families; signage/posters) ahead of time. This should also consider management of media enquiries. Prepare how you will facilitate communication and **social connection** between residents and their families in the event of an outbreak.
Workforce planning	Prepare staffing contingency plans. Plan for a **dedicated staffing model** to be implemented, in which staff (clinical and non-clinical) do not work across units or sites, where possible. Employee cohorting within the service where possible; this should be negotiated before any escalation of response and clearly documented.

Vaccination	Encourage all staff who are employed, or engaged, by or on behalf of the RACH are up to date with COVID-19 vaccinations, including booster doses. Encourage staff, residents, and visitors to be vaccinated against influenza every year. Encourage all residents and visitors to be up to date with their COVID-19 vaccinations. Consider maintaining records of all persons sufficiently vaccinated. Comply with the Australian Government's COVID-19 vaccination reporting requirements. For further information on COVID-19 and influenza vaccination in RACH, visit: Information for aged care providers, workers, and residents about COVID-19 vaccines. Responsibilities of residential aged care providers
Care for residents	Discuss with residents and their families their preferences for treatment including antivirals and transfers to hospital in the event of a severe respiratory illness diagnosis. Medical interventions should consider the resident's condition and their preferences for care. Ensure preferences and choices are clearly documented. Have **advanced care directives** and **goals of care** in place for appropriate clinical management in the event of severe respiratory illness. Prepare for treatment of residents by establishing processes to support timely access and appropriate administration of antiviral medication for COVID-19 and influenza, in accordance with local regulations.
Information for PHS	Provide a **map/plan** of your facility. Ensure **resident and staff details** are current and collated in an Excel spreadsheet, including correct names (i.e., not nicknames), date of birth, contact details and vaccination status if available. Public Health will provide the RACH with a line list (in the form of an Excel spreadsheet) to record key information about cases (Appendix 4). In the event of an outbreak, **the RACH should update the line list and send it to Public Health daily to** cdpuoncall@health.tas.gov.au.
Engage with your visiting GPs	Talk with your visiting GPs about your respiratory illness outbreak management plan including management of COVID-19 and influenza. Some areas for engagement include: Maintain an up-to-date list of visiting GPs and their contact details, including out of hours arrangements. Involve GPs in discussions about goals of care, including access to antivirals, and advance care directives for your residents. Involve GPs in planning and preparedness activities; ensure they are aware of your outbreak management plan and their role in an outbreak. This may include establishing arrangements for prescribing and dispensing therapies

	for respiratory illnesses including COVID-19 and influenza. Consider contingency plans for delivering primary care to residents if your usual GPs are unable to attend in person during an outbreak; consider the arrangements for telehealth and GP cover.
PPE	Train staff in the correct infection control practices, particularly Standard Precautions, Transmission-Based Precautions and safe PPE donning and doffing. See Tasmanian Department of Health Infection Prevention and Control Ensure **appropriate and sufficient PPE available for an outbreak** (to last at least 72 hours but one week's supply is recommended). Where possible, staff should be fit tested for use of P2/N95 masks and ensure a fit check is performed each time a P2/N95 mask is worn. Identify how PPE will be sourced and stored during an outbreak. Identify appropriate donning and doffing areas within the facility. Prepare signage demonstrating donning and doffing PPE.
Environmental cleaning	Prepare for additional environmental **cleaning and disinfection** requirements: Ensure adequate cleaning and disinfection supplies. Increase frequency of cleaning and disinfection for high-touch surfaces. Use a disinfectant that contains a minimum 1000ppm of sodium hypochlorite or hydrogen peroxide OR makes label claims against COVID-19.

Appendix 2: Summary of PCR testing process for COVID-19, influenza, RSV, and other acute respiratory infections in RACH

It is recommended that all facilities in Tasmania have available the equipment required to perform the collection of swabs for PCR testing, should this be required. Hobart, Launceston, and North West Pathology are able to provide specimen collection packs which contain detailed collection instructions, the swabs required and specimen transport bags. They may be obtained from your nearest laboratory by phoning:

- Hobart Pathology - 6223 1955
- Launceston Pathology - 6334 3636
- North West Pathology - 6432 8800

Swabs for respiratory virus PCR testing may be collected by an appropriately trained RACH staff member or by a GP.

If you have a resident(s) with respiratory symptoms:

- Initiate appropriate infection control precautions, including isolation of the suspect case
- Liaise with the patients treating or covering GP to discuss the requirement for PCR testing.

If testing is indicated:

- Complete a specimen request form on behalf of the requesting doctor.

Ensure:

- patient details are correct.
- if the patient has a mobile phone, its number written on the form.
- the requesting doctors' details are provided.
- In the test required section write ***COVID-19 and RVP PCR*** (RVP = respiratory virus panel).
- Don appropriate PPE and collect the sample, as per the instruction sheet.

Please note:

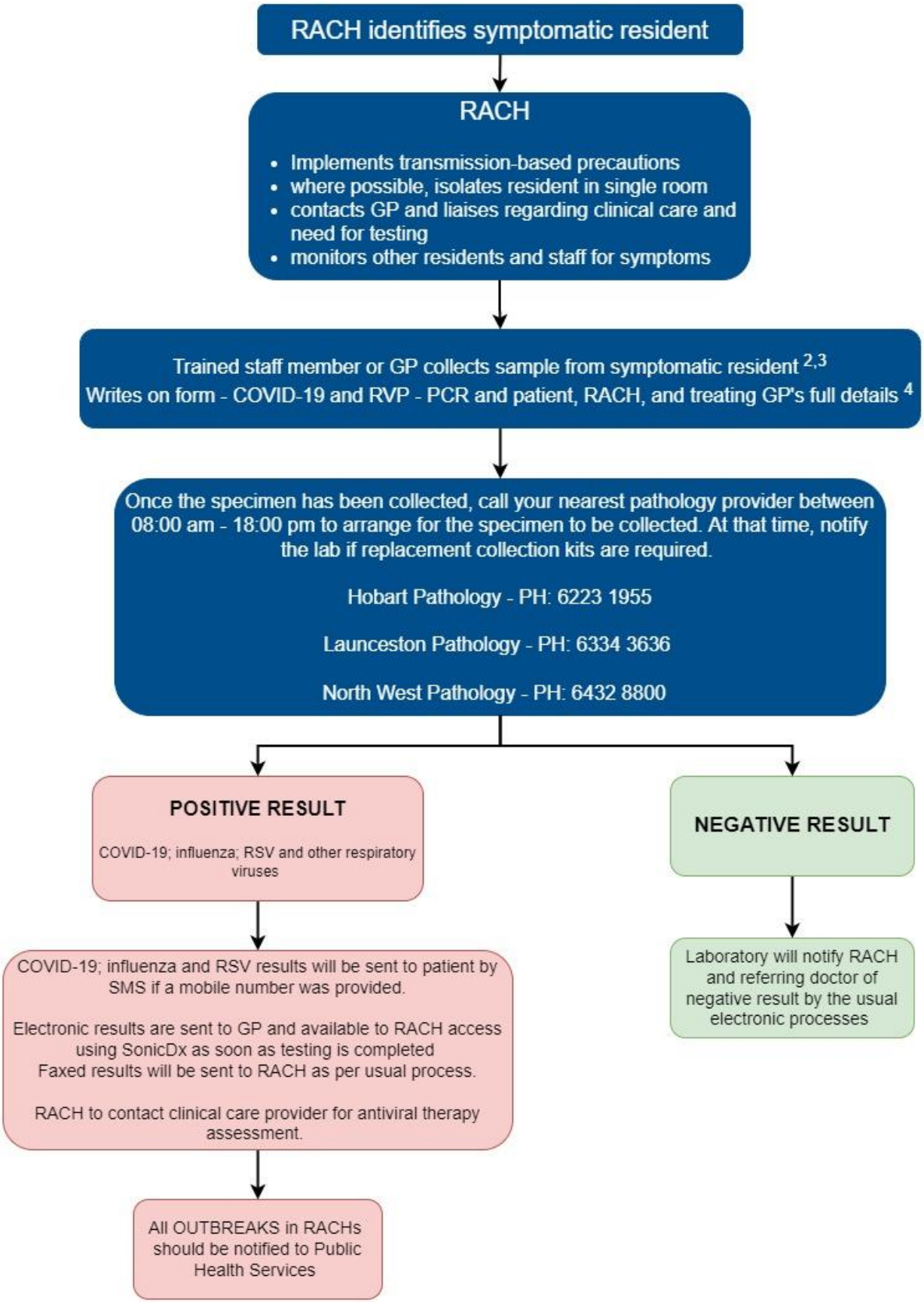
- The optimal specimen for respiratory virus PCR testing is a single combined throat and naso-pharyngeal swab.
- If this is not able to be obtained (e.g., due to patient reluctance or intolerance of naso-pharyngeal swabbing) a throat followed by a deep nasal swab is an acceptable alternative.

Testing & results:

- All specimens collected from a RACH will be tested for COVID-19, influenza, RSV and 5 other respiratory viruses that circulate commonly in our community.
- Once the specimen has been collected call your nearest laboratory (details as above) between the hours of 8am and 6pm to arrange for the specimen to be collected. At that time, notify the lab if replacement collection kits are required.
- The results of respiratory virus PCR testing are generally available within 24 hours of the specimen arriving at the laboratory.

- If the patient has a mobile phone number provided on the request form, they will receive a SMS with the results of COVID-19, influenza, and RSV testing as soon as it is completed.
- Results will also be sent electronically to the referring doctor as soon as they are available and will be able to be accessed by the RACH using the SonicDx[1] portal.
- Results will also be sent to the RACH by fax as per usual practice.
- While awaiting test results, please continue to follow infection control measures for symptomatic residents.
- For testing in residential care facilities other than aged care, please follow site-specific protocols or call Public Health to discuss.

Figure 2: Flowchart summary of PCR testing process with Sonic Pathology



Notes

1. If assistance is required in accessing SonicDx please contact clientservices@dspl.com.au
2. A RAT and PCR should be taken on initial symptomatic residents. If the RAT is positive initiate appropriate management while awaiting the PCR result.
3. It is suggested that each RACH keep on hand a small number (for example 5 – 6) of PCR Collection Packs. These contain detailed collection instructions, the required swabs and specimen transport bags and may be obtained from your nearest laboratory by phoning the numbers shown above.
4. When completing the request form please ensure the patient details are correct, the patient's mobile number is listed (if available) and the requesting doctor's details are documented.
5. If testing is part of an outbreak a resident with a positive RAT does not need a PCR test. If symptomatic and RAT negative a PCR should be collected.

Appendix 3: Roles and responsibilities in a respiratory virus outbreak

There are many stakeholders involved in management of a respiratory virus outbreak in a RACH. The following table outlines the key responsibilities of the main organisations involved.

Stakeholder	Key role and responsibilities
The RACH	• Has main responsibility for managing ARI outbreaks in that setting. • Activates an internal outbreak response team. • Implements its outbreak management plan and manages the outbreak in accordance with guidelines. • Ensures infection prevention and control measures for confirmed and suspect case(s) are followed. • Manages cases and outbreaks in line with Public Health requirements. • Provides information on cases and contacts to Public Health as required. • Where required, undertakes contact tracing in accordance with Public Health guidelines. • Continues to provide high quality care to residents. • Liaises with GPs and other clinical care providers. • Communicates with residents, staff, and families, in liaison with Public Health • Manages staffing. • Monitors and supports health and wellbeing of residents.
Visiting GPs	• Provide clinical care for residents, including provision of antiviral medication where indicated. • Assist with outbreak management. • Liaise with secondary and tertiary care providers.

Public Health	• Provides outbreak management advice and support. • Collates, analyses, and disseminates information on cases and outbreaks. • Advises on the management of cases and contacts. • Advises on the public health aspects of the outbreak response. • Monitors and reports on the outbreak. • Works with the facility to coordinate on-site investigations if needed. • Has legal responsibilities under the *Public Health Act 1997.* • Advises on infection prevention and control. • Coordinates and supports integrated COVID-19 planning, preparedness and response across aged care services in Tasmania. • Assists the organisation responsible for the facility with communications about the outbreak. • Activates and coordinates the Outbreak Management Coordination Team (OMCT) in response to an outbreak in a RACH.
Australian Government Department of Health and Aged Care	Only where a COVID-19 outbreak is identified, the Australian Government Department of Health and Aged Care: • supports surge workforce supply.
Aged Care Quality and Safety Commission	• Continues to act as regulator. • Resolves complaints about the delivery of aged care services. • Provides support as required.

The Outbreak Management Coordination Team

- In the event of an outbreak of COVID-19, a multi-agency Outbreak Management Coordination Team (OMCT) may be activated, whose key role is to coordinate the various agencies involved in responding to the outbreak.
- The OMCT is generally coordinated by Public Health. The membership of the OMCT will vary depending on the specific outbreak but may include representation from the following organisations: Public Health, Aged Care Quality and Safety Commission, Australian Government Department of Health, and Aged Care, TIPCU, and representatives from the RACH.

Appendix 4: Example Line List

To assist management of cases and outbreaks of COVID-19, influenza, RSV or other respiratory viruses, Public Health will provide the RACH with a line list (in the form of an Excel spreadsheet) to record key information about cases.

- The RACH should update the line list and send it to Public Health daily by email to cdpuoncall@health.tas.gov.au.
- Below is an example only of information that might be included in a line list provided by Public Health for completion.

Today's Date:	Organisation Name: < enter name here>	COVID ONLY																	
Disease	Resident/Staff	Location in Setting	First Name	Last Name	Date of Birth	Sex	Positive Test Date *(date the individual was tested)*	Report Date *(Date result reported on line list)*	Test Type	Date last worked	Symptoms Yes/No	Date of symptoms onset	Date into Isolation	COVID Vaccination Status - Number of Doses	Antivirals Given	Case Outcome	Date of Death	Postcode	Mobile Number	Email Address
COVID-19	*Staff*	*Garden*	*Easter*	*Bunny*	*01/01/2000*	*Female*	*22/04/2022*	*22/04/2022*	*RAT*	*22/04/2022*	*Yes*	*01/06/2022*	*22/04/2022*	*4*	*No*	*Ongoing*		*7000*	*61447021213*	*e.bunny@bigpond.com*
COVID-19	*Staff*	*Roof*	*Santa*	*Claus*	*01/02/2000*	*Male*	*22/04/2022*	*22/04/2022*	*PCR*	*22/04/2022*	*No*	*N/A*	*23/04/2022*	*1*	*Yes*	*Ongoing*		*7000*	*61447021213*	*s.claus@gmail.com*

Appendix 5: TAS RACH quick guidance for COVID-19 outbreaks

	TAS RACH guidance for COVID-19 outbreaks
Notification and activate outbreak management plan	Notify as per Notification to Public Health Services
Management of symptomatic individuals	Staff who are symptomatic should leave the facility and undertake testing Residents who are symptomatic should be managed with appropriate IPC precautions and undertake testing as per Key initial actions for the RACH on identification of a symptomatic resident(s)
Case management	**Staff:** • **Should not attend work for a minimum of 5 days. Return to work after 5 days from symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved and COVID-19 RAT is negative OR after 7 days if acute symptoms resolved for 24 hours, no testing required. If symptoms continue, return when acute symptoms resolved and no fever for 24 hrs.** **Residents:** • **Isolate away from other residents and implement appropriate IPC precautions for a minimum of 5 days. Release from isolation after 5 days from 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.** See Isolation • Liaise with GP for clinical assessment and provision of antiviral treatment as soon as possible. • Cases can be supported to cohort together.

Contact Management	• Undertake contact tracing to identify close contacts- see Glossary Staff: • Inform employer. • It is recommended that staff who are close contacts avoid the workplace where possible until 7 days from exposure to a case. • If required to come to work, check your workplace policy and consider additional risk mitigation strategies i.e., PPE and RAT prior to shift. Residents: • who are sharing the same wing/area are recommended to be managed as close contacts. • in general residents should be given the choice to continue to mix with other residents with similar exposure or to remain in their rooms. • If the COVID-19 case or person exposed to the case was wearing an P2/N95 respirator mask for the whole time, the exposed person is not considered a contact.
What is an affected wing/area	• A specific wing or defined area of a facility with one or more cases.
Initial testing in an outbreak	Initial testing: • Initial sweep of the affected area(s) via RAT once outbreak identified/declared. • For smaller RACH, testing of the whole facility *may* be recommended by Public Health on a facility-by-facility basis. • If recovered cases develop new symptoms, they should undergo testing as per standard pathways. • Testing refusal. • If a resident in the affected wing/area refuses testing, consider additional precautions. • Other asymptomatic residents not residing in affected wings/areas who refuse testing would not generally have any restrictions. • Discuss specific concerns with Public Health.

Ongoing testing regimen - Staff	Every two to three days RAT pre-shift until outbreak stood down (if staff not rostered during this period, one RAT pre returning to work).
Ongoing testing regimen - Residents	After initial test of affected area(s), residents in proximate areas (to case/cases) are recommended repeat testing every 3 days. Once a full round of testing has been completed with all negative results, can continue to test every 3-5 days until outbreak stood down.
PPE	Guidance on the use of personal protective equipment (PPE).
Managing visitors in an outbreak	Workplaces should have a policy in place to manage visitors during an outbreak. See Key general actions for the RACH in an outbreak.
Standing down an outbreak	An outbreak may be stood down once: • 7 days have passed with no new resident cases identified (where day zero is the date the last case tests positive or the date of isolation of the last case in a resident, whichever is longer). • The advised testing regime of residents in affected areas has been completed. New staff cases where appropriate PPE has been worn and where there were no breaches, should not delay the standing down of an outbreak where the above criteria are otherwise met.