Guidance for COVID-19 in Social Care Group Homes and Residential Care Services – Disabilities

1. Introduction

Data from international Covid-19 outbreaks has identified significant levels of mortality and morbidity in high-risk groups. Therefore, particular attention is required when considering how the needs of vulnerable people are managed to support prevention, identification and clinical management scenarios arising within them.

Structured approaches to supportive care and anticipatory planning may also affect the course and disease outcomes although evidence at this stage of the outbreak is limited in this regard. **Be aware that within the changing nature of the epidemic clinical guidance regarding management may change quite quickly and keep updated with relevant sites at www.hse.ie and www.hpsc.ie.**

Who is this guidance intended for?

Healthcare workers and managers delivering care in residential settings where the main model of care delivery is non-medical. This includes

- Transitional Living Units & Supported Living Services for people with disabilities
- Disability-care settings including;
    - Low Support Community Residence where individuals who are independent in many all areas of their everyday living skills. The residents generally have a supervisor/care staff who plays a supportive role in their care. In this scenario, carers may visit the individual but are not there 24 hours a day.
    - Medium support community residence where residents have moderate levels of independence but may require some assistance or support for certain activities. This would include transitional living units and supported living services.
    - High support community residence where individuals can live in the community but who require 24-hour supervision/support for a variety of reasons. Individuals can be supported in their own homes or in group settings.

Not included in this guidance are;

- Those with disabilities in receipt of home support. This cohort are included in specific guidance document
- Those in receipt of MDT or therapeutic supports in their home. Recommendations in relation to these supports and alternative models of care for delivery of these services are being finalised.
- Maximum support group homes for those with complex presentations and congregated settings. These services are generally nurse-led. A separate guidance document for this cohort is available.

This document gives general advice on the management of those with disabilities in community settings. It also gives specific advice for named scenarios and includes supporting information in appendices.

Social Care Group Homes and Residential Services are services delivered by health care professionals who are not clinically trained i.e. services are not delivered by medical or nursing professionals. Medical cover is provided by either the individual service users GP or GP providing cover to the house/facility. As such, care that is provided does not include symptom monitoring, clinical investigations, clinical management of service users. While some carers can administer medications, this is only the case if the medication is prescribed for the individual. As such, it would be recommended that paracetamol PRN should be prescribed for all those receiving care in the community. All clinical decisions will be deferred to the individual's GP.

Care homes/residential services are not expected to have dedicated isolation facilities for people living in the home but they should implement isolation precautions when someone in the home displays symptoms of COVID-19 in the same way that they would operate if an individual had influenza. If isolation is needed, a resident's own room can be used. If a dedicated isolation facility is required and not available in the home or across the organisation, the matter should be escalated to the local Disability Manager for follow up in line with HSE Operational Pathways of Care for the assessment and management of patients with Covid-19.

The unnecessary use of PPE will deplete stocks and increases the risk that essential PPE will not be available colleagues when needed. This guidance in this document advises adherence to the recommendations of the Health Protection & Surveillance Centre (HPSC). Full details outlining what PPE is required per clinical scenario are available on their webpage;
https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/Interim%20Guidance%20for%20use%20of%20PPE%20%20COVID%2019%20v1.0%2017_03_20.pdf

2. General Information

Coronavirus disease 2019 (COVID-19) is a new illness that can affect your lungs and breathing. While most people with COVID-19 develop mild or uncomplicated illness, approximately 14% develop severe disease and need more medical and oxygen support and 5% may require admission to an intensive care unit. Coronavirus is spread in sneeze or cough droplets. In order to get infected, the virus has to get from an infected person's nose or mouth into the eyes, nose or mouth of another person. It can take up to 14 days for symptoms of coronavirus to appear.

The main symptoms to look out for are:

- a cough - this can be any kind of cough, not just dry
- shortness of breath
- Myalgia or muscle pain
- Fatigue /tiredness
- Fever equal to or above 38^{o} /Chills
- Confusion

- Loss of appetite
- Unexplained change in baseline condition

Less Common Symptoms

Anorexia	Sputum production	Sore throat
Dizziness	Headache	Rhinorrhea
Conjunctival Congestion	Chest pain	Haemoptysis
Diarrhoea	Nausea/vomitting	Abdominal Pain

Risk Factors for severe disease

Ischaemic heart disease	Chronic heart failure	Hypertension
Diabetes	Chronic Lung Disease	1° or 2° immunosupression
Cancer	Age >60 with disability	Frailty

Red flags: Urgent need to contact GP

Fast Breathing i.e. >30 breathes/min	Difficulty Breathing	Person becomes confused or disorientated
Person feels dizzy or lightheaded/faint and/or has chest pain		Person hasn't passed urine >12 hours

How they test for COVID-19

Throat and nose swab for laboratory detection of virus is the method used to confirm the diagnosis. Although the test is considered generally reliable when taken in symptomatic people the test is not perfect and reliability depends on sample quality (a properly taken swab). This means that a person who has been exposed to the virus can test negative initially before they show symptoms and tests may need to be repeated, particularly if the person has been in close contact with another person confirmed as being COVID-19 positive.

On confirmation of a diagnosis of COVID-19 further investigations may be considered appropriate to assist with management. Decisions about any further tests should be made by the service users GP.

Further information on COVID-19 is available on the HSE website at:
https://www2.hse.ie/conditions/coronavirus/coronavirus.html

This guidance is aimed to support Disability Services on how to;

- Implementing best possible infection prevention and control practice
- Protect staff and individuals with disabilities who they are supporting in the community
- Look after COVID-19 positive service users and escalate to the appropriate care.
- The guidance has been updated based on HSE/HPSC guidance on testing in residential and long term care facilities published on 19.4.2020 (see appendix 6) , V3 of the Interim Public Health & Infection Prevention Control Guidelines on the Prevention and management of COVID-19 cases and outbreaks in Residential Care Facilities & Similar Units and COVID-19:

Interim Public Health Guidance for the management of COVID-19 outbreaks. This guidance document summarises many of the recommendations within that document. If additional detail is required on any element of this guidance document, the reader should refer to the full Guidelines which are available at https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Preliminary%20RCF%20guidance%20document.pdf and https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/outbreakmanagementguidance/COVID%20HP%20Outbreak%20Plan.pdf

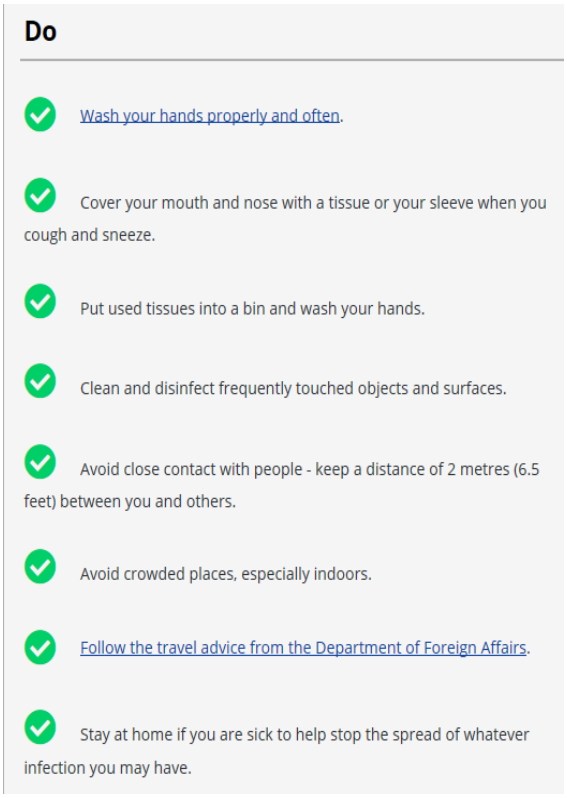
3. General Measures to reduce the risk of accidental introduction of COVID-19 to a client/service user

Current information suggests that COVID-19 can spread easily between people and could be spread from an infected person even before they develop any symptoms. For these reasons we suggest greater attention to cleaning and general hygiene, social distancing measures such as visitor restrictions, limited social mixing generally and especially indoors in communal areas as well as greater support to those with chronic illness/ disability. Facilities should ensure the availability of supplies including tissues, alcohol based hand rub (ABHR), hand wipes, cleaning products (including disinfectants) and personal protective equipment (PPE) and liaise with local CHO management if there is difficulty in obtaining such supplies.
The following are some general recommendations to reduce the spread of infection in a home or facility:

3.1 Each Facility should identify a lead person for COVID-19 preparedness and response within the facility/organisation. The lead should be a person with sufficient authority to ensure that appropriate action is taken.

3.2 Close attention to national guidance set out on preventative measures for COVID-19 by all staff, residents and visitors on www.hscp.ie including ;

- Informing all staff of the signs and symptoms of COVID-19 and advise them of actions to take if they or any close family members develop symptoms and to follow HSE guidance. The National Public Health Emergency Team requires that all staff have their temperature taken at the start of each shift, In addition, at the start of each shift, all staff should confirm verbally with their line manager that they have no symptoms of respiratory illness.
- Inform service users of the symptoms and what they should do if they aren't feeling well. Please see appendix 3 for some easy read supporting information on symptoms



- Careful attention to hand hygiene with provision of hand sanitiser and or hand washing facilities at all entrances (where practical to provide sinks)
- Coughing / Sneezing into tissue / elbow crook
- Surgical masks should be worn by healthcare workers when providing care to residents within 2m of a patient, regardless of the COVID-19 status of the individual.
- Surgical masks should be worn by all healthcare workers for all encounters, of 15 minutes or more, with other healthcare workers in the workplace where a distance of 2m cannot be maintained
- Visitor notices advising of hand hygiene measures before, during and after visiting
- Families and friend should be advised that all but essential visiting is suspended in the interest of protecting residents at this time. Family and friends should be aware of the circumstance in which they can visit and that all essential visits are permitted only when arranged in advance with the facility. Visitors with fever or respiratory symptoms will not be permitted.
- Notices to this effect should also be posted in the building.
- While the positive impact of seeing friends and family is acknowledged, this needs to be balanced against the need to keep service users sage and as such there will be the need to introduce visitor restrictions in event of COVID- 19 outbreak. A log of all visitors should be kept.
- Where possible facilitate alternative ways of engaging with friends and family (e.g. Skype / Facetime)
- Appropriate Social Distancing measures being observed by staff and as appropriate for service users within homes/facilities where clinically appropriate
- Careful attention to hand washing with provision of hand washing and hand sanitizer at all entrances and strategic points.
- Group activities that are necessary for residents welfare should be risk assessed for necessity and only conducted with small groups of residents where possible. Consider discontinuing completely for a short period of a few weeks.
- Contractors on site should be kept to a minimum
- Chaplaincy visits/cultural support are recognised as an important part of a resident's well-being. Visitors providing chaplaincy support should be reminded of the need to minimise physical contact and to follow advice particularly around hand hygiene and respiratory hygiene and cough etiquette. Phone or video link is preferred.
- Increase cleaning regime and ensure all hard surfaces that are frequently touched such as door handles, keyboards, telephones, hand rails, taps and toilet fittings are cleaned regularly with a household detergent.

3.3 Where possible, each ward/floor should try and operate as a discrete unit or zone, meaning that staff and equipment are dedicated to a specific area and are not rotated from other areas. This may not be feasible in smaller facilities but in larger facilities this practice may reduce exposure to risk for staff and residents in the event that COVID 19 is introduced into the facility.

3.4 If a member of staff if concerned that they may have COVID-19, they should refer to HSE guidance. If advised to self isolate at home, they should not visit or care for individuals until it is safe to do so. Please see appendix 5 for information on workplace exposure. Staff and managers should also refer to Health Surveillance & Protection Centre (HSPC) website for the most current information in terms of recommendations in relation to healthcare

workers including derogation for essential healthcare workers. Please see appendix 3 for guidance on self-isolation for staff

3.5 Regular infection prevention and control training for staff with emphasis on Standard Precautions (including hand hygiene) and including the appropriate use of personal protective equipment. If possible, one or more staff members should be trained in collecting samples for testing for COVID-19

3.6 Outings with service users/clients or any care off site should be reduced in accordance with public health advice and policy.

3.7 Service users health passports should be updated in case of requirement to transfer to another setting or changes to regular staffing. See link for same https://www.hse.ie/eng/services/news/media/pressrel/launch-of-the-hse-health-passport-mission-possible-short-film.html

3.8 Appoint designated staff to care for COVID-19 resident/zone for each shift. The service should maintain a log of all staff members caring for service users with COVID-19

3.9 Staff should only work in one residential unit and not move across settings.

3.10 Ideally care equipment should be dedicated for the use of an individual. If it must be shared, it must be cleaned and disinfected between use.

3.11 Efforts should be made to explain the changes in practice to the service user in so far as possible. To this end, please see appendix 2 which includes some easy read materials which may be useful

3.12 Prepare a service preparedness plan that reflects staff training in infection prevention & control (IPC) measures, contingency planning for outbreak management including isolation measures and cleaning procedures. These should be in line with HIQA guidance (see appendix 4) This should include;

3.12.1 Having a plan for dealing with people who become ill with symptoms including;

3.12.1.1 how individuals will be isolated from other service users i.e. designation of zones with staff assigned to zones

3.12.1.2 Plans for cohorting individuals

3.12.1.3 Enhanced IPC

3.12.1.4 Additional PPE supplies

3.12.1.5 Staff training

3.12.1.6 Surge capacity

3.12.1.7 Who to call for medical advice for each individual (the individuals GP or GP providing cover to the service)

3.12.1.8 A plan for how the setting will manage core services in the event of either service user or care staff becoming unwell

3.12.2 Having a plan for how the setting will manage core services in the event of either service user or care staff becoming unwell

4. General advice regarding actions required where service users/clients suspected or infected during COVID-19 epidemic in any disability setting

- All residents should be checked for symptoms twice a day
- Testing is indicated for any resident with symptoms of fever, cough, shortness of breath OR lethargy, confusion, loss of appetite, unexplained change in baseline condition

- If a resident presents with symptoms, all residents in the facility should be tested
- All staff within the facility should be tested
- All staff when coming on duty should be checked for symptoms
- Prioritised testing can be arranged via the National Ambulance Service
- The staff member should also contact the service manager. The service manager should contact area Disability Manager also.
- Public Health should be notified of any suspected case as well as the regional Medical Officer of Health[1]
- A local Incident Management/Outbreak Control Team (OCT) should be established.(See appendix 7 for summary of role/function of this Team). This group should try and establish whether it is likely an outbreak might occur taking in to account the following:
    - Could onward transmission have already occurred e.g. resident had widespread contact with others in the 48 hours before symptom onset?
    - Are they in a single room or sharing?
    - Is the resident ambulatory?
    - Have they spent time with others in communal areas or group activities?
    - Are there behavioural characteristics which might be increased risk of transmission?
    - Identify are any other residents symptomatic and if so, what are their symptoms?
    - Identify are any staff symptomatic or has there been an increase in staff absenteeism?
    - Identify residents and staff who were in close contact with the symptomatic resident in the 48 hours before symptom onset or before isolation and transmission based precautions were implemented
- This team will also need to;
    - Seek additional resources: PPE, staff, IPC support, Medical input
    - Oversee the isolation/cohorting of residents in so far as possible with;
        a. Residents with confirmed/suspected COVID-19 cohorted in adjacent rooms to define a contaminated zone
        b. Allocation of separate staff groups to care for those with confirmed/suspected COVID-19 and those without
        c. Staff should don PPE before entering contaminated zone and remain in PPE until leaving the zone
    - Ensure appropriate environmental cleaning and disinfection as per IPC guidance
    - Oversee adherence to recommendations for staff from occupational health & avoid derogation in as far as practical

[1] The Medical Officer of Health (MOH) has the responsibility and authority to investigate and control notifiable infectious diseases and outbreaks, under the Health Acts 1947 and 1953. Under the Infectious Disease Regulations 1981, all medical practitioners, including clinical directors of diagnostic laboratories, are required to notify the Medical Officer of Health (MOH) of cases and outbreaks of Notifiable Infectious Diseases. It is the legislative responsibility of the MOH to "make such enquiries and take such steps as are necessary or desirable for investigating the nature and source of such infection, for preventing the spread of such infection and for removing conditions favourable to such infection

- For the purposes of public health action, the threshold for an outbreak of COVID-19 is defined as[2]:
    - a single suspected case of COVID-19 in a resident or staff member acquired in the facility

      OR
    - one confirmed case of COVID-19 in a resident or staff member acquired in the facility.
- For the purposes of epidemiological surveillance, an outbreak of COVID-19 is defined as[2]:
    - two or more cases of illness consistent with COVID-19 infection in residents or staff members and at least one person is a confirmed case of COVID-19

      OR
    - two or more cases of illness consistent with COVID-19 infection in residents or staff members and there is a strong suspicion that it is caused by COVID-19 (do not report as outbreak at this time)
- Note that it is important to stress that having one or more residents with COVID-19 in a facility is not an outbreak if those residents already had COVID-19 before they transferred to the facility. An outbreak means that there is evidence of spread of infection within the facility.
- On recognition of an outbreak the following steps are important;
    - all relevant agencies with a responsibility for the investigation and management of the incident are informed
    - steps are taken to gather further information about the cases and how they may have been exposed
    - an initial risk assessment is undertaken
    - urgent control measures are put in place to protect public health Please see appendix 8&9 for guidance on outbreak management and checklist for same
- Public Health doctors from the Regional Department of Public Health will provide overall leadership for the management of a COVID-19 outbreak in a residential facility.
- Ideally, the local OCT should have regular, active involvement of a Public Health Doctor. However, if that is not practically possible, following initial consultation and advice from Public Health the OCT should liaise on a regular ongoing basis with the regional Public Health Department to provide updates on outbreak progress and seek further advice as appropriate. An outbreak log should be opened and maintained. Detailed recording of all aspects of the outbreak and its management must be undertaken. Detailed minutes should be taken at every meeting. The minutes should document all decisions taken, actions agreed and the person/people with responsibility for executing each action.
- The OCT should have a chair and membership should be decided at local level and will depend on available expertise. Members of the OCT may include any of the following however in many settings it may not be possible to include all the expertise referred to below:
    - Specialist in Public Health Medicine and/or Public Health Department Communicable Disease Control Nurse Specialist
    - GP/Medical officer/Consultant to facility (dependent on nature of facility)
    - Director of Nursing or Nurse Manager from facility or person in charge
    - Management representative from the facility i.e. manager or CEO
    - Community Infection Prevention and Control Nurse (CIPCN) where available

[2] *These definitions may be subject to change as the COVID-19 pandemic evolves*

- Administration support
- Other members who may need to be co-opted if it is an extensive or prolonged outbreak include
  - Community Services General Manager
  - Occupational Medicine Physician
  - Representative from HPSC
  - Communications officer

- Every member involved should have a clear understanding of their role and responsibility
- The frequency required for the outbreak meeting should be decided and they should be carried out remotely.
- Public Health will formulate a case definition, assign an outbreak code and decide as to whether an onsite visit is required or not
- The facility should inform HIQA as per usual protocols, local CHO for Residential Care Facilities.
- Before the first meeting of the OCT, the local incident team should gather as much information as possible to include:
  - A line list of all residents and staff.
  - Identify the total number of people ill (residents & staff) and the spectrum of symptoms.
  - Identify staff and residents who have recently recovered, developed complications, been transferred to acute hospitals and those who have died.
  - Information on laboratory tests available including the number of tests taken to date and the date sent to the laboratory.
  - Determine if the number of symptomatic residents/staff varies between units/floors/wards or if the outbreak is confined to one unit only.
  - Use the case definitions for possible, probable and confirmed COVID-19 available on the HPSC website
  - A checklist for outbreak management can be found in appendix **
- Outbreak cases should be entered directly into the Computerised Infectious Disease Reporting (CIDR) system.
- In order to declare that a COVID 19 outbreak is over, a setting should not have experienced any new cases of infection which meet the case definition for a priod of 28 days (2 incubation periods)
- Once an outbreak is over, the facility can re-open to new admissions.
- In all service settings, the service user with possible COVID 19 should be isolated while awaiting results with precautions as advised in current guidance using standard precautions. Visitors should be restricted while the individual is in isolation
- In general, service users/clients who are COVID-19 Positive should be managed in their homes/facilities in line with recommendations.
- Transfer to hospital/intermediate care is appropriate where essential i.e. where there is a high likelihood that the person will require and benefit from full mechanical ventilation. Decisions to transfer should be discussed in advance with service user/client, their families/carers in conjunction with their GP & documented. Any service user/client requiring hospitalisation who they believe may have COVID-19 should be flagged with the receiving hospital beforehand to discuss their individual care needs relating to their disability.
- Decisions regarding care should be individualised to the service user/client.

- In the case of an outbreak of COVID-19 within a residential service, the service should be closed to all new admissions during time of the COVID outbreak
- Proactively manage communications with service users/client, staff, families and others. Refer all for guidance from www.hse.ie and www.hscp.ie

5. Management of service users with confirmed COVID-19 status in residential services (including their own home)

There is currently no 'treatment' for COVID-19. The approached taken in managing patients is symptom management. Symptoms which can be managed in a non-clinical setting include temperature management.

- Health Care Assistants are able to provide medication to service users once they are included on the individuals' prescription. To this end, paracetamol PRN should be added to all prescriptions.
- Medical support can be requested through the local Incident Management/Outbreak Control Team
- In general, if single occupancy rooms are available they should be used. If this is not feasible, multiple patients with confirmed COVID-19 can be cohorted into the same room or unit of accommodation.
- Staff should don PPE before entering contaminated area and remain in PPE until leaving the area
- Service users/clients should be encouraged to drink and eat
- They should be advised to stay in their room as much as possible and avoid contact with others until they have had no temperature for five days and it's been 14 days since they first developed symptoms.
- Their symptoms should be checked regularly. If they become more unwell their GP should be contacted by phone. If it is an emergency, contact an ambulance and tell them there is a confirmed case of COVID-19.
- While it is discouraged, if a service users has to go into the same room as other people they should try to be in the space for as short a time as possible, and keep a distance of at least one metre (3 ft, preferably 2m) away from others and be encouraged to clean their hands regularly & should wear a mask.
- If they can, they should use a toilet and bathroom that no one else uses. If this is not possible, the toilet and bathroom should be kept clean as per specific HPSC guidance i.e. either 2-step clean (using detergent first, then disinfectant) or 2-in-1 step clean (using a combined detergent/disinfectant) is required. Additional information is available at https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/RCF%20Guidance%20March%2021%202020%20Final%20noag.pdf
- They should be advised to clean their hands regularly especially before eating and after using the toilet and to follow respiratory hygiene practices as outlined in the boxes above.
- They should be advised not to share food, dishes, drinking glasses, cups, knives, forks and spoons, towels, bedding or other items that they have used with other people in the facility.

- Ideally crockery and cutlery should be washed in a dishwasher (if one is available) or if a dishwasher is not available then wash with washing up liquid. Rubber gloves should be worn to wash the items.
- All surfaces, such as counters, table-tops, doorknobs, bathroom fixtures, toilets and toilet handles, phones, keyboards, tablets, and bedside tables, should be cleaned every day with your usual cleaning product. Follow the instructions on the manufacturers label and check they can be used on the surface you are cleaning. Environmental cleaning/disinfection of self-isolation facilities when person leaves facility

6. Infection Prevention and Control Measures

Note. Implementing infection prevention and control practice is extraordinarily difficult with service users who are unable to comply with requests from staff. In that setting the only practical approach is to apply the key principles of infection control as much as possible.

If an individual is unwilling/unable to comply with testing for COVID-19 and they are symptomatic, they should be managed as if they have confirmed case as described above.

A specific sub-group is being established to look at supports for those with behaviours that challenge and to make recommendations on how to ensure safety of the individual, staff and other service users

Scenario	Guidance
Management of a service user who is identified as a COVID-19 Contact (No symptoms) **This applies to both group settings and situations where a person is being cared for in their own home. It also applies to all levels of support**	1. Covid Lead should be informed as well as Outbreak Control team 2. Testing should be requested as priority with National Ambulance Service 3. All residents should be checked for symptoms twice daily. 4. Staff should be checked asked to confirm that they don't have any symptoms before coming on duty. 5. In a group setting, service users should be requested to avoid communal areas and wait in their room for their period of observation (until 14 days after exposure) and until Public Health advice confirms the service user can resume normal activity 6. If they have to go into the same room as other people they should try to be in the space for as short a time as possible, and to keep a distance of at least one metre away from others and be encouraged to clean their hands regularly. 7. If they can, they should use a toilet and bathroom that no one else uses. If this is not possible, the toilet and bathroom should be kept clean. 8. They should be advised to clean their hands regularly 9. They should be advised not to share food, dishes, drinking glasses, cups, knives, forks and spoons, towels, bedding or other items that they have used with other people in the facility. 10. Ideally crockery and cutlery should be washed in a dishwasher (if

	one is available) or if a dishwasher is not available then wash with washing up liquid. Rubber gloves should be worn to wash the items. 11. Service user may go outside if appropriate, alone or accompanied by a staff member maintaining a distance of at least 1m (2m when possible) however unnecessary outings should be avoided. 12. Staff members who can avoid physical contact and maintain a distance of at least 2 m do not require apron, gloves or mask but should attend to hand hygiene. 13. Standard precautions should be used at all times for all service users in particular hand hygiene. 14. Staff members providing direct care e.g. changing incontinence wear, assisting with toileting, providing personal hygiene, bathing/showering, transferring a person etc should wear long sleeved disposable gown, facemask, gloves as per standard precautions. Eye protection is recommended when there is a risk of blood, body fluids, excretions or secretions splashing in to the eyes. Where possible limit time (interventions of 15 mins) and distance exposure(2m) 15. Staff members should monitor at least four times per day and record if the resident has developed symptoms of infection 16. Disposal of waste from residents confirmed or suspected COVID-19 as healthcare risk waste. If healthcare risk waste service is not available in the facility then all consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, tied placed in a second bag and left for 72 hours. This should be put in a secure location prior to collection. 17. Waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system.

Scenario	Guidance
Management of a service user who develops fever (above 38°C) or symptoms of acute respiratory tract infection **This applies to both group settings and situations where a person is being cared for in their own home.**	1. Covid Lead should be informed as well as Outbreak Control team 2. Testing should be requested as priority through the National Ambulance Service 3. All residents should be monitored for symptoms twice daily 4. Staff should be checked for symptoms at the beginning of each shift 5. Public health should be notified 6. In a group setting, such service users should be requested to avoid communal areas and wait in their room until assessed. 7. Where COVID-19 is not suspected to be the primary cause of symptoms, and testing is not considered appropriate the service user should avoid communal areas until 48 hours after resolution

It also applies to all levels of support	of respiratory symptoms or fever or until another cause of fever that does not requires specific infection prevention and control precautions is apparent 8. Residents may go outside alone if appropriate accompanied by a staff member maintaining a distance of 1m (ideally 2m) if appropriate. If coughing, the resident should wear a surgical mask. If no mask is available, they should be asked to cover mouth with tissue when coughing. 9. Staff members providing direct care e.g. changing incontinence wear, assisting with toileting, providing personal hygiene, bathing/showering, transferring a person etc should wear long sleeved disposable gown (for high contact activities)/apron (for low contact activities), facemask, gloves as per standard precautions. Eye protection (as per risk assessment) is recommended when there is a risk of blood, body fluids, excretions or secretions splashing in to the eyes. Where possible limit time (interventions of 15 mins) and distance exposure(2m) 10. Disposal of waste from residents confirmed or suspected COVID-19 as healthcare risk waste. If healthcare risk waste service is not available in the facility then all consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, tied placed in a second bag and left for 72 hours. This should be put in a secure location prior to collection. 11. Waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system. 12. Ensure appropriate **environmental cleaning** and disinfection as per IPC guidance for RCFs

Scenario	Guidance
Management when testing of a resident for COVID-19 is considered necessary (Suspect Case) **This applies to both group settings and situations where a person is being cared for in their own home. It also applies to all levels of support**	1. The service user should be considered as a suspect COVID-19 case 2. Covid Lead should be informed as well as Outbreak Control team 3. Testing should be requested as priority through the National Ambulance Service 4. All residents should be monitored for symptoms twice daily 5. Staff should be checked for symptoms at the beginning of each shift 6. Public health should be notified 7. In a group home setting, every attempt should be made to introduce 'self-isolation' for the service user. As discussed previously, self isolation in non-clinical residential services generally mean isolation in the service user's own bedroom. 8. The service user should avoid communal areas but may go outside alone or accompanied by a staff member maintaining a distance of 1m(ideally 2m) if appropriate. If

coughing, the resident should wear a surgical mask. If no mask is available, they should be asked to cover mouth with tissue when coughing.

9. In a group setting, group activities should be suspended pending test results. If this is not possible given the overall welfare of residents activities may be conducted with small groups of residents with maintain of social distance as much as possible. (for example unaffected residents may be able to access communal areas or go outside in small groups on a rota basis with avoidance of direct contact or close contact)
10. Service users should stay in their room as much as possible and minimise contact with others pending test results
11. Service users should be encouraged to perform hand hygiene and respiratory hygiene and cough etiquette
12. Healthcare workers working directly with the service user, or within the service should increase their attention to hand hygiene and respiratory hygiene and cough etiquette & facemasks should be worn when within 2m of service user
13. Visiting should be restricted to absolute necessity
14. Public outings should be avoided
15. In a group setting, care for the service user who is awaiting testing should be delivered by a single nominated person on each shift. Where an individual is being supported to live at home, the number of carers per 24 hours should be reduced where feasible to avoid additional unnecessary exposure
16. If more than one Service User is suspected as being COVID positive, cohort residents and allocate separate groups of staff groups to care for those with confirmed or suspected COVID-19 and those without
17. Staff should don PPE before entering contamination room/area and remain in PPE until leaving the area. Recommendations on appropriate PPE are found on at https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/Interim%20Guidance%20for%20use%20of%20PPE%20%20COVID%2019%20v1.0%2017_03_20.pdf
18. The service user should be encouraged to wear a surgical mask if available or otherwise, if possible, to cover the mouth and nose with a tissue when a staff member is within 2 m
19. Staff members providing direct care e.g. changing incontinence wear, assisting with toileting, providing personal hygiene, bathing/showering, transferring a person etc should wear long sleeved disposable gown(for high contact activities)/apron (for low contact activities), facemask, gloves as per standard precautions. Eye protection (as per risk assessment) is recommended when there is a risk of blood, body fluids, excretions or secretions

	splashing in to the eyes. Where possible limit time (interventions of 15 mins) and distance exposure (2m). For aerosol generating procedures, the above should be following but an FFP2 mask (rather than surgical mask) and long sleeved gown) is advised 20. Disposal of waste from residents confirmed or suspected COVID-19 as healthcare risk waste. If healthcare risk waste service is not available in the facility then all consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, tied placed in a second bag and left for 72 hours. This should be put in a secure location prior to collection. 21. Waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system. 22. Ensure appropriate **environmental cleaning** and disinfection as per IPC guidance for RCFs 23. If the test is reported as negative for COVID-19 management of the service user should be as for other respiratory tract infection/illness

Scenario	Guidance
Management if a service user tests positive for COVID-19 **This applies to both group settings and situations where a person is being cared for in their own home. It also applies to all levels of support**	1. Local Incident Management/outbreak control team should be established as described previously 2. Public Health to be notified 3. Testing should be requested for all residents and staff 4. Residents should be checked for symptoms twice daily 5. All staff should be checked for symptoms when coming on duty 6. In a setting with more than one service user, all group activities should be suspended. If this is not possible given the overall welfare of residents activities may be conducted with small groups of residents with maintain of social distance as much as possible. (for example unaffected residents may be able to access communal areas or go outside in small groups on a rota basis with avoidance of direct contact or close contact) 7. Service user should be supported with respect to self-isolation in their own bedroom 8. Staff entering the residents room/isolation area should don PPE before entering contaminated room/area and remain in PPE until they are leaving the area. 9. The service user should avoid communal areas until 14 days after onset of illness and with five days free of fever (or in line with current HPSC guidance). 10. The service user but may go outside alone if appropriate or accompanied by a staff member maintaining a distance of 1m (ideally 2m) if appropriate. The service user should wear a

	surgical mask. 11. Service users should be encouraged to perform hand hygiene and respiratory hygiene and cough etiquette 12. Healthcare workers should increase their attention to hand hygiene and respiratory hygiene and cough etiquette 13. Visiting should be restricted to absolute necessity 14. Care for the service user who has tested positive should be delivered by a single nominated person on each shift 15. If more than one Service User has tested positive, residents should be cohorted and care provided to these individuals should be by a separate group of staff. 16. In a group setting, if more than one service user has tested positive consider feasibility of having one nominated person on each shift care for those service users who have tested positive and any patients awaiting testing 17. In addition to Standard Precautions, staff who are providing direct care need to implement Contact and Droplet precautions (apron, gloves and a surgical mask) when within 2 m of the service user for a brief period to perform a simple task 18. The service user should be encouraged to wear a surgical mask if available or otherwise, if possible, to cover the mouth and nose with a tissue when a staff member is within 2m. 19. If care of the service user requires close physical contact, in addition to Standard Precautions, staff members should wear a gown, surgical mask, and gloves and eye-protection if there is an assessed risk of splashing of blood or body fluids 20. Disposal of waste from residents confirmed or suspected COVID-19 as healthcare risk waste. If healthcare risk waste service is not available in the facility then all consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, tied placed in a second bag and left for 72 hours. This should be put in a secure location prior to collection. 21. Waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system 22. Ensure appropriate **environmental cleaning** and disinfection as per IPC guidance for RCFs

Scenario	Guidance
Management if more than one service user in a facility tests positive for COVID-19 i.e. potential COVID- 19 outbreak	1. Public Health should be informed as soon as possible of all suspected and confirmed outbreaks of COVID-19. (This is a legal obligation) 2. Local Incident Management/outbreak control team should be established as described previously. This group will oversee emergency planning/escalation as indicated

V3 of the Interim Public Health & Infection Prevention Control Guidelines on the Prevention and management of COVID-19 cases and outbreaks in Residential Care Facilities & Similar Units available at https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Preliminary%20RCF%20guidance%20document.pdf	3. HIQA will also require notification (NF02 form) 4. Contact should also be made with Disability Operations 5. All residents and staff should be tested. 6. Residents should be checked for symptoms twice daily 7. All staff should be checked for symptoms when coming on duty 8. Outbreak control measures should be implemented immediately 9. Staff must ensure that Standard Precautions are reinforced and Droplet and Contact Precautions are implemented immediately, if not already in place 10. Local hospitals and National Ambulance Service notified (in event of anticipated service user transfer). 11. Identified outbreaks should be notified to GP/ MO/ OOH services 12. GP / MO to liaise with local treating acute hospital physicians where appropriate in decisions re transfers 13. GP to monitor clinical condition for change and follow national guidance on criteria for hospital/intermediate care centre admission where this is the ongoing treatment plan 14. Care planning should reinforce all infection prevention and control measures to cover eventuality of hospital / other facility transfer 15. Consider cancelling non-essential outward movement of service users 16. Close the facility to new residents and transfers if possible 17. Close the facility to all non-essential visitors 18. Disposal of waste from residents confirmed or suspected COVID-19 as healthcare risk waste. If healthcare risk waste service is not available in the facility then all consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, tied placed in a second bag and left for 72 hours. This should be put in a secure location prior to collection. 19. Waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system 20. Ensure appropriate **environmental cleaning** and disinfection as per IPC guidance for RCFs

Scenario	Guidance
Management of transfer of service user to hospital/ intermediate care for treatment of COVID-19 **This applies to both group settings and situations where a person is being cared**	1. A person who is COVID-19 positive with severe symptoms should be transferred to an acute hospital/intermediate care centre for management of their symptoms on the advice of their GP/GP assigned to the service. Decision making should be documented in writing. Family members should also be involved in decisions around transfer to hospital. 2. Depending on the severity/acuity of their presentation an ambulance should be called. 3. Acute hospital/intermediate care centre should be notified about the planned transfer and given summary information on the

for in their own home. It also applies to all levels of support	individual's current status as well as care needs. 4. Family should be notified immediately 5. Where feasible, a staff member can transfer with the service user to the hospital, however where this is not possible, a hospital 'passport' which describes the individuals needs in terms of cognition/communication etc should travel with them (please see link for information on same https://www.hse.ie/eng/services/news/media/pressrel/launch-of-the-hse-health-passport-mission-possible-short-film.html) 6. Individual should be asked to wear surgical mask 7. When transferring a person, the healthcare worker should use PPE as described previously 8. Once an individual with COVID-19 leaves the facility the room where they were isolated the room should not be cleaned or used for one hour and during this time the door to the room should remain closed. 9. Ensure all surfaces that the service user came in contact with are cleaned. 10. The person assigned to clean the room should wear gloves (if available), either disposable latex free gloves or household gloves, then physically clean the environment and furniture using a household detergent solution followed by a disinfectant or combined household detergent and disinfectant for example one that contains a hypochlorite (bleach solution). Products with these specifications are available in different formats including wipes. 11. No special cleaning of walls or floors is required. 12. Cleaning of communal areas If a service user spent time in a communal such as dining room, reception area, play area, or used the toilet or bathroom facilities, then these areas should be cleaned with household detergent followed by a disinfectant (as outlined above) as soon as is practicably possible.

Scenario	Guidance
Management of service user being repatriated from acute hospital post COVID-19 **This applies to both group settings and situations where a person is being cared for in their own home. It also applies to all levels of support**	If admission to acute hospital/intermediate care centre for symptom management is indicated, the individual service user should be supported to returning to their residence as soon as they are medically stable and can have their care needs managed outside of the acute hospital setting. Ideally they should be COVID-19 negative, however if they are still positive they should be managed as outlined in the guidance above

Scenario	Guidance
Management of those with profound disability (in a non-clinical setting). Please note that a separate document outlining care of individuals on nurse led services for those with disabilities	The guidance outlined above applies to those with profound disability. The main differing elements include; - The need for more than one carer at any given time. As such, the guidance with respect to allocating one carer to the individual may not be feasible. This group of patients also generally require more personal care and as such, maintaining a distance on >1m will not be possible. Where a resident is showing symptoms of COVID-19, steps should be taken to minimise the risk of transmission through safe working procedures. Staff should use personal protective equipment (PPE) for activities that bring them into close personal contact, such as washing and bathing, personal hygiene and contact with bodily fluids. Aprons, gloves and fluid repellent surgical masks should be used in these situations. If there is a risk of splashing, then eye protection will minimise risk. New PPE must be used for each episode of care. It is essential that used PPE is stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely and kept separate from other waste within the room - Transfer to inpatient setting is appropriate where this will confer additional benefit and where the medical needs of the individual cannot be managed in the social care setting. Decisions to transfer should be discussed and documented and should be made in conjunction with the person, their families and their advanced care plans if appropriate. - Ensure in as far as possible that discussions with residents and families reflecting care preferences have been identified, documented and updated. - The issue of capacity and ability to make decisions around their own care may also be an issue. Support provided to the individual and their family should be in line with assisted decision making legislation. - Everyone is entitled to access immediate medical care to alleviate distress if this can't be managed in the care setting. In the case where an individual has an advance care plan, this care can be delivered in a hospital or in collaboration with palliative care services.

Scenario	Guidance
Management of a person who can no longer be supported in their own home (secondary to lack of carer availability)	Please see separate document outlining Covid - 19 Contingency Plan for Home Support Managers and Health Care Support Assistants and Disability Managers/Personal Assistants Due to the Covid - 19 pandemic there is a risk that normal service could be interrupted and therefore alternatives will have to be explored. It is acknowledged that it will be necessary to work in collaboration with a range of community volunteer organisations and consideration must be given to the optimal and safe utilisation of these services. Work is

	ongoing in this regard as part of the overall response in relation to Covid -19.

Scenario	Guidance

Death in the residential setting
When a resident dies (COVID-19 positive)
Coroner
Refer to statement from the Coroners Society of Ireland version1. Dated 11/03/2020 http://www.coroners.ie/en/COR/Coroners%20Service%20COVID-19%20110320.pdf/Files/Coroners%20Service%20COVID-19%20110320.pdf
Communication of level or risk
	Use the HSE guidance documents on Verification and Pronouncement and Death. Please refer to your local service policies on Regulation 19 General Health And Regulation 14 Care Of The Dying
	
	As COVID-19 is a new and emerging pathogen it is understandable that those who will be handling the remains will be concerned and may wish to be made aware of the patient's infectious status.
	Embalming
	• Embalming is not recommended.
	Hygienic preparation
	• Any infection control procedures that have been advised before death must be continued in handling the deceased person after death
	• Hygienic preparation includes washing of the face and hands, closing the mouth and eyes, tidying the hair and in some cases shaving the face.
	• Washing or preparing the body is acceptable if those carrying out the task wear long-sleeved gowns gloves , a surgical mask and eye protection if there is a risk of splashing) which should then be discarded.
	Transporting the deceased person
	• Bodies should be placed in a body bag prior to transportation to the mortuary as this facilitates lifting and further reduces the risk of infection.
	• A face mask or similar should be placed over the mouth of the deceased before lifting the remains into the body bag.
	• Those physically handling the body and placing the body into the bag should wear, at a minimum, the following PPE:
	  ○ Gloves
	  ○ Long sleeved gown
	  ○ Surgical facemask
	  ○ Play close attention to washing hands after removal of PPE
	Once in the hospital mortuary, it would be acceptable to open the body bag for family viewing only. The family should be advised not to kiss the deceased and should clean their hands with alcohol hand rub or soap and water after touching the deceased. PPE is not required for transfer once the body has been placed in the coffin
	See guidance document for funeral directors
	https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/funeraldirectorsguidance/Guidance%20Funeral%20Directors%20v1.3.pdf

Appendix 1

Personal Protective Equipment			
Precaution	**Contact**	**Droplet**	**Airborne**
Gloves	Yes	As per standard precautions	As per standard precautions
Gown/Apron (impermeable)	When healthcare worker's clothing is in substantial contact with the patient, items in contact with the patient, and their immediate environment	As per standard precautions	As per standard precautions
Surgical Mask	When in close contact (less than 1m)	Yes	No
P2/N95 Respirator	Not required	Not required	Yes
Goggles/face shield	Not required	As per standard precautions	As per standard precaution

Types of PPE

- **Disposable plastic aprons:** are recommended to protect staff uniform and clothes from contamination when providing direct patient care and when carrying out environmental and equipment decontamination.
- **Fluid resistant gowns:** are recommended when there is a risk of extensive splashing of blood and or other body fluids and a disposable plastic apron does not provide adequate cover to protect HCWs uniform or clothing.
- If non- fluid resistant gowns are used and there is a risk of splashing with blood or other body fluids a disposable plastic apron should be worn underneath.
- **Eye protection/Face visor:** should be worn when there is a risk of contamination to the eyes from splashing of blood, body fluids, excretions or secretions (including respiratory secretions)

  - Surgical mask with integrated visor
  - Full face shield or visor
  - Goggles / safety spectacles
- **Surgical Face Masks**
  - Surgical Face Masks (Fluid Resistant Type 11R)

- **Tips when wearing a surgical face mask**
  - Must cover the nose and mouth of the wearer
  - Must not be allowed to dangle around the HCWs neck after or between each use
  - Must not be touched once in place
  - Must be changed when wet or torn
  - Must be worn once and then discarded as health care risk waste (as referred to as clinical waste)

Appendix 2 – Easy Read Information on Standard Precautions & Symptoms

How can I protect myself?	
Wash your hands with soap and warm water	
Dont touch your face with your hands	
When you cough and sneeze, cover your mouth and nose with your bent elbow or a tissue	
Put used tissues into a closed bin and wash your hands	
Make sure to keep surfaces clean, especially surfaces people touch a lot	
Don’t shake hands	
Keep your distance and reduce the amount of time you are close to other people. Don’t go to crowded places	

What happens if you catch it?

It can take 14 days before you realise you have it.

You will get:

- A cough.

- A fever with a high temperature of over 38 degrees celsius.

- Difficulty with breathing.

You may get 1 or 2 or all of these things.

Appendix 3 – Self Isolation Guidance for Staff (HPSC)

What is self-isolation?

Self-isolation means you stay at home while you have coronavirus (COVID-19). Even though the symptoms are mild you can still spread the virus to others. This will help to protect your friends, colleagues and the wider community and will help control the spread of the virus. The instructions below are to help you try and limit the spread of infection to others within your household as much as possible.

When can I return to normal?

You can stop self-isolating at home, if you have had no temperature for five days and it's been 14 days since you first developed any symptoms.

Keeping yourself safe and well

- It is very easy to become anxious and lonely when you have to spend time on your own but remember, you can always pick up the phone and call a friend - the virus does not travel through phones lines
- Although you have been asked to stay at home it is important you keep yourself mobile by getting up and moving around as much as possible. If you have a garden or backyard go out and get some fresh air but please keep away from other people including neighbours. Keeping a distance of more than 1 metre (or 3 feet) from other people is recommended.
- Eat well and drink plenty of fluids to keep you hydrated.
- Try and avoid alcohol if you are feeling unwell.
- Do not smoke or vape – if you do have a virus infection it is best not to do anything that might harm your lungs.

- If you start to feel very unwell but it is not an emergency, you should call your regular doctor.
- If it is an emergency and you need to call an ambulance, call 112 or 999 and remember to tell the ambulance service that you have been diagnosed with COVID-19 virus.
- If you have questions regarding the instructions below please call your local Public Health department.

Appendix 4 – HIQA

COVID-19 Contingency Planning in Designated Centres

Chief Inspector of Social Services

Health Information and Quality Authority

Communique 4

COVID-19 Contingency Planning in Designated Centres

23 March 2020

Dear provider,

The Health Information and Quality Authority (HIQA) continues to pay close attention to the rapidly-developing situation in respect of COVID-19 (coronavirus).

I recognise that providers of designated centres are working hard in an unprecedented situation. In these challenging times, it is essential that residents continue to receive safe, and high-quality care.

Further to my correspondence of 12 March 2020, I am contacting you today with regard to the contingency plans in place in your designated centre to manage the COVID-19 (coronavirus) outbreak.

Please consider if your contingency plans include the elements below, while also ensuring to review HSE (www.hse.ie) and Government (www.gov.ie) guidelines and updates on a daily basis.

GOVERNANCE AND MANAGEMENT CONSIDERATIONS:

At group level

- Have you systems in place to maintain daily contact with each designated centre under your governance and management structure?
- Have you access to appropriate clinical expertise for each centre as the need arises during this public health emergency?
- Has each unit of each designated centre adequate supplies of anti-bacterial products, hygiene equipment, and personal protective equipment; and will they continue to have access to such products/equipment for as long as necessary?
- Where relevant, are there contingency plans in place if centralised services such as catering and or laundry facilities have to cease operation?
- Are the medication stock levels in each centre adequate to meet the needs of the residents and will they continue to remain adequate for as long as necessary?
- Have you updated plans in place to manage visitors coming to the centre to ensure measures are proportionate and in line with public health advice?
- How have you assessed the impact of current precautions and public health messaging on residents, including the potential impact on their mental health?

At individual centre level

- Have you access to appropriate clinical expertise during this public health emergency?
- Have you adequate supplies of anti-bacterial products, hygiene equipment, and personal protective equipment; and will you continue to have access to such products/equipment for as long as necessary?

- Are your medication stock levels adequate to meet the needs of the residents and will they continue to remain adequate for as long as necessary?
- Have you updated plans in place to manage visitors coming to the centre to ensure measures are proportionate and in line with public health advice?
- How have you assessed the impact of current precautions and public health messaging on residents, including the potential impact on their mental health?

STAFFING CONSIDERATIONS:

- Are all staff working directly with residents trained on the COVID-19 virus, including how to minimise the risk of getting the disease, and in the prevention of infection?
- Do you have plans in place for staff to report and manage a confirmed/suspected case of COVID-19 within the designated centre?
- Do you have plans in place to ensure continuity of care to residents in the event of a significant shortfall of staff attending work due to required self-isolation or an outbreak of the COVID-19 virus?
- Have you reviewed the effectiveness of your on-call systems to ensure your staff have 24/7 access to managerial and clinical support and advice at all times?

INFECTION CONTROL CONSIDERATIONS:

- Have you updated relevant policies and procedures in relation to responding to an outbreak of COVID-19?
- Has your risk strategy been updated to minimise the risk of infection of COVID-19 to residents and staff working in designated centres?
- Have you identified suitable facilities and accommodation in your services where you can provide care and support to a resident(s) who may require isolation?

Please be advised that this is not a definitive list, but rather aspects of service delivery to consider when reviewing your overall approach to contingency planning. Depending on the nature of your service, additional or alternative considerations may be relevant.

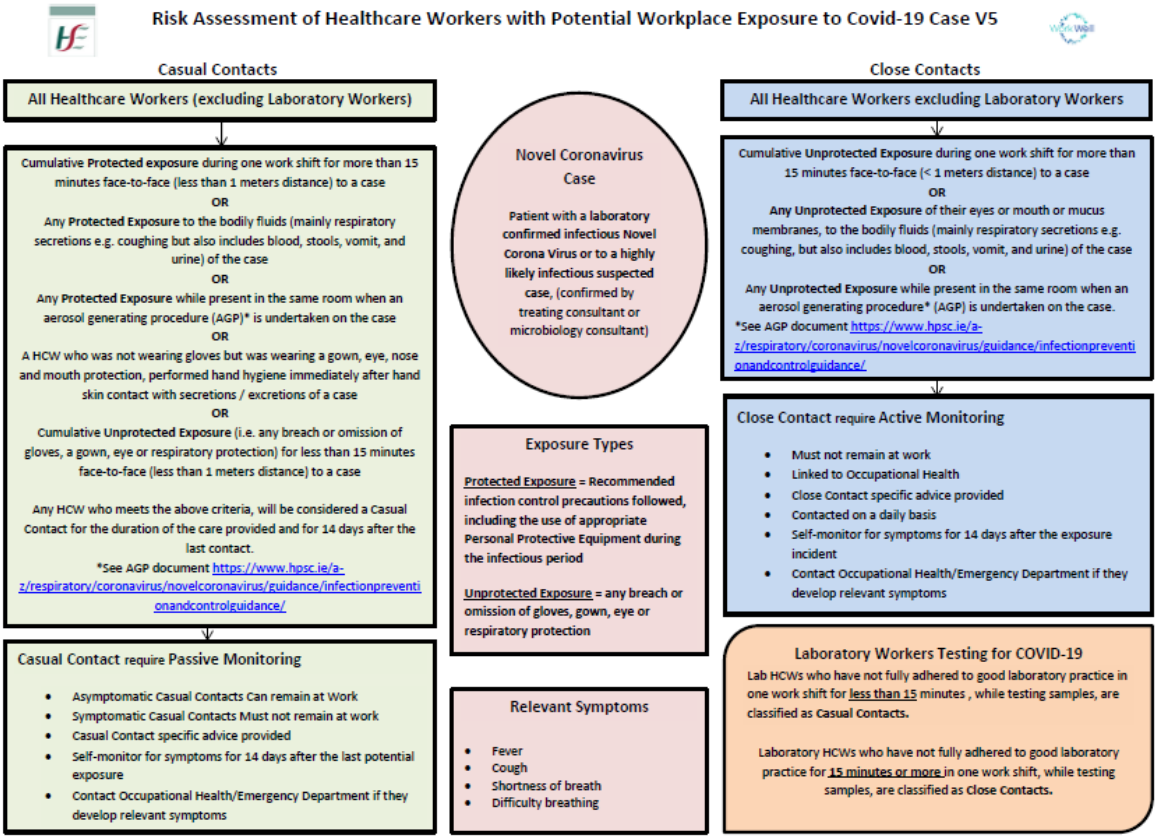
There is no requirement to send your contingency plan to us - we will maintain contact with you during this time.

Yours sincerely,

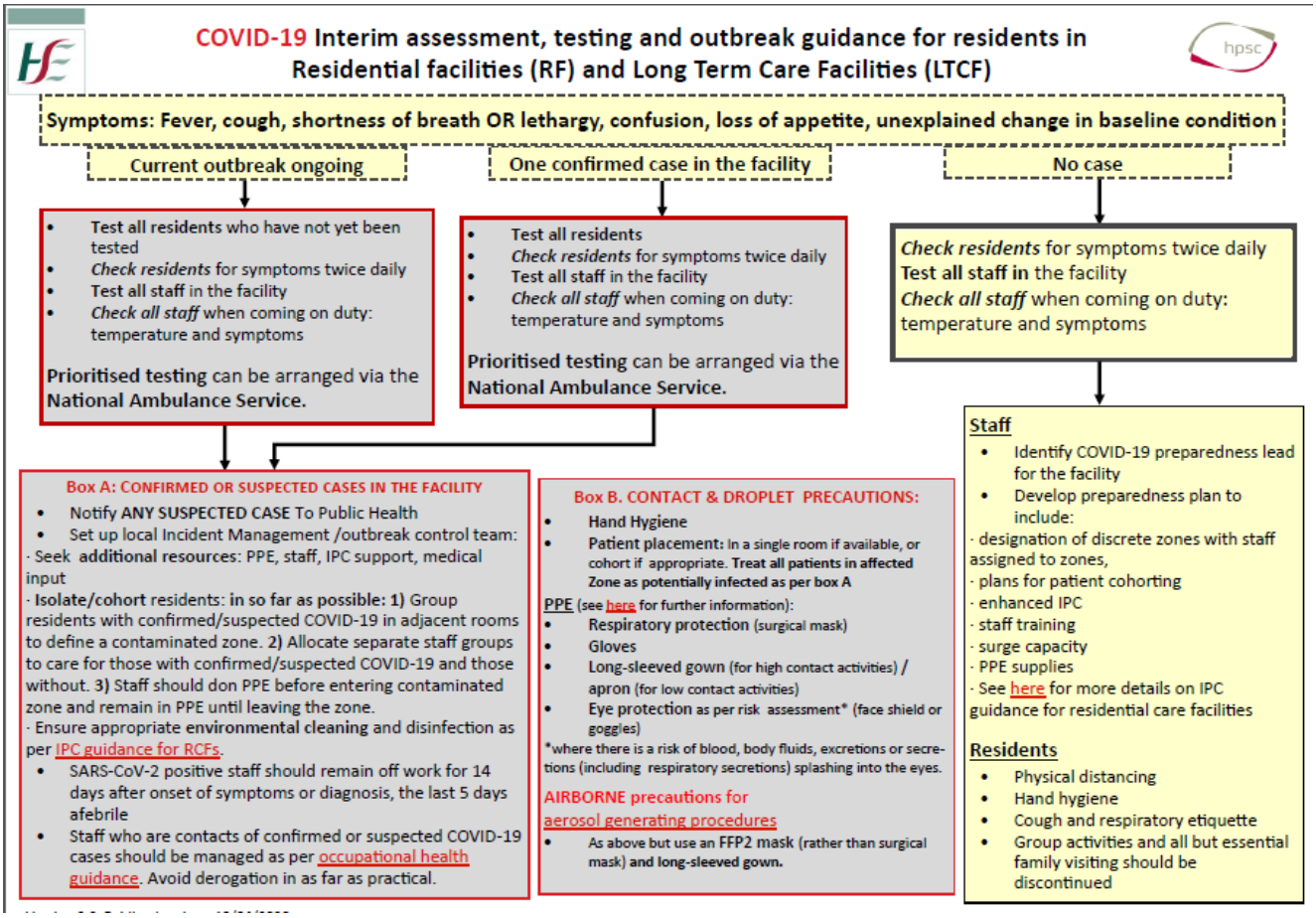
Mary Dunnion

Chief Inspector of Social Services

Appendix 5 – guidance on COVID-19 contacts



Appendix 6 – Updated guidance on testing in Long term care and residential facilities 19.4.2020



Appendix 7 – Prevention & Control of Outbreaks of COVID-19 in Residential Facilities

	Domain	Action	Comment
Pre-Outbreak Measures	Planning and Administration	Written Policies	Immunisation policies Standard transmission based precautions including droplet and contact Written outbreak management plan
		RCF Lead (Named person)	To oversee development, implementation and review of policies and procedures
		Training and Education	For all staff Ongoing training Measures to improve compliance
		Provision of supplies	Hand hygiene supplies, PPE, disinfection materials, arrangements for prioritised testing of samples
	Standard Precautions	Standard infection control procedures	SP should be practiced by all staff at all times
	Surveillance	Awareness of signs and symptoms of COVID	
Early recognition	Case Definition	As per HPSC guidance	Case definition may change as pandemic progresses
	Outbreak Definition	Action threshold for outbreak control measures	One suspected or confirmed case for public health action
	Communication of suspected outbreak	Notification of senior management, medical and public health staff, CHO and NH lead	Follow RCF algorithm
	Formation of outbreak control team (OCT)	OCT may be convened following risk assessment	
	Testing	Viral swab	As per current guidance
	Initial Actions	Daily Case list	
		Activate Daily surveillance	
		Appropriate IPC precautions in place	Droplet and contact precautions in the cohorted area/zone
		Resident placement	Single rooms Cohorting or Zone allocation
		Respiratory etiquette	
During an Outbreak	Infection Control Measures	Hand Hygiene	5 Critical points: • Before patient contact • Before septic task • After body fluid exposure • After patient contact • After contact with patient surroundings Hand hygiene after PPE removal
		PPE	Gloves Aprons Gowns Face protection
		Aerosolised generating Procedure	See HPSC guidance document. Highest level of PPE (FFP2/3) available if performing a high risk AGP
	Environmental control measures		Resident environmental cleaning and disinfection Residential Care Equipment Laundry Eating utensils and crockery
	Containment Measures		New admissions restricted Transfers restricted Restricted communal activities Staffing precautions Visitor restrictions
Post Outbreak	Declaration of end of outbreak		As advised by Public Health
	Final evaluation	Review of management of outbreaks and lesson learned	Coordination with Public Health and OCT if this was convened

Appendix 8 – Standards for managing outbreaks

Action	Performance Standard
Outbreak Recognition	Initial investigation to clarify the nature of the outbreak begun within 24 hours
	Immediate risk assessment undertaken following receipt of initial information
Outbreak Declaration	Decision made and recorded at the end of the initial investigation regarding outbreak declaration and convening of Outbreak Control Team
Outbreak Control Team	OCT convened and first meeting held within appropriate time period
	Appropriate representation/expertise at OCT meeting
	Roles and responsibilities of OCT members agreed and recorded
	Lead organisation with accountability for outbreak management agreed and recorded. Governance arrangements clarified and recorded.
	Control measures documented with clear timescales for implementation and responsible parties identified
Investigation of Outbreak	Case definition agreed and recorded
	Robust descriptive epidemiology undertaken
	Analytical study considered
	Investigation protocol prepared if an analytical study is undertaken
	Reasons for not conducting analytical study recorded
Communications[16]	Communications strategy agreed at first OCT meeting
	Absolute clarity regarding Lead Agency at all times with appropriate handover in place
End of Outbreak	Final outbreak report completed within 12 weeks of the formal closure of the outbreak
	Report recommendations and lessons learned reviewed 12 months after formal closure of the outbreak

Appendix 9 – Checklist for Outbreak Management

	Discussion point	Decision/action to be taken (date completed)	Person responsible
1	Declare an outbreak and convene an OCT following Public Health risk assessment		
2	Agree the chair		
3	Formulate an outbreak code and working case definition		
4	Define the population at risk		
5	Active case finding, request line listing of cases and staff from the RCF		
6	Discuss whether it is a facility-wide outbreak or unit-specific		
7	Confirm how and when communications will take place between the RCF, CIPCN, CHO NH lead, Public Health and the laboratory		
8	Review the control measures (infection control necessary to prevent the outbreak from spreading). Confirm that the management of the facility is responsible for ensuring that agreed control measures are in place and enforced		
9	Discuss which specimens have been collected. Notify the laboratory of the investigation.		
10	Confirm the type and number of further laboratory specimens to be taken. Clarify which cases and staff should be tested.		
11	Confirm that the laboratory will phone or fax results (both positive and negative) directly to the requesting doctor and that this person will notify Public Health. Review the process for discussing laboratory results with the RCF's designated officer.		
12	Liaise with the RCF and laboratory regarding specimen collection and transport		
13	Identify persons/institutions requiring notification of the outbreak e.g. families of ill or all cases of the facility; health care providers e.g. GPs, physiotherapists etc.; infectious disease consultants, consultant microbiologists, infection prevention & control specialists, Emergency Departments; local hospitals, other RCF, HPSC		
14	Discuss whether a media release is required		
15	Ensure that the incident is promptly reported to HPSC and surveillance details entered onto CIDR		
16	Provide updates on the investigation to the Assistant National Director, ISD-Health Protection when/if required		
17	Discuss communication arrangements with HSE management ± HSE crisis management team		
18	Discuss communication arrangements with local GPs and Emergency Departments		
19	Decide how frequently the OCT should meet and agree criteria to declare outbreak over		
20	Prepare/circulate an incident report/set date for review meeting		