Guidance for COVID-19 in Nurse Led Residential Care Services for people with Disabilities

1. Introduction

Data from international Covid 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**.

This guidance document has been updated based on HSE/HPSC guidance on testing and outbreak guidance for residents in residential facilities and long term care 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

2. Who is this guidance intended for?

Healthcare professionals, healthcare workers and managers delivering care in residential settings for those with disabilities where the main model of care delivery is nurse-led.

Not included in this guidance are;

- Those with disabilities supported in social care settings (non nurse led) or in their home by home support staff
- 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.

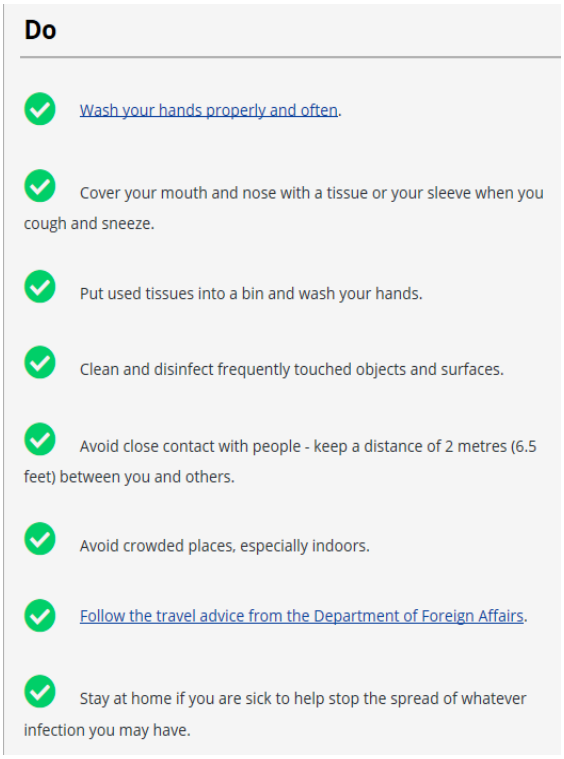
3. General Measures to reduce the risk of accidental introduction of COVID-19 to a client/service user

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 (see appendix 1 for easy read documentation which may be helpful in this regard)
- Careful attention to hand hygiene with provision of hand sanitiser and or hand washing facilities at all entrances (where practical to provide sinks)
- 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
- Coughing / Sneezing into tissue / elbow crook

- 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 safe 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 alternative ways of engaging with friends and families e.g. Skype or Facetime should be facilitated.
- Appropriate Social Distancing measures being observed by staff and as appropriate for service users within homes/facilities where clinically appropriate
- Careful attention to handwashing with provision of handwashing and hand sanitizer at all entrances and strategic points.
- Contractors on site should be kept to a minimum
- Chaplaincy visits/cultural support are recognised as an important part of a resident'swell-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 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.

3.4 If a member of staff if concerned that they may have COVID-19, they should refer to HSE guidance. Please see appendix 5 for information on risk assessment for contacts. Staff and managers should also refer to Health Surveillance website for the most current information in terms of recommendations in relation to healthcare workers including derogation for essential healthcare workers. 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 2 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. 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.

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

3.7 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.

3.8 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

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

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

3.11 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.

3.12 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. This should be in line with HIQA guidance (see appendix 4) and 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

4. General advice regarding management of service users/clients suspected or infected during COVID-19 epidemic in a disability setting

- All residents should be checked for symptoms twice a day
- All staff within the facility should be tested
- All staff when coming on duty should be checked for symptoms
- In general, residents in residential care who are COVID-19 Positive should be managed in their residential home.
- Transfer to hospital/intermediate care is only appropriate where this will confer additional benefit. Decisions to transfer should be discussed in advance with senior clinician (DON / ADON /PIC) in conjunction with GP/MO/OOH and should be made in conjunction with the person, their families (and their advanced care plans if appropriate). The decision making process and agreed outcomes should be documented and signed. Any decisions around escalation of care should be in line with HSE Operational Pathways of Care for the assessment and management of patients with COVID-19
- Ensure as far as possible that discussions with residents and families reflecting care preferences including at end of life have been identified, documented and updated as appropriate. Be aware that significant and rapid clinical change can be a feature of COVID-19 disease in some vulnerable groups and encourage timely discussions in line with same.

- Where appropriate, advance care planning should take place. These should be conducted in a safe and supportive environment by a senior clinician, and with sufficient time for the client and family members to consider the implications. The process and outcome of the Advance Care Plan should be documented.
- Decisions regarding care should be individualised to the resident.
- Seek advice from relevant acute hospital clinicians and palliative care services when appropriate. This may assist with ongoing clinical management and inform decisions re clinical appropriateness of potential decisions regarding transfer to hospital for acute management. Consideration should be made as to the appropriateness and likely outcome of full mechanical ventilation.
- Proactively manage communications with residents, staff, families and others. Refer all for guidance from www.hse.ie and www.hscp.ie

5. When a resident presents as clinically suspect for COVID-19 status procedures to be applied;

- 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
- Prioritised testing can be arranged via the National Ambulance Service
- The staff member should also contact the service manager. The Disability Manager should also be informed.
- 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 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

[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

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

- 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 of 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
- All outbreaks of COVID-19 in FACILITY must be reported to the regional Medical Officer of Health (MOH) at the Department of Public Health at the earliest opportunity.
- Public Health doctors from the Regional Department of Public Health will provide overall leadership for the management of the COVID-19 outbreak in the FACILITY.

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

- Ideally, the local outbreak control team 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 nominated 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
    - Management representative from the facility i.e. manager or CEO
    - Community Infection Prevention and Control Nurse (CIPCN) where available
    - Administration support
    - Other members who may need to be co-opted if it is an extensive or prolonged outbreak include
    - Community Services General Manager
    - Administrative support
    - 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 centre is appropriate where essential. Decisions to transfer should be discussed in advance with service user/client, their families/carers in conjunction with their GP. 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. The individual's health passport should go with them.
- Decisions regarding care should be individualised to the service user/client.
- In the case of an outbreak of COVID-19 within a residential services, 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

6. Common Symptoms and Signs indicative of possible COVID-19 illness:

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 medical/senior clinician review required

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

7. Clinical Investigations supporting diagnosis of 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).
Contact should be made with the National Ambulance Service to request Covid- 19 home assessment and testing for individuals in residential settings.

Where there is a high clinical index of suspicion for COVID-19 (e.g. during facility outbreak), failure to detect the virus in a nose / throat swab does not entirely exclude the possibility of COVID-19.

Note also that if a resident has a clinical picture of viral respiratory tract infection, even if they do not have COVID-19 they are likely to be infected with another virus that can spread to other residents, therefore additional infection prevention and control precautions remain appropriate until the resident has recovered.

On confirmation of a diagnosis of COVID-19 further investigations may be considered appropriate to assist with management. e.g. FBC, UEC, LFTs, CXR

Investigations to out-rule underlying non-COVID-19 related conditions may be appropriate

Clinical discretion and judgement should be used regarding further investigation and in particular in identifying whether same will alter overall patient management and risks posed by transfer to and from acute hospital/intermediate care facilities for same

8. Clinical Monitoring and management of patients with suspected or confirmed COVID-19 status in a nurse-led residential service

Monitoring of vital signs by pulse oximetry, BP, RR, Temp on twice daily basis / as determined in conjunction with GP/ MO or other medical advice

Monitor for common symptoms identified above and treat accordingly with supportive measures including paracetamol and oxygen, nasal prongs where appropriate

Optimise and encourage good oral fluid and nutritional intake

Use clinical judgement regarding appropriateness of monitoring where there is an expected change in the patient's clinical condition

Rapid and unexpected change in clinical status may occur (typically days 7-9). Ensure insofar as possible that appropriate measures to ensure comfort are made available and that staff are aware and trained in meeting resident's needs to cater for this situation.

As appropriate, develop an anticipatory care plan with resident and / or family member using national palliative guidance and ethical framework. . Where appropriate, advance care plan should be put in place. These should be conducted in a safe and supportive environment by a senior clinician, and with sufficient time for the client and family members to consider the implications. The process and outcome of the plan should be documented.

9. Decision algorithm in regards to escalation reflecting anticipatory guidance (if appropriate)

The following anticipatory decision log below is to offer guidance to doctors and nurses who may not be familiar with the Service User as to what approach to take in the event of their acute deterioration. This document cannot cover all clinical eventualities but it may act as a guide in deciding the appropriateness of certain interventions. It is not prescriptive. The treating clinician should use their discretion to provide whatever treatment they see fit; depending on the clinical scenario is partnership with the Service User.

Intervention	Date	Date	Date	Date	Date	Date
Attempt CPR	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
IV/SC Fluids	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Antibiotics	Yes/only if aids symptoms	Yes/only if aids symptoms	Yes/only if aids symptoms	Yes/only if aids symptoms	Yes/only if aids symptoms	Yes/only if aids symptoms
Transfer to Acute Hospital	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Other						

1. 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)	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. Such residents 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 resident can resume normal activity 6. If a single room is not feasible, try to isolate in a specific area. Contact your local Community Health Social Inclusion or Public Health Link for advice. 7. Service Users may go outside if appropriate, alone or accompanied by a staff member maintaining a distance of 1m (ideally 2m) 8. Staff members who can avoid physical contact and maintain a distance of 2 m do not require apron, gloves or mask but should attend to hand hygiene 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, 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(1m) 10. Staff members should monitor at least twice per day and record if the Service User has developed symptoms of infection 11. 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. 12. 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	1. Covid Lead should be informed as well as Outbreak Control team

develops fever (above 38°C) or symptoms of acute respiratory tract infection	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. Such residents should be requested to avoid communal areas and wait in their room until assessed. Inform families if appropriate 7. Maintain a strong index of suspicion for likely Covid 19 positive disease in the service with all other residents and follow isolation protocols accordingly as described previously. 8. Where Covid 19 Positive is not suspected to be the primary cause of symptoms, the Service User should avoid communal areas until 24 hours after resolution of respiratory symptoms or fever or until another cause of fever that does not requires specific infection prevention and control precautions is apparent 9. Service Users may go outside alone if appropriate accompanied by a staff member maintaining a minimal 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. 10. 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(1m). For aerosol generating procedures, the above should be following but an FFP2 mask (rather than surgical mask) and long sleeved gown) is advised. 11. 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. 12. 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. 13. 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)	1. Covid Lead should be informed as well as Outbreak Control team 2. Priority testing should be arranged both for the individual resident and all residents & staff within the facility 3. Public Health to be notified 4. All Residents should be checked for symptoms twice daily 5. All staff should be checked for symptoms when coming on duty 6. The Service User should be supported to self isolate. 7. Communal areas should be avoided but the service user may go outside alone or accompanied by a staff member maintaining a minimal 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. 8. 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) 9. Service Users should stay in their room as much as possible and minimise contact with other residents pending test results 10. Service Users should be encouraged to perform hand hygiene and respiratory hygiene and cough etiquette 11. Healthcare workers should increase their attention to hand hygiene and respiratory hygiene and cough etiquette. Surgical masks should be worn as advised above 12. Visiting should be restricted to absolute necessity 13. Care for the Service User who is awaiting testing should be delivered by a single nominated person on each shift 14. 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. 15. 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 16. 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 1 m 17. 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(1m). For aerosol generating procedures, the above should be following but an FFP2 mask (rather than surgical mask) and long sleeved gown) is advised 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 21. If the test is reported that Covid -19 is not-detected management of the resident should be as for other respiratory tract infection

Scenario	Guidance
Management if a service user tests positive for COVID-19	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. 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. Resident should be supported to isolate 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 post onset of symptoms as 5 days since they had a 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 minimal distance of 1m, ideally 2m if appropriate. The service user should wear a surgical mask. If no mask is available, they should be asked to cover mouth with tissue when coughing. 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 if self care not feasible 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 addition to standard precautions, staff who are providing direct care need to implement contact and droplet precautions (apron, gloves and a surgical mask see appendix 3 for PPE information) 17. 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 1m care of the Service User requires close physical contact, in addition to standard precautions, staff members should wear a gown, surgical mask, eye protection and gloves 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 if more than one service user in a facility tests positive for COVID-19 i.e. potential COVID- 19 outbreak **For full details on Outbreak Management please refer to V3 of the Interim Public Health & Infection Prevention Control Guidelines on the Prevention and management of COVID-19 cases and**	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 3. Disability Operations will also require notification 4. All residents and staff should be tested. 5. Residents should be checked for symptoms twice daily 6. All staff should be checked for symptoms when coming on duty 7. Daily Outbreak Control Team OCT meetings to report on outbreak control measures and updates on potential and confirmed new cases 8. Outbreak control measures should be implemented immediately 9. Disability facility staff must ensure that Standard Precautions are reinforced and Transmission Based Precautions, including Droplet and Contact Precautions are implemented immediately, if not already in place 10. Local hospitals and National Ambulance Service notified (in event of

outbreaks in Residential Care Facilities & Similar Units which is available at https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Preliminary%20RCF%20guidance%20document.pdf	anticipated patient transfer) by senior clinician. 11. Identified outbreaks should be notified to GP OOH services 12. GP/NCHD and Area DON to liaise with local treating acute hospital physicians where appropriate in decisions re transfers 13. 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 Service User s 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 21. Ensure appropriate **environmental cleaning** and disinfection as per IPC guidance for RCFs

Scenario	Guidance
Management of transfer of service user to hospital /intermediate care centre for treatment of COVID-19	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. Consideration should be made as to the appropriateness and likely outcome of full mechanical ventilation. 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 individual's current status as well as care needs. 4. If the individual is being transferred to an acute hospital/intermediate care centre and has an advance care plan, this should be communicated to the hospital in advance of transfer. 5. Family should be notified immediately 6. 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. (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 7. Individual should be asked to wear surgical mask 8. When transferring a person, the healthcare worker should use PPE as described previously 9. 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. 10. Ensure all surfaces that the service user came in contact with are cleaned. 11. 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. 12. No special cleaning of walls or floors is required. 13. 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 /intermediate care centre post COVID-19	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 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
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.i**	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 should 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

e/en/COR/Coroners%20Service%20COVID-19%20110320.pdf/Files/Coroners%20Service%20COVID-19%20110320.pdf Communication of level or risk	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 – easy read information on standard precautions and 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 2 – 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 3

PPE information

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 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.

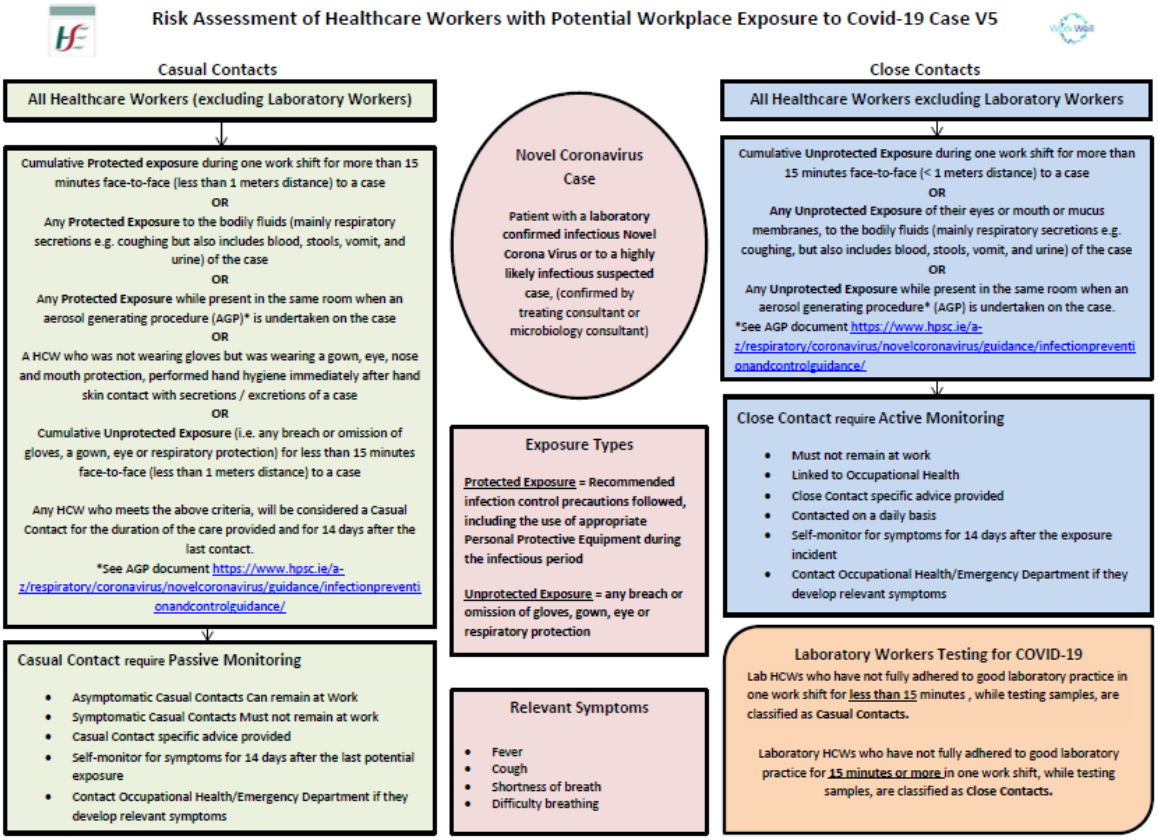
There is no requirement to send your contingency plan to us - we will maintain contact with you during this time.

Yours sincerely,

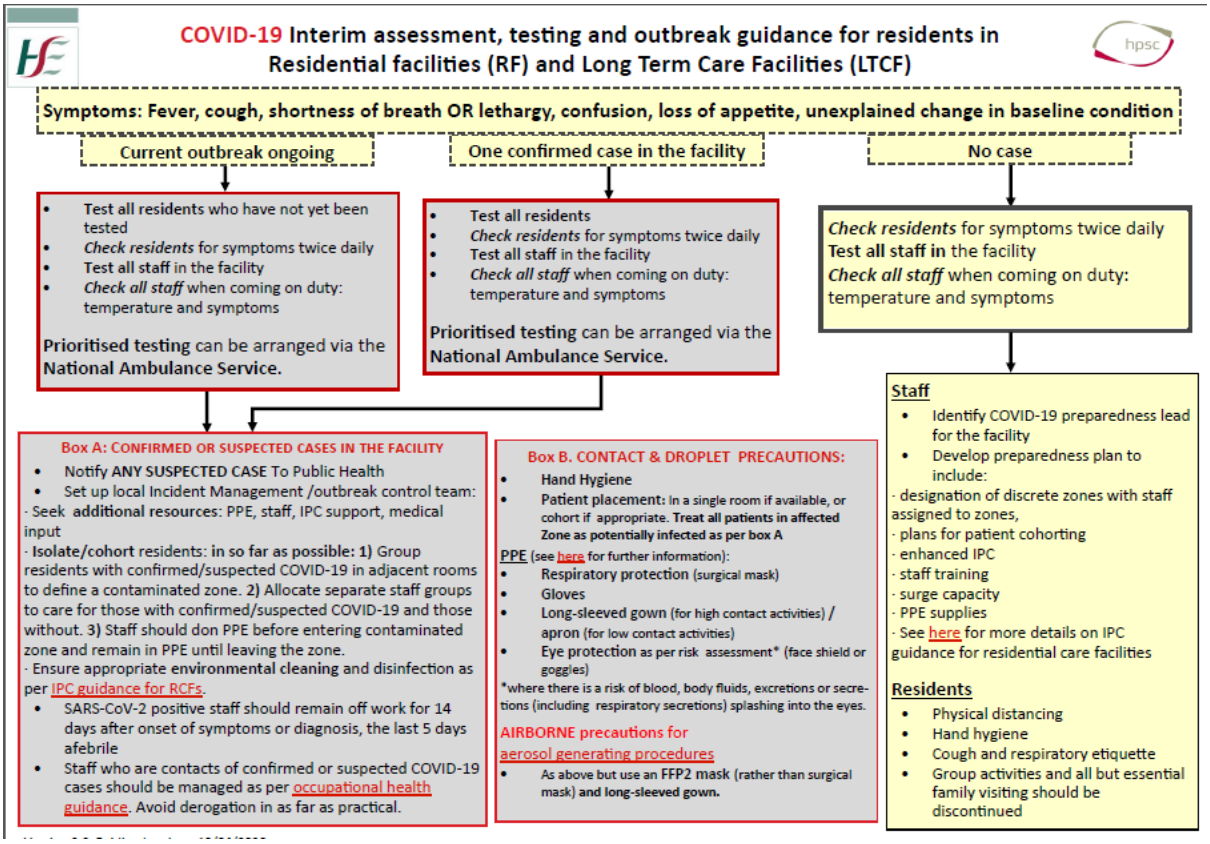
Mary Dunnion

Chief Inspector of Social Services

Appendix 5 – HSPC Guidance on risk assessment for COVID contacts



Appendix 6 – testing and outbreak guidance for residents in Residential Facilities & LTC



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		