Disability Supplement

to the CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia

Revision history			
Version	**Date**	**Reason / Changes**	**Endorsed by**
1.0	16/03/21	Initial Release	CDNA

Preface

The Disability Supplement (Supplement) provides national guidance on the prevention and management of COVID-19 outbreaks in disability residential services (DRS). The Communicable Diseases Network of Australia (CDNA) has developed the Supplement to support DRS providers (providers) and public health authorities to respond to the risk and occurrences of COVID-19 outbreaks in these settings. It also serves to support existing state and territory advice, and promote an aligned approach to outbreak prevention and management in DRS throughout Australia.

The Supplement tailors and adds to advice contained in the *CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia* (RCF Guidelines) to address the particular challenges of outbreak prevention and management in DRS. Providers and public health authorities should refer to the RCF guidelines for additional context. Where the Supplement differs from state and territory protocols, the local requirements in the state or territory should be followed.

This guideline captures the knowledge of experienced professionals and provides guidance on good practice, based on the available evidence at the time of completion. Readers should not rely solely on the information contained within this guideline. Guideline information is not a substitute for advice from other relevant sources including advice from a health professional. Clinical judgement and discretion may be required in using these guidelines.

While every effort has been made to ensure the accuracy and completeness of the contents of this guideline at the time of publication, members of CDNA and the Australian Health Protection Principal Committee (AHPPC), and the Commonwealth of Australia as represented by the Department, do not warrant or represent that the information in the guideline is accurate, current or complete. CDNA, AHPPC and the Department do not accept any legal liability or responsibility for any loss, damages, costs or expenses incurred by the use of, reliance on, or interpretation of, the information in this guideline.

Table of Contents

1. Introduction

Avoiding exposure is the single most important measure in preventing COVID-19 outbreaks in disability residential services (DRS). However, early identification and response to suspected or confirmed cases of COVID-19 can minimise the impact of an outbreak. Accordingly, this supplement focuses on the measures that providers should take to prevent, prepare for, and manage outbreaks in DRS, as well as how other stakeholders can support the implementation of those measures.

This guidance applies to all DRS in Australia. For the purpose of this guidance, a DRS is any public or private service providing accommodation and disability support services to two or more people with disability. This includes:

- supported independent living and/or specialised disability accommodation (including legacy stock arrangements) provided under the NDIS
- group homes provided outside of the NDIS
- supported residential services (SRS)
- assisted boarding houses
- other similar accommodation settings in Australia

This guidance does not apply to residential aged care facilities, long stay hospital wards or rehabilitation hospitals.

For the purpose of investigation, a COVID-19 outbreak is defined as a single confirmed case of COVID-19 in a resident, staff member, or frequent attendee of a DRS.

1.1. Regulatory Framework

The regulatory framework a DRS operates in will depend on a number of factors including:

- the state/territory the DRS operates within
- the type of DRS (e.g. SRS, assisted boarding house, other)
- whether the provider delivers supports and services funded through the NDIS
- whether the provider is registered with the NDIS

It is the responsibility of providers to identify and comply with relevant legislation and regulations, including obligations to protect the safety and wellbeing of residents (which are of particular significance during the COVID-19 pandemic). Providers must also comply with relevant public health orders or directions, as issued by the Commonwealth or state and territory agencies.

The NDIS Quality and Safeguards Commission (NDIS Commission) regulates all NDIS supports and services. Any provider delivering supports to NDIS participants (NDIS providers), and their employees, must comply with the NDIS Code of Conduct. Providers that are registered with the NDIS Commission (registered NDIS providers) are required to

operate in accordance with the *National Disability Insurance Scheme Act 2013* (Cth) (*NDIS Act*) and the rules created under that instrument. Registered providers must also meet the Conditions of Registration (including meeting relevant NDIS Practice Standards).

2. Roles and Responsibilities

2.1. Disability Providers

Providers are required to provide quality care and ensure the safety and well-being of residents in their care. Providers are required to follow state and territory government directions and advice from the public health unit (PHU). The provider also has responsibility for:

- adhering to applicable quality standards, complying with public health orders
- resident care, staff work health and safety (WHS), and infection control within their DRS

Providers must do the following for each DRS they operate:

- identify the critical disability support needs of residents that must be met and continue to be met in the event of a COVID-19 outbreak
- implement measures to prevent and prepare for an outbreak and manage outbreaks in accordance with this guideline and applicable state/territory guidance
- detect and notify outbreaks to state/territory health departments or PHUs
- follow jurisdictional advice on infection prevention and control measures and appropriate use of personal protective equipment (PPE)
- manage the outbreak in consultation with the responding PHU and in accordance with their outbreak management plan
- notify residents and families of how to access independent free and confidential disability advocacy supports

NDIS providers must also:

- if registered, notify the NDIS Commission of any change or events impacting their service(s) as a result of COVID-19
- meet their obligations under the NDIS Code of Conduct, the NDIS Practice Standards, and their conditions of registration to manage risks and provide safe, quality supports and services to NDIS participants

PHUs, state and territory health departments, and (in the case of NDIS providers) the NDIA and the NDIS Commission will support providers in their response to outbreaks.

2.2. State and Territory Health Departments

The public health section within state and territory health departments and/or the local PHU are responsible for preventing and minimising public health risks to the community, and for leading the public health response for a COVID-19 case or outbreak. They will

support DRS to detect, characterise, respond to, and manage COVID-19 outbreaks. This includes:

- declaring the outbreak and issuing directions about the infection control measures for cases and outbreaks, in line with jurisdictional requirements
- providing advice about diagnostic testing and repeat testing (where needed)
- providing guidance on outbreak management and infection prevention and control
- monitoring outbreak outcomes (case numbers, hospitalisations and deaths)
- informing relevant stakeholders and the broader community of outbreaks
- in some cases, facilitating access to PPE (e.g. where a provider cannot access PPE through private suppliers or the National Medical Stockpile (NMS))

2.3. NDIS Quality and Safeguards Commission

The NDIS Quality and Safeguards Commission (NDIS Commission) is the national regulator of providers of NDIS-funded supports and services. The role of the NDIS Commission is to:

- regulate the delivery of all NDIS supports and services, including the registration of NDIS providers
- respond to concerns, complaints, and reportable incidents (including abuse and neglect) relating to NDIS participants
- provide information to providers and workers to assist them in understanding their obligations to comply with the NDIS Code of Conduct, NDIS Practice Standards, as well as their obligations to maintain the delivery of supports
- monitor the use of restrictive practices by NDIS registered providers
- provide guidance to registered providers to support them in meeting their obligations to NDIS participants throughout the COVID-19 pandemic

2.4. National Disability Insurance Agency (NDIA)

The NDIA is an independent statutory agency. Its role is to implement the NDIS. The NDIA supports NDIS participants and registered providers during an outbreak through:

- assisting the Australian Government Department of Health to distribute PPE to registered providers and self-managing participants from the National Medical Stockpile (NMS), when PPE cannot be accessed through the private market
- working with providers to ensure continuity of supports, and supporting providers to source a surge workforce in the event of staff shortages
- conducting proactive outreach to high-risk NDIS participants to ensure their welfare during the COVID-19 pandemic

2.5. Australian Government Department of Health (herein referred to as the Commonwealth)

The Commonwealth is responsible for facilitating access to the NMS for supplies of PPE when commercial supplies are exhausted.

The Commonwealth is also responsible for the coordination of the Australian Government response outlined in the Management and Operational Plan for People with Disability, part of the Australian Health Sector Emergency Response Plan for the Novel Coronavirus (COVID-19). It also publishes national guidance on COVID-19 for providers of disability services, people with disability, their families, carers and supporters.

3. Planning

Parts 4 and 5 of the Supplement outline measures that providers should implement to prevent, prepare for, and manage outbreaks in DRS. Providers should ensure that these measures are encapsulated into two plans (or one overarching plan):

- an **outbreak prevention and preparedness plan** - encapsulating the measures outlined in Part 4
- an **outbreak management plan** - encapsulating the actions outlined in Part 5

Each plan should specify:

- relevant measures needing implementation (and those already implemented)
- the role (and current holder of the role) responsible for the implementation of each measure
- considerations specific to the support needs of the DRS
- how the plan will be reviewed and amended, including measures to ensure the plan remains up to date with local state and territory public health guidance

4. Outbreak Prevention and Preparedness Measures

Outbreak prevention and preparedness measures should be considered 'business as usual' measures during the pandemic. This approach will reduce the likelihood of an outbreak and ensure DRS are adequately prepared should one occur.

4.1. Outbreak Prevention Measures

4.1.1 Ensure staff are adequately educated

All DRS staff must be able to identify the signs and symptoms of COVID-19, understand how the infection spreads and be aware of their role in preventing the introduction of COVID-19 in DRS. Staff must complete up-to-date training in any infection prevention and control measures that they may have to implement.

Topics for outbreak prevention education include:

- how to recognise symptoms of COVID-19
- hand hygiene, sneeze and cough etiquette, distancing awareness in all settings
- infection prevention and control (IPC) principles including Standard Precautions (see Box 1 below) and transmission-based precautions (see Box 2 below)

- the use of PPE, including hands-on competency based training in donning (putting on) and doffing (taking off PPE)
- what to do if staff are experiencing symptoms of COVID-19 including:
    - do not attend work
    - get tested
    - isolate
    - report symptoms to your place(s) of work
- other circumstances in which staff should not attend work (i.e. when in quarantine due to contact with a known case or recent travel from a COVID-19 hotspot, as declared by state and territory health departments)
- state and territory advice on local COVID-19 hotspots and/or cross-border arrangements

All DRS staff should complete the free basic infection control training module available at https://covid-19training.gov.au/login, and undergo regular refresher training on infection prevention and control measures. Arrange in-reach face-to-face education on infection prevention and control and PPE use where possible (some state and territory health departments provide these services). Staff should also be trained to observe each other to ensure safe and effective use of PPE.

4.1.2. Communicate with residents and visitors

DRS should provide information to residents, their families, supporters and any person responsible/guardian of a resident, regarding their role in preventing COVID-19:

- Raise awareness of symptoms, hand hygiene, cough and sneeze etiquette, and physical distancing.
- Visitors (and staff) must monitor themselves for symptoms of COVID-19. They must know the importance of not visiting if they are unwell, are a close contact of a known case, or have recently travelled from a COVID-19 hotspot. A sample letter outlining the steps families and visitors can take to reduce the risk of bringing COVID-19 into the DRS is provided at **Appendix 1.**
- Use signage and other forms of communication (e.g. factsheets, Easy Read material) to convey key messages. This includes actions the DRS is taking and explaining what everyone can do to protect themselves and residents. Signage should indicate the current infection prevention and control requirements for visitors, including instructing anyone who is unwell to not enter.

Some residents will benefit from the use of Easy Read documents and/or story-based learning. However, not all will be capable of learning and/or implementing actions aimed at infection control and this will need to be reflected in provider planning. Easy Read resources on COVID-19 can be accessed online through the Commonwealth's Coronavirus (COVID-19) Easy Read collection. Additional resources are available on the Commonwealth's Coronavirus (COVID-19) advice for people with disability webpage.

4.1.3. Provide hygiene resources

Provide hand hygiene stations (either hand washing sinks with soap or TGA-approved hand sanitiser[1]), tissues and lined disposal bins for residents, visitors, and staff to use. These should be located, at a minimum, at the entrance of the DRS, in bathrooms, in visitor areas, and in each resident's room. Providers need to institute safe and regular emptying of bins and disposal of the contents.

4.1.3. Screen individuals for symptoms prior to entering DRS

Providers should have a regular program for screening staff and visitors.[2] Entry arrangements to DRS should include:

- compliance with all relevant visitor restrictions and legal requirements relating to staff and visitors that apply in their state/territory (for example, influenza immunisation)
- having a staff monitored single point of entry
- screening every person entering the DRS by asking a standard set of risk screening questions

The following questions could be given to each staff member or visitor in a printed form on arrival, in an online questionnaire or app, or otherwise displayed for entrants to see. Questions might include:

- Over the past 14-days have you been unwell or been aware of any of the following symptoms: fever, night sweats or chills, cough, runny nose, sore or scratchy throat, shortness of breath, loss of sense of smell or taste?
- Have you been overseas or visited a COVID-19 hotspot in the last 14-days?
- Have you been in contact with a confirmed or suspected case of COVID-19 in the last 14-days?
- Are you in close contact with someone who is currently unwell with symptoms of COVID-19, or someone deemed a close contact of a person with COVID-19?

If the answer to any of the screening questions is 'yes', then the staff member or visitor must not enter the DRS. Keep a record of all admission decisions and reasoning, and include staff and visitor details.

Staff (including casual, domestic, hospitality and volunteer workers) who have COVID-19 symptoms must:

- self-isolate
- report their symptoms to the DRS
- get tested for COVID-19
- not come to work until they test negative for COVID-19 and their symptoms resolve

[1] https://www.tga.gov.au/hand-sanitisers-information-manufacturers-suppliers-and-advertisers
[2] States and territories may have specific advice on screening staff and visitors. This advice should be implemented, if available.

Support (e.g. through flexible leave policies) all staff (including casual staff) to exclude themselves from all workplaces and to seek testing when they have COVID-19 symptoms. Any staff who test positive for COVID-19 should follow all advice provided by the local PHU on duration of isolation and any repeat COVID-19 testing required.

4.1.4. Implement standard precautions

Box 1. Standard Precautions

Standard precautions are IPC practices used routinely in healthcare. They should be used in areas with significant community transmission of COVID-19 (and in DRS with a suspected or proven COVID-19 outbreak) and **apply to all staff, residents and visitors.**
Key elements are:

- **Hand hygiene** before and after each episode of resident contact and after contact with potentially contaminated surfaces or objects (even when hands appear clean).
    - Gloves are not a substitute for hand hygiene. Staff should perform hand hygiene before putting gloves on and after taking them off.
- **Use of PPE** if exposure to body fluids or heavily contaminated surfaces is anticipated (gown, surgical mask, protective eyewear, and gloves).
- **Cough etiquette and respiratory hygiene.**
    - Cough into a tissue (and discard the tissue immediately) or into the bend of the elbow; perform hand hygiene.
- **Regular cleaning of the environment and equipment**.
- **Safe handling of linen and waste**
- Safe food handling and cleaning of used food utensils
- **Provision of alcohol-based hand sanitiser** at the entrance to the DRS and other strategic locations.

Note: DRS should ensure all staff are trained in the correct use of PPE, appropriate to their role. Incorrect removal of PPE increases the risk of personal contamination and spread of infection.

Adapted from *COVID-19 guidelines for IPC in RCF (Infection Control Expert Group)*: Standard Precautions

4.1.5. Apply local restrictions

DRS must comply with all Commonwealth, and state or territory directions, including

- restrictions on visitation
- restrictions on support workers working at multiple worksites
- use of items of PPE or other hygiene practices as an infection prevention measure

In areas with community transmission of COVID-19, DRS should implement infection control practices recommended at a state or local level in addition to Standard Precautions. Support workers working in these areas should use the appropriate level of PPE (including, where appropriate, surgical masks and eye protection) when providing personal support within 1.5 meters of others. Further information is available at: ICEG Guidance on the use of PPE by health and residential care workers in areas with significant community transmission of COVID-19.

Providers must adhere to state and territory requirements on the use of PPE by disability workers. These requirements may vary between jurisdictions.

4.1.6. Establish strategies to maintain resident social connection in the event of restrictive public health orders or guidance

Restrictions on visitation of DRS are likely to have detrimental impacts on resident wellbeing. Changes to visitation, staff, and usual routines can also have a major impact on people with intellectual and developmental disability, leading to expressions of distress including through changes in behaviour.

Deterioration in the mental health of residents can impact on behaviour and the ability of residents to safely protect themselves and others. Accordingly, providers should establish strategies (such as the use of video calls) to enable residents to remain as connected as possible to friends, family, supporters, medical and allied health professionals. These strategies should be easily introduced if there is an outbreak or public health orders/advice result in visitation being limited.

Where behaviours of concern arise or are expected, behaviour support plans should be revised. Talk with the person's GP, psychiatrist or behavioural support specialist about developing alternate strategies to minimise the potential behaviours of concern if resident movement is restricted.

NDIS-registered providers should review the NDIS Commission resource *Coronavirus (COVID-19): Behaviour support and restrictive practices* for guidance on the NDIS Commission requirements around the development of behaviour support plans and the use of restrictive practices.

4.2. Outbreak Preparedness and Early Detection Measures

Providers must ensure that DRS are prepared for outbreaks of COVID-19 including for the occurrence of their first case of COVID-19, by implementing the actions outlined below. Providers should also review the recommendations from the Infection Control Expert Group (ICEG), a subcommittee of the Australian Health Protection Principal Committee: *Coronavirus (COVID-19) guidelines for infection prevention and control in residential care facilities*.

NDIS registered providers should also consider guidance on outbreak prevention and management issued by the NDIS Commission.

4.2.1. Ensure staff are adequately trained in transmission-based precautions and their role in outbreak preparedness and management

In addition to the staff education topics identified in 4.1.1, staff must be trained in:

- the use of PPE and transmission-based precautions when providing care to suspected or confirmed COVID-19 case, including additional PPE requirements when caring for residents with challenging behaviours

- identifying, handling, and disposal of clinical waste[3]
- outbreak management actions (outlined in this Supplement and state and territory advice) and the outbreak management plan of the DRS

New staff must complete practical face-to-face training in the proper use of PPE and all existing staff should complete regular refresher training. Staff must be particularly careful to remove PPE in a way that prevents contamination of their clothing, hands, and the environment. Staff should:

- immediately discard PPE into appropriate waste bins
- perform effective hand hygiene when donning and doffing of PPE

Some state and territory health departments provide online training in PPE use, and some PHUs provide in-house training and review of transmission-based precautions and PPE use.

4.2.2. Review capacity to implement transmission-based precautions and consider how isolation measures will be implemented

Transmission-based precautions (Box 2 below) are infection prevention and control practices used ***in addition*** to standard precautions, to reduce transmission due to the specific route of transmission of a pathogen. Respiratory infections, including COVID-19, are most commonly spread by contact and droplets. Airborne spread may occur during aerosol generating procedures (AGPs).

Implement transmission-based precautions for:

- confirmed cases
- residents who are unwell with COVID-19 symptoms
- residents who are well but are in quarantine due to contact with a confirmed case

Accordingly, providers must ensure that DRS have the capacity to implement these measures.

[3] Clinical waste may include waste from patients known or suspected of having a communicable disease including COVID-19 (such as PPE, bandages, wound dressings). Clinical waste should be disposed of in clinical waste streams. Non-clinical should be disposed of into general waste streams. This includes food waste, disposable items such as cups, and PPE that has not come into contact with a suspected or confirmed case of COVID-19. Definitions of clinical waste vary across jurisdictions. Check your jurisdictional guidance for further information on clinical and non-clinical waste.

Box 2. Transmission-based Precautions

Contact and droplet precautions

Transmission based precautions apply to:

- Health care workers and DRS staff during the clinical consultation and physical examination of residents with suspected or confirmed COVID-19, or who are in quarantine.
- All staff when in contact with ill residents.

Key elements are:

- **Standard precautions** (see Box 1 Standard Precautions).
- **Use of PPE** including gown, surgical mask, protective eyewear, and gloves **when in contact with an ill resident.**
  - Protective eyewear can be in the form of safety glasses, eye shield, face shield, or goggles.
  - Prescription glasses are not considered protective eyewear.
- **Isolation of affected residents** in a single room, if possible. If a single room is unavailable see below: **Box 3. Isolation**.
- **Enhanced cleaning and disinfection** of the ill resident's environment.
- **Limit the number** of staff in contact with the ill resident.
- **Nebulisers** have been associated with a risk of transmission of respiratory viruses and their use **should be avoided**. A spacer and puffer should be used instead.

Note: When caring for an asymptomatic resident in quarantine, follow contact and droplet precautions (PPE includes a gown, surgical mask, protective eyewear, and gloves).

Airborne precautions

Particulate filter respirators (PFRs), such as P2 or N95 respirators, instead of surgical masks, are recommended, **in addition to all other precautions outlined above,** when performing certain high-risk (aerosol generating) procedures on patients with COVID-19. However, AGPs are likely to be performed infrequently in a DRS.

In addition, the use of a **particulate filter respirators (PFR)** such as P2 or N95 respirator, may be considered when one or both of the following apply:

1. **For the clinical care of residents with suspected or confirmed COVID-19, who have cognitive impairment, are unable to cooperate, or exhibit challenging behaviours**.[4]
2. **Where there are high numbers of suspected or confirmed COVID-19 patients/residents AND a risk of challenging behaviours and/or unplanned aerosol-generating procedures** (e.g. including intermittent use of high flow oxygen).

In these situations, use of a PFR, for up to four hours, if tolerated, will avoid the need for frequent changes of face covering.

Note: PFRs should only be used by staff who have been trained in their use "and have been fit-tested". They should be fit checked with each use to ensure an adequate face seal. Unless there are adequate numbers of trained staff to care for residents in these circumstances, consideration should be given to transferring infected residents who are distressed and exhibiting challenging behaviours to hospital, if possible.

Adapted from COVID-19 guidelines for IPC in RCF (Infection Control Expert Group): Transmission-based precautions

[4] There is anecdotal evidence of a link between health and care worker infection and **challenging behaviour,** such as shouting, by residents who are agitated or find instructions hard to follow, especially during the first week of infection, when viral load may be high. However, there are many factors that may contribute to this and there is no direct evidence that the use of a PFR will prevent health or care worker infection.

In some circumstances, cohorting (grouping) arrangements may be put in place to help DRS manage an outbreak. Further information on cohorting in larger residences is available in the RCF guidelines.

Isolating or cohorting residents for more than a short period may be extremely difficult in some DRS, due to the size of the residence and the use of shared bedrooms and bathrooms. Further, complex behaviours may be encountered among residents with some disabilities (for example, intellectual or psychosocial disability) reacting to isolation, cohorting, and changes in the support they receive. For these reasons, isolating and cohorting residents on-site may be unsafe. Accordingly, the Outbreak Management Team (OMT) may determine that a resident or multiple residents should be relocated to alternative accommodation.

Providers should review whether it is feasible and safe to isolate residents on-site as part of their preparedness planning, and identify alternative accommodation and care arrangements if needed, in consultation with families and carers. This may include short-term accommodation and assistance facilities, accessible holiday accommodation or other privately procured arrangements, or family home. The flowchart in **Appendix 3** can assist providers assess whether isolation can safely occur on-site or in alternative accommodation.

4.2.3. Establish and maintain a record of staff and visitor attendance

Maintain digital records of all staff and visitors who attend the DRS. Also keep records of any staff who are working in other congregate support or care settings at the same time as they are working in the DRS. These records should be accessible at short notice in the event of an outbreak. This register should include:

- full name, address, and contact details (including mobile phone number)
- time and date of visit/work hours
- name of person they are visiting in the DRS
- name of other facility (DRS of congregate care setting) they have worked in/visited

4.2.4. Ensure adequate supply of PPE and other materials for during an outbreak

DRS should ensure that they hold stock levels of all consumable materials required during an outbreak, and should have an effective process in place to obtain additional stock from commercial suppliers as needed. Supplies include:

- personal protective equipment (gloves, gowns, masks, eyewear)
- hand hygiene products (at least 60% alcohol-based hand rub, liquid soap, paper hand towel)
- cleaning supplies (detergent and disinfectant products)[5]
- clinical waste bags

The amount of PPE required will be different for each DRS. As a guide, for a DRS with 5 residents providers should determine:

[5] Refer to the TGA's *Disinfectants for use against COVID-19 in the ARTG for legal supply in Australia* and the Department of Health advice on cleaning.

- the number of times staff members (including cleaners) access a resident's room (e.g. 20 times per day)
- add in the additional number of times this access needs to be 2 carers (e.g. +3 times per day)
- multiply this number by the number of residents in the facility (e.g. multiply by 5)

This facility would need to have on site 115 ((20+3) multiplied by 5) sets of PPE (mask, gloves, gown) for one day; 1610 sets for 14 days. To effectively monitor stock levels, DRS should regularly count stock and review usage.

NDIS providers who can no longer access PPE supplies through the private market can contact the National Medical Stockpile by emailing NDISCOVIDPPE@health.gov.au. More information about accessing PPE for NDIS providers is available at: *Coronavirus (COVID-19) - Information for support workers and access to Personal Protective Equipment (PPE)*.

Non-NDIS providers who can no longer access PPE through usual means should contact their state or territory health authority or PHU.

4.2.5. Identify sources of replacement staff

Providers should identify contingency measures for replacing staff who are unable to work due to acute respiratory illness symptoms, exposure to a confirmed case, or contracting COVID-19. During an outbreak, additional staff will also be required. Providers should plan for how they will manage this, which may include exploring options such as:

- establishing a rapid response group of staff who are willing to be redeployed quickly to take over where staff from a facility need to isolate
- reorganising staff rosters between different DRS locations managed by the same provider
- exploring opportunities to access staff from other disability service providers or residential aged care facilities (RACFs)
- hiring agency staff

Workforce planning should consider the need to minimise the movement of staff across multiple areas. During an outbreak, staff should not work at other DRS or residential care facilities.

4.2.6. Implement early detection measures - monitor staff and residents and test for COVID-19

DRS should implement systems to monitor staff and residents for COVID-19 with a high-level of vigilance and have a low threshold for investigation, as residents may not be able or reliable in articulating symptoms, or may have atypical presentation. Effective surveillance will facilitate early recognition and management of cases.

Identification of a resident or staff member with COVID-19 symptoms should be followed by a prompt phone call to a clinician and the implementation of transmission-based precautions. The treating clinician may consider testing for COVID-19 and other respiratory infections in residents with any new respiratory symptoms and/or atypical signs and symptoms of COVID-19.

4.2.7. *Develop a Communications Plan*

Develop a list of contact details including the local PHU, attending general practitioners, the local health department and primary health network (PHN).

During an outbreak, residents, families and staff are likely to experience high levels of anxiety and uncertainty about how they will be impacted and how risks will be managed. Prepare a communication plan that includes all those concerned.

DRS should have a communication plan in place to support the provision of clear, consistent, and timely information to all groups. The communications plan should include the following elements:

- dedicated staff to manage communications
- identified communication channels such as email, phone numbers, webinars, website and social media
- pre-prepared signs that comply with current public health advice
- Plain English, Easy Read and translated resources, email templates and talking points focused on initial announcement of the outbreak and what residents, families and staff should expect during the outbreak period
- protocols for managing media enquiries
- a strategy for providing information to residents, families, resident's legal guardian (if applicable) and staff during the outbreak period including:
    - messaging for staff on how infection risks are managed and support for staff who are identified as infected or as close contacts
    - how families will be updated on the status and welfare of individual residents
    - options for connecting residents with families during extended periods of isolation, such as window visits, video calls and phone calls

The *Disability Advocacy Network of Australia* has resources available to assist communications with residents and families.

4.2.8. *Develop an Outbreak Management Plan*

Preparing an outbreak management plan will help staff identify, respond to, and manage a potential COVID-19 outbreak. Prompt implementation of an outbreak management plan will help protect the health of staff and residents, and reduce the severity and duration of outbreaks should they occur.

Include the outbreak management actions guideline outlined in Part 5 in the DRS outbreak management plan.

5. Outbreak Management Actions

Action 1: Isolate a suspected or confirmed case and implement transmission-based precautions

Key tasks:

- immediately isolate residents who display COVID-19 symptoms or who have tested positive for COVID-19 and minimise interaction between other residents;
- provide PPE supplies to staff:
    - make PPE, including face masks, eye protection, gowns and gloves available immediately outside of the resident's room
    - place a lined disposal receptacle near the exit inside the resident's room, to make it easy for staff to discard PPE before leaving the room
    - place alcohol-based hand rub near the exit of the resident's room
    - post signs on the door or wall outside the resident's room advising entrants to use contact and droplet precautions (see Box 2 above)
- avoid aerosol generating procedures (such as nebulisers) where clinically safe to do so
- review all residents and staff for symptoms and document the results of this review
- arrange testing for anyone with symptoms compatible with COVID-19

It may be difficult for a resident to undertake the required testing in some circumstances, including when there is a lack of understanding of the testing process, communication barriers, and/or behavioural resistance.

All options to facilitate testing of residents should be explored e.g. leaving a swab for familiar staff members to use at a later time, supervised self-testing, or alternative modes of testing such as saliva testing if verified in the DRS's jurisdiction. If no test can be undertaken due to lack of consent, resistance, or distress, treat the resident as though they had tested positive. Provide the resident with care in isolation until such time as a test can be undertaken or they have completed an appropriate period of isolation.

Box 3. Isolation

Confirmed case: Place any resident who has tested positive to COVID-19 and does not require hospitalisation in isolation in a single room with their own bathroom, if possible, or cohort them with other infected residents, until released under public health orders. In some states and territories, confirmed cases may be moved to hospitals in the first instance.

Symptomatic/suspected case: Test any resident with symptoms of COVID-19 and place them in isolation in a single room in the DRS with their own bathroom, if possible, while awaiting test results.

Close contact: Any resident determined a close contact of a confirmed COVID-19 case by the relevant PHU should be quarantined in a single room with their own bathroom, if possible, for a period of 14-days following last contact with the confirmed case. Monitor close contacts for symptoms during this period. They should be tested if they develop symptoms. PHU's will usually also test the contact prior to release from quarantine.

Staff member: If a diagnosis of COVID-19 is confirmed in a staff member, the staff member must isolate at their place of residence (or other suitable accommodation) until they meet the criteria for release as directed by the PHU (see *CDNA COVID-19 National Guidelines for Public Health Units)*. The DRS must still make appropriate notification to the relevant authorities.

Residents in isolation and quarantine should not leave the place of isolation for any reason unless it is for urgent medical attention. Use telehealth where possible, or the provider may facilitate access to the residence by a health professional. If a resident must leave the home for urgent medical attention, make transport arrangements in consultation with ambulance services. Staff escorting residents to appointments must wear PPE.

Place a droplet and contact precautions sign outside the room of any resident who is symptomatic or has tested positive to alert staff and visitors to the requirement for transmission-based precautions. Signs are available at the Australian Commission for Safety and Quality in Health Care website *(www.safetyandquality.gov.au/our-work/healthcare-associated-infection/infection-control-signage)* or in the appendices of the RCF guideline.

Confirmed cases or close contacts may need to be isolated/quarantined externally if it is not safe to do so on-site (see Section 4.2.2). The flowchart in **Appendix 3** can assist providers in assessing whether isolation can safely occur on-site or in alternative accommodation.

Action 2: Notify positive test

2a: Immediately notify state/territory health department

The DRS must notify the relevant state or territory health department as soon as it becomes aware of a positive case amongst a staff member, resident, or regular visitor if the responding PHU has not yet contacted them. A sample reporting template is provided at **Appendix 2**.

Up to date local state and territory health department contact details are available on the Commonwealth Department of Health website.

2b: Notify the NDIS Commission

NDIS registered service providers must notify the NDIS Commission by completing and submitting the COVID-19 Notification of event form.

Action 3: Confirm the outbreak

For the purposes of investigation, a COVID-19 outbreak is defined as **a single confirmed case of COVID-19 in a resident, staff member, or frequent visitor to a DRS.**

This definition does not include a single case in an infrequent visitor of the DRS. To determine whether someone is a frequent or infrequent visitor, consider the frequency of visits, time spent in the setting, and number of contacts within the setting. Discuss with the PHU as soon as possible.

The responding PHU will declare an outbreak and assist the DRS to manage the outbreak as outlined in the CDNA COVID-19 National Guidelines for Public Health Units.

Action 4: Establish an outbreak management team (OMT) with the responding PHU

The provider is responsible for quality of care, safety, and well-being of residents and should take a strong leadership role with support from PHU staff. Establish an OMT with the PHU to monitor the outbreak and direct and oversee the outbreak response. The OMT should meet regularly (usually daily - in person or by video or teleconference) at the height of the outbreak to monitor the outbreak, identify problems, initiate changes to response measures, and to discuss outbreak management roles and responsibilities.

The OMT should be co-led by the provider and the local PHU, and should include at minimum:

- a senior officer of the provider (e.g. CEO, senior executive, DRS manager)
- a lead public health officer appointed by the PHU
- an officer with expertise in Infection Prevention and Control (IPC)
- administrative and clinical support personnel, as required

Where possible, include a primary care professional with expertise in disability in the OMT.

Additional positions may be included as part of the OMT, as determined by the relevant state or territory public health authority. Providers should refer to state or territory advice when establishing the OMT. Further detail of OMT roles is available in the RCF Guidelines.

Action 5: Implement the communications plan

The provider should implement an appropriate communications plan (see Section 4.2.7 for content of communications plan).

Action 6: Restrict visitors and communal activities

During a COVID-19 outbreak, visitor access into and within the DRS will be limited. DRS should implement the following:

- suspend all group activities, particularly those that involve visitors
- suspend communal dining
- postpone visits from non-essential external providers
- regular visitors and families of residents of the COVID-19 outbreak should only visit for essential and compassionate reasons. Young children should not visit as they are generally unable to comply with standard precautions and PPE requirements. Record the name and phone number of visitors on a register and who they visit. Screen any visitors for risks and illness
- instruct visitors to:
- wear PPE as directed by staff
- enter and leave the DRS directly without spending time in communal areas
- perform good hand hygiene before entering and after leaving the DRS and the resident's room.

Action 7: Manage staff

Once resident isolation, cohorting, or alternative accommodation measures are in place, allocate specific staff to the care of residents in isolation. Staff caring for residents with suspected or confirmed COVID-19 should not care for those in quarantine. Doing this will further reduce the risk of transmission. Keep a register of staff members supporting patients with COVID-19 and make it available to PHU staff, if requested.

Ensure that staff members:

- minimize movement between their allocated room/section and other areas of the DRS and, as far as possible, provide support only to their allocated residents, as agreed with the PHU
- wear appropriate PPE depending on the residents they are providing care for
- continue to monitor themselves for signs and symptoms of COVID-19 and do not attend work if unwell (even if symptoms are very mild)
- do not work in other congregate care settings (including DRS, residential aged care facilities, hospitals, child care centres etc.) until the outbreak is declared over

Continue to check all staff for symptoms at the beginning of every shift. Record staff screening details in a register. All staff working on site should participate in any whole-site testing. The PHU will determine and provide advice on testing requirements during an outbreak.

Action 8: Monitor progress of the outbreak

Increased and active observation of all residents for the signs and symptoms of COVID-19 is essential in outbreak management. Active observation will enable the daily identification of any emerging illness, ongoing transmission and/or gaps in infection control measures that should be addressed.

Providers should ensure that ongoing actions for individuals in the defined setting are implemented. These continuing actions include:

- isolating individuals who test positive
- quarantining close contacts
- testing, including repeat testing, as advised by the PHU

Update key information about the outbreak daily for the OMT meeting. This will include a line list, which includes all the residents and their current status (e.g. well/unwell, quarantine/isolation/neither) as well as information about supplies, staffing, communication, and any other concerns. If a death or hospitalisation occurs during the outbreak, the PHU should be notified by their preferred means of contact.

The provider should keep residents, families, any person responsible/guardian of a resident, and staff fully informed of the progress of the outbreak.

Action 9: Declare the outbreak over

The time from the onset of symptoms of the last case until the outbreak is declared over can vary. Repeat testing of the quarantined cohort allows for close observation of the outbreak. It will also help determine when it can be declared over. In most circumstances, a COVID-19 outbreak can be declared over 28-days following the date of isolation of the last case. **The PHU will declare the outbreak over and inform the OMT.**

When the outbreak is over, there are some ongoing actions for the provider:

- reviewing the actions taken during the outbreak and improving planning and preparedness activities
- maintaining general infection control measures
- monitoring the status of ill residents and communicating with the PHU and relevant primary care providers if their status changes
- notifying the PHU of any late COVID-19-related deaths that occur
- alerting the PHU to any new cases, signalling either re-introduction of infection or previously undetected ongoing transmission
- advising relevant state/territory/national agencies of the outbreak, if applicable

6. Considerations for Public Health Units

6.1. Staffing and Organisational Considerations

6.1.1. Presence of health professionals in DRS

Do not assume that DRS have health professionals working onsite, or that they have access to health professionals to assist in the event of an outbreak; most DRS will not have access to such personnel.[6] The capacity of providers to identify and manage COVID-19 infection should be understood within this context.

A responding PHU may need to escalate concerns around the capacity of a facility to manage an outbreak, including identifying where there is no suitably trained health professional or IPC Officer who can assist in responding to an outbreak and supervise disability support workers' provision of support to suspected or confirmed cases (should isolation occur onsite). The PHU or local health district may need to arrange for an appropriately trained individual to fulfil this role.

6.1.2. Replacement workforce

DRS, particularly those administered by smaller providers, may have difficulty sourcing replacement staff in the event of an outbreak. External support may be required to meet staffing needs where difficulties are encountered. Registered providers should make immediate contact with the NDIA and NDIS Commission to discuss any workforce issues and access NDIS-related resources available for providers.

6.1.3. Organisational considerations

In some cases:

- smaller providers will have limited organisational capacity, particularly when compared to the larger organisations that often run DRS. This is likely to affect their capacity to manage an outbreak
- there will be more than one provider involved in the provision of supports to people with disability living in a DRS. Where this occurs there will need to be close cooperation between providers in the coordination of the outbreak response

Both scenarios may require the responding PHU to assist in sourcing infection prevention and control practitioners, and take a leading role in ensuring the OMT is able to effectively manage the outbreak.

6.2. Cohorting, Isolation and Relocation of residents

Most DRS will not have large spaces, such as wings or units that can be used for the purposes of isolation or cohorting. Many utilise shared bedrooms and/or shared bathrooms, which may render onsite isolation and cohorting unsafe (see Section 4.2.2). Further, many

[6] Some larger providers may employ health or allied health professionals who provide advice and may visit DRS operated by the provider.

DRS do not have appropriate spaces for dealing with clinical waste. Accordingly, isolation will need to occur externally in many instances.

In situations where one or more residents display complex or challenging behaviours, re-location of those residents to an external isolation environment may be less disruptive and safer for co-residents and disability support staff.

A suitable external isolation environment will be a site where appropriate IPC measures can be implemented and the support needs of any individual undergoing isolation can be met. This may include short-term accommodation and assistance facilities, a health care facility, or other privately procured arrangements. Make decisions about re-location with a person-centred approach, based on a risk assessment of relocation on all parties affected, and in consultation with the PHU.

Appendix 1. Letter to Families – Preventing Spread of COVID-19 in Disability Residential Services (DRS)

[DRS Letterhead]

……/……/……

Dear <family member>

We would like to notify you that there is local transmission of COVID-19 in the community. COVID-19 primarily causes respiratory illness in humans, and while all types of respiratory viruses can cause sickness, COVID-19 is a particularly contagious infection that can cause severe illness and death for vulnerable people.

COVID-19 Pandemic
COVID-19 has caused outbreaks of illness in Australia and local transmission has occurred in some communities. Disability residential services (DRS) are particularly susceptible to COVID-19 outbreaks. Even when DRS actively try to prevent outbreaks occurring, many external factors may lead to residents or staff contracting COVID-19.

Families play an important role in protecting their relatives from community viruses. Practical steps you can take to prevent COVID-19 from entering DRS are outlined below.

Avoid spreading illnesses
Washing your hands well with liquid soap and water, or using alcohol-based hand rub before and after visiting and after coughing or sneezing will help reduce the spread of disease. Cover your mouth with a tissue or your elbow (not your bare hand) when coughing or sneezing and dispose of used tissues immediately and wash your hands.

Follow any restrictions the DRS has put in place
DRS will post signs at entrances and within their units to inform you if an outbreak is occurring, so look out for these warning signs when entering the DRS. It is important to follow the infection control guidelines as directed by the DRS. This may include wearing a face mask and/or other protective equipment (gloves, gowns) as instructed. Certain group activities may be postponed during an outbreak.

Stay away if you are unwell
If you have recently been unwell, been in contact with someone who is unwell or you have symptoms of respiratory illness (e.g. fever, cough, shortness of breath, sore throat, muscle and joint pain, or tiredness/exhaustion) you should get tested and please do not visit the DRS until your symptoms have resolved. If you have been in contact with a confirmed case of COVID-19 you must stay away until you are released from isolation.

Limit your visit
If there is an outbreak in the DRS you may not be able to visit until after the outbreak is declared as being over. If you are permitted to visit, we ask that you only visit the person you have come to see and keep children away if they or your resident family member is unwell. Avoid spending time in communal areas of the DRS if possible to reduce the risk of spreading infection.

Thank you for your assistance in adhering to these steps. These measures will greatly assist DRS and protect the health of your relatives in the event of a COVID-19 outbreak.

Should you require further information regarding COVID-19, please refer to the Commonwealth Department of Health website:

https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert

Yours sincerely,

[Name]
[Position]
[DRS/Organisation]

Appendix 2. Template Report to a PHU – COVID-19 Outbreak in Disability Residential Service (DRS)

Date/time: _____ Public Health Officer: _____

Contact details:

Person notifying outbreak: _____ Position: _____

Telephone number: _____ Email: _____

Case details:

Name: _____ Age: ___ Sex: ___

Current location of the case: _____

DRS details:

Name of DRS: _____

Address: _____

DRS Manager / Director: _____

Telephone number: _____ Fax number: _____

Email address: _____

Description of DRS: *e.g. group home, SRS, assisted boarding house*

Total number of residents: _____ Total number of staff: _____

Age range of residents: _____

Number of areas / rooms in DRS: _____

Attached floorplan with location of case marked: Yes / No

Residents:

Unit name	Resident Name	Long term	Short term / Respite	Complex care needs	Other e.g. Behaviours of concern

DRS Staff:

Staff type	No. of DRS staff	No. agency staff	No. casual staff	No. volunteers
Management				
Administrator				
Support Worker Agency				
Cleaner				
Nurse				
Other (specify)				

Appendix 3. Self-Isolation Flowchart