Mirrors Care Acute Respiratory Infection (ARI) Outbreak Management Plan

Revision history			
Version	Date	Reason / Changes	Endorsed by
1.0	09/01/25	Initial Release	MD

Contents

1. Background

1.1 Purpose

The information in this plan applies to all Mirrors Services and can be used to help with planning, preparation, detection and management of cases and outbreaks of acute respiratory infection (ARI).

1.2 Disability Residential Services

A DRS includes accommodation that provides support services to two or more people with disability. This includes:

- supported independent living supports provided in shared disability living arrangements that are funded under the NDIS
- group homes funded outside of the NDIS

Lower-risk settings

Where a DRS is a lower-risk setting (e.g. a setting with a small number of clients who do not have multiple comorbidities or other risk factors that increase their risk of serious outcomes from respiratory infection and lower staff numbers) Mirrors may choose to follow state or territory guidance on managing outbreak guidelines. These household requirements typically specify actions around testing, isolating and/or limiting movements of symptomatic people and close contacts.

In determining whether a DRS is a lower-risk setting and whether they will follow local household requirements, Mirrors will consider:

- state and territory guidance
- clients' preferences (i.e. whether they would prefer the service to follow household requirements), and
- input from clients' health care Mirrors Care on the risk ARI poses to them

2. Key Principles

2.1 Acute Respiratory Infections

Acute respiratory infection (ARI) means recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion with or without other symptoms (see box below).

- Acute respiratory infections (ARI) as defined in this document encompasses a range of infections caused by respiratory viruses, including but not limited to, COVID-19, influenza, and respiratory syncytial virus (RSV).
- ARI transmission is primarily via respiratory droplet and aerosol spread when infected individuals cough, sneeze, talk or shout.
- Many ARI can be spread before symptoms appear in an infected person, therefore early identification of cases and early implementation of infection control procedures, testing and treatment are essential to contain spread and minimise the chance of serious illness or death.
- Symptoms of ARI are often similar regardless of the virus causing illness and therefore testing clients with symptoms is essential to confirm the diagnosis and guide management.

Symptoms of acute respiratory infection

New or worsening acute respiratory symptoms:

- cough, breathing difficulty, sore throat, or runny nose/nasal congestion
- headache, muscle aches (myalgia), fatigue, nausea or vomiting and diarrhoea. Loss of smell and taste and loss of appetite can also occur with COVID-19.
- fever (≥37.5°C) can occur, however is less common in some people with disability, and those who are frail or elderly.
- other symptoms to consider are change in baseline behaviour, new onset or increase in confusion, mobility, or exacerbation of underlying chronic illness (e.g., increasing shortness of breath in someone with congestive heart failure).

Clinical syndromes resulting from respiratory viral infections can vary from no symptoms to severe disease and death. Anti-viral treatments are available for COVID-19 and influenza and therefore early recognition, testing and diagnosis are important for individual patient management as well as for preventing spread to others.

Severity of ARI can be increased in people with multiple comorbidities. Some populations are at especially high risk of severe disease (e.g. people with intellectual disability, people with Down syndrome) and rapid deterioration.

2.2 Identifying Acute Respiratory Infections in Clients with Disability

Some people with disability may have difficulty making their communication of ARI symptoms understood by people who support them. For some people with disability changes in behaviour will be a communication that they are unwell.

People who are up to date with vaccination against COVID-19 and influenza may experience milder symptoms from these illnesses.

Mirrors Care will ensure that staff, family and clients are aware of:

- ARI symptoms
- the possibility that a person with disability may communicate the presence of an ARI through changes in behaviour, and
- the need to report any changes to senior staff when observed.

A clients's general practitioner (GP), behaviour support practitioner (if one is engaged) and family members may be able to advise whether specific changes in behaviour could be an indication of ARI and what further investigation may be required.

2.3 An Inclusive and Proportionate Approach to Managing the Risk of Acute Respiratory Infection

Mirrors Care will adopt an inclusive and proportionate approach to managing the risks of ARI which is considerate of resident wellbeing.

An inclusive and proportionate approach to management of the risk of respiratory infections will be different between services due to the diversity between the people that Mirrors Care supports. These differences will also mean that Mirrors Care may apply the guidance in this document in different ways, in order to best support the health and wellbeing of their clients.

An inclusive approach is where:

- Mirrors Care consult with clients (and their families and/or substitute decision makers) on their approach to ARI outbreak prevention and management.
- Mirrors Care understand the needs and preferences of each individual resident (it may be appropriate to involve a resident's GP and/or behaviour support practitioner), and
- the preferences of clients will shape key decisions made by the provider, especially those relating to more substantial infection prevention and control measures (e.g. approaches to isolation and visitation restrictions).

When engaging with clients on these topics and when implementing infection prevention and control measures, Mirrors Care will need to tailor communications to make them accessible to individual clients.

A proportionate approach to the management of the risks respiratory infections pose to clients is one that is considerate of the detrimental effect some infection prevention and control measures (e.g. isolation) can have on the health and wellbeing of clients. In other words, Mirrors Care will take a holistic approach when assessing the risks ARI poses to clients and the impact of measures aimed at reducing that risk.

That approach requires consideration of the:

- likelihood of ARI being introduced and transmitted within the DRS
- severity of consequences will clients become ill, and
- measures that can be safely introduced to reduce likelihood of spread and mitigate potential consequences (e.g. precautionary separation or isolation of clients while test results are awaited) and the impact those measures will have on clients.
- The support needs and risk factors for individual clients will need to factor into this assessment and decision making.

3. Preparedness and outbreak management planning

Mirrors Care has consulted with clients when undertaking ARI preparedness and outbreak management planning. Clients are encouraged to consider and communicate what an outbreak will mean to them. Their preferences on outbreak prevention and management approaches will shape the development and implementation of plans.

Mirrors Care will also consider how preparedness and outbreak management planning is addressed in organisational risk management policies and procedures.

3.1 Preparedness and prevention

Mirrors Care will prevent the entry and spread of ARI (in the absence of any known cases) and ensure that DRS are ready to respond to suspected and confirmed cases when they arise.

Mirrors Care enacts preparedness and prevention in the following ways:

- Planning
    - Reviews capacity to implement standard precautions (as a baseline measure) and transmission-based infection prevention and control (IPC) precautions.
    - Identifies how clients can isolate and be cohorted (if possible or appropriate), or follow close contact requirements
    - Plan sfor management of clients with behaviours of concern during an outbreak.
    - Engages clients and substitute decision makers in key decisions prior to an outbreak.
- Vaccination
    - Reviews and recommend the implementation of the latest vaccination requirements for staff and visitors.
    - Promotes COVID-19 and influenza vaccination among clients, staff and visitors.
    - Monitors and records vaccination status of clients, staff.
- Supply of key materials, including:
    - personal protective equipment (PPE),
    - hand hygiene, waste and cleaning supplies and equipment, and
- Case identification and testing
    - Has established a systematic method for detecting and recording the development of ARI symptoms among clients, such as fever or cough.
- Clinical management
    - Has establish clinical management, treatment, and referral pathways for clients.
        - Works with clients' GPs to plan how ARI can be best managed for each resident.
        - Identifies pathways to access anti-viral treatments rapidly, when required.
- Workforce
    - Ensures infection prevention and control (IPC) training for staff including appropriate use of PPE and recognition of ARI symptoms.
    - Ensures staff are trained in responding to an ARI outbreak response.
    - Ensures workforce continuity by establishing workforce surge capacity and undertaking contingency planning for staff absenteeism. This may include:
        - maintaining a list of workers who can be reallocated to direct support or care roles if needed, or

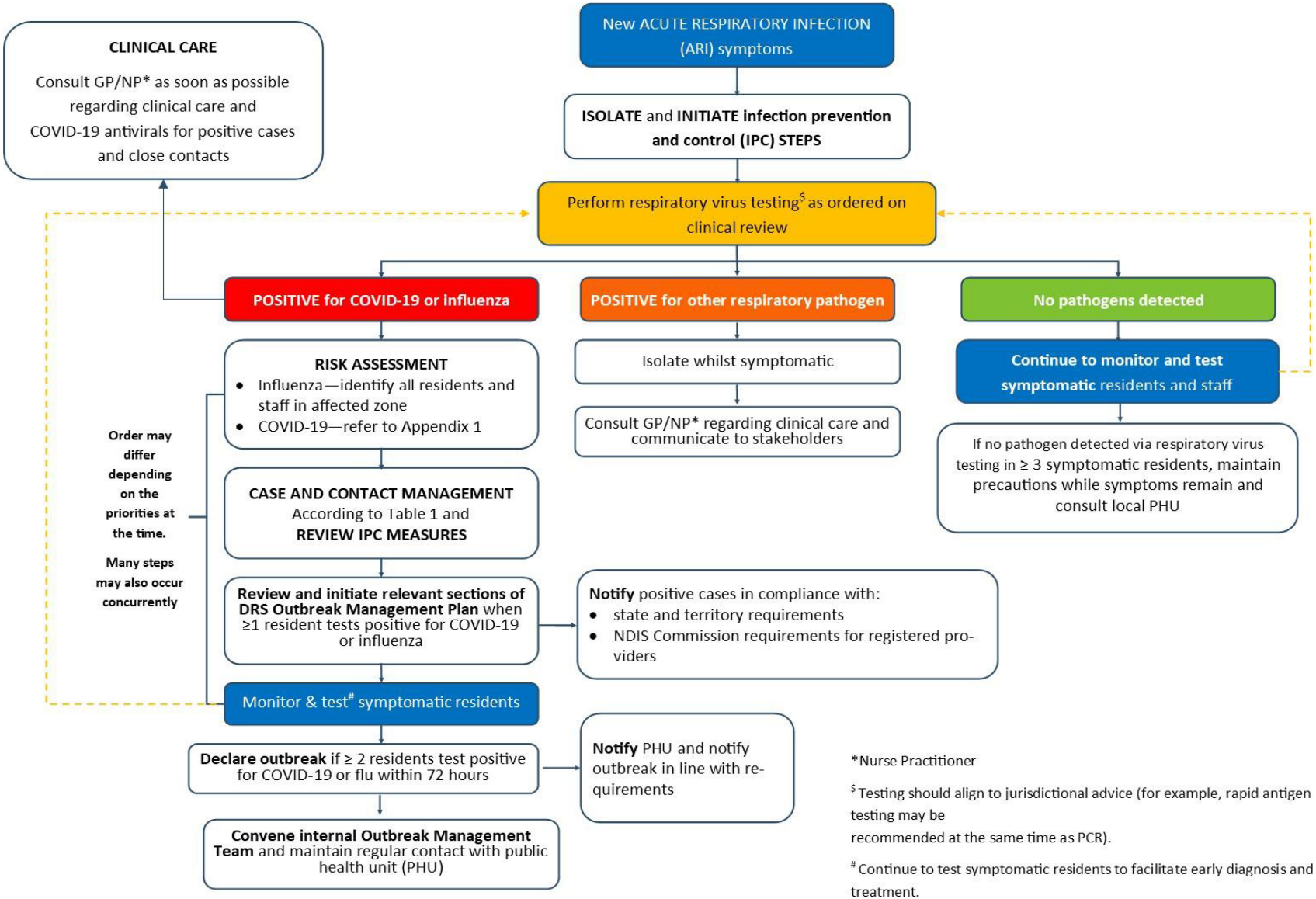
- partnering with Shape Disability to support each other in the event of major staff disruptions.

4. Responding to new ARI symptoms in a resident

The steps outlined below are a guide only and the step-by-step order may differ depending on the priorities at the time. Some steps may need to occur concurrently.

DRS must consider current advice (Public Health Unit, Department of Health or equivalent) in relation to screening of visitors and staff prior to entry into the service and use of PPE.

Figure 1. Overview of initial actions – New Acute Respiratory Infection (ARI) Symptoms



*Nurse Practitioner

$ Testing should align to jurisdictional advice (for example, rapid antigen testing may be recommended at the same time as PCR).

Continue to test symptomatic residents to facilitate early diagnosis and treatment.

Step 1: Isolate and step-up infection prevention and control

Isolation definition:

For the purposes of this document the term 'isolate' means keeping clients separate from other clients, which may involve keeping clients in their own room. It can include ensuring mask wearing when clients are moving between rooms such as moving to a shared bathroom, in communal areas or when there are other people around.

(a) Where symptoms identified in resident

Key tasks for Mirrors Care if a resident displays ARI symptoms:

- Isolate
  - Symptomatic clients will isolate immediately in their own room, where possible, to prevent opportunity for ARI spread within the DRS.
  - Allocate separate staff to support symptomatic clients and limit cross over with staff supporting non-symptomatic clients (cohort staff and clients).
- IPC
  - Implement initial IPC measures including transmission-based precautions – contact, droplet and airborne precautions (e.g. N95/P2 respirator mask, eye protection, gown and gloves to be worn by staff caring for symptomatic resident/s)[5]
  - Post signs on the door or wall outside the resident's room advising entrants to use standard and transmission-based precautions – contact, droplet and airborne precautions.
  - Set up dedicated donning/doffing area with signage, PPE and hand hygiene:
    - make sure that appropriate and sufficient PPE is available outside of the resident's room,
    - store additional stock onsite in an appropriate and accessible location and
    - place a lined disposal receptacle near the exit inside the resident's room, to make it easy for staff to discard PPE before leaving the room
  - Where possible and if tolerable, isolating clients will wear a surgical mask:
    - when staff members or visitors are in their room, or
    - if they need access shared area (e.g. a bathroom)
  - Avoid using aerosol generating procedures (such as nebulisers) on symptomatic clients if clinically safe. The resident's GP will be consulted on the safety of any changes to these procedures.
- Vaccination
  - Review vaccination status (COVID-19 and influenza) of clients and staff and prioritise vaccination of those not up to date.
- Environmental cleaning, disinfection and waste disposal
  - Schedule daily cleaning in line with environmental cleaning and disinfection principles for COVID-19.6
  - Allocate trained staff for cleaning of affected areas and waste disposal – ensure they are skilled to perform routine and additional cleaning and waste disposal.

(b) Where symptoms identified in staff or visitors

- Attendance
    - Staff or visitors will not attend a DRS if they have ARI symptoms – even if they have tested negative.
    - If symptoms develop or are identified in staff or visitors while at a DRS, they will be instructed to leave the premises. Steps will be taken to ensure that resident care and support needs are still met if staff or visitors are requested to leave.
    - Symptomatic staff or visitors will seek COVID-19 testing in line with jurisdictional recommendations or consult their GP for respiratory pathogen testing. Staff or visitors will inform the DRS of the outcome of testing.
- Environmental cleaning and disinfection will occur in areas symptomatic staff or visitors attended.

Step 2: Testing and clinical review

Testing for ARI is critical for establishing a diagnosis and facilitating early treatment. It also enables early planning and control of any potential outbreak.

Symptomatic person/s will be tested as soon as possible.

Initial cases of ARI within a DRS will be tested by RAT and PCR to establish the pathogen. PCR will include COVID-19, influenza A and influenza B. A wider panel of respiratory viruses will be tested as clinically indicated.

DRS will consult with a general practitioner (GP) or nurse practitioner (NP) regarding clinical review and testing of all clients with ARI symptoms and soon as possible.

Where **clients** have symptoms of acute respiratory infection, Mirrors Care can use the following pathway:

- Test for COVID-19 on the person with symptoms using a rapid antigen test (RAT) or arrange a PCR.[7] Testing by RAT may be preferable due to availability and quick turnaround.
    - If COVID-19 RAT or PCR is **positive** commence on the positive result pathway (see figure 1).
    - If COVID-19 RAT is **negative**:
        - Local jurisdictional advice may recommend that a negative RAT is followed up with a PCR test for COVID-19 (PCR testing for influenza may be provided alongside a COVID-19 PCR).

Regardless of the outcome of COVID-19 testing seek clinical review by GP or NP to assess clinical status of the patient and arrange further testing for respiratory pathogens, including influenza, if required.

- In the absence of clear diagnoses in symptomatic clients, precautions (isolation and other IPC measures) will be maintained while clients are symptomatic and the PHU or a GP contacted for further advice.

DRS will take steps to ensure access to appropriate testing services and clinical review before testing is required.

DRS will work with clients' GPs (and other primary care Mirrors Care) to ensure that clients can be quickly tested at the onset of symptoms and that advice on testing can be accessed efficiently. This may include:

- discussing barriers to testing and how they will be managed, and
- having tests pre-ordered on pathology forms in the event a resident develops symptoms of a respiratory infection.

Where **staff** report symptoms of ARI, they will be directed to their primary care provider.

Step 3: Assess risk of ARI spread

When dealing with suspected or known ARI cases, Mirrors Care will make decisions to manage and mitigate the risk of ARI spread. Sometimes these decisions will need to be made with incomplete information (e.g. uncertainty about who has been exposed to a virus that causes ARI, or what ARI is spreading in a DRS).

When assessing the risk of ARI spread and how to respond to that risk DRS will consider:

- the **likelihood** of spread (e.g. the closeness of clients during the infectious period, whether masks were worn, the duration of contact, and other factors such as aerosol-generating behaviours and procedures)
- the **consequences** of spread (e.g. a large, uncontrolled outbreak, spread to clients who are at greater risk from ARI), and
- the **measures** that can be safely introduced to reduce likelihood of spread and mitigate potential consequences (e.g. precautionary separation of clients while test results are awaited) and the impact those measures will have on clients.

Assessing risk once a case of COVID-19 or influenza has been confirmed

Where a case of COVID-19 or influenza is confirmed in anyone who has spent time in the service while they were infectious, Mirrors Care will assess the risk to clients and manage close contacts according to local jurisdictional guidance (see Step 5).

Other critical actions will include:

- Review IPC measures and identify and address any gaps.
- Assess and manage risk from symptomatic staff. Furlough symptomatic staff and direct them to their GP.

Step 4: Case management

Immediately escalate to management if a resident tests positive for influenza or COVID-19 where they have been at the DRS during their infectious period.

(a) Clients

- Treatment
    - On diagnosis, DRS will promptly contact the resident's GP or NP regarding clinical assessment, care, and eligibility for treatment.
    - Clients' GP/NP will continue to provide their routine primary care as needed either onsite and/or virtually.
- Isolation and cohorting
    - The positive resident will continue to isolate (as established prior to testing) and receive ongoing daily care.Cases will be managed according to the diagnosis, as shown in Table 1. WA Health may implement additional requirements above these recommendations.
    - Clients who have tested positive for the same virus can cohort together for social and/or management benefit. This may be necessary if they cannot isolate in their own room.
    - Clients with different viruses will not cohort together.
    - Clients who have been exposed to or tested positive for COVID-19 or influenza will still attend essential off-site appointments (e.g. dialysis), in consultation with the off-site service provider and in accordance with local jurisdictional requirements.
- IPC Measures
    - Maintain standard and transmission-based precautions – contact, droplet, and airborne precautions (N95/P2 respirator mask, eye protection, gown and gloves to be worn by staff caring for symptomatic resident/s).
    - Identify the areas of the DRS that are at risk. Where the whole DRS is impacted or at risk, whole-of-service actions will be taken.
    - Apply the risk assessment outcomes and test results to confirm areas in the DRS that:
        - are staff only e.g., kitchen, reception area (e.g., Blue zone)
        - are likely to be completely unaffected and can be staffed with nonexposed staff and managed separately (e.g., Green zone)
        - have been affected due to exposures or cases (e.g., Amber Zone)
        - cases (e.g., Red zone)
    - Where possible, allocate staff to one zone for the duration of the outbreak.
    - Donning and doffing stations and clinical waste disposal bins will be set up with appropriate signage for use by staff or visitors entering areas where positive clients are isolating or cohorting.

(b) Staff or visitors

- Isolation
    - Positive cases among staff or visitors will isolate at home.
    - When they are permitted to return to the service will depend on local jurisdictional requirements (see Table 1).
- Vaccination[8]
    - During a confirmed influenza or COVID-19 outbreak, staff who are not up to date with their vaccination are recommended to work only if asymptomatic and wearing a mask. See local jurisdictional guidance.

Table 1 – Recommended case management for COVID-19, influenza, RSV and other confirmed respiratory pathogens.

			COVID-19 (RAT or PCR)	Influenza (PCR)	Other confirmed respiratory pathogen including RSV
CASE	**Resident**	Case isolation*	At least 7 days from positive test date, until asymptomatic. Case can cohort with other COVID-19 positive clients.	5 days from symptom onset. Case can cohort with influenza positive clients.	The resident will isolate whilst symptoms remain. Resident can cohort with clients with same confirmed pathogen.
		End of isolation*	After day 7 if substantial resolution of acute respiratory symptoms and no fever for 24 hours. No testing required.[9]	After 5 days from symptom onset, or until they are symptom-free, whichever is longer **or** 72 hours after antivirals commenced. No testing required.	Once symptoms resolve. No testing required.
		Antiviral treatment	COVID-19 antivirals and other disease modifying therapies as indicated (via clinical review)	Discuss treatment options with patient's GP.	Nil/seek guidance from GP on clinical management.
	Staff	Return to work	After 7 days (minimum) if no symptoms for 24 hours, no testing required. If symptoms continue, return when substantial resolution of acute respiratory symptoms no fever for 24 hrs.[1]	5 days from symptom onset, or until symptom-free, whichever is longer or 72 hours after antivirals commenced. No testing required.	Once symptoms resolve. No testing required.
	Visitors	Visitors to DRS	Can visit DRS after 7 days (minimum) if no symptoms.	Exclude from DRS for 5 days from symptom onset or until symptom-free, whichever is longer.	Exclude if symptomatic.

*Isolation for the purpose of this document includes keeping clients separated from other clients, which may involve keeping clients in their own room or mask wearing when clients are moving between rooms such as moving to a shared bathroom, in communal areas or when there are other people around.

Note: WA Health may implement additional requirements and/or recommendations.

Step 5: Contact management

- Following an exposure, DRS will undertake exposure assessment to determine if any staff or clients have been exposed to the case and develop an agreed management plan based on the degree of assessed risk.
- In assessing contacts of a positive case, the DRS will identify all staff and clients who have been potentially exposed. In small DRS (e.g. group homes), it is possible that all clients will have been exposed.
- To support assessment and management of staff and resident contacts of a positive COVID-19 case (for known exposures or single case with a known source), refer to Appendix 1.
- Ensure contacts who are clients are monitored for symptoms and limit movement within the DRS.
- All clients in the identified zone (the area or areas where people may have been exposed to the virus) will be tested to find cases, irrespective of whether they have

symptoms. See Appendix 1. In smaller DRS (e.g. group homes) it might be appropriate to test all clients.

- Seek advice from the treating GP and/or public health unit on the use of influenza antivirals during influenza outbreaks as post exposure prophylaxis for clients in the affected zone.
- It is important that DRS use a risk-based approach to contact assessment and management. The risk of transmission will be managed whilst balancing the risk related to social isolation through application of the least restrictive controls appropriate.

Table 2 – Contact management for COVID-19, influenza, and other confirmed respiratory pathogens.

			COVID-19 (RAT or PCR)	Influenza PCR	Other confirmed respiratory pathogen
CONTACTS	**Resident**	Contact testing	For smaller DRS (e.g. group homes) testing for all clients is recommended. For larger DRS, all clients in affected zones (e.g. wings)	Symptomatic clients in the same zone (likely wing).	Test based on clinical advice.
		Contact isolation	Limit movement while test results pending and risk assessment completed. See Appendix 1.	Clients who are in same zone(s) will avoid moving between different zones.	Nil
		Contact post-exposure prophylaxis	Nil	Discuss prophylaxis options with resident's GP and the PHU.	Nil
	Staff	Return to work	See Appendix 1.	Immediately if no symptoms or once symptoms have resolved. Must wear a mask and other PPE as required when at work. Unvaccinated staff will not work in affected areas.	Immediately if no symptoms or once symptoms have resolved.
		Post-exposure prophylaxis	Nil	Staff who are unvaccinated or staff at higher risk of severe disease due to existing conditions will discuss the use of influenza antivirals with their GP.	Nil
	Visitors	Return to DRS	Can attend from Day 8 if no symptoms.	Immediately if no symptoms.	Immediately if no symptoms.

Note: WA Health may implement additional requirements and/or recommendations.

Step 6: Notification and reporting

(a) Notify state/territory health department as required by local guidance

Mirrors Care will be required to notify their relevant state or territory health department of a COVID-19 or influenza case among a staff member, resident or visitor. Mirrors Care must be aware of local reporting requirements as these vary between WA Health.

Notify the local PHU of an OUTBREAK when 2 or more clients test positive to COVID-19 or influenza within a 72-hour period.

(b) Notify the NDIS Commission

Registered NDIS Mirrors Care must notify the NDIS Commission of certain changes and events, especially those which substantially affect the provider's ability to provide the supports and services they are registered to provide.

Mirrors Care will notify the NDIS Commission of positive cases of COVID-19 including any changes to service delivery arrangements or inability to meet their conditions of registration using the Notification of event form – COVID-19.

More information on providing notice of changes and events can be found on the NDIS Commission's website: Notice of changes and events.

(c) Notify others

Notify important people identified by the resident, any substitute decision maker or guardian of a resident (if known), other support Mirrors Care and disability services, hospitals where clients have had a high-risk exposure and have subsequently been transferred or require immediate transfer for care.

Step 7: Declaring an Outbreak and Convening Outbreak Management Team

An outbreak will be declared if:

- 2 or more clients test positive for COVID-19 within a 72-hour period or
- 2 or more clients test positive for influenza within a 72-hour period

- Once an outbreak has been declared, the Mirrors Care will convene an internal outbreak management team (OMT) meeting and confirm the staff members who will be designated:
  - Outbreak Management Lead (and their backup) and
  - Infection Prevention and Control lead (and their backup).
- The OMT will meet and communicate regularly, with decisions documented.
- Mirrors Care will remain in regular contact with the PHU.
- The PHU will determine whether an inter-agency OMT meeting is required in a COVID-19 outbreak.

During the outbreak

- IPC measures
    - Mirrors Care will establish isolation of the cohort, where possible. Ensure all areas:
        - are clearly designated with clear signage in place.
        - have an adequate number of sites for hand sanitiser, ideally at each bed space, and entrance/exit to the home.
        - have hand hygiene, PPE station and waste disposal at entry if appropriate. Donning and doffing area will be separate.
        - are decluttered as much as possible to make cleaning and disinfection easier.
        - have limited entry/access to each cohort.
    - Have separate break areas for staff where physical distancing can be maintained.
    - A risk assessment will inform the appropriate level of PPE for staff providing direct care or working within the resident zone.
    - The assessment will consider controls already in place and also the clients' pre-existing likelihood of COVID-19, resident factors that enable transmission, nature of the care episode and physical location.
- Increase the frequency of cleaning and disinfection.
    - Frequently touched surfaces and those closest to clients will be cleaned more often. These surfaces include:
        - equipment
        - door handles
        - trays
        - tables
        - handrails
        - chair arms
        - light switches
        - patient care equipment (e.g., commodes, lifter slings, etc)
    - Activate strategies established for increases in clinical and general waste storage and removal and linen cleaning and supply.
- Resident movement during an outbreak
    - Essential off-site appointments also will continue (e.g., dialysis), with negotiation with the service provider if the resident has been exposed to COVID-19 or influenza.
    - Any transfers (other than on the basis of clinical need) will be planned and coordinated with hospital services and in consultation with the resident, their family or alternative decision-makers and public health units. The receiving hospital must be informed about the outbreak at the DRS, regardless of whether the resident being transferred is a case or not.
    - If practical, clients of similar exposure or the same diagnosis can also be cohorted together.
    - Clients in unaffected zones are able to attend external appointments.
    - Consider relocating clients who are on a palliative care pathway and require additional supports (e.g., compassionate care / visiting, symptom

control) to an area where they are less at risk of further exposure (or if cases, plan for how resident could be supported with visits).

- Staff considerations
    - During a confirmed influenza outbreak, staff who have not received the influenza vaccination are at higher risk of acquiring influenza, therefore they are recommended to work only if asymptomatic, wearing a mask. The use of antivirals prophylaxis will only on advice of a clinician and will be discussed with the PHU. Any antiviral use by staff will be documented.
    - Contingencies (e.g. alternative staffing options) will be in place for any staff who do not meet this criteria.
    - Staff who are higher risk contacts will not move between their section and other areas of the DRS, in line with basic IPC principles.

Other considerations relevant to an outbreak

- New and returning clients to DRS from the community, hospital, or emergency department.
    - The presence of an outbreak will not prevent new and returning clients from being entering or returning home to the DRS with appropriate IPC measures in place. Decisions will be based on the advice of the local OMT and in consultation with the PHU, clients and their representatives.
    - Clients and families entering the DRS during an outbreak will be informed of the current situation, as well as any associated restrictions (e.g., visitor limitations).
- Resident choice regarding isolation
    - Consumer dignity and choice are foundational standard 1 in the National Quality Standards for Disability Care. The NDIS Code of Conduct requires workers and Mirrors Care who deliver NDIS supports to act with respect for individual rights to freedom of expression, self-determination, and decision-making in accordance with relevant laws and conventions. Participant independence and informed choice is also a Core Module outcome of the NDIS Practice Standards.
    - Clients will be given the choice to self-isolate while an outbreak is in progress or to mix with people with the same condition or exposure. Their preferences will be recorded in their support plans and regularly reviewed.
    - Exposed clients will not socialise with positive cases or clients from unaffected areas.
    - Clients who have not been exposed, are not symptomatic or positive for ARI will be given the choice to self-isolate if they desire to do so.
- Where it is practical, and the DRS can manage this subject to resident preferences:
    - Clients with the same condition or exposure will be allowed to engage in social activities and eat together if they are well enough to do so and if they can be kept separated from clients who are exposed or unaffected.
    - Clients exposed to the same pathogen may choose to leave their rooms to eat in shared dining rooms and participate in social activities with other clients from the exposed area[10]. Exposed clients will not socialise with positive cases or clients from unaffected areas. Unexposed clients can leave their rooms to participate in shared activities and dining with other unexposed clients (e.g., with dedicated staff, dining room, social room).
    - Where possible, visits to affected clients will occur in an area with good ventilation (see Appendix 2).

Step 8: Communicate

- Ensure all affected clients are aware of their diagnosis, exposure status, testing and isolation requirements. Individual communications strategies need to be considered for clients who may have difficulty following instructions due to cognitive impairment or language barrier. These will be recorded in the resident's support plan.
- Ensure clients' family and carers are aware of the exposure/outbreak at the service and status of individual clients, including their diagnosis and management.
- Ensure staff are aware of the exposure/outbreak at the service and remain on high alert monitoring themselves and clients for ARI symptoms
- Ensure visitors are aware of the exposure/outbreak at the service. State and territory guidance on visitation will be followed (see appendix 2 for information on visitation during exposure/outbreak in a DRS).
- Put up notices of the outbreak at all entrances informing entrants of the exposure/outbreak at the service. Signage will also be displayed outside the room of affected clients. This will help minimise unnecessary visits that may lead to inadvertent transmission.

Step 9: Declaring an outbreak over

- A decision to declare the outbreak over will be made by the PHU or OMT. Generally, this is:
    - when no new cases occur within 8 days following the onset of symptoms in the last resident influenza case.
    - 7 days after the last COVID-19 case tests positive **OR** the date of isolation of the last COVID-19 case in a resident, whichever is longer.
- However, additional testing or measures may be recommended by the PHU in the 7 days following an outbreak being considered "over".
- DRS will remain on high alert and:
    - seek clinical review and appropriate testing for anyone with new symptoms, no matter how mild; and
    - carefully monitor clients with high-risk exposure for behavioural changes, lack of appetite, and lethargy; and
    - ensure visitors (who may be at higher risk themselves) are aware that there has been an outbreak.
- Individual cases will remain in isolation for the required period (as per Step 4) even if the outbreak has been declared over for the DRS.
- Where there is extensive or poorly understood transmission, or where there are significant numbers of clients not up to date with immunisations, the PHU may advise the DRS to continue to manage as an outbreak until at least 14 days have passed since the last case tested positive.
- Once an outbreak is over, DRS will evaluate the response to and management of the outbreak to identify strengths and weaknesses. Consider conducting a DRS debrief with all employees and contractors involved with the outbreak.

Appendices

Appendix 1: COVID-19 exposure and outbreak management

Appendix 2: Visitation during an outbreak

Appendix 3: Key documents and resources

Appendix 1: Examples of risk assessment and response for COVID-19 exposures and outbreaks

Table 3. Suggested actions based on classification of high-risk COVID-19 exposure*

High-risk exposure (close contact)	Suggested actions based on classification of high-risk exposure (close contact)
Staff Where a worker has been exposed to COVID-19 case in a workplace setting where the risk of exposure is defined as high. High-risk exposure include: - staff who were not wearing PPE (N95/P2 masks and eye protection) where aerosol generating behaviours or procedures have been involved - 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, - greater than 2 hours within the same room with a case during their infectious period, where masks have been removed for this period.	• Review affected staff to assess exposure and risk. • Staff who if absent will have a high impact on services, will be able to continue attending work with specific requirements in place: - Continue to work with negative Day 1 PCR/RAT - RAT test every working day, until Day 7 result clear (prior to commencement of workday) - Monitor for symptoms, test (RAT and if negative PCR), and isolate immediately if symptoms develop. Additional mitigation steps: - Work in a surgical mask or P2/N95 respirator for the first 7 days following exposure - No shared break areas - Limit work to a single site/area - Consider redeployment to an area with lower risk clients.
Clients If a resident has been exposed to a COVID-19 case: - in a shared defined area (e.g., prolonged contact during activity, co-located in a wing of a DRS) and/or - who have had household-like exposure with a case during their infectious period, or - outbreak-related contact (e.g., cases in the same wing / zone with unknown exposure). **Note: the risk of transmission will be managed whilst balancing the risk related to social isolation through application of the least restrictive controls appropriate.**	• Isolation or separation for 7 days. • Test (PCR/RAT) Day 2 and Day 6 **OR** Consider allowing clients to leave room after risk assessment, <u>with</u> - Baseline and Day 6 PCR, or - RAT at least every second day from Day 0-7

Table 4. Examples of situational risk and response in the context of outbreak of COVID-19 in DRS*

Outbreak Situation	Testing, isolation, IPC and closure
Simple Cases arising from single / known exposure and/or limited to a few cases in one area of the DRS and/or limited secondary transmission.	- Cases isolate for 7 days as per Table 1 (Case and Contact Management) and CDNA Series of National Plans (SoNG) on COVID-19. - Baseline and Day 6 (D6) PCR for defined at-risk clients, stay in room for 7 days OR allow at-risk clients to leave room as long as they remain with clients of similar risk but with RAT testing every second day. - If no cases detected from D6 PCR in at-risk clients release from quarantine after 7 days and outbreak may be declared over.
Complex Poorly understood exposure, or multiple cases affecting multiple areas, or ongoing transmission, or difficultly isolating clients.	- Cases isolate for 7 days as per Table 1 (Case and Contact Management) and CNDA Series of National Plans (SoNG) on COVID-19. - At-risk clients in affected areas will remain in quarantine. Develop a regular schedule of testing in the affected zone for negative at-risk clients every 72 hours by RAT (or PCR) and continue until 7 days after the last case. - Declare outbreak over 7 days after the last positive resident case detected or 7 days after the last positive infectious resident case was effectively isolated (whichever is longer). - Continue to monitor clients for symptoms in affected zone for a further 7 days after the outbreak declared over. - Staff maintain higher standard of PPE for a further 7 days (P2/N95) after the outbreak declared over.

*Responses to situational risk will be based on a risk assessment which considers the risk cases of ARI pose to clients and staff. WA Health may implement additional requirements and/or recommendations.

Appendix 2. Visitation

Visitor restriction and resident wellbeing

Restrictions on visitation to DRS are likely to have detrimental impacts on resident wellbeing. Changes to visitation, staff, and usual routines can also have a major impact on clients. This may lead to expressions of distress including through changes in behaviour among people intellectual disability, developmental disability and acquired brain injury.

Deterioration in the mental health of clients can impact on behaviour and the ability of clients to safely protect themselves and others. Accordingly, Mirrors Care will establish strategies (such as the use of video calls) to enable clients to remain as connected as possible to friends, family, carers, supporters, medical and allied health professionals. These strategies will be easily introduced if there is an outbreak or public health order or advice which results in visitation being limited.

Visitors and isolation

Where a case or outbreak has occurred in DRS, WA public health guidance on visitation will be followed.

Ensure any visitors are aware of the exposure/outbreak at the service. The level of PPE visitors wear will be dependent on the COVID-19 or influenza status of the resident and whether the visit is indoors or outdoors.

Communal activities of non-infected clients that do not conflict with the isolation of positive cases will go ahead in unaffected zones.

DRS Mirrors Care will plan for how visitor access will be managed in consultation with participants, as part of their planning to manage the impact of COVID-19 and associated risks.

Appendix 3. Further resources

Infection prevention and control

- The Australian Commission on Safety and Quality in Health Care's (ACSQHC) has published posters on standard and transmission-based precautions.
- The Australian Commission on Safety and Quality in Health Care's (ACSQHC) NHHI Learning Management System has a series of online learning modules on hand hygiene and infection prevention and control.
- The Australian Plans for the Prevention and Control of Infection in Healthcare has detailed guidance about standard and transmission-based precautions, including:
    - 3.1.1 Hand hygiene (p36 –)
    - 3.1.3 Routine management of the physical environment – including environmental cleaning (p62 –)
    - 3.1.5 Respiratory hygiene and cough etiquette (p99)
    - 3.1.7 Waste management (p105 –)
    - 3.1.8 Handling of linen (p106)
- The Infection Prevention and Control Expert Group (ICEG) has endorsed a collection of resources for infection prevention and control.

Personal protective equipment

- The Australian Department of Health has published factsheets and videos on use of PPE.

Environmental cleaning

- ICEG also has a resource for Environmental cleaning and disinfection principles for health and residential care facilities
- ACSQHC has resources including Environmental cleaning: information for cleaners, and a Principles of Environmental Cleaning Product Selection factsheet and a flowchart outlining The process and product selection for routine environmental cleaning.
- COVID-19 Environmental cleaning and disinfection principles for health and residential care facilities factsheet.

Communicable Diseases Network Australia National Plans for Public Health Units

- CDNA National Plans for Public Health Units. Coronavirus Disease 2019 (COVID-19)

- Superseded Plans:

    - CDNA national plans for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia (2022). Contains useful background information and resources.

    - CDNA national plans for the prevention and management of COVID-19 outbreaks in disability residential services - The Disability Supplement (2021). Contains useful background information.

COVID-19 Oral Treatments

- The Australian Department of Health and Aged Care has information on Oral treatments for COVID-19, which includes links to an Information sheet for people with disability – COVID-19 oral medicines and a COVID-19 medicines – Easy read document.

COVID-19 Vaccination

- The Australian Department of Health and Aged Care has Information for people with disability about COVID-19 vaccines, Information for disability workers about COVID-19 vaccines, and Information for disability service Mirrors Care about COVID-19 vaccines.

NDIS Commission

- The NDIS Quality and Safeguard Commission has a range of resources for NDIS participants and NDIS Mirrors Care. This information is to inform and support NDIS Mirrors Care to continue to deliver quality and safe supports and services to NDIS participants during the pandemic in accordance with their obligations under the NDIS Act: COVID-19 resources and information | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)