COVID-19
Guidance to support assessment of workers, residents and visitors in Residential Disability Care

This document contains a framework to assist in determining the risk to disability workers, residents (known as consumers in some facilities) and visitors in Disability Group Homes when there has been contact with someone with COVID-19 either at the facility or group home. The person with COVID-19 may be a staff member working at the facility, a resident, or a visitor. It is important that appropriate actions are taken to minimise the risk of spread of COVID-19. NSW Health acknowledges the work of the Commonwealth Department of Health and NSW Public Health in updating this document.

Part 1 of this guidance provides a process to support safe decision making when determining whether to place work permissions/restrictions on a worker after a COVID-19 exposure in the context of an outbreak (and outbreak management plan has been put into action) and community transmission of COVID-19. Part 2 of the guidance provides a framework to assist in determining the risk to residents and visitors. This guidance applies to all disability care providers, including those working in residential and home care.

The guidance considers the current context of the pandemic, including the significant vaccination coverage in Australia, the commencement of booster vaccination, the emergence of Omicron, and likely future progression. In view of the increased transmissibility of the Omicron variant, the expected higher number of incident cases in the community, and the majority of individuals experiencing mild to moderate illness, the revisions allow for greater flexibility in balancing the need to reduce transmission against a detrimental loss of workforce.

As a critical industry, disability care services should ensure that eligible staff and residents have received a booster vaccination and maintain QR code check-ins to allow for rapid identification of contacts if there is a high-risk transmission event.

Approved providers of disability care, including residential disability care facilities (RDCFs) and providers of home and community home support programs, should apply a broad hierarchy of control framework to minimise and manage the risk of transmission of COVID-19. A system-based risk managed approach that applies appropriate mitigations reduces the risk of exposure in disability care settings. However, it is acknowledged that risk cannot be completely eliminated and that exposures will occur.

Disability care providers are responsible for this assessment when an outbreak or exposure occurs in their setting. Disability care providers are also responsible for considering the impact on the workforce as part of the outcomes of assessment in both circumstances and are responsible for being familiar with and, where relevant for RDCFs, to operationalise these guidelines as part of their outbreak management plan. Disability care providers should be prepared to make assessments on their own, in line with Outbreak Management Plans, in instances where Public Health Unit (PHU) advice is not available.

Decisions regarding work permissions and restrictions for the worker should be accurately documented and decisions regularly reviewed by the provider in the context of the evolving local epidemiological and public health situation. If a large number of workers are affected by community transmission (as a case or contact) or an outbreak escalates, it may be necessary to review the recommended restrictions to facilitate continuation of essential care.

Registered providers of disability care are responsible for notifying and communicating with their local PHU and the NDIS Quality and Safeguards Commission of any positive cases. Where available, PHUs will consider applying a process of monitoring and evaluation locally, in line with jurisdictional requirements.

Part 1 – Work permissions and restrictions for workers who are COVID-19 contacts

Detailed follow up of individual cases and identification of contacts will not be possible with increasing levels of population exposure, high caseloads, and potential impacts on essential service delivery. Moving forward the focus will be on household or household-like contacts as the key group to quarantine.

Steps for service/PHU:

1. Determine worker exposure and type of contact (if exposed in the community this may already have been done by the PHU) (see Staff Contact risk assessment matrix on page 7)
2. Assess the impacts of work restrictions on safe, ongoing service delivery
3. Once exposure and impact determined, refer to Table 1
4. Service to document all delegates, decisions and actions
5. Regular review of decisions and workplace situation

COVID-19 contact

COVID-19 Low-risk exposure / contact

If a worker has been exposed to a COVID-19 case through social contact in the community, educational or workplace setting, low risk work permission and restrictions can be applied as per Table 1.

COVID-19 High-risk exposure / contact

If a worker has been exposed to a COVID-19 case in a high-risk setting, high risk work permission and restrictions may be applied as per Table 1.

COVID-19 high-risk exposure in a workplace setting in the context of an outbreak

Where a worker has been exposed to a COVID-19 case in a workplace setting where the risk of exposure is defined as high:

- staff who were not wearing airborne precautions PPE (P2/N95 masks, eye protection, gowns and gloves) where aerosol generating behaviours or procedures have been involved

OR

- have had at least 15 minutes face to face contact where both mask and eyewear were not worn by exposed person and the case was without a mask

OR

- greater than 4 hours within the same room with a case during their infectious period, where masks have been removed for this period.

Management of high-risk worker contacts in the context of high impact on health service delivery

High levels of community transmission or an outbreak of COVID-19 may result in significant pressures on health service capacity including workforce shortages due to furloughing requirements.

Permissions and restrictions for asymptomatic, high-risk contacts should only be applied as a contingency strategy. Work permissions in these circumstances must be approved by an appropriate delegate.

Alternative mitigations to consider when adjusting restrictions to support the continued delivery of disability care services

- More regular screening requirements (e.g., daily Rapid Antigen Test (RAT) at commencement of a shift. PCR testing is not required.
- Additional PPE requirements – this should be based on the advice of IPC (Infection Prevention and Control) expertise (or PHU if IPC unavailable), in line with local requirements and may involve requirements to wear a P2/N95 respirator for the first 7 days following exposure.
- Minimising risk of exposure to vulnerable people.
- Diligence with routine cleaning of shared equipment. E.g., phones and computer keyboards and maintaining physical distance where possible.
- No shared break areas, car-pooling, and avoidance of public transport.
- Adjusting staff rosters to minimise risk to residents and/or exposure of other staff. E.g., exposed workers tending to COVID-19 cases.

Circumstances must include the following:

- Health service understanding of their minimum number of staff required to provide a safe work environment and safe care under normal circumstances.
- Current understanding of local community transmission levels
- Contingency capacity strategies to mitigate staffing shortages have been activated and applied to mitigate staff shortages. E.g., all non-essential procedures and visits/appointments cancelled, shifting of staff to support, delaying leave, addressing social factors that may prevent staff attending work (transport, accommodation, childcare)
- Communication has occurred with local, state, and national health partners to identify additional staffing
- Health service capacity is under significant strain and alternative options for surge support have been exhausted

Where these adjustments are insufficient, and further action is needed to support the continued delivery of essential health services, additional work permissions for **workers** may be considered.

In these circumstances, work permissions and restrictions for high-risk contacts when there is high impact on service delivery should be time limited and regularly reviewed as the situation evolves. Where demand on service decreases to manageable levels, work permissions should be shifted back to 'low impact on services' (see Table 1).

Table 1: Recommended work permissions and restrictions as determined by exposure risk and impact on safe service delivery

NB These provisions cannot be used for workers who can safely complete duties from home.

	Management of low-risk exposure	Management of high-risk exposure
Low impact on services	Continue to work, remain vigilant for symptoms, test and isolate immediately if these occur. Surveillance testing: - Monitor for symptoms - If symptomatic immediately isolate (Test RAT or PCR) * Additional: - Work in surgical mask or P2/N95, based on IPC advice, for the first 7 days following exposure. - No shared break areas**	Immediately isolate for 7 days. - Day 1-2 and 6 RAT - Return to work (RTW) when day 6 test result returns negative and asymptomatic - After RTW, RAT at least every second day until day 14 - Routine PCR testing is not required - Continue to monitor for symptoms for until day 14 and immediately isolate and test if symptomatic* - Apply additional requirements on RTW as below
High impact on services ***Critical risk to service delivery Requires PHU and senior management risk assessment***	Same as above	**If symptomatic and/or unwell:** Immediately isolate and perform RAT. If positive, isolate for 7 days and follow NSW Health advice. If negative: - Recommend PCR testing if symptomatic* - Day 1-2 and 6 RAT (if PCR negative or unavailable) - RTW if day 1-2 and 6 tests are negative. Apply additional requirements below. - After RTW, RAT at least every second day until day 14 - Continue to monitor for symptoms until day 14. **Asymptomatic:** - Continue to work with negative day 1 RAT - RAT at least every second day, until day 14# (prior to commencement of workday) - Monitor for symptoms, test and isolate immediately if symptoms develop. **Additional requirements:** **Return to work with risk management plan in place:** - Use P2/N95 respirator for the first 7 days following exposure if at work during this period - Do not use shared break areas - Limit work to a single site/area - Continue to isolate in community until cleared or negative test day 6-7, travel to work via own transport or individual ride share following a negative RAT.

Adapted from Interim Guidance on managing workforce in regard to COVID-19 in aged care

IPC – infection prevention and control; PCR – polymerase chain reaction; RAT – rapid antigen test; RTW – return to work

* PCR testing is recommended if symptomatic and RAT negative

**The service must provide an adequate place for workers to observe their breaks.

If required testing unavailable, staff must not attend the workplace for 7 days after exposure.

Part 2 – Exposure risk determination for Residents and Visitors

The COVID-19 exposure risk determination provides a framework to determine the type of risk for residents and visitors following an exposure to COVID-19 (see risk matrix on page 8). The matrix considers personal protective equipment (PPE) worn, contact time, enclosed spaces and if an aerosol generating procedure (AGP) was being performed or if there were aerosol generating behaviours (AGBs).

Definition of aerosol-generating procedures and behaviours

Aerosol-generating procedures (AGP) are procedures performed on patients that are more likely to generate higher concentrations of infectious respiratory aerosols and may be associated with a higher risk of infection transmission. Examples of AGPs include non-invasive ventilation (for example, BiPAP, CPAP), nebuliser use, suctioning of respiratory tract secretions, tracheostomy suctioning, high-flow nasal oxygen therapy, and cardiopulmonary resuscitation.

Aerosol-generating behaviours (AGB) are behaviours that are more likely to generate higher concentrations of infectious respiratory aerosols such as persistent and/or severe coughing, sneezing, screaming, shouting, singing, heavy breathing and panting.

Risk level associated with various scenarios

In the following tables there are three levels of risk associated with various scenarios: low, medium and high. Some examples of these scenarios are:

Low-risk scenarios: observing residents during a meal in the dining area, walking past a resident in the corridor, emptying garbage bins in the dining area, placing an item on a resident's table in the dining room (resident sitting at the table)

Medium risk scenarios: handing a resident their medications, assisting a resident out of their chair or with a meal, participating in a recreational room event, car-pooling (short trips), interacting in a shared staff room

High-risk scenarios: assisting a resident to use their CPAP machine, assisting a resident who is aggressive or yelling, close personal care activities.

Rapid Antigen Test (RAT)

The use of RATs for the diagnosis and clearance of people with COVID-19 continues to evolve. The performance of a RAT does depend on the adequacy of sampling, conducting the test appropriately and correct interpretation of the result, and therefore any staff who are performing a RAT must ensure that they follow the manufacturers' instructions. For more information on Rapid Antigen Tests from NSW Health see here. The Therapeutics Goods Administration (TGA) also has information here.

*** PPE Breach Risk Assessment key principles.**

Perform a risk assessment to determine the level of exposure as applied to COVID-19 suspected/confirmed.

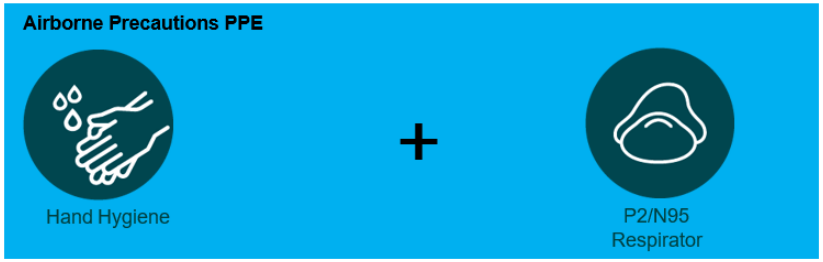
LOW RISK BREACH	Breaches in PPE that occur below the neck and managed immediately (e.g. torn glove)	Remove from situation Remove item Perform hand hygiene
MODERATE RISK BREACH **INCREASED RISK OF INFECTION**	Incorrect use of PPE, incorrect PPE for task Contamination occurs during doffing (occurs above neck)	Remove from situation Remove PPE Perform Hand Hygiene Screening/testing and continuous monitoring
HIGH RISK BREACH **LIKELY RISK OF INFECTION**	Exposure of mucous membranes by direct droplets from confirmed COVID positive. (e.g., spitting in HW face by confirmed COVID) Gross contamination during incorrect doffing	Remove from situation Remove contamination Remove PPE Closely Monitor, screen/test, consider removing from clinical duties

Adapted and modified from work developed by AUSMAT Quarantine management and operations compendium for the Howard Springs Quarantine Facility for the Repatriation of Australians at the Centre for National Resilience. National Critical Care and Trauma Response Centre. Darwin 2021.

Contact Precautions protect the Health Worker (HW) by minimising the COVID-19 transmission risk from direct physical contact with patients or indirect contact from shared patient care equipment or from contaminated environmental surfaces

Droplet Precautions protect the HW's nose, mouth and eyes from droplets produced by the patient coughing and sneezing

Airborne Precautions protect the HW's respiratory tract from very small and unseen airborne particles that become suspended in the air



For more information refer to COVID-19 IPAC manual

Staff Contact

[#] Depending on risk assessment

[##] Depending on risk assessment for AGB/AGP

PPE worn by health worker contact and case	Contact type: Transient contact – Low Risk Scenarios Transient, limited contact that does not meet the definition of face-to-face contact Note: always subject to local documented risk assessment, including assessments of occupational exposures and of the closed space	Medium Risk Scenarios Face-to-face contact within 1.5 metres for less than 4 hours OR Based on agreed documented risk assessment including assessments of occupational exposures and of the physical environment	High Risk Scenarios Face-to-face contact within 1.5 metres for 4 hours or greater OR Case with AGBs / undergoing AGP
Staff Contact: No PPE **Case**: No PPE	**Moderate[#]**	**Moderate**	**High**
Staff Contact: Surgical mask **Case**: No PPE (or vice versa)	**Low**	**Moderate[#]**	**High**
Staff Contact: Surgical mask **Case**: Surgical mask	**Low**	**Low[#]**	**Moderate[##]** OR **High**
Staff Contact: Surgical mask and eye protection **Case**: No PPE	**Low**	**Low[#]**	**Moderate[##]** OR **High**
Staff Contact: Surgical mask and eye protection **Case**: Surgical mask	**Low**	**Low**	**Low (if no AGB/AGP)** OR **Moderate[##]**
Staff Contact: P2/N95 mask and eye protection **Case**: With or without PPE	**Low**	**Low**	**Low**

LOW RISK	Continue to work DCW alert to mild symptoms Test (RAT or PCR) if symptomatic
MODERATE RISK	Continue to attend work with risk management plan RAT not earlier than day 2 post exposure For 14 days after exposure: - Consider redeploying to lower patient risk area if possible - Mask wearing at all times – surgical or N95 as per CEC guidance - Do not enter shared spaces such as tearooms & do not participate in any staff gatherings - Careful monitoring for symptoms
HIGH RISK	Immediately isolate for 7 days. - Day 1-2 and 6 RAT - Return to work (RTW) when day 6 test result returns negative and asymptomatic - After RTW, RAT at least every second day until day 14 - Routine PCR testing is not required - Continue to monitor for symptoms for until day 14 and immediately isolate and test if symptomatic* - Apply additional requirements on RTW as per Table 1

Resident or Visitor Contact		Contact type		
		Transient contact – Low Risk Scenarios Transient, limited contact that does not meet the definition of face-to-face contact	**Medium Risk Scenarios** Face-to-face contact within 1.5 metres for less than 4 hours	**High Risk Scenarios** Face-to-face contact within 1.5 metres for 4hours or greater OR Case with AGBs / undergoing AGP
PPE worn by resident/visitor contact and case	**Contact**: No Mask **Case**: No Mask	**Moderate**[#]	**Moderate**	**High**
	Contact: No PPE **Case**: Surgical mask	**Low**	**Moderate**[#]	**High**
	Contact: Surgical mask **Case**: No PPE	**Low**	**Moderate**[#]	**High**
	Contact: Surgical mask **Case**: Surgical mask	**Low**	**Low**	**Moderate**[##]
	Contact: P2/N95 and eye protection **Case**: Surgical mask	**Low**	**Low**	**Low**

[#] Depending on risk assessment

[##] Depending on risk assessment for AGB/AGP

Note: For actions based on risk classification in the matrix above, see the table on page 9.

Actions based on risk classification			
Risk classification	**Low Risk**	**Moderate Risk**	**High Risk**
For all categories below, monitor for symptoms, and test[1] and isolate if symptomatic			
Requirements for staff	Isolation not required Continue to work	Continue to attend work with risk management plan Initial RAT test usually not earlier than day 2 post exposure For 14 days after exposure: • Consider redeploying to lower patient risk area if possible • Wear a mask at all times on site - surgical or N95 as per CEC guidance • Do not enter shared spaces such as tearooms and do not participate in any staff gatherings	Immediately isolate for 7 days. - Day 1-2 and 6 RAT[1] - Return to work (RTW) when day 6 test result returns negative and asymptomatic - After RTW, RAT at least every second day until day 14 - Routine PCR testing is not required - Continue to monitor for symptoms for until day 14 and immediately isolate and test if symptomatic If in a role essential to service delivery and asymptomatic, fully vaccinated staff may continue to attend work with manager approval and with a risk management plan. - Apply additional requirements on RTW as per Table 1
Requirements for residents	Isolation not required	Isolate until negative day 6 swab[2] Test at day 2, 6, 9 and 12 post exposure[3]	Isolate for 7 days[2] Test at day 2, 6 post exposure[3] Test every 48-72hrs from day 8-14 (where removed from isolation and able)
Requirements for visitors	Isolation not required	Do not attend the Disability Care Facility until negative day 6 swab Isolation in the community not required Test at day 2 and 6 post exposure	Do not attend the Disability Care Facility for 14 days Isolate in community until day 7 if negative day 6 swab Test at day 2 and 6 post exposure

Please note: Testing in this document refers to rapid antigen test (RAT). [1] PCR testing is recommended if symptomatic and RAT negative

[2] An assessment should be made regarding the ability of residents to be isolated within the Aged Care Facility. Cohorting of residents based on level of risk may be required depending on the layout of the premises and resident factors.

[3] Where residents cannot be effectively isolated from each other, more frequent swabbing may be required to detect cases early, identify ongoing transmission and guide implementation of additional infection control measures.