Northern Region Guidance for the Prevention, Identification and Control of COVID-19 Outbreaks in Aged Residential Care

Interim guidance as at December 2021

Version 6

This document will be updated regularly

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1. Abbreviations and Terminology

AGP	Aerosol Generating Procedures
ARC	Aged Residential Care
BiPAP	Bilevel Positive Airway Pressure
CBG	Telehealth provider contracted by the Ministry of Health's National Investigation and Tracing Centre to provide a national telehealth case investigation service
Confirmed case	A case that has laboratory evidence of COVID-19
CPAP	Continuous Positive Airway Pressure
DHB	District Health Board
EPoA	Enduring Power of Attorney
GP	General Practitioner
Whakarongorau Aotearoa	Funded by the Ministry of Health to provided free telehealth advice and information
HVAC	Heating, ventilating and air conditioning systems
IPC	Infection Prevention and Control
Isolation	Separating a person who has COVID-19 to prevent the spread of disease
NITC	National Investigation and Tracing Centre
NP	Nurse Practitioner
NRHCC	Northern Region Health Coordination Centre
OMT	Outbreak Management Team
Outbreak	One or more cases of COVID-19 in an ARC resident, health care or support worker, or visitor that has been at the ARC facility during their infectious period
PHU	Public Health Unit
PPE	Personal Protective Equipment
Probable case	A high degree of suspicion of COVID-19 ie high exposure history and clinical criteria but no laboratory confirmation (this is determined by the Public Health Unit)
Public Health Team	Public Health agencies supporting case and contact management including Public Health Units, National Investigation and Tracing Centre, CBG Health Research, managed and community isolation services and Whakarongorau Aotearoa.
Quarantine	Separating/isolating a person who may be infectious to prevent spread of disease
RAT	Rapid Antigen Test
SURV code	Surveillance code (used on COVID-19 test)

2. Introduction

People living in Aged Residential Care (ARC) are at increased risk of serious illness or death from COVID-19 due to increased age, frailty, chronic conditions and communal living arrangements. While a COVID-19 outbreak in an ARC facility will be very challenging, the ARC Provider, District Health Board (DHB) and the Public Health Unit (PHU) will work together to manage the outbreak.

The Northern Region has adopted a three stage approach to managing COVID-19 in an ARC facility:

1. **Prepare** – measures to prepare for an outbreak and to reduce the risk of an outbreak occurring
2. **Alert/Standby** – an early response to any possible case of COVID-19 affecting an ARC facility
3. **Outbreak** – response to a case of COVID-19 affecting an ARC facility.

Te Tiriti o Waitangi obligations should be met by all health providers to ensure equity and wellbeing for Māori. Māori health and health equity must be central to all COVID-19 planning and response to ensure a strong focus on delivering effective and culturally appropriate care for Māori, Pacific peoples, people with disabilities and people considered at higher risk of the effects of COVID-19.

2.1 Purpose of this document

This guidance outlines how ARC providers can prepare for, identify and respond to COVID-19. This is an iterative document that is intended to align with and not substitute guidance from the Ministry of Health. It does not replace clinical judgment, public health advice from a Medical Officer of Health or their delegate or other official advice. As the COVID-19 situation evolves, this document remains interim and is intended as guidance only. This version has been updated to reflect:

- A shift from a COVID-19 elimination strategy to 'minimisation and protection'
- A shift from Alert Levels to the COVID-19 Protection Framework (traffic light system)
- Updated ARC guidance for operation under the COVID-19 Response Framework
- Lessons from recent outbreaks of the Delta variant in the Northern Region
- The role of vaccination and vaccine mandates
- Updated roles and responsibilities for the ARC facility, DHB, PHU and other Public Health agencies
- Updated advice and links on testing, contact classification, Infection Prevention and Control (IPC), Personal Protective Equipment (PPE) and screening questions for staff and visitors.

This guide should be read alongside Ministry of Health's COVID-19 Outbreak Response Toolkit for Aged Residential Care the New Zealand Aotearoa Pandemic Response Policy for Aged Residential Care the Ministry of Health ARC guidance for operation under the COVID-19 Response Framework and Information on COVID-19 for ARC providers on the Ministry of Health website.

2.2 Scope of this document

Aged residential care in a residential facility, including the following levels of long-term care:

- Rest home care
- Secure dementia care
- Private hospital care
- Secure psychogeriatric care

The guide also applies to short-term respite care, convalescent care and disability support provided in these facilities. Independent living in a retirement village or apartment is excluded.

While the guidance focuses on ARC facilities it could be used to inform COVID-19 planning and response in other residential health care facilities e.g. disability support services, mental health respite facilities and hospice.

3. Understanding COVID-19

3.1 Recognising COVID-19

COVID-19 is a contagious viral illness, caused by infection with SARS-CoV-2. Presentation can range from no symptoms (asymptomatic) to severe illness with life-threatening complications. The Ministry of Health's COVID-19 case definition is available here. Common symptoms of COVID-19 are similar to colds or influenza. A person may have one or more of the following symptoms:

Common symptoms	**Less common symptoms**
• new or worsening cough • sneezing and runny nose • fever • temporary loss of smell or altered taste • sore throat • shortness of breath **Considerations for older people** Atypical presentations may be more common in older people. Older people may also present with: • increased confusion • behavioural change • worsening chronic conditions • loss of appetite • reduced mobility and falls	These almost always occur with one or more common symptoms: • diarrhoea • headache • muscle aches • nausea • vomiting • malaise • chest pain • abdominal pain • joint pain • confusion/irritability

Most people with COVID-19 have mild disease and recover; but in ARC residents, severe disease and deaths are more common. The illness may appear stable for several days, followed by rapid deterioration from complications including; pneumonia, respiratory failure, septic shock or multi-organ failure. Severe illness is much less likely with vaccination.

3.2 Incubation and infectious periods

People with COVID-19 generally develop signs and symptoms between 1 and 14 days of infection (commonly 2 to 5 days). People are considered to be able to transmit the virus from 48 hours before onset of symptoms, until both 10 days after the onset of symptoms, and until 72 hours after symptoms resolve, for those who have a mild illness and are not hospitalised. There are different criteria if the person has had a more severe illness and has been admitted to hospital.

3.3 Routes of transmission

COVID-19 is transmitted via respiratory droplets during close unprotected contact with an infected person and less commonly via fomites (objects or surface transmission). In ARC, a key route of transmission is person-to-person transmission among staff, with subsequent spread to and among residents. There is increasing recognition of the role of spread by aerosols, particularly with new variants of the virus.

4. Prepare

ARC providers must ensure they are prepared for an outbreak of COVID-19 in their ARC facility including planning for an outbreak and implementing measures to reduce the risk of an outbreak.

Planning tasks include:

- Keeping up to date with regional and national advice
- Developing an outbreak management plan
- Allocating roles and responsibilities
- Ensuring access to medical assessments and testing
- Business continuity and workforce planning
- Ensuring supply and stocks of equipment and consumables
- Ensuring residents' care plans are up to date
- Planning for residents being in isolation
- Practice scenarios

Prevention tasks include:

- Vaccination including booster vaccinations for staff and residents
- Screening for COVID-19 with Rapid Antigen Tests where indicated (refer 4.2)
- Measures to prevent introduction of infection into the facility by staff, visitors and residents
- Monitoring and managing residents with symptoms
- The use of virtual visits, appointments and telehealth
- Infection prevention and control measures
- Personal protective equipment
- Contact tracing records
- Educating staff, residents and visitors

Planning and preparation activities offer an opportunity to build and strengthen relationships across key stakeholders including the ARC providers, the DHB and PHU.

4.1 Planning

Keep up to date

Ministry of Health information for the aged care sector is available on the Ministry of Health website and specific information for ARC providers is available here.

The Āwhina app can be used to stay up to date on the latest information relevant to the health and disability sector and receive notifications when content is added or updated. Details including how to download the app can be found here.

ARC clinical staff may also find the Medinz messages helpful. Providers should have access through the organisation's Healthpoint dashboard. If you are not registered and do not receive these messages, please contact Healthpoint directly.

ARC providers can also stay up to date with the latest COVID-19 information from the Ministry of Health through the Key Health Messages and Director General of Health updates.

Outbreak management plan

Each ARC facility should have a written COVID-19 Outbreak Management Plan which sits alongside their pandemic plan. In order to develop this, relevant documents should be reviewed, including this guidance and the Ministry of Health's advice. Be mindful that advice may change as the national and international situation evolves, so it's important to keep up to date. The outbreak management plan should also include a communications plan for staff, residents and their whānau, see here for a communications plan template.

Allocate roles and responsibilities

Identify who will lead any response at the ARC facility, including key operational and clinical roles in the event of an outbreak. Consider the implications if any of these key roles are stood down and are unable to be onsite. There are a number of key roles and responsibilities that should be identified:

- Facility director, manager or nursing manager who will lead the facilities response on the Outbreak Management Team
- COVID-19 response coordinator for the facility
- Workforce lead
- Infection Prevention and Control (IPC) lead
- Communications lead
- Administration support
- General Practitioner (GP) or Nurse Practitioner (NP) for rapid assessments and testing

Access to medical assessments and testing

All ARC facilities should have a specified GP or NP who can conduct rapid assessments and testing if required, including during weekends and out of hours. If your facility has difficulty accessing GP or NP cover (in particular for in-person assessments), please discuss this with your DHB programme manager.

Business continuity and workforce planning

Facilities should ensure plans to safeguard services during increasing levels of COVID-19 in the community or in the event of a COVID-19 outbreak in the ARC facility. Plans should also include measures to support the psychosocial welfare of staff, residents and their whānau.

Workforce planning

In an outbreak, some staff may need to be stood down due to quarantine or isolation requirements. During an outbreak, staff ratios will need to increase to enable safe donning and doffing of PPE, increased cleaning, and care of any resident cases in isolation and resident contacts in quarantine. Facilities should develop a workforce plan to manage staff absences, and additional staffing demands, including the impact on support services, cleaning, catering and laundry. Suggested actions include:

- Develop a workforce plan for additional workload and staff who may be stood down
- Consider the implications if senior managers are stood down and strategies to prevent this

- Identify sources of replacement staff and how to manage rosters with less staff
- Maintain a contact list for casual staff members and nursing agencies for a surge workforce
- Managers should discuss with their teams their availability to fill staff shortages
- Plan how the workforce could be cohorted or 'grouped' to reduce the spread of infection.

Workforce planning should consider how staff who are stood down could provide support remotely and should include steps to support the mental health and wellbeing of staff.

Plan for new staff

In an outbreak, some of the ARC facility staff may be stood down following risk assessment. Temporary staff are unlikely to be familiar with the residents or the facility processes and procedures, including IT systems to access care plans or other resident information.

Facilities should plan how to quickly orientate new staff including how residents will be identified and essential cares delivered. Consider developing a quick orientation guide, maps and way finders, and consider how staff who have been stood down could provide virtual support for surge staff.

Plan for vulnerable staff

Some ARC workers have underlying health conditions which can make them more susceptible to severe consequences of COVID-19 infection. Providers should use workforce risk assessment guidance and tools to identify staff vulnerable to the effects of COVID-19 and work with these staff to mitigate their risk and review the impact on staffing. Risk assessment guidance and assessment tools are available on the TAS website.

Plan for supporting resident and staff wellbeing

Plan how the facility will implement measures to monitor and support staff and resident psychosocial wellbeing and welfare in the event of an outbreak.

Measures to support staff could include Employee Assistance Programmes (if available), accessing cultural and pastoral support, assistance with laundry and government-funded temporary accommodation. The Ministry of Health has additional resources for health care and support worker welfare and psychosocial support here.

Measures to support residents could include connecting with family, friends, cultural and religious supports e.g. via telephone or Zoom. In room activities to prevent boredom and low mood while isolating and measures to support physical wellbeing and prevent deconditioning (e.g. nutrition, strength, mobility). Ensure staff can recognise signs of physical and psychosocial deterioration in residents. For additional information on supporting the wellbeing of Māori, see Whānau Ora's Kaumātuatanga: The needs and wellbeing of older Māori.

Equipment and consumables

Ensure you have adequate stocks of consumables, including PPE, thermometer covers, hand sanitiser and cleaning products and ensure there are sufficient supplies of clinical equipment (e.g. thermometers, pulse oximeters), and other equipment (e.g. linen skips and non-touch rubbish bins).

Ensure a PPE supply chain, and establish processes for monitoring stocks and consumption of PPE and have a stock control process in place, including security measures for stock. Processes should be

in place to ensure damaged or out of date PPE is not being used. Follow the regional process for requesting PPE (Appendix 1) and contact your programme manager if you have issues accessing PPE.

Resident care plans, enduring power of attorney and shared goals of care

Ensure up-to-date resident lists (including room numbers, wing/ward, vaccination status) are available. Ensure resident care plans (including photo identification) are up-to-date and risk assessments complete, with copies of relevant plans and forms available for surge staff and if required when transferring to hospital. Keep records of very high risk residents including residents:

- Requiring aerosol generating procedures (AGP) e.g. those with tracheostomies, non-invasive ventilation such as BiPAP or CPAP, or nebulisers
- Receiving hospital-based dialysis
- Who are severely immunocompromised
- Who are obese or with poorly controlled diabetes, blood pressure or have chronic obstructive pulmonary disease.

These residents may need special cares, including transfer to hospital, during an outbreak. Prepare specific management plans for these residents, including identifying whether those usually receiving AGP can have these discontinued or substituted with alternatives.

Details of enduring power of attorney (EPoA) / welfare guardian 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 a resident's health status. More information and resources are available on the advance care planning publications page on the Health Quality and Safety Commission's website, including an advance treatment plan template.

Plan for resident isolation during an outbreak

Determine the capacity of the facility to isolate residents who are cases or contacts and identify isolation rooms and wings. A floor plan may be useful to plan isolation for resident cases and quarantine for any residents who are contacts. Isolation requires a single room, with an ensuite where possible. Rooms should be able to be externally ventilated (e.g. through open windows). If no rooms with ensuites are available, consider how shared bathrooms might be used exclusively for those in isolation, how residents will be transferred there, and cleaning procedures after use. Ensure sufficient facilities for these isolation rooms, including hand-washing facilities, non-touch rubbish bins, linen skips and dedicated clinical equipment.

Consider how residents in isolation or quarantine might be 'cohorted' or grouped together in the facility, for example within the same area or wing so that the same staff are caring for them (noting that residents in isolation should be in single rooms with non-shared bathrooms). If the facility is large, consider how different areas or wings may be kept separate, for example by restricting access between them. The logistics and safety of moving residents should be taken into account.

The principle of 'cohorting' is particularly important for high risk areas such as secure dementia or psychogeriatric care settings.

Practice scenarios

As part of planning, consider, if possible, completing scenario testing in collaboration with the DHB and PHU, including responding to a resident or residents with new respiratory symptoms, staff being stood down or an outbreak situation. See here for practice scenario resources.

4.2 Prevention

The following section outlines measures to prevent and reduce the risk of infection being introduced into the ARC facility and transmitted within the facility.

Vaccination

High rates of COVID-19 vaccination among residents and staff are essential in protection against outbreaks at the ARC facility. Vaccination provides protection against severe illness and reduces the risk of transmission from people who are infected.

Understand prospective residents' vaccination status, and encourage vaccination ahead of admission to the facility if possible. Support residents to get vaccinated (including boosters) either through your GP/NP, community pharmacy or if feasible at a community vaccination site. Contact your DHB Programme Manager if you have residents who you cannot get vaccinated through these channels.

The COVID-19 Public Health Response (Vaccinations) Order 2021 requires all health workers to have received their first dose of the COVID-19 vaccine by 15 November 2021 and to be fully vaccinated by 1 January 2022.

COVID-19 booster vaccines are recommended for residents who have completed their COVID-19 vaccination course and are mandatory for health workers. As of January 3rd 2022 the minimum interval between the second dose and the booster vaccine has been shortened to 4 months (previously 6 months).

Facilities should ensure vaccination status of all staff is validated. More information is available on the Ministry of Health website.

High coverage of influenza vaccination will help to reduce the additional burden influenza places on health resources and staffing. Ensure there is a strong organised staff influenza immunisation policy and campaign, and consider standing orders for influenza immunisation for all residents.

Screening for COVID-19 with rapid antigen tests

The Ministry of Health have recently communicated the availability of Rapid Antigen Tests (RATs) for use in ARC. At the time of writing the Northern Region Health Coordination Centre (NRHCC) is working with the Ministry of Health and ARC sector to develop regional guidance on implementing surveillance screening with RATs in the Northern region.

At times of medium or high prevalence of COVID-19 in the community there may be a role for regular RATs for ARC staff (staff surveillance testing) and for one off RATs for visitors and admissions entering the ARC facility. Dual testing (PCR + RAT) may also be considered in situations where

laboratory capacity for PCR testing is overwhelmed, and turn-around times are deemed too long. The NRHCC will advise ARC when these prevalence or laboratory capacity thresholds are in place.

The Outbreak Management Team will provide advice on any additional testing including the use of RATs in the event of an outbreak.

RAT kits are available to ARC facilities at no charge in a Red or Orange COVID-19 response level, see Appendix 1. Additional information on RATs is also available on the Ministry of Health website.

Preventing infection being introduced by staff

Staff screening questions

Staff should be proactively screened for COVID-19 symptoms and exposure risk at the beginning of each shift with the staff screening questions outlined in Appendix 2.

Staff who report COVID-19 symptoms on screening should go home, get tested immediately and remain home until they have a negative test and are symptom-free for 24 hours.

Staff who report a COVID-19 exposure risk on screening should go home, follow public health advice and contact the COVID-19 Healthline (0800 358 54 53) if they have any questions.

Ensure staff are aware of the signs and symptoms of COVID-19 and are supported to remain home if they are unwell and get tested at their local general practice or community testing centre. Staff who develop symptoms during their shift should notify their supervisor, go home and get tested.

Staff should notify the facility if they are being tested for, or are confirmed to have, COVID-19. Staff are also required to notify the facility if they have been told they are a close contact of a COVID-19 case or if a member of their household has been classified as a close contact or COVID-19 case.

Staff who have received an exclusion letter or exclusion advice from Public Health should remain away from work in accordance with the conditions of the letter or advice.

Staff may need to be stood down due to Section 70 Orders issued by the Director General of Health. It is important to stay well informed on these Orders so you can support your staff to adhere to these instructions.

Staff movement between facilities

The ARC guidance for operation under the COVID-19 Response Framework provides guidance on staff movement between facilities at different COVID-19 response levels. Appropriate management plans should be in place (e.g., testing and risk assessment) to safely manage any staff movement between facilities, as the impact of COVID-19 increases in the community, movement of staff across facilities should be reduced.

Staff movement from a facility with a COVID-19 case is not permitted (unless there are exceptional circumstances and appropriate management measures have been specifically approved by the Public Health Unit and Outbreak Management Team).

Staff movement within facilities

In periods of increased community risk or during an outbreak in a facility, it is recommended, where possible, to cohort (or group) staff to minimise the number of staff or residents contacts if there was a case, and to reduce the risk of transmission of infection across the facility.

Where possible cohorted staff should consistently work in specific areas, such as a particular wing or unit and minimise crossover between teams e.g. changing rooms, during meal times and breaks. This includes care and cleaning staff and considering how to minimise contact between kitchen, laundry staff and others. This is particularly important in settings where the consequence of infection may be highly significant, such as secure units.

Preventing infection being introduced by visitors

Ensure all visitors (including visiting health workers, volunteers or trades people) are managed in accordance with the ARC guidance for operation under the COVID-19 Response Framework.

Facilities should ensure all recommended public health, basic hygiene and IPC measures are adhered to including; mask wearing for all visitors aged 12 and older (and encouraged in children aged 6 and older if they can do so safely and effectively), hand hygiene, cough and sneeze etiquette and a visitors log and QR code to support contact tracing. Facilities should ensure measures to prevent infection being introduced by visitors are operating at all entrances to the facility.

Family visits are allowed with appropriate IPC measures in place for example mask wearing and facilitating visits outdoors where appropriate. As the impact of COVID-19 in the community increases more restrictive measures may apply, for example limiting the number of visitors and frequency of visits and visits by appointment only.

All visitors should be screened for symptoms of COVID-19 and any exposure risk for COVID-19 as per the visitor screening questions in Appendix 3. If possible, this should be before the visitor arrives at the facility (ie by phone prior) and again at the door before entry. Visitors answering yes to any of the COVID-19 symptoms or COVID-19 exposure risk questions should not enter the facility.

Visitors will be asked for evidence of vaccination status, and if not vaccinated, a negative COVID-19 test 48-72 hours before their visit. Facilities should identify ways (e.g. visiting in the outside areas, mask wearing) to enable visiting by unvaccinated family members (e.g. children) when there are lower levels of COVID-19 in the community, see the ARC guidance for operation under the COVID-19 Response Framework for more information.

During an outbreak, the Outbreak Management Team will provide advice on visiting restrictions as part of the Outbreak Management Plan. It is likely that family visits will be cancelled in facilities with COVID-19 positive cases. Visitor restrictions can have a psychosocial impact on residents and their whānau. Consider other ways for residents to stay in touch with their loved ones, including writing cards or letters, using telephone or video calls, and using photographs.

Preventing infection being introduced by residents

The ARC guidance for operation under the COVID-19 Response Framework provides guidance on ARC facility admissions, respite care and transfers at different response levels and if there is a COVID-19 case in the facility.

Admissions should be screened using the COVID-19 Screening form for a person to enter an aged residential care facility. The form must be completed a maximum of 48 hours before transfer or admission to the facility. This form provides guidance on when it is safe to transfer patients and any testing or isolation requirements based on their COVID-19 clinical and contact risk status.

The ARC guidance for operation under the COVID-19 Response Framework provides guidance on resident outings and religious or spiritual services and different response levels. As the risk of COVID-19 in the community increases residents should only visit places with vaccination certification requirements or outdoor areas, and should ensure contact tracing, mask wearing and adherence to all public health measures.

Monitor and manage residents with symptoms

The ARC facility should have a documented (and easily accessible) process in place for resident monitoring, with a clear plan for the management of COVID-19 symptoms.

- Carry out twice daily screening of all residents for COVID-19 symptoms and other signs of deterioration in residents' health status.
- If a resident becomes unwell, their GP or NP should be promptly notified to arrange review.
- Regardless of their vaccination status, residents with symptoms consistent with COVID-19 should be treated as a potential case until you are sure they are not. Immediately isolate the resident in a single room (if possible) and use PPE as per the Ministry of Health's advice. And arrange assessment and testing (see 5. Alert).

Agree a process in advance with your facility's GP or NP for getting residents assessed and tested, including getting tests to the lab. Include a process for getting residents assessed if it is after hours.

Using virtual visits, appointments and telehealth

The role of virtual appointments and non-contact services and delivery is outlined in the ARC guidance for operation under the COVID-19 Response Framework This includes the use of telehealth, virtual medical appointments and delivering social connections, health promotion and educational services at increasing response levels. The use of technology to support virtual appointments becomes increasingly important as levels of COVID-19 increase in the community or in the event of a case in the facility.

Effective infection prevention and control

High vaccination coverage, avoidance of exposure, and rapid identification are the most important measures for preventing COVID-19 transmission in ARC. Facilities should ensure they have an effective infection prevention and control plan in place in accordance with Ministry of Health infection prevention and control practices in health and disability care settings and COVID-19: Infection prevention and control recommendations for health and disability care workers. Infection Prevention and Control measures include basic hygiene measures, regular cleaning and disinfection, Standard Precautions and appropriate use of Transmission-based Precautions, including PPE.

The facility should place signs in the facility and outside rooms to remind staff and visitors of the infection prevention and control measures in place.

Basic hygiene measures
Basic hygiene measures are essential to effectively reduce the spread of infection and include hand hygiene, cough and sneeze etiquette, avoiding touching your face, and surface cleaning.

Adequate facilities for hand washing (including alcohol-based hand gel where appropriate and ensuring against accidental ingestion) should be available in every room, as should tissues and rubbish bins. Gloves should never be considered an alternative to hand hygiene. Hand hygiene is required before putting gloves on and immediately after taking them off. Hand hygiene should be performed on entry and exit of a resident's room.

Place posters around the facility reminding staff and residents to perform hand hygiene, including large-print hand washing signs in all bathrooms. Residents may require staff support to perform effective hand hygiene.

In periods of increased community risk or during an outbreak in an ARC facility, it is recommended that changing areas (and showers if possible) are identified for staff to change out of personal clothes into their uniforms at work and back into personal clothes at the end of the shift.

Environmental cleaning

Clean and disinfect all high-touch surfaces (like doorknobs, taps, handrails) frequently and routinely (e.g. daily, before/after meals) and immediately when visibly soiled. Cleaning products should be a 2-in-1 step product (which contain both cleaning and disinfectant properties) to increase efficiency. Cleaning agents should be used according to manufacturer instructions.

There are additional requirements for cleaning following a case of COVID-19 in your facility. Identify who will carry out cleaning in contaminated areas and ensure staff are trained appropriately, including how to use the required PPE, see cleaning guidance available here.

If cleaning is done in the presence of the case i.e. cleaning the bedroom while the case is present, cleaning staff should wear full PPE i.e. gloves, gown, eye protection and a P2/N95 Respirators (P2/N95 'Masks') and should have been fit tested for P2/N95 Respirators (P2/N95 'Masks'). Facilities should also have provision for managing increased clinical waste collections that will be necessary during an outbreak.

Physical distancing and ventilation

It is recommended that physical distancing of at least 1 metre (ideally 2 metres) is maintained in healthcare settings between staff, residents and visitors. Whenever feasible, this distance should increase especially in indoor settings. When caring for residents with respiratory symptoms increase physical distancing to 2 metres (where possible), adhere to Transmission-based Precautions and try to minimise the length of interaction.

Plan how physical distancing can be implemented for staff, residents and visitors. For staff this includes handovers, meal breaks, communal areas and shared transport. Implement changes at handovers and staff meetings: including physical distancing, minimising the number of participants and conducting meetings in well-ventilated spaces including outside, where possible. Encourage staff to have outdoor meal breaks if possible and consider using virtual staff meetings.

Review and understand, if any, the limitations of the facilities ventilation. Determine if ventilation is provided by natural means only, e.g. the opening of doors or windows or by heating, ventilation and air conditioning (HVAC) systems. If there is a HVAC system in your facility then review the maintenance schedule to make sure that it is well maintained and working effectively. Additional information on ventilation including HVAC modifications (done by a qualified engineer), air cleaning technologies and high efficiency particulate air (HEPA) filters can be found here.

During an outbreak try to maintain unidirectional airflow by ensuring that open doors and windows do not enable air to move from potentially infected areas (i.e. areas with residents in isolation) to areas where other residents or staff could be exposed.

Standard Precautions and Transmission-based Precautions

Standard Precautions are the basic set of IPC practices that should be used for all resident cares, regardless of diagnosis or suspected infectious status. Standard Precautions include hand hygiene (the 'five moments for hand hygiene'), the use of PPE, good respiratory hygiene/cough etiquette, regular cleaning and disinfection of the environment and equipment, prevention of sharps injuries and safe waste management and handling of linen.

Transmission-based Precautions are used in addition to Standard Precautions for residents who may be infected with infectious pathogens, to prevent transmission of infection from residents to staff, and resident to resident. The type of Transmission-based Precaution to adhere to is determined by the mode of transmission of the infectious agent. These are termed Contact, Droplet and Airborne Precautions. More information on Standard and Transmission-based Precautions is available here.

Infection prevention and control in dementia care settings

Risk of infection transmission is particularly high in secure dementia or psychogeriatric 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 requirements. Staff should have a high index of suspicion for emerging cases in the dementia facility, wing or unit.

If possible, apply the principles of the 'bubble' by creating physical or temporal separation within the unit or facility and limit contact between residents. Note, restraint legislation and policies apply.

Additional precautions include, where possible:

- Maximise opportunities to limit surface contact and co-mingling.
- Assign residents to small groups (cohorts) and limit activity to different 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.
- Increased cleaning of high touch surfaces.
- Safely locate hand sanitiser to ensure residents cannot drink it but it is accessible for staff
- Support residents to complete more frequent hand hygiene.
- Appropriately redirect residents away from situations where there may be an increased risk of transmission.

Personal protective equipment

PPE should be considered as one of a range of infection prevention and control measures that can reduce the risk of infection from COVID-19 when used correctly, and in the appropriate context.

The correct PPE that staff should use depends on the COVID-19 Protection Framework setting and the residents risk of having COVID-19. The Ministry of Health COVID-19 Interim guide for PPE selection provides guidance for different situations. The Ministry of Health's COVID-19: Infection prevention and control recommendations for health and disability care workers provides more information on how to undertake a risk assessment of a residents risk of having COVID-19.

When taking a swab follow the COVID-19 the Ministry of Health PPE guidance for COVID-19 testing

Ensure that the necessary PPE and facilities for safe disposal are available in areas where resident care is provided. All staff who may enter rooms or areas where a resident is in isolation or quarantine should be trained to don and doff PPE and should be fit tested for P2/N95 particulate respirators (P2/N95 'Masks). Where PPE is required, place posters outside the resident's room reminding staff about the correct use of PPE.

Hand hygiene should be performed before putting on PPE, and after removing PPE. Consideration needs to be given to climate and temperature control, comfort and hydration breaks

ARC Facilities should have processes to report, investigate and manage PPE breaches including assessment of any exposure and ensuring corrective actions are put in place e.g. training or buddying.

Medical masks

The Ministry of Health recommends that all ARC workers wear medical masks in all COVID-19 Protection Framework 'traffic light' settings. In some instances a medical mask should be replaced with a P2/N95 Respirators (see below). In the event of a COVID-19 case in the facility compliance with wearing masks or respirators is considered when classifying and standing down staff contacts.

ARC residents are not required to wear a face covering within the facility but should be encouraged to do so when in the community, in line with general community guidance.

P2/N95 particulate respirators (P2/N95 'Masks')

As indicated by Ministry of Health advice on PPE staff may need to use P2/N95 respirators in place of medical masks. To be effective, a tight facial seal covering the nose, mouth and chin is required.

Formal fit testing for P2/N95 respirators is required for all staff wearing P2/N95 respirators prior to first use. However, if it is not practicable to complete fit testing in advance of first use (such as in an urgent or evolving situation), respirators that have been donned with a careful seal/fit check each time should be used when recommended by IPC guidance. Fit testing should be scheduled as soon as is reasonably practicable and clinically safe. **Staff that work with COVID-19 positive residents must have undergone fit testing.**

Putting on the respirator correctly is key. The staff should be fit tested to a particular brand and type of respirator. Once fit tested they should only wear that brand/type of respirator and be competent at seal/fit checking it each time they don a respirator. The Ministry of Health website has additional information on medical masks and P2/N95 particulate respirators including manufacturers' guidelines for fit/seal checking.

Gloves, gowns and eye protection

The Ministry of Health website has information on other PPE items including gloves, gowns and eye protection. Information on gloves when providing care during the COVID-19 pandemic in available here. Nitrile gloves (rather than vinyl gloves) should be used when contact with blood or body fluid is anticipated or when gloves are recommended by the Ministry of Health COVID-19 Interim guide for PPE selection.

Sessional PPE

Sessional (or continuous) use of PPE is the ability to wear specific PPE items including medical masks, P2/N95 particulate respirators (P2/N95 'Masks'), eye protection and unsoiled gowns without needing to remove and replace them every time you undertaken an activity.

A session refers to a period of time where a worker is undertaking duties in specific zones/areas and ends when they leave that area or zone. The duration of a session varies depending on the activity, but will typically not exceed 4 hours. PPE used during a session should be guided by Ministry of Health advice on PPE selection.

Sessional PPE guidance

- Medical masks, P2/N95 particulate respirators (P2/N95 'Masks'), eye protection and gowns must be changed every 4 hours or earlier if soiled, damp, uncomfortable or damaged.
- Medical masks, P2/N95 particulate respirators (P2/N95 'Masks'), eye protection, gowns and gloves should be removed when staff go for meal breaks and new PPE donned when staff return to duties.
- Gloves should not be worn sessionally and should be changed and hands washed or sanitised between tasks. Staff must not 'double' gloves or sanitise gloves.
- A single-use face shield can be worn by the same staff member for a number of sessions, provided it is cleaned between sessions with a disinfection wipe. For a face shield with a foam band, do not immerse in a solution which will saturate the foam. Do not share a face shield with another staff member.
- PPE should be changed after completing a task with a resident who has confirmed COVID-19. If delivering care to more than one confirmed COVID-19 case, masks, eye protection and gown (if unsoiled) can remain in place until that session of care ends. Gloves and soiled gowns should always be changed between residents. If caring for one confirmed COVID-19 case in their room staff should don new PPE as they enter the room and doff PPE as they exit.
- PPE should be changed after completing a task with a resident suspected of having COVID-19 (ie resident with COVID-19 symptoms who is awaiting a test result). If delivering care to more than one resident suspected of having COVID-19, mask, eye protection and gown (if unsoiled) can remain in place until that session of care ends. Gloves and soiled gowns should always be changed between residents. If caring for one resident suspected of having COVID-19 in their room staff should don new PPE as they enter the room and doff PPE as they exit.
- PPE should be changed after completing a task with an asymptomatic resident who is a close contact of a COVID-19 case. If delivering care to more than one resident who is an asymptomatic close contact, mask, eye protection and gown (if unsoiled) can remain in place until that session of care ends. Gloves and soiled gowns should always be changed between residents. If caring for one resident who is a close contact of a COVID-19 case in their room staff should don new PPE as they enter the room and doff PPE as they exit.

Aerosol generating procedures

Aerosol generating procedures (AGP) are interventions that can generate fine airborne particles (<5 microns). These fine particles remain suspended in the air for longer periods than larger particles

and can be inhaled resulting in a risk of airborne transmission. Some AGP that may increase the risk of airborne transmission of COVID-19 include:

- Open suctioning of the respiratory tract (including upper respiratory tract)
- Tracheostomy procedures (insertion, open suctioning or removal)
- Non-Invasive Ventilation (e.g. Bi-level Positive Airway Pressure Ventilation, Continuous Positive Airway Pressure Ventilation, High Frequency Oscillatory Ventilation, High Flow Nasal Oxygen)
- Induction of sputum (cough).

Additional information and further examples of APGs are available here. A P2/N95 particulate respirator should be worn by staff during any AGP if the patient meets the moderate or higher risk criteria as outlined in the Ministry of Health PPE advice.

Contact tracing records

Facilities must have secure systems in place so that everyone working on-site or visiting can scan in or provide their details for contact tracing. Display the NZ COVID Tracer QR Code at all entrances and keep a list of all visitors, including times they arrived and left, and contact details. Ensure staff and residents (where relevant) keep a record of their movements for contact tracing purposes, either via the NZ COVID Tracer App or paper-based options such as the NZ COVID Tracer Booklet. Resident's progress notes, staff rosters (including last minute changes) and digital data e.g. access swipe cards can also assist with rapid contact tracing for staff and residents.

Educate staff, residents and visitors

Communicate regularly and clearly with staff, residents, families and visitors. Provide information about the preparations the ARC facility is taking to protect them and their loved ones, including the rationale for any measures that are put in place to prevent COVID-19 infection within the facility.

Each ARC facility is responsible for ensuring that all staff are adequately trained in the relevant components of an outbreak response, including understanding the facility's infection prevention and control guidelines and recognising and responding to signs and symptoms of COVID-19.

Topics for staff education and training should include:

- Symptoms and signs of COVID-19 in residents and appropriate response
- Exposure risks for COVID-19
- Personal hygiene, particularly hand hygiene, sneeze and cough etiquette
- Appropriate use of PPE including how to 'don' (put on) and 'doff' (remove) PPE correctly
- Actions to take if unwell with symptoms of COVID-19
- Handling and disposal of clinical waste
- Cleaning of reusable equipment and environmental cleaning
- Infection Prevention Control measures including Standard and Transmission-based Precautions
- Laundering/management of potentially contaminated linen
- Food handling and cleaning of used food utensils

Consider liaising with the facility GP/NP to support the facility Registered Nurse(s) to train to safely perform swab tests for COVID-19. See the Advice on COVID-19 testing in aged residential care in Auckland for more information.

5. Alert/Standby

It is vital that you identify a case of COVID-19 quickly and effectively. The aim of the Alert phase is to:

- identify COVID-19 cases as early as possible by testing staff and residents who are unwell
- prevent spread of COVID-19 while waiting for COVID-19 test results
- reduce the spread of all infectious respiratory illnesses amongst residents and staff.

A **COVID-19 Alert** is when a resident, staff member, or visitor is a potential COVID-19 case.

An **Outbreak** is when there is a confirmed case of COVID-19 in an ARC facility (see 6. Outbreaks)

Appropriate infection prevention and control precautions must be implemented and testing completed as soon as possible for any resident with symptoms consistent with COVID-19.

Staff with COVID-19 symptoms should get tested and stay home until they have a negative test and have been symptom-free for at least 24 hours.

The Alert Phase steps are outlined below. Please contact your DHB Programme Manager if you have concerns about your capacity to respond to an Alert. The DHB Programme Managers will contact the Operations Manager at the Public Health Unit if specific public health guidance is required.

5.1 Identify and test quickly and decisively

Residents

There should be a low threshold for testing symptomatic residents, regardless of vaccination status. **Testing is the most important step in identifying an outbreak rapidly**, and preventing its spread. Testing should be done as soon as possible after identifying that someone has a symptom that may be due to COVID-19. People with symptoms of COVID-19 should be tested with **a PCR test** using nasopharyngeal swab or combined oropharyngeal and bilateral anterior nasal swab.

Advice for testing is in the document Advice on COVID-19 testing in aged residential care. Tests should be authorised by your GP or NP, and can be done by them or a trained nurse in the facility.

Residents with symptoms of COVID-19 should be treated as a potential COVID-19 case until COVID-19 is ruled out, regardless of their vaccination status.

Ensure use of PPE for testing in accordance with current Ministry of Health guidance

Staff and visitors

Staff and visitors who develop symptoms (regardless of their vaccination status) should go home immediately and get tested in the community (e.g. community testing centre or general practice). They can contact the COVID-19 Healthline (0800 358 54 53), their GP or visit www.healthpoint.co.nz for further advice and information on testing.

SURV codes
SURV codes should be used for all resident and staff swabs to ensure any COVID-19 cases are linked to an ARC facility. The SURV code SURV-ARC should be used for ARC residents. SURV code SURV-ARCW should be used for staff. Encourage staff to advise the community testing centre or GP that they are an ARC staff member and what facility they work in so that this can be recorded on the e-notification and enable any identified case to be linked to the facility as quickly as possible.

5.2 Isolate the symptomatic resident

Symptomatic residents should be isolated in a single room, if possible with its own bathroom. Staff should implement appropriate infection prevention and controls, including use of PPE in accordance with current Ministry of Health guidance and excellent hand hygiene.

5.3 Monitor the resident's condition

Monitor the resident's condition, vital signs and oxygen saturation. Liaise with the facility's GP or NP where there is a significant change in health status. If you do not have a GP or NP to provide medical assessment when required, please inform the DHB Programme Manager as soon as possible.

5.4 Review other residents and staff

Review all other residents and staff to determine if any have symptoms consistent with COVID-19. Any other residents with symptoms should also be isolated, with testing arranged. Any symptomatic staff must go home immediately and arrange testing.

5.5 Identifying and managing contacts and other residents and staff

Begin to identify all residents and staff who are close contacts of the resident or staff member under investigation. A close contact is a person with defined exposure to the potential case within the cases infectious period without appropriate PPE.

In this Alert phase, staff members who are close contacts of a person under investigation for COVID-19 can continue to work if they are asymptomatic while the test results are awaited, providing they do not answer yes to any of the staff screening questions in Appendix 2.

Residents who are close contacts of a person under investigation for COVID-19 do not need to be quarantined while the test results are awaited unless there is a high degree of suspicion that the person under investigation is likely to be a case (e.g. they are a close contact of a confirmed case or symptomatic).

5.6 Review

Confirmed cases - declaring an outbreak
An outbreak will be declared for **one or more COVID-19 cases confirmed by laboratory testing** that are residents, staff or visitors in the ARC facility during their infectious period (Refer 6. Outbreak)

Suspected cases are negative on testing – no outbreak

If the result is negative, the staff member or resident may not be able to leave self-isolation for a number of reasons. For example, close contacts of a confirmed case will need longer in isolation and repeat testing). See the Negative Test Result webpage for more information.

Even where the illness has been determined not to be COVID-19, IPC precautions are likely to still be required, in alignment with the Ministry of Health guidance. This may include physical distancing and ongoing isolation with Transmission-based Precautions. Discuss this with the resident's GP/NP. Note that more than one resident or staff member with similar symptoms raises the possibility of other infectious disease outbreaks. Consider discussing this with your Public Health Unit. Consider testing for other respiratory viruses, such as influenza.

6. Outbreaks

If one or more cases of COVID-19 are confirmed within an ARC facility this meets the criteria for a COVID-19 outbreak. The confirmed case may be in:

- A resident
- A staff member who has had close contact with residents or staff while they were infectious.
- A visitor who has had close contact with residents or staff while they were infectious.

A probable case is a person where there is a high degree of suspicion of COVID-19 but no laboratory confirmation. A probable case may be sufficient to declare an outbreak in some circumstances; this should be discussed with the Public Health Unit (PHU).

The declaration of an outbreak should be made in consultation with your PHU.

In most instances an ARC outbreak is begins among staff, with transmission to residents.

An outbreak of COVID-19 in an ARC facility requires a swift and well-coordinated response from key stakeholders including the DHB, PHU and ARC facility.

The following section outlines the steps to be taken when a COVID-19 case has been confirmed in an ARC facility (resident, staff or visitor). Each case will be risk assessed by the PHU and Outbreak Management Team and a tailored outbreak plan developed and implemented. Some cases and exposure events may be deemed lower risk. In these cases and exposure events the PHU and Outbreak Management Team will adapt and scale back the outbreak response as appropriate.

6.1 Notification

COVID-19 is a notifiable disease in New Zealand. Positive tests are notified directly by the laboratory to the PHU. The PHU will inform the ARC facility and DHB if it becomes aware of a confirmed case linked to an ARC facility. If the ARC Facility becomes aware of a positive COVID-19 case among staff, residents or visitors they must notify the DHB Programme Manager and PHU. ARC facilities should ensure they have contact phone numbers (in hours and out of hours) to alert the PHU and DHB Programme Manager of a COVID-19 case in their facility.

6.2 Establish the outbreak management team

The Outbreak Management Team (OMT) consists of representatives from the DHB, PHU and ARC facility to ensure a coordinated and collaborative approach to managing the outbreak. Within the first few hours of notification, the OMT should meet. If the notification is received after hours, flexibility may be required. The OMT should then agree a meeting schedule for the course of the outbreak. The OMT may include the following members:

DHB representatives:

- DHB Incident Control Management
- ARC Programme Manager and/or Health Of Older Peoples Funding Manager
- Infectious Disease Specialist
- IPC specialist/laboratory expert
- Senior Gerontology Medical or Nursing specialist
- Logistics, communications, occupational health and cultural support as needed.

ARC Facility Representatives (in some facilities one person may have more than one role):

- Owner/Director of the Facility
- Facility / Operations Manager
- Clinical Manager
- IPC lead
- GP
- Administrative, human resource and communications roles

PHU Representatives:

- Medical Officer of Health or senior PHU staff with experience managing ARC outbreaks e.g. Health Protection Officer, Public Health Nurse or Senior Medical Officer
- PHU case manager for case(s)

The DHB Programme Manager will establish the OMT, schedule meetings and record the daily situation report which includes the number of cases, hospitalisations and deaths.

6.3 Roles and responsibilities

The PHU will provide senior leadership in the first days to develop and implement the Outbreak Management Plan. This will include advice on case and contact management, isolation, quarantine, contact classification, testing, cohorting and movement of staff and residents, visitor restrictions, other infection prevention and control measures and communication planning. The ARC facility and DHB will coordinate and implement these plans. The PHU will continue to attend OMT meetings and will provide additional review of the outbreak management as needed e.g. new or unexpected cases.

The 'wider' Public Health Team

As the COVID-19 response has evolved the role of the PHU has also evolved. Public Health case and contact management is now managed by a number of agencies, referred to in this document as the wider Public Health Team. This wider Public Health Team includes the local PHU, other PHUs working

remotely, the National Investigation and Tracing Centre (NITC), CBG Health Research, managed and community isolation services (e.g Whānau HQ) and Whakarongorau Aotearoa.

Public Health Unit and wider Public Health Team roles and responsibilities:

Outbreak response and management

- Inform the ARC Provider and DHB's Incident Management Team and Programme Manager as soon as possible of a COVID-19 case linked to an ARC Facility
- Attend the OMT meetings
- Undertake an initial risk assessment with information supplied by the DHB and ARC facility
- Assist facilities in confirming outbreaks and infectious periods by applying the case definition
- Provide senior leadership and support to develop and implement the Outbreak Management Plan including; advice on case and contact management, isolation, quarantine, contact classification, testing plan, cohorting and movement of staff and residents, visitor restrictions, other infection prevention and control measures and communication planning.
- Review and amend the Outbreak Management Plan in response to new information or emerging issues (e.g. new cases) and provide guidance on outbreak management as required by the OMT.
- Issue Directions to address non-compliance with Public Health Orders
- Support the facility with communications for staff, residents and residents whānau
- Close the outbreak response when completed and declare the outbreak over.

Case and contact management

- Undertake case interviews and scoping (the facility manager or clinical lead will be included in the interviews for cases who are residents). For less complex cases this may be done by the wider Public Health Team.
- Support case management and care planning for cases who are resident in the ARC facility
- Transfer the management of cases who are not resident in the ARC facility to managed or community isolation services for ongoing follow-up e.g. symptom and welfare checks and ensuring medical assessment if they become unwell.
- Identify contacts of cases (with assistance from the DHB and ARC facility). This may be done by the wider Public Health Team.
- Classify contacts and provide advice on quarantine, testing and if staff or visiting health workers need to stand down. Latest advice on health care worker exposures will inform these decisions.
- Ensure management of contacts of cases who are not residents e.g. quarantine advice, symptom and welfare checks, testing schedule, and additional testing and medical assessment if they become unwell. This may be done by the wider Public Health Team.
- Notify the cases GP (done by managed or community isolation services via a notification to the GPs patient management system inbox)
- Issue release letters for cases and contacts. This may be done by the wider Public Health Team.

Aged Residential Care provider roles and responsibilities:

Outbreak response and management

- Detect and notify COVID-19 cases to the PHU and DHB Programme Manager

- Attend the OMT meetings
- Follow preparation and alert guidance outlined in sections 4. Prepare and 5. Alert.
- Implement the Outbreak Management Plan developed in partnership with the DHB and PHU
- Prepare and provide information to the OMT about residents, staff and the facility e.g. resident list, staff list, facility floor plan
- Develop and implement an Infection Prevention and Control Plan (with support from the DHB)
- Ensure sufficient stocks and supply of equipment and consumables including PPE
- Work to maintain the care of all residents and the safety and welfare of staff
- Prepare and activate surge workforce planning including cover for vulnerable staff
- Communicate outbreak updates to residents, whanau, GPs, staff, suppliers and contractors.
- Notify the GP of a resident who has tested positive
- Engage with DHB/NRHCC communications on responding to media enquiries
- Notify HealthCert of a viral outbreak under Section 31 of the Health and Disability Services (Safety) Act 2001

Case and contact management

- Isolate all cases and implement appropriate infection prevention and control measures
- Identify contacts of cases in the ARC facility (staff, residents, visitors) and provide details to PHU
- Manage residents who are cases in the ARC facility (ie not been transferred), in accordance with the PHU instructions and Outbreak Management Plan
- Ensure nursing and medical review and care of cases in the facility as directed by the GP/NP and DHB clinical teams (including any need for transfer to hospital)
- Manage residents who are contacts of cases, in accordance with the PHU instructions and the Outbreak Management Plan including testing and quarantine requirements and ensure they are tested and reviewed if they become symptomatic
- Twice daily symptom checking of all residents
- Daily symptom screening of all staff as they come on shift

The District Health Board roles and responsibilities:

Outbreak response and management

- Establish the OMT and schedule meetings
- Attend the OMT meetings
- Write and disseminate OMT daily situation reports
- Support the facility to manage outbreaks in accordance with the Outbreak Management Plan developed in partnership with the facility and PHU
- Support the facility to prepare information for the OMT about residents, staff and the facility
- Arrange testing in accordance with PHU instructions and the Outbreak Management Plan e.g. book mobile testing units or primary care
- Support the facility in aspects of outbreak management including IPC and occupational health
- Support the facility to manage staff availability and source additional workforce
- Support the facility to source equipment and consumables e.g. pulse oximeters, PPE

- Inform relevant stakeholders of outbreaks including; the facility and any parent organisation, DHB Incident Management Team, Ministry of Health, NRHCC and local whānau, hapū, iwi and Māori communities, where appropriate
- Support the facility to communicate updates on the outbreak to residents, residents whanau, staff, suppliers and contractor and engage with DHB/NRHCC communications for media enquires

Case and contact management

- Support the facility to manage residents who are cases and currently in the facility (ie not been transferred), in accordance with the PHU instructions and the Outbreak Management Plan
- Support the facility to ensure nursing and medical review and care of cases in the facility as directed by the GP/NP and DHB clinical teams (including any need for transfer to hospital)
- Support the facility to manage residents who are contacts of cases, in accordance with the PHU instructions and the Outbreak Management Plan including testing and quarantine requirements
- Provide additional clinical support that may be required e.g. primary care, DHB geriatrics services

The level of support an ARC facility needs from the DHB will vary depending on the size and capability of the facility and any support the facility has from a parent organisation.

6.4 Initial risk assessment and immediate public health actions

For a confirmed or probable case, the PHU will provide the following immediate advice to facilities:

- Isolate all resident cases and ensure staff case(s) has gone home to isolate
- Limit movement within the facility
- Ensure no visitors enter or exit the facility (except on compassionate grounds agreed by the OMT)
- Arrange a symptom check for all residents and staff
- Advise and arrange testing for residents as identified by the PHU (NRHCC to provide SURV code)
- Arrange appropriate PPE for staff
- Consider cohorting certain areas of the facility (including staffing and movement of residents)

The PHU will undertake risk assessment using the following information from the facility including:

- Total number and names of residents and staff with suspected or confirmed COVID-19 and where they are residing or working, symptoms, symptom onset dates, vaccination status, what PPE was used, where they have been in the facility and any visits out of the facility.
- Facility description e.g. number of staff, number of residents, level of care provided, nominated GPs, vaccination coverage, any shared bathroom or kitchen facilities
- List of all residents in the whole facility, including NHIs, area of residence, room numbers, exposure date if exposed, presence and onset date of any symptoms and vaccination status
- List of all staff and their contact details, work areas, exposure date if exposed, presence and onset date of any symptoms, vaccination status and PPE worn when in contact with case(s)
- List of anyone in contact with the case during their infectious period, include details of length of time and PPE used (residents, staff, visitors or contractors)
- Floor map with room number and wings and any shared bathrooms identified on the map.

- List of visitors or contractors who have been to the facility at the specific time
- List of any COVID-19 test, date of testing and results (if available).
- Names of people transferred to or from hospital with acute respiratory infection or COVID-19
- Any existing Outbreak Management Plans for the facility
- Any known exposures to cases or contacts including locations of interest for staff or residents, any staff or residents who were recently unwell, admitted to hospital or deceased.

The PHU will use this information to:

- Confirm the presence of an outbreak and infectious periods
- Identify any potential source of the outbreak or investigation needed to establish this
- Identify all other cases and contacts
- Identify and classify contacts and define the required actions e.g. quarantine and testing.
- Lead the management and follow up of staff, visitors and other community based cases and contacts (this may be done by the wider Public Health Team).
- Guide the Outbreak Management Plan including advice on case and contact management, isolation, quarantine, contact classification, testing plan, cohorting and movement of staff and residents, visitor restrictions, other infection prevention and control measures and communication planning.

On the basis of this risk assessment, the OMT will determine the most appropriate place of care for residents who are cases and contacts.

6.5 COVID-19 outbreak management plan

An Outbreak Management Plan tailored to the outbreak should be developed and implemented by the OMT. The initial plan will need to be developed, and many decisions taken, within a very short timeframe (4-6 hours) of an outbreak being declared. The plan will include:

- Source investigation and testing plan
- Case management e.g. required isolation, duration, location, monitoring and release criteria
- Contact management e.g. contact classification, quarantine, staff stand down, symptom checking and testing
- IPC measures e.g. cleaning, basic hygiene, PPE, Standard and Transmission-based Precautions
- Other measures to interrupt transmission e.g. restricting movements within and in/out of the facility, visitor restrictions, cohorting staff and residents, standing down staff, additional testing
- Ensuring workforce and service provision
- Ensuring residents care and staff welfare
- Communications plan
- OMT members and contact details and agreed process for escalating risks or issues

The situation reports will be used to monitor progress against the Outbreak Management Plan.

6.6 Managing cases

Residents

Management of COVID-19 cases who are residents and remain in the facility will be led by the ARC facility and DHB. The PHU (or wider Public Health Team) will complete the initial scoping interview and will provide direction and support on public health management e.g. isolation requirements (duration, location) and release from isolation. The facility manager or clinical lead will be included in the interviews for cases who are residents.

The ARC facility GP and DHB clinical team will provide assessment and advice on medical management including any transfer to hospital. The DHB will provide IPC support and advice.

All residents who are confirmed or probable cases, or have symptoms consistent with COVID-19, should be **placed in isolation immediately,** the PHU (via the OMT and Outbreak Management Plan) will provide advice on isolation requirements e.g. duration, location and release criteria.

Twice daily symptom checks should be performed and documented on all residents.

The ARC facility should arrange for residents with **new or worsening symptoms to be assessed** by their GP or NP for medical management. Additional clinical support may be provided by DHB clinical teams (e.g. Gerontology Nurse Specialist or community geriatrician) if required.

Staff caring for residents who are cases, should adhere to **appropriate Infection Prevention Control Precautions, and recommended PPE** as per Ministry of Health advice for every contact. This includes a P2/N95 particulate respirator, gown, gloves and eye protection and meticulous hand hygiene. **Staff that work with COVID-19 positive residents must have undergone fit testing and should seal check P2/N95 particulate respirator (P2/N95 masks) with each use.**

The resident should receive care only from staff specifically assigned to them, who if possible should not care for other residents. All staff should be fully vaccinated. Detailed records should be kept for staff caring for cases and who else these staff work with and come in contact with on each shift.

Avoid potentially aerosol generating procedures such as suctioning and nebulisation. If a resident with suspected, probable or confirmed COVID-19 requires such a procedure this should be discussed with the resident's GP as additional precautions will be necessary and an alternative treatment or hospital transfer considered.

Clinical management will need to be adapted to the care setting, including the resources and supports available from the DHB, which may vary. The DHB will need to continue to monitor the resident's condition virtually or in person and will provide clinical management support as required, e.g. assessment of cases, consideration of hospitalisation or medical/nursing supports.

Staff should avoid showering COVID-19 positive cases if possible, with bed baths or sponge baths used instead.

Non-residents e.g. staff, visitors and other community based cases

Management of COVID-19 cases who are non-residents e.g. staff, visitors and other community based cases will be led by the PHU or wider Public Health Team. The PHU (or wider Public Health

Team) will complete the initial scoping interview and will provide the case with advice on public health management e.g. isolation requirements (duration, location and release criteria).

Ongoing case management and follow-up e.g. symptom and welfare checks and release from isolation will be led by either the managed or community isolation services (depending on whether the case is isolating in a managed facility or at home). On-going case management and follow up for complex cases will be led by the PHU.

The agency leading case and contact management (e.g. managed or community isolation services or PHU) is responsible for notifying the case's GP and for ensuring cases receive medical assessment and treatment (including transfer to hospital if required) if they become unwell.

6.7 Managing contacts

Residents

Management of COVID-19 contacts who are residents and remain in the ARC facility will be led by the ARC facility and DHB. The PHU and OMT will provide advice on public health management for residents who are contacts of a COVID-19 case including any:

- Contact classification
- Quarantine requirements e.g. duration, location and release criteria
- Testing requirements e.g. frequency, timing, testing method
- Cohorting and restriction on movements
- Other measures to interrupt transmission including IPC and PPE requirements
- Any requirements for secondary contacts (ie contacts of the contact)

Quarantine should ideally be completed in single rooms with ensuite bathrooms. If this is not possible a single room is still advisable, and the bathroom they use should be cleaned and disinfected after each use. Commodes dedicated to specific individuals could be considered where ensuites are not available.

Residents who are in quarantine should not be using shared common rooms or dining facilities. If possible, residents who are in quarantine should be housed in one wing or area of the facility (in single rooms), and specific staff should be allocated to care for them.

Staff caring for residents who are contacts, should adhere to appropriate Infection Prevention Control Precautions, and recommended PPE as per the Ministry of Health advice (also see section 4.2 for more information on PPE). If a resident who is considered a contact needs to leave their room, for example to seek medical attention, they should wear a medical mask (if possible) and should be supported to perform hand hygiene.

Residents should continue to be monitored for signs and symptoms of COVID-19 at least twice daily (remembering that older people may present less typically), and if any symptoms develop, residents should be isolated immediately (if not already done) and assessment and testing arranged urgently.

The DHB should arrange testing of resident contacts as per PHU advice and outbreak management plan.

Non-residents e.g. staff, visitors and other community based contacts

Management of contacts who are non-residents e.g. staff, visitors and other community based cases will be led by the PHU or wider Public Health Team who will provide advice on:

- Contact classification
- Quarantine requirements e.g. duration and release criteria and time off work
- Testing requirements e.g. frequency, timing, testing method
- Other measures to interrupt transmission including IPC and PPE requirements
- Any requirements for secondary contacts (ie contacts of the contact)

The OMT will work with Public Health to support management of staff contacts e.g. arranging testing

The PHU or wider Public Heath Team leading contact management will perform symptom and welfare checks, will ensure quarantine and testing requirements are met and will release contacts when quarantine is completed. The Public Heath Team will ensure any contacts with COVID-19 symptoms are isolated, tested and medical assessment and management arranged if needed.

The PHU (or wider Public Health Team) will assess the exposure risk for staff who are contacts of the case. The PHU (or wider Public Health Team) will provide advice on quarantine, testing, symptom checking and any additional IPC or PPE requirements if they are able to continue working.

6.8 Residents with special needs

Some residents may need special care and consideration in an outbreak. If you have residents in any of the following categories, discuss them with the DHB as admission may be warranted.

- Residents requiring aerosol generating procedures
  - Those with tracheostomies
  - Non-invasive ventilation
  - Suctioning
  - Administration of high flow nasal oxygen
  - Nebulisers
  - *Note: sputum induction should be avoided*
- Hospital based dialysis - alert dialysis unit and consider if they need to be cared for elsewhere
- Severely immune-compromised

6.9 Infection prevention and control measures

Effective infection prevention and control measures are essential. A detailed outbreak Infection Control Plan should be developed and adapted as necessary throughout the outbreak. The ARC facility should work with the OMT to discuss specific requirements. The OMT includes infection prevention and control expertise.

Additional advice on Infection Prevention and Control is available from the Ministry of Health infection prevention and control practices in health and disability care settings and COVID-19: Infection prevention and control recommendations for health and disability care workers.

Infection Prevention and Control measures include basic hygiene measures, regular cleaning and disinfection, Standard Precautions and appropriate use of Transmission-based Precautions including PPE. Considerations for infection prevention and control in dementia care are outlined in Section 4.2.

Basic hygiene measures are outlined in Section 4.2

Standard Precautions

Standard Precautions should already be in place but should be reviewed with all staff. They must be used while providing care for all residents every time and are especially important during an outbreak. Standard Precautions include hand hygiene (the 'five moments of hand hygiene'), the use of PPE, good respiratory hygiene/cough etiquette, regular cleaning and disinfection of the environment and equipment, prevention of sharps injuries and safe waste management and handling of linen. More information on Standard Precautions is available in Section 4.2 and on the Ministry of Health website.

Transmission-based Precautions

Transmission-based Precautions are used in addition to Standard Precautions to prevent the spread of COVID-19 and include **contact, droplet** and **airborne** precautions. More information on Transmission-based Precautions is on the Ministry of Health website.

Environmental cleaning and disinfection

Regular, scheduled cleaning of all staff and resident care areas is essential during an outbreak. Frequently touched surfaces such as objects, counters, table tops, doorknobs, light switches, lift buttons, railings, phones, bathroom fixtures, and toilets should be cleaned more often. Enhanced cleaning of residents' rooms and common areas is required and additional cleaning staff may be required. Identify who will carry out cleaning in contaminated areas and ensure staff are trained appropriately, including how to use the required PPE. If cleaning is done in the presence of the case i.e. cleaning the bedroom while the case is present, cleaning staff should wear full PPE i.e. gloves, gown, eye protection and a P2/N95 Respirators (P2/N95 'Masks') and should have been fit testing for P2/N95 Respirators (P2/N95 'Masks'). See cleaning guidance available here.

Additional precautions are needed when managing linen and crockery and cutlery.

Equipment and items in the resident's room should be kept to a minimum. Ideally, reusable resident care equipment should be dedicated for the use of an individual resident. If it must be shared, it must be cleaned and disinfected between each resident use.

Facilities should have provision for managing increased clinical waste collections that will be necessary during an outbreak.

Physical distancing and ventilation

Information on physical distancing and ventilation are included in Section 4.2. During an outbreak measures to increase physical distancing, minimise close contact interactions and improve ventilation should be reviewed and strengthened. During an outbreak try to maintain unidirectional airflow by ensuring open doors and windows do not enable air to move from potentially infected areas (ie areas with residents in isolation) to areas where other residents or staff could be exposed.

6.10 Personal protective equipment

The correct PPE that staff should use depends on the COVID-19 Protection Framework setting and the residents risk of having COVID-19 (e.g. presence of symptoms, contact history and if they are a confirmed case). The Ministry of Health COVID-19 Interim guide for PPE selection to protect primary provides guidance for different situations. The Ministry of Health's COVID-19: Infection prevention and control recommendations for health and disability care workers provides more information on how to undertake a risk assessment of a residents risk of having COVID-19.

The OMT will provide advice on any additional PPE measures that should be taken for example any additional use of P2/N95 Respirators (P2/N95 'Masks') within the facility over an above the Ministry of Health advice.

Ensure that the necessary PPE and facilities for safe disposal are available in areas where resident care is provided. All staff who may enter rooms or areas where a resident is in isolation or quarantine should be trained to don and doff PPE. All staff required to wear P2/N95 Respirators (P2/N95 'Masks') should be fit tested (if not already been done). Refresher training is recommended for all existing staff, including non-clinical support staff, and as required for new staff. Where PPE is required, place posters outside the resident's room reminding staff about the correct use of PPE. PPE use should be audited regularly throughout the outbreak.

Hand hygiene should be performed before putting on PPE, and after removing PPE. Consideration needs to be given to climate and temperature control, comfort and hydration breaks.

Medical masks must be used throughout the facility (as is standard at all times). This is in addition to the additional PPE (P2/N95 Respirators, gloves, gowns and eye protection) for contact with COVID-19 positive cases and as indicated by the COVID-19 risk assessment. Information on medical masks, P2/N95 Respirators, gloves, gowns, eye protection, sessional use and aerosol generating procedures is available in Section 4.2 and on the Ministry of Health website.

ARC Facilities should have processes in place to report, investigate and manage PPE breaches including reporting any breaches to the OMT who can provide advice on any exposure risk and ensuring corrective actions e.g. contact management, training or buddying.

6.11 Testing plan

The PHU will provide advice on testing including who should be tested, when testing should occur and the type of test to be administered. Arrangements will need to be agreed by the OMT for in-facility testing from mobile testing services and/or the facility GP or local primary care services.

6.12 Other control measures and considerations

Screening for COVID-19 symptoms and exposures
In addition to the required symptom checking for cases and contacts during an outbreak. Established processes for checking COVID-19 symptom and exposure risks should continue ie symptom checking resident's twice daily, screening staff at the start of each shift and visitors when permitted to enter the facility, see Section 4.2 and Appendix 2 and 3 for further details.

Staff movement between facilities

Staff who normally work at other sites as well as the outbreak facility should be urgently reviewed to limit the risk of transmission to other sites. This may include the facility's GP or NP. Staff movement from a facility with a COVID-19 case is not permitted (unless there are exceptional circumstances and appropriate management measures have been specifically approved by the PHU and OMT.

Staff movement within facilities

During an outbreak the OMT will provide advice on the need to cohort staff to reduce transmission of infection across the facility. This is particularly important if not all wings/units are affected by the outbreak. Where possible cohorted staff should consistently work in specific areas, such as a particular wing or unit and minimise crossover between teams.

Consider all the potential opportunities for staff interaction, and how this might be prevented. This could include adapting shift times to avoid staff interaction in the carpark, allocating toilets to particular staff cohorts and identifying alternative area for staff to take breaks. Consider how to minimise contact between kitchen, laundry staff and others. Staff should also minimise contact with one another outside of the workplace where possible.

Transfers and admissions

During an outbreak the OMT will provide advice on transfers and admissions to and from the ARC facility. Apart from transfer of residents to hospital, all transfers of residents into or out of the facility should be avoided until the outbreak is declared over. If a resident needs to transfer to a higher level of care, this should be discussed within the OMT, with input from the PHU. The facility should not accept new residents until the outbreak is declared over.

Visitors

During an outbreak, the PHU and OMT will provide advice on visiting restrictions as part of the Outbreak Management Plan. Visitors should only be entering the building in accordance with guidance from the OMT and if pre-arranged with the facility manager and only for compassionate grounds, or, to provide essential services. Their visit, including donning and doffing of PPE, should be supported by trained staff. Ensure visitors who are permitted to attend the facility are recorded on a register of visitors and comply with the following:

- Pre-arrange the visit
- Complete a wellness declaration and temperature check prior to visiting
- Report to the designated area on arrival
- Visit only the specified resident in their room
- 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 the facility
- Sign in using the NZ COVID Tracer App
- Only enter the facility if necessary, for example deliveries could be left outside

A detailed log should be kept of all visitors during an outbreak, including contact details, time of visit, use of PPE and escort and staff contact.

Using virtual visits, appointments and telehealth
The use of technology to support telehealth, virtual medical appointments and delivering social connections becomes increasingly important in the event of a case in the ARC facility.

Providing care after death
Deceased bodies should be placed in a leak-proof bag, and staff handling deceased bodies should wear a gown, P2/N95 Respirators (P2/N95 'Masks'), gloves and protective eyewear. Only registered funeral directors can lawfully handle, store and transport deceased persons. Information on deceased patients' funerals and tangihanga is available from the Ministry of Health.

6.13 Staffing and service continuity

Staffing in outbreaks is a major challenge with some staff potentially needing to be stood down and replaced and higher staffing ratios will be necessary to deliver care during an outbreak. Key decisions will need to be taken very soon after an outbreak is declared, in discussion with the DHB and PHU teams. These decisions will need to take into account both the immediate risk of further transmission and the need to ensure the facility is adequately staffed to deliver safe care.

Replacement staff may not be familiar with residents, the facility, normal facility routines and processes, and other staff. Good handover and written aids and resources around the facility including signage are essential. The usual facility staff will be an important resource, including providing advice and support remotely.

The role of any vulnerable staff should be reviewed (refer Section 4.1).

All staff should self-monitor for signs and symptoms of COVID-19 and stay home if unwell. If staff are unsure whether they should work they should phone their manager prior to their shift for guidance. Staff should be screened for COVID-19 symptoms and exposure risk at the start of each shift.

Staff should consider how they can keep people in their own homes safe.

6.14 COVID-19 outbreak communications plan

A communications plan covering the following areas should be developed. Ensure that privacy is maintained as much as possible, including how the outbreak is named. It is vital to maintain the confidence of staff, residents, and families. Ensuring information is accurate and timely is important. Acknowledge areas of uncertainty but ensure that people know what is being done to address these.

Communications will be a major draw on staff time during an outbreak with many requests each day. It is recommended that a single email contact is established and each day a duty person is nominated to be first contact. That person should have a contact list for all key staff involved.

Contents of communication

- A description of the situation and, if known and appropriate, how it occurred
- Specific communication for various groups (residents, staff, and wider community)
- Actions already taken and being taken to investigate and monitor the situation
- Actions already taken and being taken to control the situation
- What we need other people/ groups to do (and not do)

- Resident safety and welfare and visitor policy
- Staff safety and welfare

Communication targets

- All people/organisations involved in managing the outbreak
- Other internal communications (staff, residents, residents' families)
- External communication (other health and social service providers, suppliers, contractors)
- If communications with media is required these should be discussed within the OMT and DHB/NRHCC communications alerted to lead media communications

Methods for communication may include

- Letters or circulars
- Points of discussion guidance and phone scripts
- Signage
- Frequently asked questions, advice sheets and protocols
- Facility websites

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. Appropriate signage must be placed outside symptomatic residents' rooms to alert staff and visitors to the requirement for relevant Transmission-based Precautions.

6.15 Staff and resident wellbeing

Experience with previous outbreaks in ARC facilities has demonstrated that these are highly stressful events with impacts on both staff and residents. Implement measures to monitor and support staff and resident psychosocial wellbeing during the outbreak.

Measures to support staff could include Employee Assistance Programmes (if available), assistance with laundry and accessing welfare and cultural support for staff cases and contacts through Public Health agencies managing their care or the NRHCC.

The Ministry of Health has additional resources for health care and support worker welfare and psychosocial support here. ARC staff may be eligible for government-funded temporary accommodation to support staff needing to stay away from their homes during a COVID-19 outbreak. More information is available here.

Measures to support residents include connecting with family, cultural and religious supports e.g. via phone/Zoom. In room activities to prevent boredom and low mood while isolating and measures to support physical wellbeing and prevent deconditioning (e.g. nutrition, strength, mobility).

6.16 Monitoring outbreak progress

Increased and active observation of all residents 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 ensure they have a process for efficiently monitoring

residents and staff displaying signs and symptoms of COVID-19, and to ensure infection prevention and control measures are implemented, reviewed and strengthened. The OMT may choose specific indicators to monitor the outbreak management process and to trigger a review of the current outbreak management plan.

6.17 Declaring the outbreak over

The outbreak response may be scaled back and stepped down as directed by the OMT and PHU. A decision to declare the outbreak over is made by the PHU.

Generally, a COVID-19 outbreak can be declared over 20 days after the last day of exposure to a case. The 20 day count starts on the last day of isolation of the last confirmed or probable resident case and/or on the last day of contact with a staff or visitor case. Residents who have not completed their quarantine period should finish that period if the outbreak is declared over.

The OMT may make decisions about Alert status or on-going surveillance after declaring the outbreak over, considering the following needs:

- To maintain general infection prevention and control measures.
- To monitor the status of unwell residents, communicating with the PHU if their status changes.
- To notify any late, COVID-19-related deaths to the PHU.
- To alert the DHB and the PHU to any new cases, signalling either re-introduction of infection or previously undetected ongoing transmission.

6.18 Reviewing outbreak management

Once an outbreak has been declared over, it is important for all parties to reflect on what worked well and what needs 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. Further resources for outbreak review are available here.

7. Appendices

Appendix 1: Personal Protective Equipment (PPE), Rapid Antigen Tests (RATs) and swab ordering process for ARC in the Northern region

The process for ordering PPE, RATs and swabs

PPE and RATs

Personal protective equipment is fully funded for Aged Residential Care at set out in the Ministry of Health's principles of supply. You will need to be registered with Onelink if you wish to order PPE.

- Standard - order through the Onelink website
- Urgent - order through the Onelink website as usual but contact Onelink to advise order is critical and request same day delivery.
    - Email mohppe@onelink.co.nz
    - Phone **(09) 815-2600** and advise your order is PPE related

Some larger national providers are registered with Heath Care Logistics (HCL) instead of Onelink and should follow their usual process to access PPE.

If you require an urgent order of PPE, RATs or swabs due to an outbreak or exposure event, please contact your programme / portfolio manager immediately to ensure that appropriate PPE is requested (including P2/N95 respirators).

Swabs

Auckland region - swabs can be ordered through Labtests - https://www.labtests.co.nz/for-referrers/consumable-ordering/

- All orders need to be made through the online ordering form – see bullet point one on the website. You will need to include the 'Practice Account ID' (format = Nxxxxxx).
- If you are unsure whether you have an account, you can call the number on the form or use the online inquiry form (see 'Contact us' – bullet point three) noting the name of the facility, physical address, contact name and contact email and contact phone
- If the order is urgent, please add URGENT to the name field on the order form.

Northland region - swabs can be ordered through NorthPharm

Appendix 2: Staff screening questions

Staff should be proactively screened for COVID-19 symptoms and exposure risk at the beginning of each shift with the staff screening questions outlined below. Ensure staff are aware of the signs and symptoms of COVID-19 and are supported to remain home if they are unwell and get tested at their local general practice or community testing centre. Staff who develop symptoms during their shift should notify their supervisor, go home and get tested.

Staff should notify the facility if they are being tested for, or are confirmed to have, COVID-19. Staff are also required to notify the facility if they have been told they are a close contact of a COVID-19 case or if a member of their household has been classified as a close contact or COVID-19 case. Staff should follow public health advice including testing, isolation and quarantine requirements.

1. Assess for COVID-19 symptoms:

Do you have any of the following symptoms?

- *New or worsening: Cough? Breathlessness? Sneezing and runny nose? New loss or altered sense of smell/taste? Sore throat?*
- *Do you have a fever?*

NB: Less common symptoms almost always occur with one or more of the common symptoms, so you don't need to screen specifically for less common symptoms. However, have a high degree of suspicion if people mention any less common symptoms (new diarrhoea/vomiting or abdominal pain, new muscle aches or headache, malaise, chest pain, joint pain or confusion/irritability), with no other explanation.

2. Assess whether a person could have COVID-19 or has exposure risk for COVID-19:

- *Have you tested positive in the last 10 days for COVID-19 infection?*
- *Are you awaiting the result of a COVID-19 test because you had COVID-19 symptoms?*
- *Have you had close contact in the last 10 days with someone who has COVID-19 infection?*
- *Have you been notified in last 10 days that you have been exposed to someone with COVID-19 and been asked to stay at home and isolate?*
- *Have you returned from overseas in the last 10 days? (excluding a Quarantine-free travel zone)*
- *Do you live with someone who has been classified as a close contact of a COVID-19 case? **

If any of these apply, ensure the staff member goes straight home.

If the staff member is symptomatic, they should go home, get tested immediately and remain home until they have a negative test and are symptom-free for 24 hours. There are some instances where people need to remain in self-isolation even after they have had a negative test. The Auckland Regional Public Health Service website explains these situations.

Staff answering yes to any points in Question 2 should go home, follow public health advice and contact the COVID-19 Healthline (0800 358 54 53) if they are unsure what to do.

*If the staff member lives with someone who has been classified as a close contact of a COVID-19 case they should follow Public Health advice and a risk assessment should be undertaken by the facility before they return to work. The staff member should not work if the person they live with who has been classified as a close contact has any COVID-19 symptoms. See Ministry of Health website for further information.

Staff who have received an exclusion letter or exclusion advice from Public Health should remain away from work in accordance with the conditions of the letter or advice. Staff may need to be stand down due to Section 70 Orders issued by the Director General of Health. It is important to stay well informed on these Orders so you can support your staff to adhere to these instructions.

Appendix 3: Visitor screening questions

Ask all visitors the following questions both over the phone (if a scheduled visit) and in person before entering the facility. This includes any non-family visitors e.g. visiting health professionals, visiting services, trades people, NGOs etc.

1. Assess for COVID-19 symptoms:

Do you have any of the following symptoms?

- *New or worsening: Cough? Breathlessness? Sneezing and runny nose? New loss or altered sense of smell/taste? Sore throat?*
- *Do you have a fever?*

NB: Less common symptoms almost always occur with one or more of the common symptoms, so you don't need to screen specifically for less common symptoms. However, have a high degree of suspicion if people mention any less common symptoms (new diarrhoea/vomiting or abdominal pain, new muscle aches or headache, malaise, chest pain, joint pain or confusion/irritability), with no other explanation.

2. Assess whether a person could have COVID-19 or has exposure risk for COVID-19:

- *Have you tested positive in the last 10 days for COVID-19 infection?*
- *Are you awaiting the result of a COVID-19 test because you had COVID-19 symptoms?*
- *Have you had close contact in the last 10 days with someone who has COVID-19 infection?*
- *Have you been notified in last 10 days that you have been exposed to someone with COVID-19 and been asked to stay at home and isolate?*
- *Have you returned from overseas in the last 10 days? (excluding from a Quarantine-free travel zone)*
- *Do you live with someone who has been classified as a close contact of a COVID-19 case? **

If visitors answer yes to any of the questions above they should not enter the Facility.

If unable to obtain a contact or exposure history, assume that the visitor has exposure risk and do not let them enter the facility.

Visitors with COVID-19 symptoms should be advised to go home, get tested at their general practice or community testing centre and remain home until they have a negative test and are symptom-free for 24 hours.

Visitors answering yes to any points in Question 2 should go home, follow public health advice and contact the COVID-19 Healthline (0800 358 54 53) if they are unsure what to do or have any questions.

*****There are some instances when people who live with close contacts of a COVID-19 case should not enter an ARC facility, and they should not enter the facility if the person they live with who has been classified as a close contact has any COVID-19 symptoms, see Ministry of Health website for further information.

Appendix 4: Additional COVID-19 resources and support

- General guidance for the public is available on the Government's Unite against COVID-19 website
- Further information for health professionals please go to the Ministry of Health website
- Further information for aged care sector please go to Ministry of Health website and specific information for ARC Providers is available here.
- Further information on COVID-19 planning and response for ARC is available from the Ministry of Health's COVID-19 Outbreak Response Toolkit for Aged Residential Care the New Zealand Aotearoa Pandemic Response Policy for Aged Residential Care the Ministry of Health ARC guidance for operation under the COVID-19 Response Framework
- The Auckland Regional Public Health Service website has additional information for ARC
- Ministry of Health Information on Infection Prevention and Control and PPE is available here
- Practical templates for use by providers can be found on the Health Quality & Safety website. The New Zealand Frailty Care Guides can also be found on the Commission website.
- PHARMAC is publishing updates on supply and other medicine issues on its website: https://www.pharmac.govt.nz/information-for/covid-19-pharmacs-response/
- Posters for keeping safe at home and work can be found on the Auckland Regional Public Health Service website.
- National Telehealth Service advice lines:
    - Healthline for general advice, triage and information (0800 611 116) available 24/7
    - Dedicated COVID-19 Healthline (0800 358 54 53) available 24/7.
    - COVID-19 Vaccination Healthline (0800 28 29 26) available 8am to 8pm, 7 days a week
    - COVID-19 clinical advice line for health professionals is available 8am to 8pm, 7 days a week including public holidays. Phone number 0800 177 622 (not to be provided to general public).
- Information on caring for people with COVID-19 in the community is available on the Ministry of Health website.
- Auckland Region HealthPathways has a suite of COVID-19 resources for health professional.