ACUTE RESPIRATORY INFECTION (ARI) GUIDELINE SUMMARY

I. ARI Definition

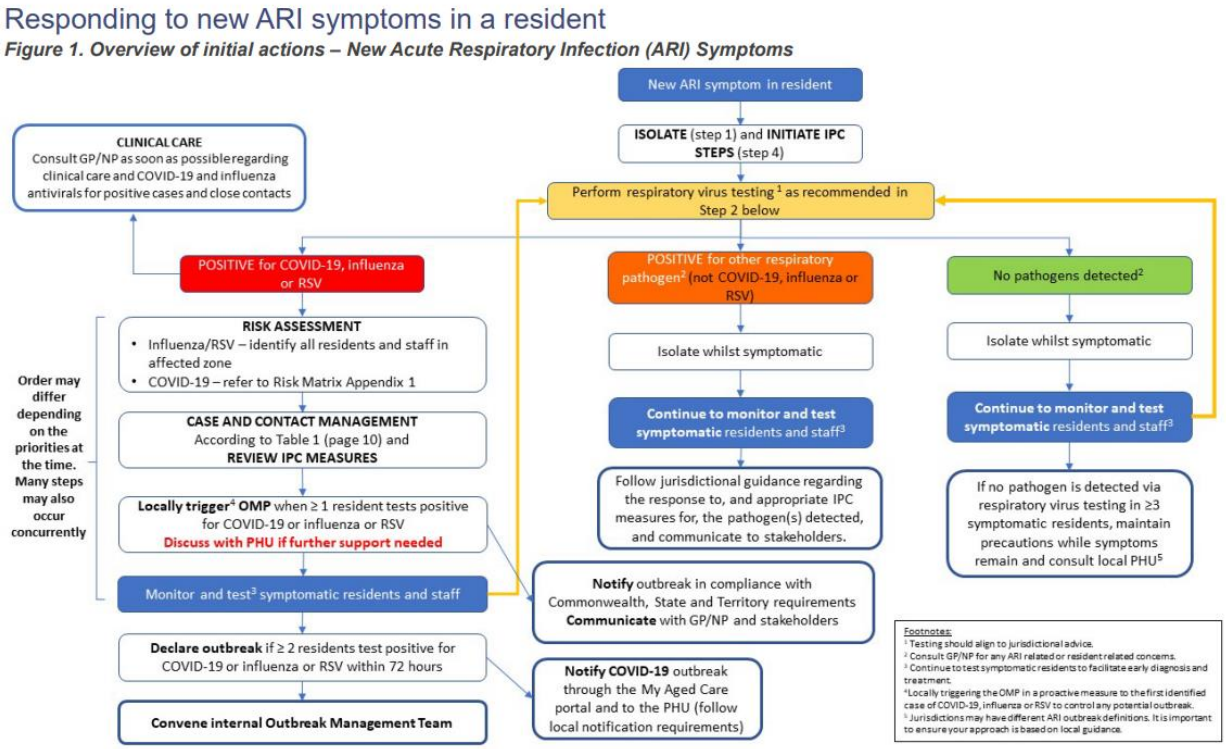
Recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion, with or without other symptoms.

Other symptoms may include:

• headache, muscle aches (myalgia), fatigue, loss of appetite, nausea or vomiting and diarrhoea. Loss of smell and taste can also occur with COVID-19

• fever (≥37.5°C) can occur, however is less common in elderly individuals

• in the elderly, other symptoms to consider are new onset or increase in confusion, change in baseline behaviour, falling, or exacerbation of underlying chronic illness (e.g., increasing shortness of breath in someone with congestive heart failure).



Source: Communicable Diseases Network Australia National Outbreak Management Guideline for Acute Respiratory Infection (including COVID-19, influenza and RSV) in Residential Aged Care Homes Version 2.0 June 2024

II. Testing

Test symptomatic residents as soon as possible to enable earlier treatment and outbreak control. Testing should align to jurisdictional advice, such as the need for confirmatory PCR testing for initial symptomatic residents.

• Work with a GP or NP to enable prompt clinical review and respiratory virus testing of residents with ARI symptoms.

• Test symptomatic residents with a COVID-19 RAT (or combination RAT, if available) and if a pathogen is not detected, a respiratory panel PCR. Ensure pathology request forms identify the name of Fairway and the requesting clinician's details for follow up and notification.

o If a false positive RAT is suspected, Fairway should consult with the resident's GP/NP for consideration of further testing.

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- Ensure all symptomatic residents remain isolated until initial testing is complete, and pathogen is known.

  o If no pathogen is detected on respiratory virus testing for three or more symptomatic residents, precautions should be maintained while residents are symptomatic, and the PHU contacted for further advice.

			COVID-19 (RAT or PCR)	Influenza (RAT or PCR)	Other respiratory pathogen (inc. RSV)
CONTACTS	Resident[4]	Contact testing	All residents in the affected zones and other contacts. See Appendix 1.	Symptomatic residents in the same zone (likely wing).	Symptomatic residents in the same zone (likely wing).
		Contact isolation	Limit movement of affected resident within the facility until test results return and risk assessment completed. See Appendix 1.	Residents who are in same zone(s) should avoid moving between different zones.	Nil.
		Post-exposure prophylaxis	Nil.	Influenza antivirals to be considered in outbreak (via treating clinician). See 'Antiviral prophylaxis considerations during an influenza outbreak' for more information.	Nil.
		Return to work	See Appendix 1.	Exclusion not needed if no symptoms. Wear a surgical mask when at work for 7 days from last exposure.	Immediately if no symptoms.
	Staff	Post-exposure prophylaxis	Nil	Consider influenza antivirals for unvaccinated staff and staff with comorbidities or pregnancy at higher risk of more serious disease (via treating clinician). See 'Antiviral prophylaxis considerations during an influenza outbreak' for more information.	Nil
	Visitors[3]	Return to RACH	Can visit after Day 7 of last contact with COVID-19 case if symptom-free.	Immediately if no symptoms. A mask should be worn for 7 days from last exposure if visiting the RACH.	Immediately if no symptoms.

Note: RACHs should ensure management is aligned with jurisdictional guidance. Jurisdictions and/or individual RACHs may have additional recommendations, including different isolation and quarantine periods. Where there is a mixed outbreak, follow the more restrictive quarantine and isolation guidance.

[1] This minimum standard aims to balance this risk with the impact of prolonged isolation on individuals and communities. A small proportion of cases may still be infectious when released from isolation.
[2] If there are critical staff shortages, staff may return to work earlier with additional precautions, in accordance with local workplace policies and guidance. RACHs may also liaise with their local PHU.
[3] Note that in an outbreak, RACHs may implement visitor restrictions. In exceptional circumstances (including visiting persons undergoing end-of-life care), it may be appropriate for persons who are cases or contacts to enter a RACH. This should occur on a case-by-case basis in discussion with the RACH, with additional mitigations in place to minimise the risk of transmission to staff and residents.
[4] Testing and isolation is not required for residents if it has been less than 4 weeks since recovery from their previous COVID-19 infection unless they become symptomatic. If symptomatic, they should isolate, even if they receive a negative result.

Source: Communicable Diseases Network Australia National Outbreak Management Guideline for Acute Respiratory Infection (including COVID-19, influenza and RSV) in Residential Aged Care Homes Version 2.0 June 2024

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Appendix 1: COVID-19 exposure and outbreak management

Table 2. Suggested actions based on COVID-19 exposure[1]

STAFF	RESIDENTS[2]
Definition Where a worker has been exposed to a COVID-19 case within or outside the RACH with: • no effective PPE (N95/P2 masks, eye protection) during aerosol generating behaviours or procedures • at least 15 minutes face to face contact where both mask and protective eyewear were not worn by exposed person and the case was without a mask, or • greater than 2 hours in the same room as a case with inadequate PPE.	**Definition** Where a resident has been exposed to a COVID-19 case: • in a shared defined area (e.g., prolonged contact during activity or shared living space) and/or • outbreak-related contact (e.g., co-located in the same ward / wing / shared area with unknown exposure).
Management • Review affected staff to assess exposure and risk. • If staff have been exposed to a COVID-19 case and are returning to work, implement the following risk mitigation strategies:[3] ○ Test (RAT initially, if negative proceed to PCR if available), followed by daily RATs (until day 7) ○ Isolate immediately if symptoms develop at any time or upon testing positive (even if asymptomatic) ○ Work in P2/N95 masks for the first 7 days following exposure ○ Avoid staff redeployment to unaffected areas to minimise risk of potential spread ○ Avoid shared spaces or meal rooms.	**Management** <u>Choose to quarantine</u> • Residents can choose to remain in room, away from others) for up to 7 days • Test (PCR if available, or RAT) day 2 and day 6. **OR** <u>Choose to not quarantine</u> • If RAT negative, enable socialisation by choice of resident with others who have similar exposure level • RAT at least every second day up to day 7. • Release from quarantine: ○ After day 7 with a day 6 negative result and asymptomatic.

[1] Jurisdictions may recommend, and RACHs may implement additional mitigations for recent cases or current contacts, particularly during periods where the risk of transmission is high. These may include testing, mask-wearing (i.e., surgical or PFR), and avoiding common areas.
[2] Testing and isolation is not required for residents if it has been less than 4 weeks since recovery from their previous COVID-19 infection unless they become symptomatic. If symptomatic, they should isolate, even if they receive a negative result.
[3] Staff should talk to their employer about their return to work and take additional precautions in accordance with local workplace policies and guidance.

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III. Isolation Period

Step 5: Case and contact management

Inform resident and/or substitute health care decision-maker / relative of positive results or exposure.

Table 1 – Case and contact management for COVID-19, influenza, and other confirmed respiratory pathogens (including RSV).

			COVID-19 (RAT or PCR)	Influenza (RAT or PCR)	Other respiratory pathogen (inc. RSV)
CASES	**Resident**	Release from isolation	• After 5 days since symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved and COVID-19 RAT is negative **OR** • After day 7 if acute symptoms resolved and no fever for 24 hours. No testing required.[1] Note: During isolation, case can cohort with COVID-19 positive residents.	• After 5 days from symptom onset, or until acute symptoms resolved, whichever is longer. **OR** • 72 hours after antivirals commenced regardless of symptoms. No testing required. Note: During isolation, case can cohort with influenza positive residents.	Once acute symptoms resolved. No testing required. Note: During isolation, case can cohort with residents with same confirmed pathogen.
		Antiviral treatment	COVID-19 antivirals (via treating clinician).	Influenza antivirals (via treating clinician).	Seek guidance from treating clinician.
	Staff	Return to work[2]	• After 5 days since symptom onset (or positive test if asymptomatic) provided that acute symptoms have resolved and COVID-19 RAT is negative **OR** • After 7 days if acute symptoms resolved for 24 hours, no testing required. If symptoms continue, return when acute symptoms resolved and no fever for 24 hrs.[1]	• 5 days from symptom onset, or until acute symptoms resolved, whichever is longer. **OR** • 72 hours after antivirals commenced. No testing required.	Once acute symptoms resolved. No testing required.
	Visitors[3]	Visitors to RACH	After day 7 if acute symptoms resolved and no fever for 24 hours. No testing required.[1]	• After 5 days from symptom onset or until symptoms resolved, whichever is longer. **OR** • 72 hours after antivirals commenced.	Exclude if symptomatic.

Resident choice regarding isolation

For aged care, consumer dignity and choice is Standard 1 in The Aged Care Quality Standards.

• Residents have the choice to quarantine during an outbreak or to mix with people with similar exposure. Unaffected residents have the right to choose their level of engagement with exposed residents and cases. Their preferences should be recorded in their care plans and regularly reviewed. Ensure residents are made aware that if they choose to not isolate during an outbreak, they may increase their risk of catching or transmitting the infection.

• Where it is practical, Fairway can manage this risk by considering:

o Enabling residents with the same ARI to engage in social activities together if they are well enough to do so and if they can be kept separated from residents who are exposed or unaffected.

o Residents exposed to the same pathogen may choose to leave their rooms to eat in shared dining rooms and participate in social activities with other residents from the exposed area.

o Exposed residents should be supported to not socialise with positive cases or residents from unaffected areas.

o Ensuring unaffected residents can leave their rooms to participate in shared activities and dining with other unaffected residents (e.g., with dedicated staff, dining room, social room).

• Where possible, ensure visits to affected and exposed residents occur in an area with good ventilation. The Aged Care Act 1997, the Charter of Aged Care Rights and the Aged Care Quality Standards include specific responsibilities that provide a legislative basis to this requirement for Fairway.

• Communicate with residents, families and visitors to inform them of the situation as soon as the Outbreak Management Plan is activated. Additionally, inform residents, families and visitors entering Fairway during an outbreak of the current situation, as well as any associated restrictions or recommendations.

Note: Fairway prefers to finish the 7 days of isolation for all residents without the need for a repeat RAT. However, if a resident persists on being released from isolation, then a negative COVID-19 RAT as per above will be required.

Source: Communicable Diseases Network Australia National Outbreak Management Guideline for Acute Respiratory Infection (including COVID-19, influenza and RSV) in Residential Aged Care Homes Version 2.0 June 2024

IV. Personal Protective Equipment (PPE's)

- According to Victorian Department of Health COVID-19 Infection Prevention and Control guidelines regarding PPE waste management
    - PPE waste can be disposed in general waste if it is not contaminated with blood or body fluids.
- According to Victorian Department of Health Personal Protective Equipment (PPE) specific recommendations for COVID-19
    - For staff looking after resident with COVID, airborne precautions (N95 and face shield) + standard precautions must be observed.
    - Gowns and gloves to be worn if contact with blood or body fluids (including respiratory secretions).
    - Some examples of when gowns and gloves should not be required are in residential corridors, when giving residents medications, and giving residents their meal trays.
    - Always perform hand hygiene between residents.

V. Crockery and Cutlery

- According to the Victorian Department of Health COVID-19 Infection Prevention and Control guidelines cutlery use
    - Disposable crockery and cutlery are not necessary. Standard precautions should always be used when handling used crockery and cutlery. Crockery and cutlery can be washed using a domestic dishwasher (on the highest temperature) or a commercial dishwasher on the 75°C setting. If a dishwasher is not available, wash with hot water and detergent, rinse and leave to dry.
    - Food trolleys that have been used in any COVID-19 clinical areas should be cleaned and disinfected before reuse.

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VI. Ventilation

- Air scrubbers are most beneficial at locations where COVID-19 virus is at its highest (eg.in resident's room).
    - If not possible to place in resident with COVID-19, consider placing an air scrubber outside the room.
- Enhance fresh air entry by opening windows (even a small gap is beneficial).
- Turn bathroom extractor fans on where possible.

Source: *VICNISS - Ventilation in Residential Care*

VII. Waste Management

Health services should have an established waste management program for the collection and removal of general waste and clinical waste that complies with EPA (Environment Protection Authority Victoria) guidance and statutory regulations.

For additional guidance, see Managing coronavirus waste from a workplace on EPA's website.

In most cases, COVID-19 waste can be disposed of as general waste. This includes used PPE generated in non-clinical care settings such as residential community care homes or general workplaces. In the context of COVID-19, PPE waste can be disposed of as general waste unless it is contaminated with blood or body fluids (this includes respiratory secretions).

Disposable components of equipment and other consumables are considered general waste unless they are contaminated with body fluids. For example, in healthcare settings, PCR and RAT swab sticks and containers are clinical waste, whereas the packaging and uncontaminated components are general waste.

Healthcare workers must refer to and always comply with their organisation's policies and procedures.

- Rapid Antigen tests are required to be disposed of in clinical waste due to contamination with body fluids.

Source: Standard and transmission-based precautions | health.vic.gov.au

VIII. Linen

Management of linen from a suspected or confirmed COVID-19 case should be in accordance with standard precautions and routine procedure.

Handle soiled laundry with minimum agitation (do not shake dirty laundry) to avoid contamination of the air, surfaces, and persons.

Linen that is heavily soiled with blood, body substances or other fluids (including water) should be contained in clear leak-proof bags.

Personal clothing that is usually laundered by the family should be placed in a plastic bag for transport.

Clothing, linen, mop heads and soft toys from health service settings should be laundered through a laundry service that is compliant with AS/NZS 4146:2000.

For residential settings, laundry should be washed at the hottest temperature the items can withstand. Use usual detergent and dry items completely.

Source: Standard and transmission-based precautions | health.vic.gov.au

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IX. Environmental Cleaning and Disinfection

• Environmental cleaning and disinfection of the affected areas should be completed by allocated staff who have the training and skill to perform thorough cleaning using:

o a physical clean using an Australian Register of Therapeutic Goods (ARTG) listed combined detergent and disinfectant product that makes specific claims for use (2- in-1 clean)

OR

o a physical clean using detergent followed by a an ARTG listed chemical disinfectant that makes specific claims for use (2-step clean).

• Further guidance for cleaning can be found in Coronavirus cleaning and disinfection for health and residential aged care homes. These cleaning principles are also applicable to RSV and influenza.

a. 2-step clean

This is when cleaning is done with detergent followed by disinfection. Use a TGA-listed hospital-grade disinfectant with activity against viruses (according to the label and product information) or a hydrogen peroxide disinfectant OR a disinfectant that contains a minimum of 1000 ppm available chlorine.

b. 2-in-1 clean and disinfection

This is when cleaning is done with a combined detergent/disinfectant product. Use a detergent and TGA-listed hospital-grade disinfectant with activity against viruses (according to the label and product information) or a hydrogen peroxide disinfectant OR a disinfectant that contains a minimum of 1000 ppm available chlorine.

X. End of Outbreak

• A decision to declare the outbreak over should be made by the Outbreak Management Team (OMT) and can be in consultation with the PHU. Generally, this is 7 days after the last case tests positive or the date of isolation of the last case in a resident, whichever is longer.

• Outbreak closure should not occur if there are pending PCR test results for contacts or symptomatic residents.

• Additional testing or measures may be recommended by the PHU in the 7 days following an outbreak being considered “over”. This is more likely where there is extensive or poorly understood transmission, where there are significant numbers of residents not up to date with vaccination, or transmission is within a memory support unit.

• Once an outbreak is declared over, Fairway should remain on high alert and:

o test appropriately anyone with new symptoms, no matter how mild;

o carefully monitor contacts for behavioural changes, lack of appetite, and lethargy; and

o ensure visitors (who may be at higher risk themselves) are aware that there has been a recent outbreak.

• Individual cases should remain in isolation for the required period even if the outbreak has been declared over for Fairway.

• Once an outbreak is over, Fairway should evaluate the response to and management of the outbreak to identify strengths and weaknesses. Consider conducting a debrief with all employees and contractors involved with the outbreak. This evaluation should lead to identifying areas for improvement and implementing appropriate actions to enhance quality control.

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