Guidance for preventing and controlling COVID-19 outbreaks in New Zealand aged residential care

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HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Kupu Taurangi Hauora o Aotearoa

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This document is based on guidance developed by the Communicable Diseases Network Australia (CDNA) and adapted for New Zealand. The document incorporates guidelines from various health authorities including the World Health Organization, Centers for Disease Control and Prevention and guidance from the New Zealand Ministry of Health.

The guidance provided is based on the available evidence at the time of completion. Guidance is not intended to be a substitute for advice from other relevant sources, such as health professionals, your local district health board (DHB), public health units (PHU), or the Ministry of Health. Clinical judgement and discretion may be required in the interpretation and application of guidance.

Health and disability providers should regularly review the Ministry of Health guidelines for health professionals relating to the management of COVID-19 in New Zealand health and disability settings.

PHARMAC is publishing updates on supply and other medicine issues on its website: COVID-19: PHARMAC's response.

General guidance for the public is available on the Government COVID-19 website and in the New Zealand National Civil Defence Emergency Management Plan.

You can also subscribe to the National Health Coordination Centre updates.

Contact your local DHB for advice about local support and procedures being put in place to support continuity of care for those receiving aged residential care services.

For specific questions about a resident's or staff member's health related to COVID-19, call Healthline on 0800 358 5453. It operates 24 hours a day, seven days a week.

Additional tools, resources and templates for use in the aged residential care setting can be found on the Health Quality & Safety Commission website.

Version note

Changes in this version:

Updated:

- link to Ministry of Health guidance
- link to revised case definition
- signs and symptoms to reflect Ministry of health guidance
- link to shared goals of care template
- link to guidance for managing staff with suspected, probable or confirmed COVID-19
- guidance for declaring an outbreak over
- Appendix 1: declaring an outbreak over.

Added:

- link to the New Zealand COVID-19 pandemic plan
- link to the World Health Organization hand hygiene poster
- link to frequently asked questions about personal protective equipment and COVID-19
- link to staff risk assessment form
- link to guidance about how to keep your home bubble safe
- link to COVID-19 cluster investigation and control guidelines
- link to general information about standard precautions
- link to Ministry of Health COVID-19 general cleaning and disinfection advice
- strategies to support family and whānau to maintain contact with residents
- link to resident admission screening form.

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Introduction

This document has been developed by the Health Quality & Safety Commission to support the prevention and control of COVID-19 outbreaks in aged residential care (ARC) facilities in New Zealand. It is an iterative document containing links to editable templates for use within the ARC setting. It is intended to align with and not substitute guidance from the Ministry of Health, or local response guidance from district health boards (DHBs).

The guidance applies to all long-term residential care facilities in New Zealand, including ARC, disability, and mental health settings.

However, while the whole population is at risk of COVID-19 (the infection caused by the SARS-CoV-2 virus), older people – often frail and subject to multimorbidity – are at highest risk for severe and fatal disease. Older people in residential care are also more at risk due to communal living and the number of staff they are in close contact with from the community. Therefore, the guidance is strongly focused on ARC facilities.

ARC includes the following types of long-term care provided in a rest home or hospital:

- rest home care
- continuing care (hospital)
- dementia care
- specialised hospital care (psychogeriatric care).

Short-term respite care, convalescent care and disability support services may also be provided in these facilities. Long-term residential care does not include independent living in a retirement village or apartment.

Appendix 1 provides a summary of COVID-19 management in ARC.

COVID-19 outbreaks

It can be difficult to tell the difference between a respiratory illness such as COVID-19 and a respiratory illness caused by other viruses based on symptoms alone. Suspected COVID-19 cases are referred to as a 'suspected case' until diagnostic testing identifies a pathogen (for example, nose or throat swab collection). If one or more cases of COVID-19 is confirmed within an ARC facility, this meets the criteria for a COVID-19 outbreak. Refer to the case classification resources from the Ministry of Health for more information.

Legal and compliance framework

All ARC providers must identify and comply with all relevant legislation and regulations. In addition, they must comply with the requirements of the national agreements which are reviewed each year:

- Age-Related Residential Care Agreement (ARRC)
- Aged Residential Hospital Specialised Services (ARHSS) Agreement.

The health and disability services standards are mandatory for those health and disability service providers subject to the Health and Disability Services (Safety) Act 2001. Their application will promote good and safe practice by providers. The health and disability services standards are made up of four standards and are available below:

NZS 8134.0:2008 Health and Disability Services (General) Standard [PDF, 3 MB]

NZS 8134.1:2008 Health and Disability Services (Core) Standards [PDF, 3.9 MB]

NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards [PDF, 3.5 MB]

NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standards [PDF, 3 MB]

Roles and responsibilities

Aged residential care facility

All providers will have an infection prevention and control programme and an in-house infection prevention and control coordinator, in accordance with the Health and Disability Services (Infection Prevention and Control) Standards.

ARC providers will:

- detect and notify COVID-19 outbreaks to their PHU and DHB planning and funding
- manage outbreaks in accordance with official guidance
- confirm and declare an outbreak in conjunction with the DHB and PHU
- access specialist infection prevention and control advice where required and ensure all staff have received education on use of personal protective equipment (PPE)
- confirm when an outbreak is over in conjunction with the DHB and PHU.

The public health unit (PHU)

The PHU, or equivalent, acts in an advisory role to assist ARC providers and the relevant DHB to detect, characterise and manage COVID-19 outbreaks. This includes:

- assisting facilities in confirming outbreaks by applying the case definition correctly and providing advice on obtaining testing samples
- providing guidance on outbreak management
- monitoring for severity of illness (recording deaths and hospitalisations)
- informing other relevant agencies, such as the Ministry of Health, of outbreaks
- coordinating contact tracing of probable and confirmed COVID-19 cases
- monitoring the number of COVID-19 outbreaks occurring as the epidemic progresses
- contributing to national surveillance.

The DHB planning and funding team

This team has a role in supporting ARC facilities to:

- establish an outbreak management team in conjunction with the PHU and/or DHB incident management team (IMT)
- ensure the facility has the resources it needs to ensure preparedness and response activities accord with national guidance
- communicate with other providers as required in planning and response activities.

Understanding COVID-19

Recognising COVID-19

COVID-19 is a contagious viral infection that generally causes respiratory illness in humans. Presentation can range from no symptoms (asymptomatic) to severe illness with potentially life-threatening complications, including pneumonia. COVID-19 is spread by direct contact with respiratory secretions or contact with fomites (objects and materials) that have respiratory secretions on them.

Case definition of COVID-19 infection

The case definitions document is being regularly updated. There is new advice on self-isolation for household contacts of cases under investigation, and information for managing relapsing cases of COVID-19.

A suspected case satisfies the following clinical criteria. Any acute respiratory infection with at least one of the following symptoms:

- cough
- sore throat
- shortness of breath
- sneezing and runny nose (coryza)
- temporary loss of smell (anosmia)
- with or without fever.

Older people may also have the following symptoms:

- increased confusion or change in cognitive function
- worsening chronic conditions of the lungs
- loss of appetite.

Elderly people often have non-classic respiratory symptoms; ARC providers should consider testing residents with any new respiratory symptom. Pulse oximetry may assist in identifying changes in respiratory function.

Early recognition and communication of signs and symptoms is critical. All people meeting the suspected case definition for COVID-19, or where the clinician has a high degree of suspicion, should be tested to confirm or exclude a diagnosis.

Refer to the Acute deterioration frailty care guide. Implement the Stop and Watch tool for caregivers.

Implement the Modified SBAR (Situation, Background, Assessment, Recommendation) communication tool for registered nursing staff.

If a resident becomes unwell their general practitioner (GP) or nurse practitioner (NP) should be notified as soon as possible for review. Family/whānau and/or enduring power of attorney (EPOA/welfare) should be informed of a change in condition by phone as soon as possible. Maintain a log of all correspondence. A template can be downloaded from the Commission website.

Incubation period

People with COVID-19 generally develop signs and symptoms, including mild respiratory symptoms and fever, on an average of 5–6 days after being infected (mean incubation period 5–6 days, range 1–14 days).

Routes of transmission

COVID-19 is transmitted via respiratory droplets and fomites during close unprotected contact with an infected person. Airborne spread has not been reported for COVID-19. However, it may occur during certain aerosol-generating procedures conducted in health care settings. Aerosol-generating procedures include manual ventilation before intubation, tracheal intubation, non-invasive ventilation, tracheostomy suctioning, cardiopulmonary resuscitation, bronchoscopy and high-flow nasal oxygen.

Faecal shedding of viable virus has been identified in some cases. Although the faecal-oral route does not appear to be a driver of COVID-19 outbreaks, it may become important in long-term care settings, as cases with ongoing diarrhoea or faecal incontinence should continue to be isolated until 48 hours after symptoms resolve.

People at risk of complications from COVID-19

People at risk of complications from COVID-19 include:

- people 65 years of age and over
- Māori and Pacific populations
- people with chronic or other medical conditions
- people with a weakened immune system (due to disease or medication).

Complications of COVID-19

Most people with COVID-19 have mild disease and will recover. Some people can develop complications which may be life-threatening and can result in death. Complications include:

- pneumonia (secondary bacterial infection)
- respiratory failure
- septic shock
- multi-organ dysfunction/failure

Elderly residents may experience a worsening of chronic health problems such as congestive heart failure, asthma and diabetes.

Preparedness and prevention

Preparation

ARC providers must ensure they are prepared for community and facility outbreaks of COVID-19 to ensure continuity of care as much as possible for all residents. This might include preparing to care for increased numbers of unwell or dying residents who might otherwise have been managed in a public hospital setting.

Prepare an outbreak management plan

If one or more confirmed COVID-19 cases have occurred within a residential care facility, an outbreak management team (OMT) should be convened. For more information see Interim Advice for Health Professionals or contact the DHB or PHU.

A checklist to assist in outbreak preparedness can be found in Appendix 2.

A facility outbreak plan template example can be found here.

Planning assumptions

It is important to note assumptions about the epidemiology and impact of COVID-19 may change as knowledge emerges.

The following public health assumptions are relevant to infection prevention and control and outbreak management planning:

A COVID-19 pandemic will affect the entire health care system and the community. Hospitals, public health units and other services may have limited capacity. ARC providers may not be able to rely on the same level of support they usually receive from other parts of the health care system or from other community services during an outbreak.

Pandemic COVID-19 plans developed by individual ARC providers should be:

- coordinated with DHB plans and local/regional pandemic plans
- consistent with the New Zealand COVID-19 Pandemic Plan and the New Zealand National Civil Defence Emergency Management Plan.

The number of health care workers available to provide care may be reduced significantly because of personal illness, concerns about transmission in the workplace, and family or whānau caregiving responsibilities.

Usual sources of supplies may be disrupted or unavailable.

A vaccine is not yet available. Once available, the vaccine will be in short supply and high demand.

The effectiveness of antivirals and other medications used to treat COVID-19 is unknown, but if antivirals and other treatment medications are shown to shorten the length of time people are ill, relieve symptoms and reduce hospitalisations, they may be introduced into standards of care. They will, however, be in short supply and high demand. Continuing rigorous infection prevention and control standards is essential.

Resources, including staff, supplies and equipment may have to be reassigned or shifted during a pandemic to meet community needs.

Care protocols may change and practice may have to be adapted.

ARC providers will need effective ways to communicate with residents' family/whānau and friends, in order to meet their needs for information and psychosocial support.

Education

Education for staff, residents and their families/whānau is vital to inform behaviour and help manage the potential occurrence for ongoing transmission in an outbreak setting.

Clear information needs to be provided to residents and families/whānau regarding the outbreak including respiratory hygiene and cough etiquette, hand hygiene and any visitor restrictions in place. Information about visitor restrictions can be found here. Links to hand hygiene and PPE guidance, including posters and videos, are below. There is general guidance on PPE from the Ministry of Health here.

Messages to staff and visitors (including volunteers and visiting health professionals) regarding staying away from the facility if they are unwell should be reinforced by signage at all entry points to the facility.

Topics for staff education and training should include:

- symptoms and signs of COVID-19
- exposure risk levels for COVID-19, including international travel
- personal hygiene, particularly hand hygiene, sneeze and cough etiquette
- appropriate use of PPE, such as gloves, gowns or aprons, eye protection and masks, including how to don (put on) and doff (remove) PPE correctly
- what to do if experiencing symptoms of COVID-19 (do not work or visit an ARC facility)
- handling and disposal of clinical waste
- cleaning and reuse of equipment
- environmental cleaning
- laundering of linen
- food handling and cleaning of used food utensils.

Hand hygiene posters

General hand hygiene reminder poster 1 (available in multiple languages)

General hand hygiene reminder poster 2 (available in multiple languages)

How to hand wash poster

How to use hand sanitiser poster

The 'Your 5 moments for hand hygiene' poster

World Hand Hygiene poster

Use of PPE posters

The Ministry of Health's technical advisory group have developed a range of PPE posters which can be accessed here. These include guidance for PPE when taking nasopharyngeal or throat swabs.

Hand hygiene and PPE videos

Auckland DHB has produced these videos:

Hand hygiene using soap and water

Hand hygiene using hand sanitiser

PPE instructional video

Appropriate use of PPE

Frequently asked questions related to PPE and COVID-19 can be found here.

Conserving PPE

Using PPE when necessary, but not over-using or misusing it will be important during the COVID-19 pandemic.

This poster from the Ministry of Health provides guidance on the specific type of PPE that should be used for a list of tasks commonly performed in an ARC facility.

Strategies to preserve or optimise PPE to prolong the supply if an ARC facility is experiencing temporary shortage include:

- clean reusable eye protection (goggles or face shield) between use
- a surgical mask may remain on until it feels damp, or for up to four hours
- do not touch face/eyes whilst wearing a mask
- remove and dispose of PPE safely as demonstrated in the poster/video
- wash hands after removal and between each interaction with residents being cared for.

Resident care plans, EPOA, and shared goals of care

As part of preparation, providers should ensure resident care plans are up-to-date and risk assessments complete. Details of EPOA contact and activation status should be documented and easily accessible.

Advance treatment planning or shared goals of care is a process allowing the resident and/or their EPOA to discuss and plan health care preferences in advance. The plan should be reviewed any time there is a change in the resident's health status.

If an advance care plan (ACP) is not in place already, plan to have sensitive conversations ahead of an outbreak occurring in your facility and documented in the resident's clinical file.

More information and resources are available on the advance care planning publications page on the Commission's website, including a shared goals of care template.

For guidance on how to approach conversations with residents and family/whānau about serious illness go to the Serious Illness Conversation Guide.

Workforce management

Facilities should have a staff contingency plan in the event of a community or facility outbreak where staff are isolated or unwell for a prolonged period until cleared to return to work.

Access guidance for managing staff with suspected, probable or confirmed COVID-19, including self-isolation requirements and return to work guidance.

Information for staff can be found here.

Staff should speak to their employer if they have any underlying health conditions that increase their risk of COVID-19. A staff risk assessment form can be found here.

Staff working at multiple health provider sites or who work across sites for the same provider should follow general advice for 'how to keep your home bubble safe'. In addition, staff should only work in areas designated for that shift. Avoid working across different wings/units/zones if possible, on that day. Where possible, staff should remain assigned to the same group of residents for subsequent shifts.

The workforce management plan should aim to cover a significant reduction in staff due to illness or stand-down. Developing and maintaining a contact list for casual staff members, external nursing agencies, and (potentially) vetted and trained volunteers, is essential to timely activation of a surge workforce should an outbreak occur. Managers should discuss with their teams their availability to fill staff shortages. Staff who work in other health care settings should advise their manager.

ARC providers concerned about staff contingency planning should discuss this with their DHB programme manager.

Prevention

The Ministry of Health has provided guidance to address the greater risk of transmission of COVID-19 in aged care services.

This guidance includes information on admissions and transfers.

Prevention of spread within and between facilities

To prevent the spread of COVID-19, the following actions should be taken:

- implement restrictions on visitor and non-essential personnel
- monitor residents and employees daily for symptoms and/or clinical criteria that meet the case definition
- restrict residents with fever or acute respiratory symptoms to their room. If they must leave the room for medically necessary procedures, have them wear a facemask (if tolerated)

- supply and use PPE as per guidance for suspected, probable or confirmed cases
- assign staff to specific groups to care for residents with suspected, probable or confirmed COVID-19
- position a disposal receptacle near the exit inside the resident room to make it easy for employees to discard PPE
- post signs on the door or wall outside of the resident room clearly describing the type of precautions (contact and droplet) needed and required PPE
- notify facilities and transport service providers prior to transferring a resident with an acute respiratory illness, including suspected, probable or confirmed COVID-19; or transferring to a higher level of care
- maintain a daily case log of those with acute respiratory illness (ARI) or confirmed COVID-19

Further guidance for staff and resident surveillance can be found here. A staff symptom surveillance template is included.

Management of infection prevention and control in dementia care settings

Risk of infection transmission is high in dementia care settings. Residents are often mobile, in frequent close contact with other residents, staff and surfaces, and may not be able to comply with isolation in a single or shared room. From the time community transmission is confirmed, facilities should have a high index of suspicion for emerging cases in the dementia facility, wing or unit. Surveillance and testing (if available) should be increased.

If possible, apply the principles of the 'bubble' by creating physical or temporary separation within the unit or facility even before the first case – and limit contact between residents. Note, restraint legislation and policies apply.

Maximise opportunities to limit surface contact and co-mingling.

- Assign residents to small groups (cohorts) and limit activity to different parts of the facility (wings or units).
- Assign specific staff to each group of residents. Staff who work in the dementia unit should not work across other parts of the facility, for example in rest home or hospital areas.
- Each group should use facilities at different times, for example, stagger dining groups or use in-room or living room dining, wipe down surfaces between groups, exercise in clusters and assign specific bathrooms to each group.

Maintain resident health and wellbeing with particular attention to:

- maintaining social contacts through virtual media use
- maintaining social interactions with staff and other residents as possible
- hydration (dementia heightens risk of dehydration)
- resident-specific daily check list and monitoring plan

- ensuring medicines and standing orders/anticipatory prescribing are clear
- ensuring EPOA contact and activation details are on file
- ensuring ACPs are up-to-date and on file
- normalising frequent hand washing – encourage staff to wash *with* the resident
- ensuring care needs for resident are well identified
- limiting exposure to newsfeeds to reduce anxiety
- maintaining physical activity and movement, which is especially important.

Educate staff. Note, COVID-19 may present with subtle signs in the elderly, including:

- change in cognitive function, mood or level of consciousness
- conjunctivitis
- any one of the usual COVID-19 signs (complaint of sore throat, fever, shortness of breath, cough).

Pulse oximetry is valuable to identify early respiratory changes.

Set up functions you will need as cases develop:

- continuous cleaning schedule
- consider commodes in room if no ensuite
- communication to residents and family/whānau – keep messages simple, reduce panic
- task reassignments for staff
- implementing visitor restrictions.

Identify your sources of infection detection and management.

- The resident's usual GP/NP should be informed to conduct assessment and provide swabbing. PPE should be provided for this.
- Can you access one-on-one special care of high-risk residents?
- If residents cannot transfer to hospital, where can you access support? Can phone or virtual support be accessed?

Isolation within the dementia care setting

If a resident becomes unwell and has been co-mingling with other residents, assume those residents and staff may also be infected.

Activate isolation of the resident where possible. Implement contact and droplet precautions within the unit.

Activate clinical support (review by GP/ NP) and testing for COVID-19.

Inform family/whānau and staff.

Once the resident is in isolation:

- cooperative and/or unwell residents can be cared for in their room using full isolation
- extra staff attention may justify a change in status of care to contain an uncooperative resident
- give time for staff to reassure and soothe residents
- isolation not seclusion – consult the resident's geriatrician if the resident is agitated
- at a minimum, keep the resident within a small group and area of the unit to limit contact with other residents and surfaces
- all efforts to limit exposure are worthwhile, for example, extra hand washing and mask on the resident while having care, if possible
- monitor status, and seek advice on status change, have a plan for deterioration.

Activate efforts to reduce co-mingling and surface contact as much as possible.

- 'Eat in rooms' or 'stay in rooms'.
- Assign one bathroom to the resident, if possible, or a commode in the room.
- Supervise exercise in restricted areas.
- Continuous cleaning of surfaces.
- Increase supervised hand washing.

Assign staff to specific residents to reduce the opportunity for infection spread.

- Limit exposure of the active case to minimum number of staff.
- Ensure education/compliance with PPE use and hand hygiene.
- Activate a staff shower/change area. Staff should shower and change into clean clothes at the end of their shift before leaving the facility. Once home, staff should wash clothes in a washing machine using hot water setting.

Identifying COVID-19

Staff or residents exhibiting signs and symptoms fitting the case definition for COVID-19 should isolate and be tested as soon as possible. Isolation and nursing with PPE should continue until tests are back. Residents should continue to be managed as a probable case even if swabs are negative but clinical suspicion is high.

Testing for COVID-19

Testing will be requested by a GP/NP and collection made by an appropriately trained GP/NP or pathology provider. ARC nursing staff who have received appropriate training in respiratory sample collection and the proper use of PPE may also collect samples.

Continue to monitor the Ministry of Health guidelines for health professionals relating to the management of COVID-19 in New Zealand health and disability settings.

PPE when taking nasopharyngeal or throat swab

Video – collecting a nasopharyngeal swab

Notification

COVID-19 is a notifiable condition in New Zealand. This means the medical officer requesting the test and/or the laboratory performing the test, are responsible for notifying the local PHU of the case of COVID-19.

A single case within a congregate care environment, such as an ARC home, should be considered a potential cluster. Rapid investigation and case-finding should be led by the local medical officer of health and be undertaken in partnership with the facility manager. More information on case notification, communication channels and management of clusters can be found here. The ARC provider must also notify HealthCert of a viral outbreak under Section 31 of the Health and Disability Services (Safety) Act 2001.

Declaring an outbreak

A COVID-19 outbreak is defined as:

- two or more cases of acute respiratory illness (ARI) in residents or staff of an ARC facility within three days (72 hours) AND
- one or more cases of COVID-19 confirmed by laboratory testing.

The PHU will assist the ARC facility in deciding whether to declare an outbreak.

Establishing an outbreak management team

Once an outbreak has been confirmed, an internal outbreak management team (OMT) should be convened to direct, monitor and oversee the outbreak, confirm roles and responsibilities and liaise with the local DHB and PHU.

The OMT should meet regularly – usually daily – at the height of the outbreak to monitor the outbreak, initiate changes to response measures and discuss outbreak management roles and responsibilities. It is likely a small number of staff will perform multiple roles in an OMT.

For more information on forming and implementing an OMT, refer to Appendix 4.

COVID-19 outbreak investigation plan

If there is a suspected, probable or confirmed case, an investigation plan should be put in place and look to identify all other cases and close contacts (without PPE protection). Every affected staff member and every resident needs to be case classified.

Providers must be prepared to provide the following information to the PHU:

- total number of residents and/or staff with suspected or confirmed COVID-19
- date of onset of illness of each person
- symptoms of each person
- total number of staff who work in the facility and in the affected area
- total number of residents in the facility and in the affected area
- whether respiratory samples have been collected
- results of any respiratory samples tested
- number of people admitted to hospital with ARI, or suspected or confirmed COVID-19.

The PHU will advise and assist with the following:

- confirming the presence of an outbreak
- identifying the control measures that need to be in place
- testing of the initial respiratory specimens
- coordinating contact tracing of probable and confirmed COVID-19 cases.

The facility should maintain a case log, and a daily situation report. A template may be provided by the PHU or an example daily case log template can be found here.

Notification – resident and facility GPs and NPs

Unwell residents must be reviewed by their GP/NP. If a COVID-19 outbreak is present, all visiting GPs/NPs should be informed. A sample letter for informing GPs/NPs can be found here.

Early notification will facilitate appropriate samples being obtained for testing, implementation of infection control procedures, and treatment for symptomatic residents. Speak with the PHU to confirm the presence of an outbreak before notifying visiting GPs/NPs.

COVID-19 outbreak management plan

Response to a suspected case of COVID-19 in a resident

Residents with suspected COVID-19 should be assessed by their primary care provider for testing and medical management.

Immediately isolate unwell residents (or group/cohort), minimise interaction with other residents and initiate testing.

Transfer residents to hospital only if their condition warrants and on the advice of the resident's GP/NP and receiving clinicians. Advise the hospital and transport provider in advance that the resident is being transferred from a facility where there is potential or confirmed COVID-19.

Aerosol generating procedures such as nebulisation and suctioning should be avoided within the ARC setting. If a resident with ARI or confirmed COVID-19 requires such a procedure the nurse administering the procedure should wear full PPE including N95 mask. Hospital transfer should be discussed with the resident's GP/NP.

Notify the PHU, or equivalent, of the transfer.

Response to an outbreak of COVID-19

An outbreak management checklist is provided at Appendix 3.

ARC providers should engage an infection prevention and control (IPC) consultant or contact the DHB IPC clinical nurse specialist (CNS) if they require support in an outbreak.

Implementing infection prevention and control measures

Standard precautions

Standard precautions must be used while providing care for all residents every time. It is especially important to use standard precautions during a suspected or confirmed COVID-19 outbreak. General information about standard precautions can be found here. Standard precautions include performing hand hygiene before and after every episode of contact with the resident or their belongings (Your 5 moments for hand hygiene), the use of PPE (including gloves, fluid resistant gown or apron, appropriate mask and eye protection) depending on the anticipated exposure, good respiratory hygiene/cough etiquette, regular cleaning of the environment and equipment, prevention of needle stick injuries and appropriate waste disposal. The PPE guidance poster is available here.

Isolation and grouping of residents

A resident with an ARI (suspected case of COVID-19) should be restricted to a single room with their own ensuite facilities, if possible, while a diagnosis is sought. In addition to the usual standard precautions, contact and droplet precautions apply. Residents may attend urgent medical or procedural appointments but should wear a face mask if tolerated. If a single room is not available, the following principles should be used to guide resident placement:

- give highest priority to single room placement to residents with excessive cough and sputum production
- place residents together in the same room (cohort) with similar signs and symptoms or infected with the same pathogen (if known) and assessed as being suitable roommates.

If a single room is not available, and grouping of unwell residents is not possible, a resident with a respiratory illness may be cared for in a room with a roommate(s) who does not have a respiratory illness. This is the least favourable option. In this case:

- residents' beds should be separated by at least two metres
- the curtain (if available) should be kept drawn between residents' beds
- the roommate should be vaccinated against influenza with the current season's vaccine at least two weeks prior to being in the same room as the unwell resident.

In shared rooms (both residents with like illness and residents with and without illness), staff must ensure they change their PPE and perform hand hygiene between caring for each resident.

Specific staff should be allocated to the care of residents in isolation, and these assignments should be documented. The provider must ensure staff members:

- do not move between their allocated room/section and other areas of the facility, or care for other residents
- self-monitor for signs and symptoms of acute respiratory illness and self-exclude from work if unwell.

Clinical management

The clinical management of older people with COVID-19 in ARC and community settings is a relatively new area. The experience of other countries will continue to inform this.

All clinical management measures will need to be adapted to the care setting, including the resources and supports available from the DHB, which may vary.

As the resident's condition may deteriorate very rapidly, prescriptions should be made in advance for the problems expected to arise and documented in the care plan. Medicines, together with the equipment required for their administration, must be available at the facility. As well as oral dosage forms, an alternative subcutaneous formulation should also be considered.

Some recent guidance on the clinical management of COVID-19 in the community can be found here. An example of a short-term care plan can be found here.

Environmental cleaning and disinfection

Frequent cleaning and disinfection of all resident care areas is essential during an outbreak. Removal of viruses such as SARS-CoV-2 (the virus that causes COVID-19) requires thorough cleaning followed by disinfection. The length of time that SARS-CoV-2 survives on inanimate surfaces will vary depending on factors such as the type of surface, amount of contaminated body fluid (eg, respiratory droplets or soiling) present, environmental temperature and humidity. Coronaviruses can survive on surfaces for many hours or days but are readily killed by cleaning and disinfection.

Guidance on cleaning aged residential care facilities following a suspected, probable or confirmed case of COVID-19.

Poster: Stop bugs travelling in aged residential care.

Ministry of Health COVID-19 general cleaning and disinfection advice.

Signage

ARC facilities should place signs at the entrances and other strategic locations within the facility to inform visitors of the infection prevention and control requirements. A 'contact and droplet precautions' sign must be placed outside symptomatic residents' rooms to alert staff and visitors to the requirement for appropriate transmission-based precautions. An example contact and droplet precautions sign can be found here.

Visitors and communal activities

During a COVID-19 outbreak, where possible, the movement of visitors into and within the facility should be restricted.

Facilities should implement the following:

- suspend all group activities, particularly those involving visitors, such as musicians
- consider alternative individual activities, including physical activity that allows for physical distancing for those residents not in isolation. Ensure all equipment is cleaned between each resident use
- postpone visits from non-essential external providers, such as hairdressers and allied health professionals
- inform regular visitors and families/whānau of residents of the COVID-19 outbreak and any visitor restrictions in place. Young children should not visit the facility as they are generally unable to comply with standard precautions and PPE requirements
- implement alternative strategies to support families/whānau and friends to maintain regular contact with residents, for example:
  - help residents use social media or make video-calls
  - read and/or write emails with the resident
  - text updates to family/whānau daily
  - designate visitor areas with physical distancing or barrier mechanisms in place ie, window visiting
- ensure visitors who do attend the ARC home on compassionate grounds to visit an unwell resident are recorded on a register of visitors and comply with the following guidance:
  - prearrange visits with the care home
  - report to the reception desk on arrival
  - visit only the unwell resident at the time agreed by the care home manager
  - wear PPE as directed by staff
  - enter and leave the facility directly without spending time in communal areas
  - perform hand hygiene before entering and after leaving the resident's room and facility.

Admissions and transfers

General guidance on admissions from the Ministry of Health can be found here.

Screening form for a person to enter an ARC home.

Monitoring outbreak progress

Increased and active observation of all residents and staff for the signs and symptoms of COVID-19 is essential in outbreak management to identify ongoing transmission and potential gaps in infection prevention and control measures. Facilities should have the capacity to monitor or count residents and staff displaying signs and symptoms of COVID-19 daily, to ensure infection prevention and control measures are implemented or strengthened.

Updates to the case log should occur through daily meetings of the OMT, or more frequently if major changes occur. Information from the case log should be provided to the PHU each day (or as arranged) until the outbreak is declared over. An example of a daily situation report template can be found here.

The OMT, in conjunction with the PHU, should review all control measures and incident management procedures if:

- the outbreak comprises more cases than can be managed with current staffing levels, management and available expertise
- the rate of new cases is not decreasing
- three or more residents are hospitalised related to COVID-19, OR
- a COVID-19-related death has occurred.

Specialised advice is available from the following sources:

- local or regional PHU (or equivalent)
- IPC CNSs may be available for advice from DHBs or as private or in-house consultants
- geriatricians may be approached for specialist management of complex conditions.

Declaring the outbreak over

An outbreak in an ARC home is considered closed when there have been no new cases for two incubation periods (ie, 28 days) from the date when all cases complete isolation within the facility, the date of death or two negative antigen tests within 24 hours – whichever is earliest. Cases in household contacts of staff are not considered part of the facility outbreak but would be considered as part of the broader cluster.

Reviewing outbreak management

Once an outbreak has been declared over, it is important for all parties to reflect on what worked well and which policies, practices or procedures need to be modified to improve responses for future outbreaks. It should involve all members of the OMT and any others who participated in the response to the outbreak. General learning may be shared to improve preparation and response to future outbreaks in similar health care settings.

Additional resources and support

For further and updated information for health professionals please visit the Ministry of Health website.

More practical templates for use by providers may be added over time to the Health Quality & Safety Commission website.

The New Zealand frailty care guides can also be found on the Commission website.

Other useful guidance

New Zealand Influenza Pandemic Plan: A framework for action

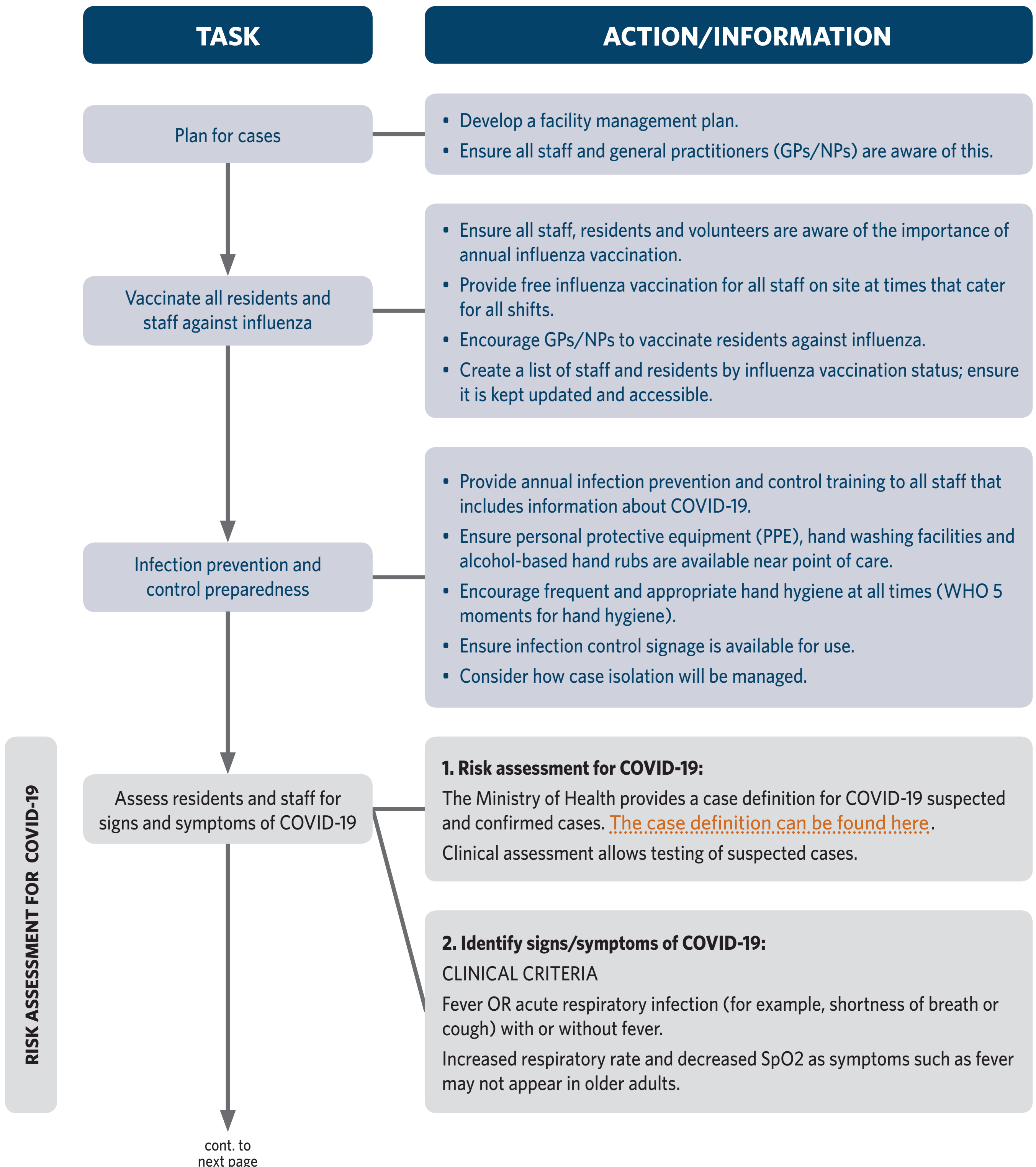
Workplace pandemic influenza guidance

Strategies to prevent the spread of COVID-19 in long-term care facilities (Centers for Disease Control and Prevention)

Appendices

Appendix 1: Flowchart for COVID-19 management in aged residential care (ARC) facilities

This guideline is intended for use within ARC facilities and has been adapted from Coronavirus Disease 2019 (COVID-19) Communicable Diseases Network Australia (CDNA) National Guidelines for Public Health Units.



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MANAGE A SUSPECTED OR CONFIRMED CASE OF COVID-19

Collect specimens

- Discuss each resident with suspected COVID-19 with treating GP/NP.
- Obtain laboratory request forms for respiratory viral testing for COVID-19.
- Collect appropriate respiratory specimens from ill residents or staff and send to validated lab for COVID-19 processing.
- Use a single viral transport collection swab for each person.
- Notify laboratory using standard procedure.
- Observe contact and droplet precautions when collecting specimens, that is, fluid-resistant gown, gloves, medical/surgical mask and eye protection (goggles). Wash hands before and after collection.

Implement additional infection control measures immediately

- Commence contact and droplet precautions including fluid resistant gown, gloves, eye protection (goggles) and a medical/surgical mask when caring for residents with a COVID-like illness. Maintain a two-metre distance between an infected person and others.
- Isolate residents with COVID-like illness, if feasible. (Single room with ensuite)
- Staff and volunteers with a COVID-like illness must stay away from the facility until well and seek medical advice.
- Request visitors do not visit the facility if unwell.
- Inform all visitors about cough etiquette and hand hygiene.
- Immunise residents and staff who have not been immunised with the current influenza vaccine as soon as possible.

Ensure appropriate management of cases

- Symptomatic and supportive treatment under the guidance of the GP/NP.
- Use of antiviral medication is a clinical decision made by the GP/NP.
- Transfer to hospital as indicated by team decision.

MANAGE A SUSPECTED OUTBREAK OF COVID-19

Confirm outbreak

- Two or more cases of acute respiratory illness (ARI) in residents or staff of an ARC facility within three days (72 hours) AND
- One or more cases of COVID-19 confirmed by laboratory testing

Document and monitor outbreak daily

- Nominate an outbreak coordinator and management team at the facility.
- Create a detailed list of residents and staff with COVID-like illness including location, influenza vaccination status, onset date, symptoms, specimens taken and results, treatment and outcome. Update the list daily.

Inform

- Inform relevant DHB & PHU. Provide regular status updates as agreed.
- Inform GPs/NPs, facility staff, residents and families of residents.

End outbreak

- No new cases for two incubation periods (ie, 28 days) for the date when all cases complete isolation.
- Send final detailed list to the local PHU, review and evaluate outbreak management.

Appendix 2: COVID-19 outbreak preparedness checklist

Planning actions	**✔**
Does your facility have an updated respiratory outbreak plan that covers all the areas identified below?	
Have the relevant health care providers/organisations in the community (for example, associated GPs, infection prevention and control consultants) been involved in the planning process?	
Are all facility staff aware of the plan including their roles and responsibilities?	
Have residents and staff had their flu vaccinations?	
Staff, resident and family/whānau education	
Have your facility's staff undergone education and training in all aspects of outbreak identification and management, particularly competency in infection prevention and control (including caregivers, registered nurses, GPs/NPs, laundry, kitchen and maintenance staff)?	
Have your registered nurses and caregivers had recent education in recognising and managing resident decline?	
Has your facility provided residents' families/whānau with information regarding prevention of transmission, including visitor restrictions?	
EPOA and shared goals of care	
Are all residents' care plans and EPOA documentation up to date? Have all residents and/or their EPOA had conversations about shared goals of care, and are decisions documented?	
Staffing actions	
Does your facility have a staffing contingency plan in case a significant number of staff fall ill and/or are excluded for 14 days?	
Has your facility developed a plan for assigning staff to specific groups of residents in an outbreak?	
Stock levels	
Has your facility acquired adequate stock of PPE, hand hygiene products, respiratory swabs and cleaning supplies?	
Is your facility medication imprest stock adequate if an outbreak occurs?	
Does your facility have adequate equipment if residents require oxygen or fluid therapy?	
Outbreak recognition actions	
Does your facility routinely *assess* residents for respiratory illness, particularly for fever or cough (with or without fever), or other changes in condition?	
Does your facility *encourage* staff to report COVID-19 symptoms during the pandemic?	
Does a process exist to notify the facility manager and local PHU as soon as practicable (and within 24 hours) of a staff or resident COVID-19 case being suspected?	
Communication actions	
Does your facility have a contact list including key contacts from the DHB, local PHU and other relevant stakeholders, such as primary care and infection prevention and control consultants?	
Does your facility have a plan for communicating with staff, residents, volunteers, family/whānau members and other service providers, such as laundry and waste, during an outbreak?	
Does your facility have a plan to restrict visitors and non-essential personnel during an outbreak to reduce risk of transmission both within the facility and externally (for example, security, signage, restricted access)?	
Cleaning	
Does the plan identify who is responsible for overseeing increased frequency of cleaning, liaison with staff or contractors, or hiring extra cleaners as necessary?	

Appendix 3: COVID-19 outbreak management checklist

Identify	✔
Confirm your facility has an outbreak plan in conjunction with Ministry of Health guidance and advice from the PHU.	
Implement infection prevention and control measures	
Isolate cohort/unwell residents.	
Implement contact and droplet precautions.	
Provide PPE outside room.	
Display sign outside room.	
Exclude unwell staff until they are symptom free (or if probable/confirmed case of COVID-19, until they meet the release from isolation criteria).	
Reinforce standard precautions (hand hygiene, PPE, and cough etiquette) throughout facility.	
Display outbreak signage at entrances to facility.	
Increase frequency of environmental cleaning (minimum twice daily).	
Collect respiratory specimens	
Collect appropriate respiratory specimens from symptomatic residents or staff and send to validated lab for COVID-19 processing.	
Notify	
The DHB health of older people management and PHU.	
Contact the GPs/NPs of symptomatic residents for review.	
Provide the outbreak letter to all residents' GP's/NPs.	
Inform families/whānau and all staff of outbreak.	
Restrict	
Restrict movement of staff between areas of the facility.	
Avoid resident transfers if possible.	
Restrict visitors unless on compassionate grounds.	
Cancel or limit group activities during the outbreak period.	
Monitor	
Monitor outbreak progress through increased observation of residents for fever and/or acute respiratory illness.	
Update the case log daily at the facility and provide to the public health unit daily.	
Add positive and negative test results to case log.	
Declare	
A decision for declaring an outbreak over should be made in partnership with the local DHB and public health unit. This will involve tracking cases in the facility and determining when there are no new cases for 28 days (2 incubation periods) from the date of isolation of the most recent case.	
Review	
Review and evaluate outbreak management – identify lessons learned and amend outbreak management plan if needed.	

Appendix 4: Forming an outbreak management team

Several functions are critical within the outbreak management team (OMT), and some roles may be performed by the same person.

The OMT should initially meet daily to:

- direct and oversee the management of the outbreak
- monitor the outbreak progress and initiate changes in response, as required
- liaise with GPs/NPs and the DHB/PHU, as arranged.

The OMT should include the following roles and functions:

Role	Function
Chairperson (facility director, manager or nursing manager)	The chairperson is responsible for coordinating outbreak control meetings, setting meeting times, agenda and delegating tasks.
Secretary	The secretary organises OMT meetings, notifies team members of any changes, and records and distributes minutes of meetings.
Outbreak coordinator (nurse, IPC specialist or delegate)	The coordinator ensures all infection prevention and control decisions of the OMT are carried out, and coordinates activities required to contain and investigate the outbreak. This role is often given to an IPC, CNS or delegate.
Media spokesperson (facility director, manager or nursing manager)	Significant media interest in outbreaks in ARC is common, especially if there are adverse outcomes. It is recommended facilities liaise with their corporate services team (if available) or their DHB prior to making media statements. The principles of the Privacy Act 1993 apply.
Visiting GPs or NPs	Some GPs/NPs may be available to participate in the OMT and their role should be identified during the planning process. It is valuable to identify a clinical lead among those GPs/NPs who attend a facility. In the management of an outbreak, the role of this person is important in facilitating assessment and management of ill residents, and in working with the ARC facility and the DHB to implement control strategies.
Public health officers	An understanding of what assistance can be provided by PHUs and role/responsibility clarification should be confirmed at the initial OMT meeting.

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