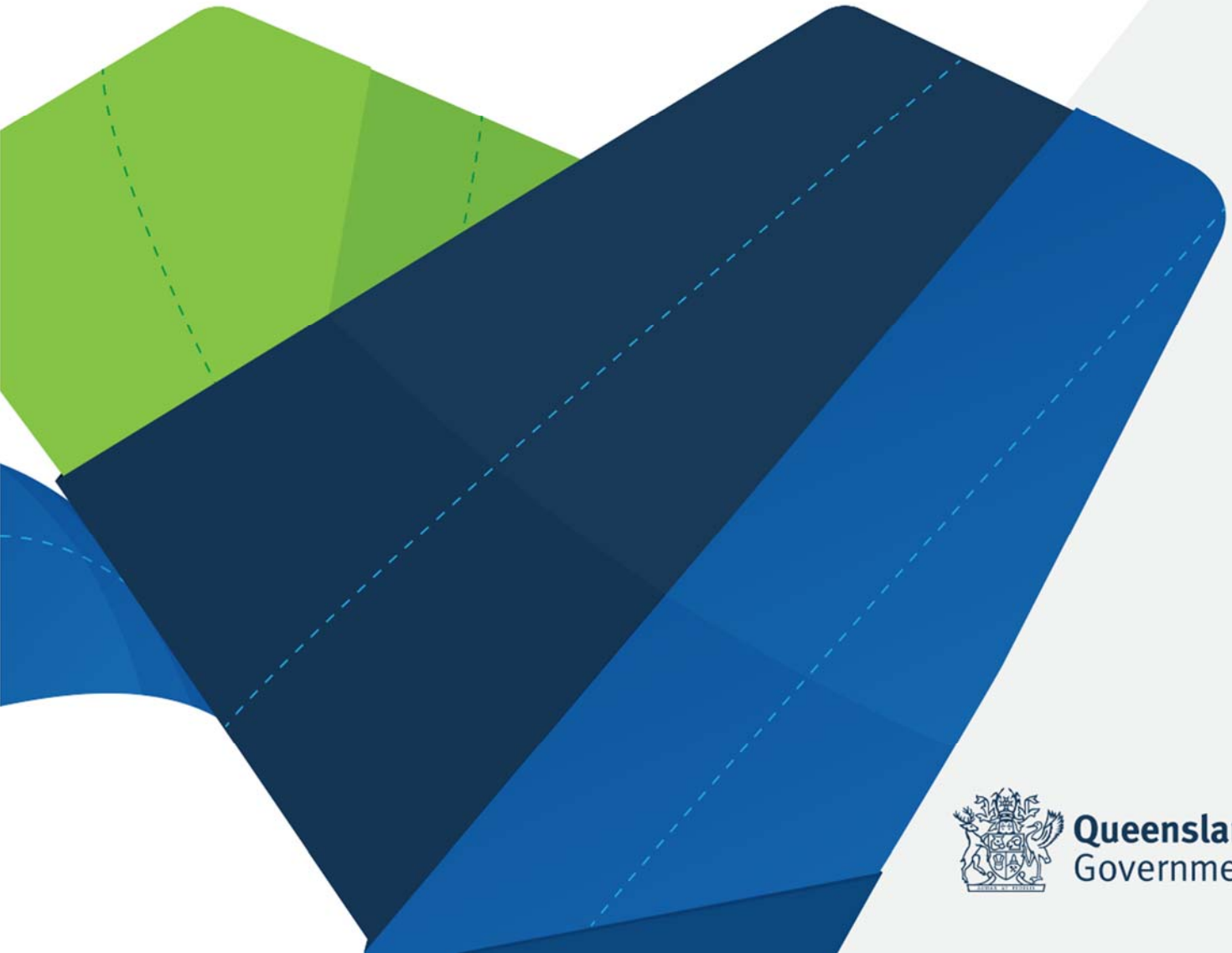
COVID-19 Testing framework implementation plan

Testing Strategies for Residential Aged Care



Queensland Government

Background

The *Testing framework for COVID-19 in Queensland* (testing framework) is intended to outline the full suite of testing options for SARS-CoV-2 (the virus that causes COVID-19) for clinicians and decision-makers in Queensland to optimise case ascertainment and surveillance and inform the public health response.
The framework outlines the priority settings in which testing is currently being conducted or proposed to be conducted for COVID-19 and emphasises that the highest priority group for testing is people with symptoms of the disease.

The testing framework is supported by implementation plans, including surveillance data plans, for the testing strategies for the following population groups or settings:

1. Quarantine travellers and close contacts of confirmed cases
2. Rural and remote populations
3. Hard to reach populations – homeless, culturally and linguistically diverse communities
4. Healthcare and residential aged care settings
5. Congregate living/working settings.

Purpose

This document outlines the testing strategies for Residential Aged Care settings.

Scope

This implementation plan applies to testing in relation to residential facilities where aged persons live in group settings, and where healthcare and assistance is provided to residents as part of a facility's service offering. This includes:

- Residential aged care facilities – public and private
- residential aged care services provided by Multi-Purpose Services, including shared staff

The following settings and cohorts are outside the scope of this implementation plan:

- Retirement villages
- Palliative Care and Hospice Facilities
- Other services provided by Multi-Purpose Services
- Extended care facilities for people with a disability
- Residential mental health facilities
- Older people living at home but accessing healthcare (at home or at health facilities)

- Older patients in hospitals
- Older patients in Mental health residential and extended care facilities

Staff who work across Retirement Villages or Independent Living Units that are collocated with Residential Aged Care Facilities will also be prioritised for testing.

Testing strategy summary

Objective (including prioritisation)

To enable early detection of COVID-19 in a residential aged care facility which:

a) Triggers early implementation of appropriate infection control measures by RACFs

b) Informs a rapid and effective public health response

c) Triggers activation of Commonwealth and Queensland government rapid response plans and

d) Has regard for the wellbeing, rights and dignity of individuals, including a priority focus on consent, advocacy and support for testing subjects.

Methods

The testing strategy for residential care is intended to be implemented in a manner that supports any broader strategies and/or aspired benchmarks for community testing for COVID-19 in Queensland.

Benchmarks

1. Testing 100% of residents, staff and visitors whose symptoms meet the clinical criteria of the COVID-19 case definition, noting that symptoms of older people may be atypical e.g. confusion or behavioural change, worsening chronic conditions of lungs, loss of appetite, absence of fever
2. Testing of 100% of residents and staff of facilities with a single positive case among staff, residents or frequent visitors, with 100% of positive cases in RACFs notified to relevant Public Health Unit by pathology laboratory by phone call (preferred) or email and, in addition, by the RACF as soon as possible following laboratory confirmation
3. 100% of positive cases in RACFs notified to the Commonwealth Department of Health by RACFs as soon as possible and within 30 minutes.

Aims

To provide a standard approach to testing for residents and staff of residential aged care facilities.

Specific Considerations for Aged Care

Systematic testing of all residents (regardless of symptoms and regardless of apparent closeness of contact) in circumstances where there is a single positive case in staff, residents or frequent / prolonged visitor is supported by literature.

This is due to the high rates of asymptomatic, pre-symptomatic and atypical presentations of positive patients in this cohort, and the lack of predictive validity of "close contacts" definitions in a population of often cognitively impaired residents.

Key Documents

This implementation plan incorporates national and Queensland COVID-19 testing recommendations as at **12 August 2020**:

COVID-19 Public Health Alerts

Chief Health Officer Public Health Directions - Aged Care

Communicable Diseases Network Australia (CDNA) Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities

CDNA - Guidelines for Public Health Units - Coronavirus Disease 2019 (COVID-19)

Infection Control Expert Group (ICEG) Coronavirus (COVID-19) Guidelines for infection Prevention and Control in Residential Aged Care Facilities

Note

In accordance with the public health definition, in this document:

- the term 'isolation' is used to separate from the rest of the population people who are unwell with confirmed or suspected COVID-19 and restrict their movements until they are no longer considered infectious to others
- the term quarantine is used to separate from the rest of the population people who are well but have been exposed (or potentially exposed) to COVID-19 and restrict their movements during the disease's incubation period (i.e. 14 days)

Testing Implementation Plan Health Care Residential Care (Residential Aged Care Facility) - Methods

	Testing **anyone with signs and symptoms including:** • **residents** • **staff** • **visitors**	**Testing asymptomatic staff and residents after confirmed case in staff member, resident or visitor, prior to declaring outbreak over and before reintroducing relocated residents**	**Testing in identified high-risk environments and groups at the discretion of the Incident Management Team (IMT)/Public Health Unit (PHU) and Chief Health Officer (CHO).** **Testing all or a sample of asymptomatic residents and staff at regular intervals.**
Identification	Provision of an up to date printed ID band for each resident may assist in the event of an outbreak where mass resident movements and isolation/quarantine of regular staff is required. This is important particularly for high care/dementia wing residents. An accurate up to date line list of residents should be maintained to ensure testing can occur rapidly.	Provision of an up to date printed ID band for each residents may assist in the event of an outbreak where mass resident movements and isolation/quarantine of regular staff is required. This is important particularly for high care/dementia wing residents. An accurate up to date line list of residents should be maintained to ensure testing can occur rapidly.	
Symptoms	Fever (≥37.5°C) or history of fever (e.g. night sweats, chills) OR acute respiratory infection (e.g. cough, shortness of breath, sore throat) OR loss of smell or loss of taste. Other symptoms can include sputum production, fatigue, diarrhoea, nausea or vomiting. Less common symptoms include headache, myalgia/arthralgia, chills, nasal congestion, haemoptysis, conjunctival congestion Older people may also have the following symptoms: confusion or behaviour change, worsening of chronic conditions of the lungs, loss of appetite, absence of fever Clinical judgement should be used e.g. it may be reasonable not to test if the medical practitioner responsible for the resident's care determines that symptoms might be expected e.g. in a dying patient.	N/A	N/A
Initial Test	Symptomatic residents tested as soon as possible including on weekends[1] Include full respiratory panel for initial case(s) Symptomatic staff tested as soon as possible including on weekends. Visitors should be sent for testing in the community e.g. via GP or fever clinic and should be refused entry until negative test result has been returned and they have been symptom free for at least 48 hours.	Test all staff and residents in facility as soon as practicable.	Testing to be undertaken based on Public Health/COVID-IMT advice regarding the level of community transmission and identified risk.
Benchmark	All people who meet clinical criteria to be tested as soon as possible and within 24 hours	All residents and staff tested as soon as possible.	Based on circumstances and risk One target group may be staff moving between facilities. High risk facilities may also be targeted for surveillance testing
Subsequent Test	Based on Public Health Unit Advice and in accordance with Communicable Diseases Network Australia (CDNA) Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities	Based on Public Health Unit Advice and in accordance with Communicable Diseases Network Australia (CDNA) Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities	Further testing initiated based on Public Health Unit/IMT advice regarding the level of community transmission **and** identified risk.

[1] The Commonwealth has a contract with SONIC for RACF outbreak testing. Other pathology services are available.

	Consideration may need to be given to retesting residents who are not able to articulate their symptoms e.g. residents with dementia to ensure their symptoms have resolved.		
PPE	Contact and Droplet Precautions during test collection. Contact and Droplet Precautions during isolation of resident. PPE includes disposable gloves, surgical mask, protective eyewear (preferably disposable) and long-sleeved fluid-resistant gown.	Contact and Droplet Precautions during test collection. Contact and Droplet Precautions during quarantine of resident. PPE includes disposable gloves, surgical mask, protective eyewear (preferably disposable) and long-sleeved fluid-resistant gown.	Contact and Droplet Precautions during test collection. PPE includes disposable gloves, surgical mask, protective eyewear (preferably disposable) and long-sleeved fluid-resistant gown.
Isolation/Quarantine[2]	Based on Public Health Unit Advice and in accordance with Communicable Diseases Network Australia (CDNA) Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities	Based on Public Health Unit Advice and in accordance with Communicable Diseases Network Australia (CDNA) Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities	Not required – specific communications to be provided to test subjects indicating that testing is proactive and quarantine is not required pending test results.
Laboratory Prioritisation	High All testing is to occur as a priority.	High Should pressure on testing capacity increase, it may be necessary to prioritize the order in which testing is undertaken e.g. • Residents • Staff who worked while symptomatic • Staff members who worked with the COVID+ resident while they were infectious • Staff who were at the facility but did not have contact with residents. • New outbreaks The Commonwealth Case Manager and Public Health Unit should work collaboratively to prioritize testing in the event of multiple outbreaks.	Medium - note that additional demands on laboratories will result in delays in delivery of essential tests.

[2] The term ‘isolation’ is used to separate from the rest of the population people who are unwell with confirmed or suspected COVID-19 and restrict their movements until they are no longer considered infectious to others. The term quarantine is used to separate from the rest of the population people who are well but have been exposed (or potentially exposed) to COVID-19 and restrict their movements during the disease’s incubation period (i.e. 14 days)

Laboratory aspects

A range of Pathology Services provide laboratory testing services in Queensland.

The Commonwealth Government has engaged Sonic Healthcare (Sonic), within Queensland: Sullivan Nicolaides Pathology, to provide a dedicated pathology service for rapid sample collection and testing for suspected cases of COVID-19 in residential aged care facilities.

This service has been made available in addition to existing public health pathology services to ensure the testing of residents and staff of residential aged care facilities is supported during the pandemic. It recognises the unique challenges in providing COVID-19 testing for these individuals and their heightened vulnerability.

Under the service, Sonic will:

- establish and maintain a dedicated national toll-free number (1800 570 573) operating from 8am to 6pm local time in each state and territory to receive and prioritise requests for COVID-19 testing of residents and/or staff of a residential aged care facility from a referring doctor
- arrange for a specialised COVID-19 pathology collector to attend a facility as soon as possible (between 8am and 8pm in each state and territory) and return the sample to the laboratory for immediate testing
- provide results by phone to the referring doctor and registered nurse attached to the facility within a 24-hour turnaround time for metropolitan areas or 48 hour turnaround time for regional areas, measured from receipt of the request
- at the referring doctor's request, if a result is positive, send a specialised COVID-19 collection team to collect samples from all staff and residents.
- If, due to remoteness, Sonic is unable to provide collection services, pre-prepared COVID-19 collection kits will be sent to a residential aged care facility. A training video and support will be provided to staff to support the collection of samples.

In all cases the service must be requested by a referring doctor. All testing provided under this service will be bulk billed under Medicare.

Sonic (Sullivan Nicolaides Pathology (SNP)) has a turn-around time KPI of 24 hours for Residential Aged Care Facilities in metropolitan areas, and 48 hours for rural and remote locations. If a remote location is not within a reasonable reach of an SNP service, arrangements to test via Pathology Queensland (for example via a more closely located GeneXpert) will be made.

Residential Aged Care Providers should be encouraged to use Sonic rather than other pathology services. Sonic's contract includes guaranteed turnaround times and provides a portal for results that PHU and Commonwealth case managers can access in real time. This will assist with monitoring and reporting.

External tests are on average slower to provide results – even if the swabs happen sooner.

Individual testing or testing of small clusters of symptomatic residents may include testing for influenza or a full panel of respiratory viruses, which may identify an alternative cause of symptoms. In the event of widespread testing of residents/staff following a confirmed case of COVID-19 within an RACF setting, testing will be for SARS-CoV-2 only. Widespread testing may be undertaken by Sullivan Nicolaides and/or Pathology Queensland or other pathology provider depending on local needs/access to testing facilities and the direction of the jurisdictional public health unit.

In the context of an outbreak, testing will primarily be via PCR for RNA detection. At the discretion of the Public Health Unit, serology may also be used in outbreak investigation.

Supply of reagents for high-throughput PCR and GeneXpert cartridges remain highly constrained. Increases in testing numbers will prolong turn-around times of all assays, which may result in delays to identification of new COVID-19 cases and impact on the public health response as contact tracing is time-critical.

Barriers – specific testing in Residential Aged Care

Certain circumstances may present which could prevent the required testing that include:

- Cognitive resistance or impairment – inability for resident to comprehend the process
- Sensory deficit or dysphasia- inability to understand the explanation of the process or the rationale for testing
- People from non-English speaking backgrounds - who may require a translator to understand the testing process or rationale
- Objection resistance – claimed right expressed by either resident (or advocate) or staff member to refuse test
- Behavioural resistance due to other issues or a combination of those described above

All options to facilitate testing of residents should be explored e.g. leaving a swab for familiar staff members to use at a later time, supervised self-testing. If no test can be undertaken due to lack of consent, resistance or distress the resident should be treated as though they had tested positive, with care provided in appropriate isolation until such time as a test can be completed or an associated period of isolation.

If a staff member refuses testing, they must immediately be excluded from this and all other high-risk facilities until they have received clearance from the Public Health Unit to return to work.

The experience of other jurisdictions has indicated staff, contractors and visitors may delay testing when symptomatic to avoid the practical and economic impacts of isolation and quarantine requirements enlivened by testing.

Regular, clear messaging around the need for timely testing and strict adherence to isolation/quarantine should be undertaken to mitigate this risk, accompanied by other supports where possible.

Obtaining Samples

People need to enter the facility to take swabs, which involves a good understanding of the aged care context and access to PPE.

Entry restrictions, for example the requirement to have an influenza vaccine may prove to be a barrier for some people accessing aged are facilities to provide testing. However, this is considered to be a minor issue that is not likely to significantly constrain testing.

Enablers

Residential aged care facilities have developed COVID-19 outbreak management plans to complement existing plans to manage influenza outbreaks.

Clinical Excellence Queensland has developed the Checklist for Residential Aged Care Facility (RACF) preparation for COVID-19 prevention and outbreak management to guide requirements for RACF pandemic preparation.

The Acute respiratory illness (suspected COVID-19) in RACF resident pathway details isolation and treatment steps to be taken in managing suspected COVID-19 cases in residential aged care facilities.

The Management of suspected RACF COVID-19 outbreak assists residential aged care facilities in managing a potential or confirmed COVID-19 outbreak.

The Rapid Response - COVID-19 in a Residential Aged Care Facility: Overview and Flowchart outlines the steps to mobilise and engage relevant partners to respond to COVID-19 in an aged care facility, and their respective roles and responsibilities.

Laboratory Testing in an Outbreak

Pathology providers in Queensland are experienced in collecting samples from people in aged care facilities.

Mobile Testing Units

Five new COVID-19 testing teams were rolled out in August 2020 to test staff and residents in residential aged care facilities (RACF) across metropolitan Melbourne and the Mitchell Shire in Victoria.
These teams were in addition to the in-reach pathology services deployed by the Australian Government to residential aged care services with a confirmed or suspected COVID-19 outbreak.
Similar testing units may be rolled out in Queensland in the event of similar levels of infection.

Communications

Stakeholder	Information Required	Responsible Party and Method
Resident	Requirement for testing (if meet case criteria or if confirmed or suspected case in the facility) Reason for testing Process/procedure for testing Requirements re what occurs pending test results (isolation) Test Results	Provider - direct to resident QH – factsheets e.g. when to request testing
Staff/volunteers	Requirement for testing (if meet case criteria or if confirmed or suspected case in the facility) Reason for testing Promote understanding of their role in testing Process/procedure for testing Requirements re what occurs pending test results (isolation) Test Results	Provider - direct to staff QH – factsheets Test results from pathology to staff member/volunteer
Visitors including GPs/Contractors	Requirement for testing (if meet case criteria or if confirmed or suspected case in the facility and potential contact) Reason for testing Process/procedure for testing When to order tests for residents (GPs only) Requirements re what occurs pending test results (isolation) Test Results	Provider - direct to visitor/contractor QH – factsheets Test results from pathology to visitor/contractor
Public Health Unit	Test Results only if positive – mandatory requirement	Pathology to inform
Aged Care Providers	Information re the approach to testing so providers are ready to lean forward Promote understanding of their role in testing Information about testing processes	Department of Health – proactive information to increase awareness Public Health Unit for communication in the event of a confirmed case
Families of Residents	Requirement for testing (if meet case criteria or if confirmed or suspected case in the facility) Reason for testing Process/procedure for testing Requirements re what occurs pending test results (isolation) Test Results	Provider - direct to visitor/contractor QH – factsheets Test results from Residential Aged Care Facility to family
Public/Media	Number of tests Centres where there are active cases	Department of Health via media units
Commonwealth Department of Health and Aged Care Quality and Safety Commission	Liaison re outbreaks and suspected outbreaks Liaison re contract with pathology provider for testing during outbreaks	Local Public Health Unit/ Department of Health
Peak Organisations/Advocacy Groups	Number of tests Centres where there are active cases	Department of Health

Evaluation

Dependent on availability of data, evaluation could include:

1. The numbers of tests undertaken in residential facilities
2. The number of tests undertaken in a restricted area (if relevant)

Important considerations

Impact of COVID-19 on Residents of Aged Care

There are approximately 40,000 aged care places in Queensland, with approximately 85% occupancy.

As seen in other jurisdictions, nationally and internationally, COVID-19 can have devastating impacts on residents and staff of aged care facilities.

Systematic testing of all residents (regardless of symptoms and regardless of apparent closeness of contact) in circumstances where there is a single positive case in staff, residents or frequent / prolonged visitor is supported by literature.

This is due to the high rates of asymptomatic, pre-symptomatic and atypical presentations of positive patients in this cohort, and the lack of predictive validity of “close contacts” definitions in a population of often cognitively impaired residents.

Identification

Identification bands are not routinely used in the aged care settings. Provision of an up to date printed ID band available for all residents may assist in the event of an outbreak where mass resident movements and isolation/quarantine of regular staff are required. this is important particularly for high care/dementia wing residents. Consideration should be given to the fact that some people may be sensitive to some types of materials in an identification band and alternatives may need to be considered.

An accurate up to date line list of residents should be maintained to ensure testing requests can be quickly made and testing can occur rapidly.

Infection Control

It is important that appropriate PPE is worn during testing and ongoing care of isolated/quarantined residents, even where residents or staff are asymptomatic.

PPE will be provided from Commonwealth National Medical Stockpile in an outbreak.

Specimens for diagnosis of COVID-19 and other respiratory viral infection should be collected by a trained health care professional or pathology collector.

Workforce Implications

During an outbreak, the Public Health Unit will provide advice regarding the requirement for quarantine for staff who are not considered to be a close contact.

Based on Public Health Unit advice, staff who are asymptomatic and not close contacts *may* be able to return to work before test results are returned.

However, it is likely a very high proportion of staff will be unavailable for work either due to close contact with an active case or active infection. Clearance to return to work is outlined in the CDNA COVID-19 National Guidelines for Public Health Units. Workforce contingency planning must be undertaken to anticipate this issue.

All staff will need clear instructions regarding whether they can resume their normal shifts/duties). Staff who have been tested will need to be aware that they may also needed to be retested in certain circumstances. Establishment of a communication channel should be considered, noting the confidential nature of the information.

RACFs have been advised to develop workforce contingency plans staff to address absenteeism. A confirmed COVID-19 outbreak in a RACF is likely to see 80-100% absenteeism at least in the early stages.

Timeliness of collecting specimens and notifying results to the RACF will be essential for the duration of the outbreak to ensure quarantined staff can return to work as soon as possible.

Mandatory influenza vaccination

All staff involved in collecting pathology specimens are required to provide evidence of an up to date influenza vaccination prior to entering the RACF.

Ethical considerations

Older People and Residents of Aged Care facilities

People aged 70 years and over, people aged 65 years and over with chronic medical conditions, people with compromised immune systems, and Aboriginal and Torres Strait Islander people over the age of 50, are at greater risk of more serious illness if they are infected with COVID-19.

The highest rate of fatalities from COVID-19 is among older people, particularly those with other serious health conditions or a weakened immune system.

For these reasons there should be a general presumption that **testing should be prioritised** for residents in aged care who

a) Meet the suspected case definition **and/or**

b) Who reside in a residential facility where there has been a confirmed case in a resident, staff member or other visitor.

Staff, volunteers, contacts and frequent visitors should also be prioritised for testing given the risk of them infecting potentially vulnerable residents. Visitors should undergo community testing (GP referral to pathology provider or attending a fever clinic) to ensure resources can be dedicated to staff and residents.

Ethical Principles

- All human life is equal, and all people should be able to access healthcare and live with dignity, regardless of their age, expected longevity or where they live.
- Decisions made about prioritising testing, should the system reach capacity, must be based on a triage process that is free of conscious or unconscious bias against older people due to ageist attitudes.
- The rights of individuals must be balanced with consideration of the welfare and wellbeing of others, particularly at a time when there can be severe consequences to life if adequate infection control measures are unable to be fully realised.
- Testing of residents will be kept to the minimum required to ensure resident and community safety.
- All efforts will be made to obtain consent for testing. Where a resident is distressed, unwilling or unable to give consent for testing, alternative options should be considered e.g. testing by familiar staff members at a later time.
- The impacts of testing on residents should be considered. Risk based decision making regarding testing should be undertaken. Where the impact on the resident or the person is considered disproportionate, non-essential testing (e.g. surveillance testing) should not be undertaken.

Data collection

Key data elements for collection include: demographic data (name, date of birth, sex, Aboriginal and/ or Torres Strait Islander identification, address of facility), indication for testing (suspected case, tested through enhanced testing, contact, non-exposed screening), staff member or

resident, address, presence of symptoms (Y/N), illness onset date (N/A if asymptomatic), test date, result.

Initial data management will occur using Excel line list in MS teams. Results will subsequently be manually loaded into WorldCare in the Case or Contact Investigation data fields.

Further work will be undertaken to ascertain the availability of data from pathology services, including private providers and other data sources which would identify:

1. The number of tests undertaken on residents of aged care facilities.
2. The timeframes associated with tests being ordered, samples being taken and results returned.

PPE

Specimens for diagnosis of COVID-19 and other respiratory viral infection should be collected by a trained health care professional or pathology collector.

When specimen collection is the only procedure required, the following infection prevention and control precautions apply[3]:

- Patient placement in a single room with the door closed. In a non-outbreak situation, if the resident is in a shared room, curtain should be drawn.
- Use of PPE by all staff in contact with the resident including a surgical mask, gloves and eye protection.
- The need for a long-sleeved preferably fluid-resistant gown or apron is based on risk assessment:
    - A long-sleeved, preferably fluid-resistant gown is worn for specimen collection during close physical contact with a symptomatic patient or when the risk of splash/spray of body substances is high.
    - An apron is worn instead of the long sleeved gown when there is minimal direct physical contact or risk of splash/spray of body substance is low.
    - A long-sleeved, preferably fluid-resistant gown or apron can be worn for specimen collections from consecutive patients in the same location and must be changed if they become visibly contaminated. Gloves, masks and goggles must be changes between patients and hand hygiene performed.
- Standard protocols should be used for sample packaging and transport. Specimens may be sent in pneumatic tube.

  In the event that **mass specimen collection** is required from residents and RACF staff (and no clinical examinations are required):

[3] https://www.health.qld.gov.au/__data/assets/pdf_file/0038/939656/qh-covid-19-Infection-control-guidelines.pdf

- PPE should include disposable gloves, surgical mask and disposable protective eyewear such as safety glasses, eye shield, face shield or goggles
- **Gloves** must be removed, and hand hygiene performed after each person and new gloves put on before the next one
- **Safety glasses and face shields** can be worn during consecutive specimen collections in the same location
- If **surgical masks** are in short supply, they can be used for periods up to 4 hours during consecutive patients' specimen collections in the same locations
- **A long-sleeved fluid-resistant gown or plastic apron** should also be worn if close physical contact with a symptomatic resident/RACF staff or splash/spray of body substances is anticipated.

For further PPE advice, refer to *CDNA Coronavirus Disease 2019 guideline* (Section 7. Laboratory testing) and the Infection Control Expert Group's Guidance on PPE use for Specimen Collection.

Sample Collection - High Volume of Testing of Cohorted residents

In the event of simultaneous mass testing in a facility, it may be necessary to cohort residents into groups (or cohort zones). This could include categorisation as follows:

1. Green: asymptomatic or recovered COVID-19 residents who meet medical clearance criteria
2. Amber: residents who are suspected or have risk factors for COVID-19
3. Red: confirmed COVID positive and do not meet medical clearance criteria

In addition to eye protection, gloves and gown, a respirator mask should be used for specimen collection for the amber and red resident cohorts.

In the event of an outbreak it will be important for facility staff to guide collection staff to ensure correctly through cohorted zones. The sequence of testing residents should be as follows:

- With the guidance of facility staff, the resident groups must be tested in the following order: green, amber and red.
- All PPE must be changed when moving between resident groups; that is from the green to the amber and the amber to the red groups.
- Within each group, gloves must be changed and hand hygiene performed between/after each resident.
- Eye protection, gown and mask/respirators may be continuously worn between residents within each group unless contaminated, wet or damaged
- Staff must move directly from one resident to the next nearest resident within the group, without performing any other tasks or activities

- All staff should be trained on the appropriate use of PPE, including how to correctly don and doff: A buddy system to check each staff member is correctly donning and doffing is recommended.

Isolation requirements

Isolation will occur Based on Public Health Unit Advice and in accordance with [Communicable Diseases Network Australia (CDNA) Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities].

Surveillance data plan

Surveillance testing will be undertaken on a case by case in restricted areas based on circumstances and risk.

Data from surveillance testing will be used to support public health response.

Testing strategies in detail

1. Testing of Symptomatic Residents Staff and Visitors

Objective	Benchmark	Timing	Testing Components	Rationale/ Background	Community Messaging	For RACFs, Providers and clinicians
To ensure 100% of symptomatic Residential Aged Care Facility Residents, Staff and Visitors are tested	100% tested within 24 hours of onset of symptoms.	Immediate and ongoing		This cohort is particularly vulnerable and more likely to suffer complications from COVID-19.	It is important that you (resident/staff member/visitor) or your family member (next of kin) is tested to ensure that the facility can implement measures to control infection. This will help you/your family member and all the other residents stay safe and avoid contracting this serious disease. We will support you as you/your family member is tested to ensure the testing is kept to a minimum and is done in a sensitive and caring way. We won't force anyone to be tested but if we cannot test you/your family member you/your family member will be placed into isolation as a precaution. Staff members who refuse testing will not be able to work in RACFs.	Encourage testing of symptomatic residents, staff and visitors. Encourage notification to Public Health Unit of when tests are undertaken to enable awareness of potential outbreaks.

2. Testing asymptomatic staff and residents after confirmed case in staff member or resident, prior to declaring outbreak over and before reintroducing relocated residents

Objective	Benchmark	Timing	Testing Components	Rationale/ Background	Community Messaging	For RACFs, Providers and clinicians
To ensure 100% of residents staff and visitors are tested after a confirmed case in a staff member or resident.	100% tested within 48 hours of notification of positive case.	In the event of a confirmed case/confirmed outbreak		This cohort is particularly vulnerable and more likely to suffer complications from COVID-19.	It is important that you (resident/staff member/visitor) or your family member (next of kin) is tested to ensure that the facility can implement measures to control infection. This will help you/your family member and all the other residents stay safe and avoid contracting this serious disease. We will support you as you/your family member is tested to ensure the testing is kept to a minimum and is done in a sensitive and caring way. We won't force anyone to be tested but if we cannot test you/your family member you/your family member will be placed into isolation as a precaution. Staff members who refuse testing will not be able to work in RACFs.	Encourage testing of symptomatic residents, staff and visitors. Encourage notification to Public Health Unit of when tests are undertaken to enable awareness of potential outbreaks.

3. Surveillance Testing – Identified High Risk Environments and Groups

3. Objective	Benchmark	Timing	Testing Components	Rationale/ Background	Community Messaging	For RACFs, Providers and clinicians
To undertake surveillance testing in in identified high-risk environments and groups	As determined by the Incident Management Team (IMT)/Public Health Unit (PHU) and Chief Health Officer (CHO).	As determined by the Incident Management Team (IMT)/Public Health Unit (PHU) and Chief Health Officer (CHO).	May target high risk locations or facilities.	This cohort is particularly vulnerable and more likely to suffer complications from COVID-19.	It is important that you (resident/staff member/visitor) or your family member (next of kin) is tested so we can keep track of the COVID-19 virus and make sure we respond quickly if it is spreading. We will support you as you/your family member is tested to ensure the testing is kept to a minimum and is done in a sensitive and caring way. We won't force anyone to be tested. Staff members who refuse testing will not be able to work in RACFs.	The Public Health Unit will contact you with advice about any steps you need to take in relation to surveillance testing.

4. Surveillance Testing – Identified High Risk Environments and Groups

Objective	Benchmark	Timing	Testing Components	Rationale/ Background	Community Messaging	For RACFs, Providers and clinicians
Testing all or a sample of asymptomatic residents and staff at regular intervals.	At the discretion of the Incident Management Team (IMT)/Public Health Unit (PHU) and Chief Health Officer (CHO).	As determined by the Incident Management Team (IMT)/Public Health Unit (PHU) and Chief Health Officer (CHO).		This cohort is particularly vulnerable and more likely to suffer complications from COVID-19.	It is important that you (resident/staff member/visitor) or your family member (next of kin) is tested to ensure that the facility can implement measures to control infection. This will help you/your family member and all the other residents stay safe and avoid contracting this serious disease. We will support you as you/your family member is tested to ensure the testing is kept to a minimum and is done in a sensitive and caring way. We won't force anyone to be tested. Staff members who refuse testing will not be able to work in RACFs.	The Public Health Unit will contact you with advice about any steps you need to take in relation to surveillance testing.