Public Health and Infection Prevention and Control guidance on the prevention and management of cases and outbreaks of respiratory viral infections in Residential Care Facilities

V2.1 05.12.24

Ver.	Date	Changes from previous version
2.1	05.12.24	General revision and editorial updates. Removal of reference to antigen testing Inclusion of duration of transmission based precautions for patients receiving antiviral therapy for the treatment of influenza. Removal of vaccination status as a consideration for extension of transmission based precautions Inclusion of link to guidance on the use of antiviral agents for the treatment and prophylaxis of Influenza Inclusion to utilise community support teams (CST) for additional support as part of an outbreak management strategy
2	21.08.24	Significant restructuring of the document to support ease of use. General revision and editorial updates. Changes to guidance to move from specifically managing COVID-19 in a pandemic setting to widen the scope of this guidance, which is applicable to the management of acute respiratory viral infections in residential care facilities Content throughout the document has been removed and direction has been provided to specific sections in the National Clinical Guidance No. 30 Infection Prevention and Control Revision to section on testing with direction to guidance on testing for Acute Respiratory Infection (ARI) in Residential Care Facilities Revision to section on identifying contacts with generic advice for respiratory viral infections provided Removal of duplicated content from various sections throughout the document Update to the section on outbreak Revision and update to section on transfers to and from RCFs Revision of appendix A Removal of appendix E Removal of records of previous changes prior to December 2023.
1.13	13.12.23	Amendments to language around management of contacts of influenza cases Editorial changes

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The following guidance documents were referred to in developing this guidance:

- Coronavirus Disease 2019 (COVID-19) Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities developed by the Communicable Diseases Network Australia (CDNA)
- COVID-19: Information and Guidance for Social or Community Care & Residential Settings Health Protection Scotland
- Public Health Guidelines on the Prevention and Management of Influenza Outbreaks in Residential Care Facilities in Ireland 2019/2020
- World Health Organization. Infection Prevention and Control Guidance for long-term care facilities in the context of COVID-19: interim guidance, 21 March 2020 World Health Organization; 2020
- HIQA-Rapid Review of Public Health guidance on infection prevention and control measures for residential care facilities in the context of COVID-19 30/3/20
- Guidance on testing for Acute Respiratory Infection (ARI) in Residential Care Facilities* (RCF) – Winter 2023/2024 V1.4 13/11/2023
- Algorithm: Guidance on testing for Acute Respiratory Infection (ARI) in Residential Care Facilities (RCF) Winter 2023/2024

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1 Introduction

This document should be used in association with the National Clinical Guidance No. 30 Infection Prevention and Control, which is available at the following link www.gov.ie/IPCclinicalguideline/. This guidance replaces the following guidance: Public Health & Infection Prevention & Control Guidelines on Prevention and Management of Cases and Outbreaks of COVID-19, Influenza & other Respiratory Infections in Residential Care Facilities V1.13 13.12.2023. The changes to the previous guidance reflect that respiratory virus guidance rather than virus-specific guidance is helpful for Residential Care Facilities managing the risk from a range of common respiratory viral illnesses, such as COVID-19, influenza and Respiratory syncytial virus (RSV) and others, which have similar routes of transmission, symptoms and similar prevention strategies for these respiratory viruses. A generic practical approach for respiratory viral infections is therefore adopted for this guidance.

A suite of bespoke AMRIC eLearning resources is available to provide additional educational content on topics contained within this guidance. A detailed list of all the AMRIC modules is available in the AMRIC Hub at www.HSeLanD.ie

1.1 Background

Co-circulation of respiratory viruses including influenza virus, RSV with SARS-Cov-2 is likely to continue to be a feature of management of viral respiratory infections at certain times each year. The clinical features caused by infection with respiratory viruses are often difficult to differentiate and the public health and infection prevention and control management is very similar. For these reasons, this document is framed as general guidance for this group of infections. The term respiratory viral infection is used throughout this guidance document, which refers to common respiratory viruses such as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), influenza, respiratory syncytial virus (RSV), and a wide range of other viruses which cause disease in humans.

The fundamental principles of basic infection prevention and control (IPC) remain key parts of the defences we have for protecting residents, our colleagues and ourselves from acquiring

respiratory viral infections. Maintaining and strengthening appropriate infection prevention and control (IPC) practices mitigates the spread of respiratory viruses in healthcare facilities, especially during peak periods of hospital admission. Timely implementation of multi-layered interventions is the key to preventing further strain on facilities (ECDC).

Vaccination and booster vaccination for certain infections play a central role in managing the risk of spread of respiratory viral infections and severe disease in the residential care facility, as in other settings, while maintaining the delivery of timely and appropriate care to the resident.

High levels of community transmission and the co-circulation of respiratory viruses can increase pressure on healthcare systems. These co-circulating viruses pose a challenge for the management of large numbers of residents with respiratory viral infections and have a tendency to cause outbreaks in healthcare settings at certain times of the year (ECDC 2023).

Respiratory viral infections are acquired as a result of exposure to a person shedding infectious virus. It is generally accepted that the highest risk of transmission occurs at about the time an infected person develops symptoms. Infection can be transmitted from people with minimal symptoms, from people before they develop symptoms (pre-symptomatic transmission) and from people who never develop symptoms (asymptomatic transmission). However, transmission from symptomatic people is generally considered the greatest risk.

1.2 Scope

This guidance applies to residential care facilities (RCF) where residents are provided with overnight accommodation, including long-term nursing home, long-term mental health residences and shorter-term respite and convalescence care. The anticipated duration of such accommodation may vary within and between different types of RCF. For example, some RCFs for older persons may offer a blend of long-term nursing home and shorter-term respite and convalescence care.

The original guidance was developed primarily for congregated care settings providing care for relatively large numbers of residents. Experience shows that spread of respiratory viruses in

these settings had profound consequences prior to the COVID-19 vaccination campaign and continues to impact some residents severely. Influenza virus can also cause severe illness in residents.

While the principles of this guidance can be applied in all residential care settings, the risks are lower in the context of residential care provided in the setting of community housing for groups of five to six people or fewer. The approach to prevention of infection and the management of outbreaks of infection in those community-housing units requires a more nuanced approach. For example, restricting people to their room for extended periods is likely to be impractical. Likewise, outbreak management needs to take account of the specific needs, interpersonal dynamics and number of people potentially at risk in such settings.

Facilities providing acute inpatient rehabilitation services are advised to refer to the 'Acute Hospital Infection Prevention and Control guidance on the prevention and management of cases and outbreaks of respiratory viral infections':

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/

2 Infection prevention and control measures for respiratory viral infections in residential care facilities

Maintaining and strengthening IPC practices can mitigate the spread of pathogens within residential care facilities, especially during peak periods of community transmission of respiratory viral infections. Timely implementation of multi-layered interventions is key to preventing further strain on residential care facility personnel and other resources. Residential care facilities governance structures should ensure adherence to IPC measures and adequate availability of resources, such as personal protective equipment (PPE).

2.1 Responsibilities

The primary responsibility for managing the risk of infection with respiratory viruses and for control of outbreaks lies with the RCF, within their responsibilities for resident care. These areas can seek specialist Infection prevention and control/Public Health advice, as per local governance arrangements. . This responsibility is referred to in the 2016 National Standards for Residential Care Settings for Older People in Ireland. The 2018 National Standards for infection prevention and control in community services are also relevant. All RCFs should have access to IPC/ antimicrobial stewardship (AMS) expertise (such as an infection prevention and control nurse, a consultant microbiologist and a local pharmacist) .and should have outbreak management plans in place.

Under the Infectious Diseases Regulations 1981, Amendment February 2020, any medical practitioner who is aware of a case of a notifiable disease or an outbreak of any infectious disease is obliged to notify the Medical Officer of Health (MOH) at the regional Department of Public Health. Contact details can be found here https://www.hse.ie/eng/services/list/5/publichealth/publichealthdepts/contact%20us/contact-details.html.

Registered providers must notify the Chief Inspector (HIQA) of an outbreak of a notifiable disease as per Statutory Notifications Guidance for registered providers and persons in charge of designated centres January 2016.

Regional Department of Public Health

The Regional Departments of Public Health are responsible for investigating cases and outbreaks of respiratory viral infections or other infectious disease and providing overall leadership and oversight for outbreak management. The IPC link practitioner is a key resource to provide IPC support within the facility Respiratory Virus Outbreak Preparedness

As part of preparedness, each residential care facility should conduct a risk assessment to identify key risk factors including transmission risks, factors such as infrastructure, ventilation, previous experience and lessons learned from outbreaks, including areas which frequently experience respiratory viral infection outbreaks and measures to mitigate against these risks.

Some key elements as part of this preparedness and planning include the following:

1. Identify a lead for respiratory viral infection preparedness and response in the RCF. The lead should be a person with sufficient authority to ensure that appropriate action is taken and requires at a minimum the support of one designated on-site IPC link practitioner (see relevant section on link practitioners). In some smaller RCFs the lead may also fulfil the role of the IPC link practitioner. In larger RCFs there may be a requirement for a liaison person on each unit in the RCF in addition to lead and link IPC practitioner roles
2. RCF settings must have respiratory viral infection preparedness plans in place to include planning for cohorting of potentially infectious residents separately from non-infectious residents, enhanced IPC, Health and Care Worker (H&CW) training, establishing surge capacity and promoting resident and family communication
3. All RCFs should consider the available COVID-19 therapeutics as part of the COVID-19 preparedness plan. Up to date guidance relating to community prescribing of currently available agents is available on the COVID-19 section on www.antibioticprescribing.ie
4. Maintain an up-to-date list of all residents in the RCF and all H&CWs working in the RCF, along with contact telephone numbers for staff.
5. Each RCF should have an area identified where a resident with suspected or confirmed respiratory viral infection can isolate from other residents. In many cases this will be the resident's room if they have a room exclusively for their own use;
6. Where possible, each ward or floor should try to operate as a discrete unit or zone, meaning that H&CWs and equipment are designated to a specific area and are not rotated from other areas (this includes night duty). This practice may reduce exposure to risk for H&CWs and residents' in the event respiratory viral infection

is introduced into the facility. This may also allow outbreak response measures to be targeted in zones, rather than having to be implemented facility-wide

7. The risk associated with movement or rotation of H&CWs is lower if H&CWs are vaccinated and have had booster vaccine against COVID-19 and seasonal influenza vaccine or have recently recovered from COVID-19
8. Facilities should ensure the availability of supplies, including tissues, alcohol-based hand rub (ABHR), hand wipes, cleaning products, disinfectants, viral swabs and personal protective equipment (PPE) and liaise with relevant supply lines if there is difficulty in obtaining such supplies
9. Supplies of PPE should be sufficient to ensure that single-use items of PPE, including visors and goggles, are used only once and then disposed of safely. Refer to IPC PPE guidance for further advice https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/
10. **Note:** the Health and Safety Authority indicate that where a risk assessment indicates that workers need to use a close-fitting respirator mask for their protection that every effort should be made to comply with the requirement for fit testing of the workers, as far as is reasonably practicable. When fit testing of all H&CWs is not immediately possible, then fit testing should be prioritised for those at greatest risk
11. A summary table of key interventions for the prevention and management of a respiratory viral infection outbreaks can be found in Appendix A.

General principles

Measures to decrease the risk of respiratory virus transmission in healthcare settings are multi-faceted and include measures such as standard and transmission based precautions, appropriate ventilation in patient[1] care areas, and minimising the contact between residents.

[1] Where the term patient is used throughout this guidance document, it refers to patients, service users, clients, residents, person, supported individual

Controlling the risk of introduction, spread and harm from respiratory viruses is challenging particularly as there is a need to balance the management of risk with respect for the autonomy and rights of residents. Vaccination of residents, H&CWs and visitors, including booster vaccination, as appropriate, plays a central part in managing all aspects of the risk.

Vaccination, including booster vaccination, of a high proportion of residents and H&CWs in RCFs against COVID-19 and influenza has had a major impact on reducing the impact of respiratory viral infections in RCFs. In this context, it is possible to manage the risk of spread of these respiratory viral infections effectively with less restriction on the lives of residents. There is however, a continuing need for vigilance to prevent infectious H&CWs or other people from entering the RCF. It remains important to ensure that residents with symptoms of respiratory infection are detected promptly and that transmission-based IPC precautions, including appropriate use of PPE are implemented in the care of infectious residents to further reduce the risk of spread.

RCFs must have systems in place to ensure that, to the greatest extent possible, residents with respiratory viral infections are rapidly identified and are cared for with appropriate transmission-based IPC precautions.

Outbreaks of infection involving both residents and H&CWs have been frequent in RCFs during the major community surges of respiratory viruses. The control of spread of the respiratory viruses in RCFs in this context continues to be challenging even after vaccination. The emergence of SARS-CoV-2 variants with higher transmissibility or that are less effectively prevented by vaccination add to the challenge of effective control.

Standard precautions

Standard precautions (SP) and, in particular, meticulous hand and respiratory hygiene are important in preventing the transmission of respiratory viruses and should be applied when caring for all residents.

Due to the likelihood of respiratory virus transmission by people with few or no symptoms, residential care facilities should ensure that physical distancing measures are applied by H&CWs, residents and visitors, particularly in common areas during peak periods of community transmission of respiratory viruses.

During periods where there is high community transmission of respiratory viruses such as SARS-CoV-2, influenza and RSV, it may be appropriate for face masks to be used in a broader sense than as part of the PPE used in Standard precautions or Transmission Based Precautions (TBP). To inform this, a dynamic risk assessment should be undertaken as clinical and epidemiological indicators show increasing community circulation of respiratory viruses. This risk assessment should include the experience of transmission of respiratory viruses in that setting, including the impact on H&CWs illness absence. It has been the experience in some healthcare settings in Ireland that the universal or targeted use of masks has had a beneficial impact by reducing for example H&CW absence with influenza. However, this is not the experience shared across all healthcare settings, where in some cases masks were not found to have had any additional beneficial impact. This will be further addressed in the section on PPE.

The National Clinical Guidance No. 30 Infection Prevention and Control" www.gov.ie/IPCclinicalguideline contains recommendations and guidance on standard precautions.

Details on standard precautions are contained in the following sections:

- Volume 1, section 2, No. 2.1.5, page 20
- Volume 1, section 3, No. 3.1 page 37
- Volume 2, section 7. No. 7.2 Checklist of PPE typically required for common procedures performed on residents
- Volume 2, section 7, No.7.3 Use of standard and transmission-based precautions, Table 41.

Links to the standard precautions poster and explainer are available on the following link: https://www.hpsc.ie/a-

z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/HSE%20West%20Standard%20Precautions%20Poster%20A3.pdf

As part of standard precautions, it is the responsibility of every H&CW to undertake a point of care risk assessment (PCRA) prior to performing a clinical care task; this will inform the level of IPC precautions needed, including the choice of appropriate PPE. For further information on PCRA, and how to use a PCRA please see links

- https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/
  AND
- https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/how-to-use-a-point-of-care-risk-assessment-pcra-for-infection-prevention-and-control-copy.pdf

For further information on standard precautions and transmission based precautions and respiratory and cough hygiene refer to HSeLanD (www.hseland.ie) online learning

Information posters to support areas with hand hygiene are available here

Vaccination

Vaccination against SARS-CoV-2 (including booster vaccination) and influenza reduces the risk of transmission in addition to reducing severity of disease in those who have completed their annual influenza vaccination and primary vaccination course against COVID-19 and have had booster vaccination/s for which they are eligible. This serves to emphasise the importance of vaccination, including booster vaccination, where appropriate, of healthcare workers not only to protect themselves but also in protecting the people that they care for. It is important that residential care facilities have systems in place to monitor the vaccination status of residents and to encourage vaccination including booster vaccination, to the greatest extent practical.

H&CW Vaccination

Protection afforded to Health and Care Workers (H&CW) by the influenza and COVID-19 vaccination, even with booster dosing, is not absolute; therefore, it remains essential to avoid intense exposure to the greatest extent possible. Vaccinated people who become infected are expected to be less infectious. However, vaccination does not eliminate the risk of transmission of influenza or SARS-CoV-2 from H&CW to resident in these settings. Therefore, H&CWs should not attend for work if they have a new onset of respiratory viral symptoms or other viral respiratory tract infections, even after booster vaccination. H&CWs should be aware that the protection afforded them by vaccination may be less when caring for people with infection with certain variants.

H&CWs, who have received vaccination, should continue to adhere to all IPC measures in this guideline in the same way as they did prior to vaccination to protect themselves and others. This advice will be reviewed regularly on the basis of emerging evidence and experience. H&CWs should avail of vaccinations as they become available in line with recommendations from National Immunisation Office.

Current recommendations for vaccination and booster vaccination are available in:

https://www.rcpi.ie/Healthcare-Leadership/NIAC/Immunisation-Guidelines-for-Ireland , refer to specific chapters:

- Chapter 5a COVID-19
- Chapter 11 Influenza

Influenza and COVID-19 vaccination are recommended at all stages of pregnancy, and vaccination of those who are pregnant or planning pregnancy is central to reducing the risk of severe disease and poor pregnancy outcomes. Pregnant workers, with specific health or work concerns should discuss those with their specialist in obstetrics and be referred to occupational health for assessment.

Further information regarding COVID-19 and pregnancy is available at:

https://assets.hse.ie/media/documents/Guidance_on_Fitness_for_Work_of_Immunocompromised_or_Pregnant_Healthcare_Worke_kp5eErs.pdf

Residents vaccination

The majority of residents and H&CWs in RCFs have received primary COVID-19 vaccination and subsequent boosters as recommended by National Immunisation Advisory Committee (NIAC) .Services should ensure local arrangements are in place for the administration of both COVID-19 and influenza vaccine based on eligibility. It is important to maintain records of vaccination uptake.

The seasonal influenza vaccine is recommended to and offered to residents of RCFs and to all healthcare workers before winter each year. Vaccine protection is not perfect and the vaccine may not work so well in people who have certain conditions or who are on a treatment that interferes with their immune system. H&CWs and residents are advised to continue to adhere to all IPC measures in this guideline after vaccination including booster.

Note: H&CWs should promote vaccination and offer vaccination to residents and H&CWs as appropriate, as this provides the best source of protection for residents and H&CWs.

Ensure that up to date vaccination records of residents are available.

2.2 Transmission-based precautions

See the following sections in the “National Clinical Guidance No.30 Infection Prevention and Control” www.gov.ie/IPCclinicalguideline

Volume 1, section 3, No. 3.2.1, page 88 Application of transmission-based precautions and relevant sections on:

- Contact precautions: Volume 1, section 3, No. 3.2.2, page 91

- Droplet precautions: Volume 1, section 3, No. 3.2.3, page 95
- Airborne precautions: Volume 1, section 3, No. 3.2.4, page 98

Transmission of respiratory viral infections in residential care facilities

The spread of respiratory viruses in the health and social care setting is a specific concern. Experience in Ireland and elsewhere indicates that transmission in hospitals and residential care facilities can occur readily when the virus is introduced from the community into the healthcare setting. Vaccination and booster vaccination has played a key part in helping to manage this risk of specific respiratory viral infections but does not eliminate it. Even with high levels of vaccination respiratory viruses can spread rapidly, particularly in crowded and poorly ventilated spaces, or if IPC precautions are suboptimal.

Managing the risk of respiratory viruses in a residential care setting can be thought of as three elements.

1. Transmission typically occurs when an unrecognised infectious person enters the facility. Control of entry to minimise risk of unrecognised introduction is therefore a key priority in preventing outbreaks. This requires a particular focus when rates of infection in the community served are high. The first element is to take all practical measures to reduce unintended introduction of respiratory viruses into the residential care facility. If these viruses are not introduced by a person with infection, then it cannot spread. In the context of residential care facilities, a key group of people who move regularly between community and the facility is H&CW. Visitors also represent a risk of introduction of respiratory viruses. Principles to support the management of risk associated with visiting is provided in the relevant section on visitors and nominated support partner
2. Even when all practical precautions are taken it is still possible that respiratory viruses will be introduced unintentionally, therefore the second element is to take all practical measures to reduce the risk of these viruses spreading if introduced. Even with high levels of vaccination the virus can spread rapidly, particularly if IPC precautions are suboptimal

3. The third element is having processes in place to minimise the risk of harm to residents and H&CWs if both other elements fail and respiratory viruses are introduced and spread. This includes the administration of specific antivirals when appropriate.

The transmission of respiratory viral infections occurs mainly through liquid respiratory particles. Respiratory particles are generated from the nose and mouth by actions such as breathing, coughing, sneezing, talking or laughing. The larger particles can be considered as droplets (larger) and the smaller as aerosols (smaller). The particle sizes form a continuum rather than two discrete categories. In practice the infection prevention and control issue is whether transmission through the air occurs primarily within a short range of space and time of the source (considered associated with droplets) or over a long range of space and time (considered associated with aerosols and airborne transmission).

Spread can also occur indirectly via respiratory secretions on hands, tissues, etc. If the infected person does not cover their mouth and nose when coughing or sneezing, those within a range of one metre may be infected. Transmission to others may result from direct impact of infectious droplets on the mucosa of persons in proximity and through contact with surfaces contaminated with infectious respiratory droplets and subsequent transfer of infectious material to the mucous membranes (droplet and contact transmission).

Transmission-based precautions should be applied for residents with suspected/confirmed respiratory viral infection, taking into consideration the microorganism, as well as factors that can affect transmissibility such as the time and proximity of contact, the requirement for respiratory support, which may pose a high-risk, the immune status of the resident and the clinical presentation. Where feasible, transmission-based precautions should also be considered for residents with suspected respiratory viral infection (e.g. residents with typical clinical presentation or with an epidemiological link to a confirmed case).

2.3 Clinical features of respiratory viral infection

Most otherwise healthy people with respiratory viral infection will have mild disease and will recover. A minority will develop an illness that is more serious.

The case definition for Acute Respiratory Infection (ARI) as per the HPSC and aligned with the European Commission/ European Centre for Disease Prevention and Control case definition includes the following:

Sudden onset of symptoms

AND

At least one of the following four respiratory symptoms: cough, sore throat, shortness of breath, coryza

AND

A clinician's judgement that the illness is due to an infection

It is important to remember that older people with respiratory viral infections very often do not have fever and respiratory symptoms and may only have symptoms such as:

1. lethargy
2. increased confusion
3. change in baseline condition
4. loss of appetite.

Clinical judgement with a high index of suspicion should be used when assessing residents.

It is important to note that people who are vaccinated and who become infected may have very mild symptoms but be infectious. This poses a risk in particular for residents who are not vaccinated or who may not have had a good response to vaccine.

RCF residents with influenza or RSV infection may have very similar clinical features to residents with COVID-19. It is important to consider and test as appropriate for other respiratory viruses when clinically relevant.

The HSE has defined categories of people who are considered very high risk for COVID-19 (also known as extremely medically vulnerable) and those at high risk for severe

disease. See the following link https://www2.hse.ie/conditions/coronavirus/people-at-higher-risk.html

For more information on symptoms and signs of COVID-19, refer to the case definition

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casedefinitions/

and on https://www2.hse.ie/conditions/covid19/symptoms/overview/

2.4 Duration of Transmission-based precautions in Residential care facilities

For residents, the period of isolation and application of transmission-based precautions for COVID-19 and other respiratory viral infections such as influenza or RSV is currently a minimum of 5 days from onset of symptoms or date of positive result (whichever first). If the resident has no or minimal residual symptoms for two days, transmission based precautions can be discontinued not less than 5 days from date of symptom onset based on risk assessment. Extension beyond 5 days may be appropriate based on experience and an assessment of local risks and is generally appropriate in people who are immunosuppressed or following consultation with their clinical team.

For patients receiving of antiviral therapy for the treatment of influenza, the period of transmission based precautions is not less than 72hrs after antiviral treatment began.

COVID-19

The time interval between exposure to the virus and developing symptoms (incubation period) has been considered five to six days for most people. The incubation period can be up to 14 days. Individuals are usually considered most infectious to others around the time they develop symptoms.

Influenza

On average, the incubation period for seasonal influenza is two days, but ranges from one to four days (ECDC). The virus is found in specimens taken from the nose and throat between one day before symptom onset and five to seven days after onset. The level of virus shedding before symptoms start is lower than after symptom onset. Viral shedding continues for a somewhat longer period in the elderly, and those who have weakened immune systems, compared to healthy adults. (ECDC 2023) https://www.ecdc.europa.eu/en/seasonal-influenza/facts/factsheet

RSV

Symptoms usually appear two to eight days after being infected (ECDC).

2.5 Discontinuation of transmission-based precautions

The decision to lift transmission-based precautions is a clinical decision in each case and should not happen by default based solely on the number of days elapsed since diagnosis.

Where a resident is asymptomatic at the time of collection of a positive sample but subsequently develops respiratory viral infection symptoms the infectious period should be considered as not less than 5 days from the date when symptoms commenced rather than from the date of sampling. If no symptoms develop, the infectious period is counted as not less than 5 days from the date of detection.

Extension of the period of transmission-based precautions beyond the minimum should be informed by ongoing clinical evaluation, in particular if the patient is supported by a high flow oxygen device or similar (such as CPAP or BIPAP).

Repeat testing for respiratory viral infection at the end of the intended isolation period is generally not recommended. However, it may be appropriate in particular settings or for

particular patients following local risk assessment as outlined above and informed by local experience.

2.6 Safely managing residents with suspected or confirmed respiratory viral infection

1. The initial assessment of the resident should be performed by their doctor
2. If the resident is eligible for consideration for specific antiviral treatment they should be referred appropriately for assessment
3. If the clinical condition does not require hospitalisation, the resident should not be transferred from the facility on infection prevention and control grounds
4. Where it is appropriate to their overall care needs, a resident with possible or confirmed COVID-19, RSV or influenza should be placed in a single room with transmission-based precautions and appropriate use of PPE by H&CWs
5. H&CWs assigned to care of a resident in these circumstances should be H&CWs who have been vaccinated (including booster vaccination);
6. Room doors should be kept closed where possible and safe to do so
7. Practical measures to increase ventilation should be taken consistent with comfort and weather. Note: the intention is to achieve gentle air circulation rather than strong air movements
8. When this is not possible, ensure the resident's bed is moved to the furthest safe point in the room to try and achieve at least 1 m distance to the door
9. Display signage to provide advice on transmission based precautions on entry to the room, and ensure confidentiality
10. Take time to explain to the resident the importance of the precautions that are being put in place to manage their care and advise them against leaving their room;
11. Ideally, the resident's single room should have ensuite facilities
12. If ensuite facilities are not available, try to designate a commode or toilet facility for the resident's use

13. In the event of a commode being used, the H&CW should exit the resident's room while wearing appropriate PPE, transport the commode directly to the nearest dirty utility room and place the contents directly into the bed pan washer or pulp disposal unit; PPE can then be removed and disposed of in the dirty utility room. A second person should be available to assist with opening and closing doors to the single room and dirty utility room. If a second person is not available, change gloves and perform hand hygiene and put on a clean pair of disposable gloves

14. If the resident must use a communal toilet, ensure it is cleaned and disinfected after every use
15. Listen and respond to any concerns residents may have to ensure support and optimal adherence is achieved during their care

16. If well enough, a resident who has infection should be facilitated in going outside alone if appropriate or accompanied by a H&CW maintaining adequate distance from both H&CWs and other residents. If the H&CW can maintain this distance, they do not need to wear PPE

17. If the resident passes briefly through a hallway or other unoccupied space to go outside, there is no requirement for any additional cleaning of that area beyond normal good practice
18. Residents with confirmed COVID-19 or influenza or other respiratory viral infections will require appropriate healthcare and social support, including access to their doctor or GP for medical management and on-site support
19. Residents with a confirmed respiratory viral infection should continue to have some access each day in their room to their nominated support person if that person acknowledges and accepts the associated risk and complies with all infection prevention and control guidance
20. Residents with influenza or who are exposed to influenza may require treatment with antiviral medication; this may also be a consideration with respect to COVID-19, as appropriate

21. A care planning approach that reflects regular monitoring of residents with respiratory viral infection for daily observations, clinical symptoms and deterioration should be put in place. Where appropriate there should be advance planning in place with residents and / or advocates reflecting preferences for end of life care and / or transfer to hospital in event of deterioration. Staffing levels / surge capacity planning should reflect the need for an anticipated increase in care needs during an outbreak
22. At a minimum, for interaction with residents with respiratory viral symptoms, healthcare workers should use a surgical mask or respirator mask. For longer episodes of care, for care within the bed space, or while performing higher risk procedures, a respirator mask and eye protection are recommended; the choice of PPE is informed by a Point of care risk assessment (PCRA)- https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/PCRAResistPoster.pdf
23. Refer to this algorithm for further advice
    https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/guidance/residentialcarefacilitiesguidance/Algorithm%20for%20testing%20for%20ARI%20in%20RCF.pdf
24. There is no requirement for repeat testing after a person has a test confirming COVID-19 infection;
25. Antiviral treatment for residents with influenza and, where appropriate, COVID-19 should be discussed promptly with the resident's doctor or with Public Health. Treatment is likely to be more effective if started early

    For advice on the duration of transmission based precautions, refer to the earlier section

    H&CWs with confirmed influenza should remain off work for 5 days from the onset of symptoms and until they are well enough to return, refer to the relevant section on staff within this guidance
26. H&CWs should be mindful that prolonged isolation is stressful for most residents. Access to a nominated support person who is willing to attend may greatly relieve that stress

27. If residents need to see people other than the nominated support person, for example because they are distressed or approaching end of life, this should be facilitated if the person they wish to see understand that there is a risk of infection and can follow recommendations to lower the risk of infection, refer to the relevant section in this guidance on visitors and nominated support person.

2.7 Cohorting residents with possible or confirmed COVID-19 or Influenza or other respiratory viral infection

Placement of residents with possible or confirmed COVID-19, influenza or RSV in a designated zone, with designated staffing to facilitate care and minimise further spread is known as cohorting.

In a RCF, cohorting can be a useful approach to managing a highly infectious disease with associated serious morbidity and mortality when a number of residents are affected at the same time. Cohorting is not required in the management of every outbreak. It is appropriate to balance the potential benefits of cohorting with the disruption and stress for residents associated with moving from the room or space that they are accustomed. These decisions should be based on safety, need, capacity for cohorting of patients with a confirmed respiratory viral infection, facility infrastructure and available resources.

1. If cohorting is necessary it requires an individual facility risk assessment approach including planning for each facility, and the zoned area might be a floor, a wing or a separate annex. In these zoned areas, heightened infection prevention and control measures are critical
2. Appropriate transmission-based precautions must apply promptly to those identified as suspected or confirmed cases of respiratory viral infections
3. H&CWs should not dismiss the significance of new respiratory viral infection symptoms on the basis of a recent test result reported as SARS-CoV-2 or influenza not-detected/ negative, because a resident could still be in the incubation period at the time of testing or could acquire infection after admission

4. There is no requirement for contact tracing including the identification of close contacts of a confirmed case of COVID-19 in an RCF. PCR testing is recommended for symptomatic contacts
5. Residents who are close contacts of a confirmed case of influenza should be monitored for development of symptoms; there is no requirement to isolate or cohort asymptomatic contacts of influenza
6. Antiviral prophylaxis may be appropriate for influenza contacts including older persons and risk assessing the patient population as per advice from the Public Department Health or infection prevention and control teams. Further information is available here https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/guidance/antiviraltreatmentandprophylaxisguidance/
7. H&CWs should not discount the possibility that symptoms represent influenza or SARS-CoV-2 infection on the basis that a patient is vaccinated
8. Testing of asymptomatic contacts is not generally necessary. If done, the approach should be based on a local risk assessment to include residents medical vulnerability. Further information on antiviral post-exposure prophylaxis and testing recommendations are available here at https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/guidance/
9. Ensure adequate ventilation in the cohort area in so far as practical, consistent with comfort and safety; the goal is gentle air circulation rather than strong air movements
10. Cohorting includes residents who are placed in single rooms close together, or in multi-occupancy areas within the building or section of a ward/unit
11. A local risk assessment should consider the type of rooms, for example single rooms, multi bedded rooms, and individual resident needs prior to considerations for cohorting (e.g. monitor for symptoms)
12. Where possible, residents with probable or confirmed COVID-19, influenza or RSV should be isolated in single rooms with ensuite facilities. If there are multiple residents and if it is necessary to cohort, these single rooms should be located in

close proximity to one another in one zone, for example on a particular floor or area within the facility

13. Where single room capacity is exceeded and it is necessary to cohort residents in a multi-occupancy room:
    a. Residents with **a confirmed diagnosis of COVID-19** can be cohorted together
    b. Residents with **a confirmed diagnosis of influenza** can be cohorted together
    c. Residents with suspected COVID-19, RSV or influenza should not be cohorted with those who are confirmed positive
    d. The risk of cohorting **suspected cases** in multi-occupancy areas is much greater than that of cohorting confirmed positive residents together, as the suspected cohort is likely to include residents with and without the specific virus infection.
14. People who are contacts should not be cohorted in an area with patients with suspected or confirmed respiratory viral infections
15. Where residents are cohorted in multi-occupancy rooms, every effort should be made to minimise cross-transmission risk:
    a. Maintain as much physical distance as practical between beds (minimum of 1m); if possible reduce the number of residents/beds in the area to facilitate physical distancing
    b. Close privacy curtains if available between the beds to minimise opportunities for close contact
16. There should be clear signage indicating that the area is a designated zone to alert H&CWs about a cohorting location in the RCF. A cohort zone may have multi-occupancy rooms or a series of single rooms
17. A designated cohort area should ideally be separated from non-cohort areas by closed doors
18. In the rare event of outbreak of two viral infections, do not cohort people with COVID-19 and those with influenza or RSV together

19. Minimise unnecessary movement of H&CWs in cohort areas and ensure that the number of H&CWs entering the cohort area is kept to a minimum
20. H&CWs working in cohort areas ideally should be vaccinated (including booster vaccination if eligible),
21. In so far as is possible, the cohort area should not be used as a thoroughfare by other residents, visitors or H&CWs, including residents being transferred, H&CWs going for meal breaks and H&CWs entering and exiting the building.

2.8 Testing

COVID-19, influenza, and other respiratory viruses are difficult to distinguish based on clinical symptoms alone and require laboratory confirmation for definitive diagnosis. Advice/recommendations regarding the testing of symptomatic individuals for COVID-19, influenza, and other respiratory viruses in Residential Care Facilities can be found in the Guidance on testing for Acute Respiratory Infection in Residential Care Facilities see below:

https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/guidance/residentialcarefacilitiesguidance/Guidance%20for%20ARI.pdf

and

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/residentialcarefacilities/Algorithm%20for%20testing%20for%20ARI%20in%20RCF.pdf

HSE videos demonstrating sample collection techniques are available at the following link

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguid

ance/sampling/

Note that testing of asymptomatic patients including asymptomatic contacts is not required.

Testing of some asymptomatic patients may be appropriate, as determined by a local risk assessment.

Routine testing of H&CW contacts is not required however, it may be recommended by an Outbreak Control Team (OCT) in the context of managing an outbreak or otherwise based on IPC/Public Health or Occupational Health risk assessment.

Note that testing of asymptomatic residents on transfer or admission is generally not required.

2.9 Personal Protective Equipment (PPE)

Good IPC practice including use of PPE is important but is not a substitute for vaccination.

As part of standard precautions, the use of appropriate PPE remains an important part of the controls within healthcare and requires a point of care risk assessment (PCRA) by the healthcare worker regarding the symptoms of the patient, and the task they plan to undertake during the episode/s of care. It is the responsibility of every H&CW to undertake a point of care risk assessment PRIOR to performing a clinical care task, as this will inform the level of IPC precautions needed. At a minimum, for interaction with patients with respiratory viral symptoms, healthcare workers should use a surgical mask or respirator mask. For longer episodes of care, for care within the bed space, or while performing higher risk procedures, a respirator mask and eye protection are recommended. In addition, respirator masks or surgical masks should be offered to patients in open or multi-bed healthcare settings who are exposed to other symptomatic patients.

PPE should be readily available outside the resident's room or cohort area.

For further information on PCRA and how to use a PCRA please see links

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/

AND

https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/how-to-use-a-point-of-care-risk-assessment-pcra-for-infection-prevention-and-control-copy.pdf

Further detail on the use of PPE is contained in the "National Clinical Guidance No 30 Infection Prevention and Control (IPC) on the following link: www.gov.ie/IPCclinicalguideline

Sections on the use of PPE for standard and transmission-based precautions are available in the following sections:

- Volume 2, Appendix 7, Section 7.3, page 250 Use of standard and transmission-based precautions, Page 250
- Volume 2, Appendix 7, Section 7.4, Table 44, page 252 Precautions for specific infections and conditions, including recommendations for the use of Personal Protective Equipment (PPE) for respiratory viral infections
- Specific recommendations on correctly fitted and fit checked respiratory protection (FFP2 respirator) is available in Volume 1, section 3, No. 3.2.4 pages 98-101, Airborne precautions, Recommendation 16.

The guidance on PPE is available on the following link:

https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/

A suite of resources including posters, videos and webinars relating to the safe donning and doffing of PPE is accessible at

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/

Follow appropriate sequence and procedure for putting on and removing PPE as outlined in HSE training materials, see poster section in:

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/posters/

Educational videos are also available on www.hpsc.ie at

https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/videoresourcesforipc/

Note: Recognising that H&CW preferences are an important consideration, surgical and respirator masks should continue to be available to H&CWs in all settings, although they are not required for most healthcare interactions outside of periods of increased community transmission of respiratory viral infections.

The Health and Safety Authority indicates that where a risk assessment indicates that workers need to use a close-fitting respirator mask for their protection that every effort should be made to comply with the requirement for fit testing of the workers, as far as is reasonably practicable. When fit testing of all H&CWs is not immediately possible, then fit testing should be prioritised for those at greatest risk. See the "National Clinical Guidance No.30 Infection Prevention and Control" www.gov.ie/IPCclinicalguideline, Volume 1, section 3.2.4 Airborne precautions, fit testing for more information.

Considerations regarding universal and targeted masking approaches

The "National Clinical Guidance No.30 Infection Prevention and Control" www.gov.ie/IPCclinicalguideline Volume 1, section 3 No. 3.1.5, page 80, Respiratory, hygiene and cough etiquette recommends the following:

‘Wearing a surgical mask (if tolerated) assists in reducing dissemination of respiratory virus in symptomatic patients and should be offered to all patients with symptoms of viral respiratory tract infection presenting in a healthcare setting. Use of a mask is in addition to and not instead of the requirement to maintain distance from others. In the context of a public health emergency or pandemic, more general use of surgical masks by patients in the healthcare setting may be advised.

PPE should generally only be used when required by the task being undertaken (avoid “ritual” use of PPE), be appropriate to the task being undertaken and be worn for a single procedure or episode of patient care where contamination with body substances is likely. Note: In the context of a pandemic or other exceptional event, continued use of certain items of PPE when seeing a number of patients with the same infectious disease in direct succession in one clinical area may be acceptable based on a risk assessment.’

It has been the experience in some Irish healthcare settings that targeted or universal use of face masks has proved beneficial in reducing impact of respiratory viruses on H&CW during periods of high community transmission of those viruses.

This has not been the experience across all healthcare settings, and as such a local decision is advised for each healthcare setting about whether and when to recommend that H&CWs use masks outside of usual PPE or transmission-based precautions.

For example, it may be appropriate that during periods of high community transmission of respiratory viruses, or significant localised outbreaks or future pandemics decisions on more widespread or targeted masking may be justified as part of multifaceted response. Considerations should include whether any wider use of masks would apply to all H&CWs, visitors and patients in common areas of the hospital, patient rooms and other areas where patient care is provided (universal masking- ECDC). Alternatively, consider whether healthcare workers should wear a medical face mask during all routine patient care (targeted clinical masking) when in contact with patients. Decisions on whether and when to implement universal or targeted clinical masking should take into account the expected benefit, as well as the burden on resources, H&CWs, patients and visitors (ECDC).

Universal and targeted clinical masking if recommended, should be kept under review and should be discontinued at an agreed time point, for example, when the period of high community transmission is over.

Unused PPE/Medication

Recommend minimal stock supplies in patient rooms that have been in close proximity to patients with suspected/confirmed respiratory viruses. This will support environmental aspects of PPE use and disposal and help to avoid unnecessary waste. Appropriately clean and disinfect supplies in covered and enclosed containers to avoid discarding unused medicines

2.10 Visitors

The following principles to support access and visiting are recommended:

1. RCFs must strike a balance between the need to manage the risk of introduction of COVID-19 or other communicable infectious diseases by people accessing the RCF and their responsibility for ensuring the right of residents to meaningful contact is respected in line with regulatory obligations
2. Full access should be facilitated to the greatest degree practical for all residents. Access may be very limited for a period of time in the early stages of dealing with an outbreak but a total withdrawal of access is not appropriate. If limitations on access are considered necessary, this should be based on a risk assessment that is reviewed regularly in view of the prevailing public health circumstances in the population served by the RCF. Risk assessments that underpin decisions regarding restricted visiting should be documented. Visits should not be restricted unless there is an identified risk
3. A RCF should have a policy on access and should have the capacity and relevant skill sets within its staffing complement to manage access appropriately. The RCF

should provide information on access that is clear, up to date and consistent across website, leaflets and when talking to H&CWs and residents. This should make it clear how access is facilitated, any limitations that apply, the reasons for those limitations and the expected duration of limitations. Residents and others should be provided with a clearly defined pathway to appeal against limitations on access that they consider as being unreasonable

4. Other than a resident transferring or returning to an RCF, no one should access a RCF who has symptoms of COVID-19, influenza or other communicable infectious disease. Very rare exceptions to this may need to be considered on compassionate grounds. In that case, careful risk assessment and planning is required
5. Everyone who accesses a RCF must adhere to directions on essential infection prevention and control practices including maintaining physical distance (in so far as appropriate to their purpose), mask use, respiratory hygiene and cough etiquette and hand hygiene. During periods of high community transmission, visitors should follow the IPC advice for that setting at that time. This may include a recommendation to wear a medical face mask at certain points during the visit, or for the duration of the visit. Visitors who have symptoms of respiratory infection should not be allowed to visit. RCFs may be obliged to refuse access to a person who is unwilling or unable to comply with reasonable measures to protect themselves and all residents and H&CWs or if the person has not complied with reasonable measures during previous access
6. Refer to Requirements for visitors to people on standard or transmission-based precautions Table 43 Page 251. NCEC National Clinical Guideline No. 30 Infection Prevention and Control Volume 1. Available at: www.gov.ie/IPCclinicalguideline

Active awareness raising by RCFs and public health authorities should be part of response preparedness. During periods of high community transmission or when there is a RCF outbreak of respiratory viral infection, visiting may need to be restricted for a specific period of time, particularly in units or wards with high-risk patients, whilst still

taking into account the well-being of patients who need some contact with family members. Any restrictions implemented should be reviewed regularly to determine if they are still required (ECDC).

Nominated Support Person

Each resident should have the opportunity to identify a nominated support person. It is acknowledged that having an individual nominated support person is challenging but at times during active outbreaks the rotation of nominated support persons should be at a minimum. The nominated support person should normally have unrestricted access to the resident for most of the day. If it is considered necessary to limit access in the morning or evening when H&CWs and residents are occupied with getting up or preparing for bed, then at a minimum the nominated support person should have access from at least mid-morning to late afternoon.

The above is in addition to and not instead of visitor access as outlined below.

The nominated support person should comply with the infection prevention and control measures that apply to a visitor when they attend the residential care facility. The right to private and family life is a human right protected in law (Article 8 of the European Convention on Human Rights). Visitors should consider taking up any COVID-19 and flu vaccines for which they are eligible. In the event of an outbreak for example COVID-19, each resident should (as a minimum) be able to have one visitor at a time inside the facility. This visitor does not need to be the same person throughout the outbreak. They do not need to be a family member and could be a volunteer or befriender. Additionally, end-of-life visiting should be supported in all circumstances. Residents should not usually be asked to avoid contact with others or to take a test following visits out of the facility.

The nominated support partner is a partner in care. Access of the nominated support partner to the resident they support, should only be more limited than outlined above if:

1. The nominated support person is subject to self-isolation or restricted movement or otherwise represents an infection risk to H&CWs or residents

2. There is a written recommendation from a public health or infection prevention and control practitioner to limit access for nominated support people for a defined period in a specific context.

Generic information leaflets are available at the following link: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/hcai-amr-information-for-patients-and-public/patient-leaflets/

Further information is available in "National Clinical Guidance No 30 Infection Prevention and Control (IPC) on the following link: www.gov.ie/IPCclinicalguideline, Volume 2, Table 43, Requirements for visitors to people on standard or transmission-based precaution

2.11 Health & Care Workers

Occupational Health

This section focuses on H&CWs and other H&CWs with shared working commitments across different healthcare facilities, including occupational safety and health, staffing and how to limit H&CWs exposure.

In the context of an outbreak

It is important that the IPCT/Public Health and Occupational Health Department are in close contact to detect rapidly if there are H&CWs with a confirmed respiratory viral infection such as influenza or COVID-19, who have any epidemiological links to wards/units with suspected cross-transmission. H&CWs are advised as per all community contacts in relation to all types of respiratory tract infections to follow Public Health advice. The exception to this is in relation to pregnant or immunocompromised H&CWs as per the below link.

https://assets.hse.ie/media/documents/Guidance_on_Fitness_for_Work_of_Immunocompromised_or_Pregnant_Healthcare_Worke_kp5eErs.pdf

Guidance in relation to occupational health COVID-19 for H&CWs is available on:

https://healthservice.hse.ie/staff/covid-19-staff-support/occupational-health-covid-19-guidance/

Practical information to help limit exposure of H&CWs to respiratory viral infections

1. Ensure there are adequate numbers of H&CWs to implement the necessary IPC precautions, in particular to adhere to hand hygiene and safe putting on and taking off of PPE
2. In general, designated one-to-one care is not essential for a single resident with suspected or confirmed respiratory viral infections
3. When there are high levels of circulating virus, leading to large numbers of infectious patients with similar respiratory viral infections in the RCF, cohorting residents with respiratory viral infections together on specific units/wards, as appropriate reduces the risk of exposure for other patients and H&CWs. Consider accommodating infectious residents in a specific cohort area, as appropriate for the RCF to the greatest extent practical, when there is a high number of residents diagnosed with the same respiratory viral infection (refer to the earlier section on cohorting). When cohorting patients with respiratory viral infections on specific wards is not practical, strict adherence to transmission-based precautions on a general ward/Unit manages the risk of exposure for other patients and H&CWs. It is still appropriate to limit the number of wards/units on which patients with respiratory viral infections are accommodated to the greatest extent practical. Placement elsewhere is sometimes essential to clinical care. When numbers of infectious patients decline, it becomes less practical to maintain cohort wards/units
4. Where practical, for the duration of each shift, assign designated H&CWs to care for patients with confirmed respiratory viral infections who may be accommodated in isolation room(s)/ cohort bay(s)/ areas of a ward. Designating H&CWs will minimise the likelihood of a H&CW caring for patients with and without respiratory

viral infections during the same shift. This is likely to be lower risk when H&CWs are fully vaccinated and have had booster vaccines for the relevant infection

5. In order to ensure appropriate care for the patient with a respiratory viral infection with the minimum of risk, H&CWs who enter the patient's room or cohort area should plan to deliver as much of the care required as possible at each entry. This is likely to be less important for H&CWs who are fully vaccinated and have had booster vaccine for the relevant infection
6. Where face-to-face discussion facilitates, decision making for patient care, such meetings should take place with appropriate precautions. The meeting space selected should facilitate the anticipated number of attendees, so that physical distancing and adequate ventilation can be achieved
7. During peak respiratory viral infection periods, rooms used for H&CW breaks or meetings should be assessed for maximum occupancy bearing in mind infrastructure, spacing and ventilation, as a standard. Promote opening of windows to improve ventilation. The maximum occupancy should be displayed on the door, so that all are made aware of when that capacity is reached or exceeded. The maximum number must not be exceeded
8. Surfaces in break, rest or meeting rooms should be kept free of clutter to facilitate regular cleaning, as a standard
9. During peak outbreaks of respiratory viral illness, confirm at the start of each shift, that all H&CWs are well, and do not currently have symptoms of respiratory viral infections. In the event new symptoms develop during a shift, the H&CW should report immediately to the person-in-charge. This applies to vaccinated H&CWs and unvaccinated H&CWs.

H&CW occupational health & workforce planning

1. H&CWs should be informed that they MUST NOT attend work if they have a fever, cough, shortness of breath, or any new respiratory symptoms. This continues to apply to H&CWs after COVID-19 and/or influenza vaccination/infection They should be aware of their local policy for reporting illness to their manager

2. H&CWs who become unwell at work should immediately report to their line manager and should be sent home. They should contact their GP for clinical assessment and testing if deemed appropriate

Occupational health guidance on COVID-19 for healthcare workers is available at: https://healthservice.hse.ie/staff/covid-19-staff-support/occupational-health-covid-19-guidance/

   a. H&CWs who test positive for COVID-19 may return to work after the end of the isolation period as defined in current public health guidance. Repeat testing at the end of the illness is generally not appropriate

   b. H&CWs who test positive for influenza may return to work 5 days after onset of respiratory symptoms if they are well enough to return
   c. There is no requirement for contact tracing including the identification of close contacts of a confirmed case of COVID-19 in an RCF.
3. It is recommended that H&CWs working in a facility that is experiencing an outbreak of respiratory viral infection should not work in any other facility
4. In addition, at the start of each shift, all H&CWs should confirm with their line manager that they do not have any symptoms of respiratory illness, such as fever, cough, shortness-of-breath or myalgia. **This continues to apply to H&CWs after vaccination.** Where relevant, H&CWs should be asked to confirm that they are not currently working in a facility where there is an outbreak.

2.12 Managing admissions, transfers and discharges between acute hospitals and RCFs

The general principles are outlined in the National Clinical Guidance No. 30 Infection Prevention and Control (IPC)" on the following link: www.gov.ie/IPCclinicalguideline

- Volume 1, Good practice point: 16, Clinical communication in infection prevention and control

Acute Hospital Infection Prevention and Control guidance on the prevention and management of cases and outbreaks of respiratory viral infections located here;

Note: testing of asymptomatic residents regardless of vaccine status on transfer or admission, is generally not required. Testing of asymptomatic residents on admission/ transfer may remain appropriate based on local risk assessment for those on non-invasive respiratory support for example CPAP/BIPAP.

It is recognised that accepting admission or transfer of residents poses a risk of introducing COVID-19 or other respiratory viral infections. However, it is also recognised that there are other risks that arise from patients or residents being cared for in settings which are not optimal to meet their care needs. Patients or residents should be admitted or transferred to the most appropriate setting and risks of transmission of respiratory viruses should be acknowledged and managed. It is important to retain vigilance for onset of symptoms of respiratory viral infection and to take appropriate actions to prevent and control transmission.

People may have been identified as contacts in other settings, such as in hospitals. Such people may transfer to an RCF if they have no symptoms of respiratory viral infection.

Planning and communication

Public Health may recommend that a person who is transferring from a particular congregated healthcare setting (a hospital or RCF) where there is evidence of ongoing transmission of a respiratory viral infection (one or more open outbreaks) is monitored for respiratory viral symptoms.

Transfers

Internal and external transfer of residents with confirmed respiratory viral infections to another hospital should be avoided during the period when they are infectious, unless it is required for medical care.

Refer to “National Clinical Guidance No 30 Infection Prevention and Control (IPC) on the following link: www.gov.ie/IPCclinicalguideline

- Volume 1, Good practice point: 16, Clinical communication in infection prevention and control for detail.

During the period of isolation, residents should wear a respirator or surgical mask if tolerated when outside their room or designated cohort area.

External Transfer

1. Transfer of residents with confirmed respiratory viral infections to another hospital should be avoided during the period when they are infectious, unless it is required for medical care
2. If transfer is required, it is the responsibility of the transferring facility to inform in advance, the H&CW in the receiving facility and the ambulance personnel of the diagnosis, the date of symptom onset and the precautions required
3. Transfer of residents should not be refused or delayed, pending results of testing for respiratory viral testing
4. Testing of asymptomatic individuals, as a condition of transfer is not acceptable. Testing of asymptomatic individuals at the receiving hospital/RCF is not generally required; however, it may be appropriate based on local risk assessment.

Transfer from primary care/ community settings using hospital transport systems

(e.g., Oncology Day Care, dialysis and other specialist areas)

During periods of high community transmission of respiratory viruses, it is recommended that residents or RCFs contact residents care unit by telephone in advance of the residents’ appointment/allocated treatment, if they have symptoms of possible respiratory viral infections rather than the resident attending the unit without making advance contact.

Residents who have no respiratory viral symptoms can travel by their usual means, with transport vehicles at full occupancy. Consideration should be given to mask use in the transport vehicle and mask use should be facilitated.

Transfer of people with respiratory viral infections

1. Any resident transferred to a RCF before they have finished their period of transmission-based precautions in the hospital must complete their period of transmission-based precautions after transfer. If the receiving RCF has no other residents with a respiratory viral infection at the time, a risk assessment should be completed by the receiving RCF to ensure appropriate IPC measures can be maintained
2. Residents transferring to an RCF with symptoms of or with confirmed respiratory viral infection can proceed to do so, provided that this has been communicated, they are clinically fit for the transfer, the facility risk assessment indicates there is capacity to care for them with appropriate isolation, and it is most appropriate place of care for the resident (e.g. ongoing need for palliative care etc.)
3. Residents normally cared for in the RCF, who are admitted to hospital while an outbreak is ongoing in the RCF, may have their discharge to the same RCF facilitated if it is deemed to be clinically appropriate, and a risk assessment has been carried out which identifies that the resident can be isolated, and the facility has capacity to manage their care needs, and where that transfer represents the most appropriate place of care for the resident
4. In all instances the discharging hospital should provide the RCF with communication on clinical handover, as a standard, that encompasses IPC related patient information, including the following information on the arrival of the resident:
    a. The date and results of any respiratory viral infection tests (including dates of tests reported as not-detected)
    b. The date of onset of any symptoms
    c. Date of last documented fever while in hospital (particularly important where resident is being transferred to RCF before the period of transmission based

precautions is complete)

d. Details of any treatment or monitoring required.

Transfers from RCF to an acute hospital

1. Influenza or COVID-19 positive status must not significantly delay transfer to an acute hospital, where it is deemed clinically appropriate. The national ambulance service (NAS) and the local receiving hospital must be informed by the RCF, in advance of transfer of any person with suspected or confirmed respiratory viral infection AND where there is a suspected or confirmed respiratory viral outbreak in the RCF
2. People with respiratory viral infections do not require to be hospitalised for the full period when transmission based precautions are required; transfer back to the RCF may proceed if the person is clinically fit for discharge, if infection was acquired in the RCF or if the RCF already has cases of the same respiratory viral infection, and the RCF has appropriate facilities and capacity for isolation and can support care.

Transfer/ discharge to home care services

1. When a patient is being discharged home to receive ongoing care in that setting, ensure that information relating to any symptoms and respiratory virus testing and vaccination status is communicated to the home care team in advance of their first attendance. This information should include information on influenza and COVID-19 vaccination status, dates and results of any symptoms and respiratory viral tests done while in hospital, residential care or other care setting. In particular, the home care team and transport H&CWs will need to know whether the person is within the infectious period.
2. Consider providing patient-held short note containing this information that can be reviewed by the home care team at each visit.

    a. Generic IPC advice for H&CWs in home care teams refer to the National Clinical Guidance Infection Prevention and Control available at: www.gov.ie/IPCclinicalguideline, Volume 1, Section 3, No. 3.4.1, page 117,

Home care and other community-based settings. These generic principles can be applied in the context of respiratory viral infections.

Transfers for a resident on ventilatory support

1. Some residents may routinely use ventilatory support such as CPAP or BiPAP which may be associated with risk of spread of virus from infectious people, use of transmission based precautions should be applied in these instances, refer to section 3.2.4 Recommendation 15, NCEC guidance
2. Particular attention to infection prevention and control precautions and a high level of awareness for features of respiratory viral infection are required in those requiring respiratory support (CPAP/BIPAP) and particularly in residents who are not vaccinated, including booster vaccination if eligible
3. Such residents should be admitted to single rooms with a window that can be opened to improve ventilation (subject to weather and security; the goal is gentle air circulation rather than strong air movements) and the door should remain closed as much as possible when ventilatory support is in use
4. Testing of asymptomatic residents who use CPAP or BiPAP is not generally required
5. If a local risk assessment indicates that testing of newly admitted residents on CPAP or BiPAP remains appropriate, then the residents should remain in their room with the door closed all of the time until the result of the test taken is available
6. If a resident has any new clinical features to suggest viral infection, any care delivered by H&CWs during the use of CPAP or BiPAP should be delivered with airborne precautions (minimise numbers and time in the room, maximise ventilation as far as is practical and use appropriate PPE); please refer to Airborne precautions 3.2.4 page 98, NCEC National Clinical Guideline No. 30 Infection Prevention and Control. If there are no clinical features to suggest viral infection, care provided by H&CWs should be delivered with standard precautions and, if indicated by point of care risk assessment, appropriate PPE
7. Newly admitted residents, including those on ventilatory support such as CPAP or BiPAP, can move around outside their room and participate in activities, subject to

confirming each day that there is no deterioration in their condition that could suggest COVID-19 or other viral respiratory tract infection

8. If at any point during admission to the RCF a person including those who use CPAP or BiPAP develops symptoms consistent with COVID 19 or influenza or other respiratory viral infection, appropriate transmission-based precautions should be introduced immediately while arrangements are made for assessment by their doctor.

Care of the Dying with suspected/ confirmed respiratory viral Infection

1. A compassionate, pragmatic and proportionate approach is required in the care of those who are dying
2. The presence of a person/people close to the resident should be facilitated (see above re nominated support person). They should be aware of the potential infection risk
3. If the person who wants to be with the resident is vaccinated, including booster vaccination if eligible, the risk is much reduced
4. Pastoral care team where requested by the person or their family and who are willing to attend should have access to the facility
5. All persons in attendance should be advised to wear a surgical or respirator mask but it is important to accept that at such a time some people may prefer not to wear mask or other PPE. A respirator mask should be available to those who wish to use them although it is unlikely that it will be practical to train most people in their correct use in this context. Gloves and apron are not essential. If it is necessary to wear additional PPE for the provision of care, visitors should be supported and advised on how to put on and take off the PPE and how to perform hand hygiene
6. The use of PPE is less important if the person accompanying the dying person is vaccinated including booster vaccination if eligible
7. Visitors should avoid interacting with residents other than the person they are accompanying.

Refer to " National Clinical Guidance No 30 Infection Prevention and Control (IPC) on the following link: www.gov.ie/IPCclinicalguideline Volume 2, Section 7.0, Care of the deceased Table 38 Application of transmission-based precautions to the deceased in the context of key infections at time of death.

2.13 Environment

General principles

Cleaning and disinfection of all patient surrounds and frequently touched objects is recommended as a standard.

Key principles include the following:

1. The care environment should be kept clean and clutter free in so far as is possible, bearing in mind this is the resident's home and they are likely to want to personalise their space with objects of significance to them
2. Residents' observation charts, medication prescription and administration records (drug kardexes) and healthcare records should not be taken into the resident's room, to limit the risk of contamination. All non-essential items should be removed. This is to prevent unnecessary waste of essential supplies, which may occur if unused items in an area become contaminated. Only the minimum amount of equipment and supplies essential to patient care each day should be stored within an isolation room, ante-room or cohort area. Consider increasing the frequency of topping-up stock to achieve this

Refer to "NCEC National Clinical Guideline No. 30 Infection Prevention and Control". www.gov.ie/IPCclinicalguideline

Refer to the following sections:

- Volume 2, Section 4: Appendices, No. 7.1 Recommend routine cleaning frequencies page 238 and Table 40 Minimum cleaning frequency page 238
- Volume 1, Table 9 Cleaning requirements for routine environmental cleaning page 57
- Volume 1, Figure 4 Processes for routine cleaning and product choice page 61.

Care Equipment/ Instruments/ Devices

Standard precautions concerning patient care equipment are very important to the care of patients with respiratory viral infections.

The use of dedicated (i.e. one for each patient), or if possible, disposable, medical equipment (e.g. blood pressure cuffs, stethoscopes and electronic thermometers), is recommended for patients with respiratory viral infections. Single use equipment and items should be disposed of as healthcare risk waste into a designated healthcare risk waste bin inside the room.

Where single use equipment is not possible, use designated care equipment in the resident's room or cohort area. In a cohort area, the equipment must be decontaminated immediately after use and before use on any other resident following routine cleaning and disinfection protocols.

1. If it is not possible to designate pieces of equipment to the resident or cohort area these must be decontaminated immediately after use and before use on any resident following standard cleaning and disinfection protocols
2. There is no need to use disposable plates or cutlery. Wash crockery and cutlery after use either in a dishwasher or by handwashing, using household detergent and hand-hot water
3. Vacuuming of carpet floor in a resident's room should be avoided during an outbreak and while the person is infectious. When the resident is recovered the carpet should be steam cleaned
4. All shared spaces should be cleaned with detergent and disinfectant

5. Equipment used in the cleaning/disinfection of the isolation area should be single use where possible, and stored separately to equipment used in other areas of the facility
6. Household and care H&CWs should be trained in the appropriate use and removal of PPE
7. In practical terms, H&CWs who are also providing care to the resident while in the single room may undertake single room cleaning.

For advice on cleaning and disinfection of equipment, refer to “National Clinical Guidance No 30 Infection Prevention and Control (IPC) on the following link: www.gov.ie/IPCclinicalguideline

- Volume 1, Section 3, No. 3.2.2 Contact precautions, recommendation 13: page 94, Single use or patient dedicated equipment.

Safe management of linen

Refer to “National Clinical Guidance No 30 Infection Prevention and Control (IPC) on the following link: www.gov.ie/IPCclinicalguideline,

- Volume 1, section 3, No. 3.1.8 Handling of linen.

Ventilation

Experience with SARS-CoV-2 has emphasised that transmission of virus through the air is complex and that the categories of droplet and airborne should be seen more as describing general patterns of transmission through the air rather than as discrete phenomena. This is particularly the case with experience in hospitals in Ireland in the context of use of high flow oxygen devices, (an aerosol generating procedure associated with increased risk of transmission). Although transmission of COVID-19 is typically via droplet pattern, a pattern of airborne type spread has been associated with closed, poorly ventilated spaces in which

many people stay for long periods of time.

The European Centre for Disease Control provides a perspective on ventilation and air conditioning in the context of COVID-19 at the following link:

https://www.ecdc.europa.eu/en/publications-data/heating-ventilation-air-conditioning-systems-covid-19

In the general clinical environment strict adherence to contact and droplet precautions remains very important in managing the risk of transmission in the absence of AGPs. However, given the experience of airborne patterns of transmission in some circumstances it is important that H&CWs have access to appropriate PPE and are aware of the role of ventilation in prevention of transmission; ventilation should be maximised to the greatest extent that is practical consistent with comfort and without introducing other potentially greater risks.

There is evidence that novel air cleaning methods in healthcare environment reduce the burden of SARS-CoV-2 in the air in poorly ventilated spaces. There remains little or no clinical evidence that demonstrates that this technology reduces the risk of acquiring infection in a clinical environment. In the absence of such evidence deployment of such systems is not generally recommended but this may be a consideration in certain settings based on risk assessment.

In this context, the following is recommended:

1. Ventilation should be maintained in so far as practical, taking account of comfort and weather and how it can be practically achieved in each setting. Note that the goal is to achieve reasonable air exchange with gentle air movement. Strong airflow into the room from outside that is readily felt and causes discomfort is not required and may contribute to airflow out of the room. It is best to avoid the use of fans that re-circulate air

2. In clinical areas where there is established mechanical ventilation that has been

appropriately commissioned, meets current standards for the healthcare environment and is well maintained, no modification of the operation of this system is required

3. In areas where there is no mechanical ventilation it is appropriate to increase natural ventilation in clinical areas by opening windows and doors in so far as practical and consistent with comfort and security of patients and H&CWs; the goal is gentle air circulation rather than strong air currents
4. In circumstances where entry of unfiltered external air is assessed as associated with a high risk for introduction of aspergillus spores into an environment where there are vulnerable patients, the exclusion of aspergillus spores takes priority over increasing natural ventilation with a view to reducing the risk of transmission of COVID-19
5. If exhaust fans are used they must be installed so that the air is released directly outdoors. The number and technical specification of exhaust fans must take account of the size of the room and the desired ventilation rate. Positioning the exhaust fan should be done so that it is not close to a ventilation air intake
6. Installation of whirlybirds (for example whirligigs, wind turbines) may be useful to increase air flow in settings where they can be deployed

7. When appropriately selected, deployed and maintained, single-space air cleaners with HEPA filters (either ceiling mounted or portable) can be effective in reducing/lowering concentrations of infectious aerosols in a single space however, they have not been shown to reduce the risk of residents acquiring infection with COVID-19 in a healthcare setting. They may have a role in settings where ventilation is not adequate based on risk assessment

8. Some healthcare settings have found it helpful to use carbon dioxide (CO2) monitors, mobile or fixed, to identify areas of poor ventilation and / or to monitor ventilation. The deployment of monitors may help to identify specific areas where ventilation is poor and where particular efforts to increase ventilation are required
9. It is important to ensure ventilation in all areas is appropriate for the intended use as per HTM 03 01. Where specialist ventilation is not required, then ventilation

should be optimised as far as is practical.

Refer to https://www.who.int/publications/i/item/9789240021280 .

Also refer to the following guidance Infection Control Guiding Principles for Buildings, Acute Hospitals and Community Health and Social care Settings and relevant sections on ventilation available on the following link: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/buildingsandfacilitiesguidance/Infection%20Control%20Guiding%20Principles%20for%20Building.pdf

Waste management

Dispose of all waste from residents with confirmed or suspected COVID-19 or influenza virus as healthcare risk waste during the period when transmission based precautions applies (also referred to as clinical risk waste). Regardless of where waste is generated (for example from isolation rooms versus routine resident care areas) the principles of determining whether it is to be treated as healthcare risk waste or non-risk waste remain the same.

Apply standard precautions to protect against exposure to blood and body substances during handling of waste; perform hand hygiene.

Refer to “National Clinical Guidance No. 30 Infection Prevention and Control (IPC)” on the following link: www.gov.ie/IPCclinicalguideline, Volume 1, section 3.1.7: Waste management.

3 Managing a cluster or outbreak of a respiratory viral infection in a residential care facility

See the "National Clinical Guidance No.30 Infection Prevention and Control" www.gov.ie/IPCclinicalguideline Volume 1, section 3, No. 3.4.2 page 125, Outbreak investigation and management

3.1 General principles of outbreak management

Community housing units with small number of younger, mainly vaccinated residents are generally lower risk settings for respiratory tract infection outbreaks than are large congregated settings for older people. In terms of size and function, they are in many ways similar to a private house. One or a small number of cases of respiratory tract infection in these settings can generally be managed by pointing H&CWs in the facility to this guidance and general public health advice. The formal process of an outbreak control team is generally unnecessary but may be appropriate in some cases based on knowledge of specific risks associated with a particular facility.

The following content on outbreak management is primarily intended to address larger congregated settings but the principles are applicable also to community housing units in the event that a formal outbreak management process is required based on the assessed risk.

An isolated positive result of SARS-CoV-2, RSV, or influenza in a resident or H&CWs is not in itself proof of current active transmission.

Residential care facilities should review their plans for management of outbreaks of respiratory viral infectious diseases, to ensure that they address early detection and rapid response to respiratory viral infections and of other communicable infectious diseases.

The usual principles of detection and management of a cluster or outbreak of a transmissible pathogens in a residential care facility setting apply to respiratory viral

infections, including the legal obligation to notify the Department of Public Health in addition to the standing obligation for dual notification of all cases of respiratory viral infections (laboratory and clinical).

Refer to:

https://www.hpsc.ie/notifiablediseases/notifyinginfectiousdiseases/, specific section on notifying outbreaks.

As part of facilities outbreak planning and response it is important to liaise with the local community support team (CST) to help plan and support an appropriate response to an outbreak in accordance with local governance arrangements.

3.2 Immediate measures

When there is a suspicion of cases of COVID-19, RSV or influenza or other acute respiratory virus infection the MOH should be informed so that they can perform a risk assessment to determine the scale of the risk and whether there is either possible or confirmed active transmission in the facility.

A local surveillance system should be implemented in each clinical area, whereby early detection of a resident with new respiratory viral symptoms is part of the routine daily assessment and handovers.

1. Surveillance (monitoring for illness) is an essential component of any effective infection prevention and control programme
2. RCFs should ensure that they have means in place to identify a new case of COVID-19 or other viral respiratory tract infection and control transmission, through active monitoring of residents and H&CWs for new symptoms of infection, rapid application of transmission-based precautions to those with suspected respiratory viral infection, prompt testing of symptomatic residents and referral of symptomatic H&CWs for evaluation

3. The RCF should ensure that there is twice daily active monitoring of residents for signs and symptoms of respiratory illness or changes in their baseline condition (e.g., increased confusion, falls, and loss of appetite or sudden deterioration in chronic respiratory disease)
4. There should be early identification of H&CWs absence/s, which may be due to respiratory viral infections including COVID-19, RSV or influenza infection.

Where a resident develops new respiratory viral symptoms, following the risk assessment process is outlined at the following:

https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/how-to-use-a-point-of-care-risk-assessment-pcra-for-infection-prevention-and-control-copy.pdf.

Apply the recommended IPC precautions as outlined previously for the management of a suspected or confirmed case and arrange for a diagnostic swab to be taken to test for respiratory viral infection, for example COVID-19 /influenza.

Inform the Infection Prevention and Control Team that a resident is being investigated for a respiratory viral infection.

When an outbreak is suspected laboratory testing should be arranged as quickly as possible. However, it is not appropriate to wait for laboratory test results before beginning initial investigation, contacting the Public Health Department or implementing control measures. There should be heightened awareness among H&CWs, so that other residents with symptoms are quickly identified.

3.3 Immediate Management of a respiratory viral infection outbreak

A local incident management meeting should be arranged promptly and involve key H&CWs including housekeeping, nursing staff, allied healthcare professional and medical staff.

This group should:

1. Try and establish whether it is likely that an outbreak is occurring, taking in to account the following:
    a. Could onward transmission have already occurred? (e.g., resident had widespread contact with others in the 48 hours before symptom onset):
        i. Are they in a single room or sharing?
        ii. Is the resident ambulatory?
        iii. Have they spent time with others in communal areas or group activities?
        iv. Are there behavioural characteristics, which might be increased risk of transmission?
2. Are all or most residents vaccinated against COVID-19 and influenza?
3. Identify if any other residents are symptomatic and if so, what are their symptoms?
4. Identify are any H&CWs symptomatic or has there been an increase in H&CW absence?
5. Identify residents and H&CWs who were in close contact with the symptomatic resident/s and monitor for symptoms and signs of infections. Follow public health recommendations for antiviral chemoprophylaxis, as appropriate, for contacts of influenza cases.

If test results from residents indicate there are respiratory virus acquisitions associated with a ward or unit, an outbreak should be declared and an outbreak control team convened

3.4 Declaring an outbreak

The declaration of an outbreak in a RCF is made by the Medical Officer of Health at the regional Department of Public Health, guided by general principles and taking account of all the circumstances. The key question is if there is reason to believe that transmission of virus is occurring in the RCF.

The declaration of an outbreak is considered when two or more cases of infection with the same pathogen (COVID-19, Influenza or other respiratory virus) are confirmed by an appropriate method and there is reason to consider that they may be epidemiologically linked in place and time.

OR

A cluster/outbreak, with two or more cases of illness with symptoms consistent with the same pattern of infection related illness, and at least one person is laboratory confirmed and there is reason to consider that they may be epidemiologically linked in place and time.

It is important to detect outbreaks in RCFs early and to manage the risk to residents and H&CWs. If it is possible to identify a likely source of infection for the index case this may assist in determining if an outbreak should be declared. It is also important to consider that declaring an outbreak in a RCF may have profound consequences for residents, for example their access to visitors, their care and social activity. It may also result in temporary restriction of access to the RCF for potential new residents who would receive better and safer care in the RCF than in their current location. It is therefore important to avoid declaring an outbreak in the absence of reasonable evidence of transmission within the facility. In forming a judgement regarding the declaration of an outbreak in a RCF it is important to consider the incidence of the infection in the community. When the incidence of infection in the community is high the detection of three or more cases of current infection in one RCF, particularly among H&CWs may be a chance finding (particularly in a very large nursing home).

3.5 Outbreak Control Team (OCT)

All outbreaks of infectious disease, including COVID-19, RSV or influenza, in a RCF must be reported to the regional Medical Officer of Health (MOH) at the Department of Public Health (DPH) at the earliest opportunity.

Following public health risk assessment and where appropriate:

1. The RCF should lead and manage the outbreak locally in line with national guidance, however, they should continue to have access to their local Department of Public Health for advice and guidance if required

2. Public Health should continue to engage in active decision-making in relation to RCF outbreaks i.e. when activities / transfers can resume and declaring an outbreak over

3. RCFs should keep a record of the numbers of cases and provide this information to their local Departments of Public Health if requested

4. An Outbreak Control Team (OCT) may be convened

If an outbreak is declared, Public Health doctors from the Regional Department of Public Health will provide overall leadership for the management of the outbreak in the RCF.

Ideally, the 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.

The OCT membership should be decided at local level and will depend on available expertise.

An OCT Chairperson should be agreed.

Members of the OCT may include any of the following, however it is recognised that in many settings it may not be possible to include all the expertise referred to below:

1. Consultant/Specialist in Public Health Medicine and/or Public Health Department Communicable Disease Control Nurse Specialist
2. GP/Medical officer/Consultant to RCF (dependent on nature of RCF);
3. Director of Nursing or Nurse Manager from RCF

4. Management representative from the RCF i.e. manager or CEO
5. Community Infection Prevention and Control Nurse (IPCN) where available
6. Administration support.

Other members who may need to be included, particularly if it is an extensive or prolonged outbreak include:

1. Executive Manager (Integrated Healthcare Areas manager or designate)
2. Administrative support
3. Occupational Medicine Physician
4. Consultant Clinical Microbiologist
5. Representative from HPSC
6. Communications officer.

Every member involved should have a clear understanding of their role and responsibility.

The frequency required for the OCT meeting should be decided. The RCF should inform HIQA or Mental Health Commission, as appropriate and the local CHO as per usual protocols.

Before the first meeting of the OCT, the local incident team should gather as much information as possible to include:

1. A line list of all residents and H&CWs. A sample template can be found in Appendix B & C
2. The vaccination history (COVID-19 and influenza) of all residents and H&CWs
3. Identify the total number of people ill (residents & H&CWs), dates of illness onset and the spectrum of symptoms
4. Identify H&CWs and residents who have recently recovered, developed complications, been transferred to acute hospitals and those who have died
5. Information on laboratory tests including the number of tests taken to date and the date sent to the laboratory, along with the tests requested and reported results

6. Determine if the number of symptomatic residents/H&CWs involves more than one unit/floor/ward or if the outbreak is confined to one area only

A checklist for outbreak management can be found in Appendix D

3.6 Communication

1. Good communication is essential for residents, family and H&CWs
2. Provide regular information sessions and education on measures required for H&CWs and assign someone to do these.

3.7 Support services for H&CWs and residents

1. The effect on H&CWs and residents during outbreak events should not be underestimated especially where there have been deaths in the RCF. Every effort should be made to support those who are impacted by outbreak events
2. Some social activity in small groups previously referred to as “pods” of up to 6 people may help to support residents in an outbreak setting. Social activity in defined pods is expected to be lower risk than activities that bring large numbers together
3. One of the key supports to H&CWs is to promote vaccination. It is important that H&CWs with questions about the benefits and risks of vaccination have access to appropriate support.

3.8 Monitoring outbreak progress

1. Monitoring the outbreak will include ongoing surveillance for symptoms in residents and H&CWs to identify new cases and to update the status of ill residents and H&CWs
2. The nominated RCF liaison person should update the line listing with new cases or developments as they occur and communicate this to the OCT on a daily basis

or more frequently if major changes occur, in line with public health recommendations until the outbreak is declared over

3. The review of this information should examine issues of ongoing transmission and the effectiveness of control measures
4. Institute active twice-daily surveillance for respiratory symptoms, including fever, cough and other symptoms suggestive of COVID-19, RSV or influenza, in residents and H&CWs until the outbreak is declared over.

3.9 Declaring the outbreak over

To formally declare that the outbreak is over, the RCF should not have experienced any new cases of infection (resident or H&CWs) considered as likely to have been acquired in the RCF which meet the case definition.

An outbreak can be closed following consultation with the Department of Public Health and/or in consultation with the local IPC team, which is based on the two incubation periods relevant to the identified respiratory virus, (for example after two incubation periods after the onset of symptoms in the last case (for COVID -19 outbreaks).

Although the outbreak remains open for 10 days it is generally appropriate for the unit to resume essentially normal operation after ~7 days from the onset of symptoms in the most recent case.

Influenza outbreaks can be declared over 8 days after the last positive case linked with the outbreak. For outbreaks caused by other viral respiratory pathogens, closure of these outbreaks will be on a case-by-case risk assessment by the local IPC Team/ Public Health.

H&CWs should retain a higher level of vigilance for symptoms of respiratory viral infection until the outbreak is formally closed.

As above, an isolated positive result of SARS-CoV-2 in a resident or H&CWs is not of itself evidence of ongoing transmission.

Further generic information can be found in “National Clinical Guidance No.30 Infection Prevention and Control” www.gov.ie/IPCclinicalguideline Volume 1, section 3, No. 3.4.2 Outbreak investigation and management, Good practice point 13, page 136, Declaring that an outbreak is over.

Further Public Health guidance in relation to identification of contacts is available https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/contacttracingguidance/

4 Education

4.1 H&CWs

1. All H&CWs should be aware of the early signs and symptoms of respiratory viral infection. They should know who to alert if they have a concern. H&CWs should be able to contact an appropriate escalation pathway 24/7. Please refer to the HPSC website for up to date information and current case definitions for COVID-19 and other viral respiratory infections
2. All H&CWs should have training in standard precautions, in particular hand hygiene, respiratory hygiene and cough etiquette, along with training in transmission-based precautions (contact, droplet and airborne), including the appropriate use of PPE for each situation
3. Refer to HSeLanD (www.hseland.ie) and the AMRIC hub for details on specific IPC related eLearning courses. RCFs should ensure that one or more H&CWs are trained to collect a viral swab sample for testing for SARS-CoV-2 and Influenza virus. Please refer to guidelines and video on www.hpsc.ie in relation to same.

4.2 Residents

1. Residents should be consulted on and kept informed of the measures being taken and the reason for these measures during this time
2. Residents should be encouraged and facilitated to clean their hands and actively assisted with this practice where necessary
3. Key messages around cough etiquette (where appropriate) include:
    a. Cover your mouth and nose with a disposable tissue when coughing and sneezing to contain respiratory secretions
    b. Discard used tissues after use and clean your hands
    c. If you don't have a tissue, cough into your forearm or the crook of your elbow
    d. Clean your hands.
4. Where possible and appropriate, residents should be made aware of the need to report any new symptoms of illness to H&CWs

5. Residents who may leave a RCF should be made aware of the general principles of staying well, generic infection prevention and control patient information leaflets are available on https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/hcai-amr-information-for-patients-and-public/patient-leaflets/
6. Residents who are in the high risk or the very high risk groups for severe disease with COVID-19 should be supported in taking additional measures to reduce their risk of infection over and above any general measures applied in the RCF if they wish to do so
7. Residents whether they are vaccinated or unvaccinated may prefer to wear a mask in certain places or at certain times in the RCF. In that case they should have access to a surgical mask or respirator mask according to their preference
8. Residents who are not vaccinated or are immunocompromised should be facilitated to wear a mask (surgical mask or respirator mask) in busy areas of the RCF or during transport to and from the facility if they wish to do so.

4.3 Social activity

1. Social activity is an essential part of community life within the RCF
2. Social activity between residents should no longer be limited on infection prevention and control grounds other than for individual residents when they are infectious or when temporary limits are required to manage an outbreak of infection; this too applies for involvement of family or visitors whom the resident wishes to join social activity
3. Residents with symptoms of COVID-19, influenza or other viral respiratory tract infection should be asked not to join in social activities until they are no longer infectious. **This continues to apply to people who have been vaccinated including booster**
4. Residents and others engaged in social activity should be encouraged to practice hand hygiene and cough etiquette

5. In the context of social interaction it is appropriate, with due regard to the weather and comfort, to use well-ventilated indoor space or outdoor space where available.

4.4 Group Activities

1. Before any group activity, confirm on that day that participants have no symptoms that suggest viral infection
2. Weather permitting, outdoor group activities are likely to be lower risk than indoor activities
3. Ensure adequate supplies of hand sanitiser and appropriate cleaning products (for example detergent wipes) are available in each activity room/area; as a standard
4. Ensure H&CWs and volunteers know that they should be vaccinated including booster and follow good infection prevention and control practice.

Appendix A: Prevention and control of outbreaks of respiratory viral infection in RCF

	Domain	Action	Comment
Pre-Outbreak Measures			
	Planning and Administration	Awareness of national guidelines with respect to vaccination (NIAC guidance) and SP/TP (NCEC IPC Guidance)	Vaccination policies Standard and transmission based precautions including droplet and contact Written outbreak management plan/contingency/preparedness plans
		RCF Lead (Named person)	To oversee development, implementation and review of policies and procedures
		Training and Education	For all H&CWs Ongoing training – Standard and transmission-based precautions, PPE Measures to improve compliance
		Provision of supplies	Hand hygiene supplies, PPE, cleaning and disinfection materials, viral swabs, request forms and arrangements for prioritised testing of samples
		Vaccination	Regularly review the uptake of vaccination in residents and H&CWs.
	Standard precautions	Standard infection control procedures	Standard precautions should be practised by all H&CWs at all times
	Surveillance	Awareness of signs and symptoms of respiratory viral infection, e.g. COVID-19, influenza etc.	Formal process to record any new symptomatic residents twice daily
	Case Definition	As per HPSC guidance	Case definition may change as pandemic progresses

	Domain	Action	Comment
Early recognition	Outbreak Definition	Action threshold for outbreak control measures	See section 3
	Communication of suspected outbreak	Notification of senior management, medical and public health H&CWs, CHO and NH lead and infection prevention and control team, as appropriate	Ensure residents and other relevant people are informed
	Formation of outbreak control team (OCT)	OCT may be convened following risk assessment	Important to consider the nature of the facility and associated risks
	Testing	Viral swab	Prompt testing of symptomatic residents
	Initial Actions	Daily Case list	
		Activate twice daily resident surveillance	
		Appropriate IPC precautions in place	Contact and Droplet precautions in the cohorted area/zone. Note should wear a surgical/respirator mask
		Resident placement	Single rooms Cohorting or zone allocation if appropriate following risk assessment
		Respiratory etiquette	
		Hand Hygiene	As per WHO 5 moments: • Before patient contact

	Domain	Action	Comment
During an Outbreak	Infection Control Measures		• Before an aseptic procedure • After body fluid exposure • After patient contact • After contact with patient surroundings Hand hygiene after PPE removal
		PPE	Point of care risk assessment for PPE selection: www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/posters/PCRAResistPoster.pdf Gloves (as required) Mask (surgical/respirator mask) Aprons / Gowns (as required)
		Aerosol Generating Procedure associated with increased risk of infection (AGP)	Ventilation, closed door, respirator mask , gown, eye protection and gloves
	Environmental control measures		RCF environmental cleaning and disinfection Residential care equipment Laundry Eating utensils and crockery

	Domain	Action	Comment
			Practical measures to ensure adequate ventilation consistent with comfort and weather (gentle movement of air rather than strong airflow is the objective)
	Containment Measures Note in most cases these measures can cease 7 to 10 days after most recent case		Consider new admissions Consider transfers Assess need for restriction of communal activities for a short period of time Staffing precautions Access for nominated support person and visitors
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 B: Details for line listing

1. Outbreak code (on top of line list as title);
2. Name of case;
3. Case ID;
4. Location (unit/section);
5. Date of birth/age;
6. Sex;
7. Status i.e., resident, H&CWs, volunteer, visitor;
8. Vaccination status of resident, H&CWs, volunteer, visitor; vaccine protection;
9. Date of onset of symptoms;
10. Date of notification of symptoms;
11. Clinical symptoms (outline dependent on case definition) e.g., fever, cough, myalgia, headache, other;
12. Samples taken and dates;
13. Laboratory results including test type e.g., RT-PCR;
14. Date when isolation of resident was started;
15. Date of recovery;
16. Duration of illness;
17. Outcomes: recovery, pneumonia, other, hospitalisation, ICU admission, death;
18. Also include work assignments of H&CWs and last day of work of ill H&CWs;
19. State if H&CW has worked in other facilities;

Have separate sheets for both H&CWs and residents

Appendix C: Part 1 – Respiratory outbreak line listing Form – Residents ONLY*

Name of Facility: ……

Name of Outbreak: …… Outbreak Code:

ID	Surname First name	Location (unit/ section)	Vaccinated (COVID-19) including booster if eligible Y/N	Vaccinated (annual influenza) vaccination) Y/N	Sex	DOB	Age	Onset (date)	Fever ≥38°C (Y/N)	Cough (Y/N)	Shortness of breath (Y/N)	Other symptoms (state)

Key: (Y =Yes, N=No, U=Unknown)

***Please complete for all current and recovered cases;**

Appendix C: Part 2 –Residents ONLY

Name of Facility: …… Name of Outbreak: …… Outbreak Code……..

	Test Results		**Outcome**			
ID	Laboratory Test Done Yes/No, If yes, date:	Type of Test and Result	Pneumonia	Hospitalisation (Date)	Death (Date)	Recovered to pre-outbreak health status. Yes/No. If Yes, date:

Key: (Y =Yes, N=No, U=Unknown)

Appendix C: Part 3 – Respiratory outbreak line listing form – H&CW ONLY*

Name of Facility: …….. Name of Outbreak: …… Outbreak Code……..

ID	First name Surname	Position	Location	Vaccinated (COVID-19) including booster if eligible/N	Vaccinated (annual influenza) vaccination) Y/N	Sex	DOB	Age	Onset (date)	Fever ≥38°c (Y/N)	Cough (Y/N)	Shortness of breath (Y/N)	Other symptoms (state)	Work at any other facility? (Y/N) If YES, state location

Key: (Y =Yes, N=No, U=Unknown)

***Please complete for all current and recovered cases; Note column 5 is only applicable for COVID-19 outbreaks**

Appendix C: Part 4 –H&CW ONLY*

Name of Facility: ……. Name of Outbreak: …… Outbreak Code:……

	Test Results		**Outcome**				**Work exclusion**
ID	Pathology Test Done Yes/No, If yes, date:	Type of Test and Result	Pneumonia	Hospitalisation (Date)	Death (Date)	Recovered to pre-outbreak health status. Yes/No. If Yes, date:	Excluded from work until (Date)

Key: (Y = Yes, N = No, U = Unknown)

Appendix D: Checklist for outbreak management

	Discussion point	**Decision/action to be taken (date completed)**	**Person responsible**
1	Consider if the criteria for declaring an outbreak are met		
2	Decide if an OCT is required		
3	Agree the chair		
4	Formulate an outbreak code and working case definition		
5	Define the population at risk		
6	Active case finding, request line listing of residents and H&CWs from the RCF		
7	Discuss whether it is a facility-wide outbreak or unit-specific		
8	Confirm how and when communications will take place between the RCF, Community IPCN, CHO NH lead, Public Health and the laboratory		
9	Review the control measures (infection prevention and 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		
10	Review vaccination status of all residents and H&CWs		
11	Discuss which specimens have been collected. Notify the laboratory of the investigation.		
12	Confirm the type and number of further laboratory specimens to be taken. Clarify which residents and H&CWs should be tested.		

	Discussion point	Decision/action to be taken (date completed)	Person responsible
13	Confirm with the laboratory that it 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.		
14	Liaise with the RCF and laboratory regarding specimen collection and transport		
15	Identify persons/institutions requiring notification of the outbreak e.g. families of ill or all residents 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		
16	Discuss whether a media release is required		
17	Ensure that the incident is promptly reported to HPSC and surveillance details entered onto CIDR		
18	Provide updates on the investigation to the Assistant National Director, ISD-Health Protection when/if required		
19	Link with Community Support Team		
20	Discuss communication arrangements with HSE management ± HSE crisis management team		
21	Discuss communication arrangements with local GPs and Emergency Departments		
22	Decide how frequently the OCT should meet and agree criteria to declare outbreak over		
23	Prepare/circulate an incident report/set date for review meeting		

Resources

HIQA have provided a useful summary of the evidence related to asymptomatic transmission at: https://www.hiqa.ie/reports-and-publications/health-technology-assessment/evidence-summary-asymptomatic-transmission

Advice from the World Health Organisation (WHO) regarding the use of masks by health workers providing care to residents with suspected or confirmed COVID-19 is available on the following link: https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC_Masks-Health_Workers-Omicron_variant-2021.1

Updated ECDC guidance can be found as follows: https://www.ecdc.europa.eu/en/publications-data/considerations-infection-prevention-and-control-practices-relation-respiratory