Rapid review of public health guidance for residential care facilities in the context of COVID-19

24 July 2020
### Version history

<table>
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<tr>
<th>Version</th>
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<tr>
<td>V1.0</td>
<td>30 March 2020</td>
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| V1.1    | 31 March 2020 | Addition of guidance from Germany, the Communicable Disease Network Australia and Hong Kong  
Update of conclusion  
Addition of Table 2  
Addition of section on restrictive measures pertaining to residential care facilities |
| V1.2    | 16 April 2020 | Updated to include differences in guidance since the initial review.  
Review expanded to include information on guidance for residential care facilities with no known cases of COVID-19. |
| V1.3    | 22 April 2020 | Updated to include differences in guidance since last review.  
Addition of guidance from Canada and Centers for Medicare and Medicaid Services. |
| V1.4    | 29 April 2020 | Updated to include differences in guidance since last review.  
Addition of information from Seattle and France on universal testing. |
| V1.5    | 06 May 2020  | Updated guidance from the Communicable Disease Network Australia and Health Protection Scotland  
Included information on universal testing that has been implemented elsewhere. |
| V1.6    | 13 May 2020  | Addition of guidance from the United States Centers for Disease Control (CDC) and Prevention. Update of guidance exceeding HPSC guidance.  
Included information on enhanced measures being taken elsewhere to protect RCFs, in particular virus-free RCFs. |
| V2.0    | 21 May 2020  | Restructured to summarise guidance using a thematic approach and addition of Table 1 summarising protective measures by country or agency. |
| V2.1    | 28 May 2020  | Included updated guidance from the CDC, New Zealand and Australia. |
As some de-escalation of measures have begun, protective measures introduced by countries have been detailed at the highest level of restriction in the main review and Table 1. The section detailing reopening has been expanded, describing the de-escalation of measures where they are happening or where they are planned.

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<tr>
<td>V2.2</td>
<td>4 June 2020</td>
<td>Updated epidemiological data from the International Long Term Care Policy Network. Updated guidance from the HPSC. Included information on allowing visits from Canada and Ireland.</td>
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<td>V2.3</td>
<td>11 June 2020</td>
<td>Updated guidance from Hong Kong, HPS and Australia. Included new guidance from the HPSC on visitation. Updated reopening plans for Canada and New Zealand.</td>
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<td>V2.4</td>
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<td>Updated guidance from CDC, CDNA, HPS, and PHE. Included new guidance from the Ministry of Health in New Zealand.</td>
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<td>V2.5</td>
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<td>Updated guidance from CDC, the UK Department of Health and Social Care and HPS. Included new guidance from Australia on easing of measures and visitation.</td>
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<td>V3.0</td>
<td>3 July 2020</td>
<td>Updated to focus on guidance for reopening. Moved the highest levels of protective measures identified in the latest version (V2.5) to Appendix A. Included updated and new information on reopening from New Zealand, Canada, Australia and the UK.</td>
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Key points

- Some countries are relaxing the protective measures previously put in place in residential care facilities (RCFs), for example, allowing outings, communal activities, removing the requirement for residents to wear face masks and allowing visits to resume.

- Guidance for when RCFs reopen has been published by the Centers for Medicaid and Medicare Services (CMS) and adopted by the Centers for Disease Control and Prevention (CDC). This outlines a three phase plan with criteria for implementing each phase and service provision guidance, including for testing, visitation, communal dining, group activities and medical trips.

- Scotland and Northern Ireland have published guidance for phased reintroduction of visitation. These outline various levels of visitor restrictions that should apply, depending on community levels of COVID-19 and individual status of an RCF. Public Health England has published guidance for decision-makers to assist them in deciding whether individual RCFs can open to visitors. This outlines the need for a risk assessment at individual RCF level, taking into account the community context.

- Ireland, Hong Kong, New Zealand, the CMS, CDC, Australia, British Columbia, Canada, Northern Ireland, Scotland and England have issued guidance for visits during reopening of RCFs. This generally recommends to limit visitor numbers, maintain visitor logs, screen visitors, maintain physical distancing (except New Zealand), implement strict hand hygiene measures and to stop visits if a case of COVID-19 is confirmed within the RCF. Scotland, Northern Ireland, England and Ireland additionally recommend face coverings for visitors.
Background

Residential care facilities (RCFs) in Ireland and across the world have been affected by outbreaks of COVID-19.\(^1\) Residents of RCFs are at higher risk of acquiring COVID-19 and RCFs are vulnerable to outbreaks.\(^1\) An analysis of 18 countries where there have been more than 100 deaths from COVID-19 (Australia, Austria, Belgium, Canada, Denmark, France, Germany, Hungary, Ireland, Israel, Portugal, Slovenia, South Korea, Sweden, England and Wales (UK), Northern Ireland (UK), Scotland (UK) and the United States) estimates that the number of deaths due to COVID-19 in RCFs as a percentage of all deaths due to COVID-19, ranges from 24% in Hungary to 85% in Canada.\(^1\)

A range of guidance has been issued internationally to protect residents and staff of RCFs in the context of COVID-19. The guidance for the most part, includes recommendations on testing, screening, monitoring, isolation, cohorting, physical distancing, visitation, environmental cleaning, immunisation, providing care for non-cases, caring for the recently deceased and governance and leadership. This guidance is detailed in Appendix A and was last updated 25 June 2020. As countries reopen and ease protective measures, guidance has been published for when RCFs reopen.

To inform guidance development by the Health Protection Surveillance Centre (HPSC) and decision-making by the National Public Health Emergency Team (NPHET), the Health Information and Quality Authority (HIQA) is undertaking an ongoing rapid review of guidance for RCFs in the context of COVID-19. The review summarises recommendations and plans that have been issued and actions taken internationally, to protect healthcare workers and residents in the context of reopening of RCFs.

Methods

The review was first undertaken on 30 March 2020 with this update undertaken on 9 July 2020, in line with HIQA’s Protocol for the identification and review of new and updated relevant public health guidance - COVID-19, available on www.hiqa.ie. A detailed account of the methods used in this review is provided in the protocol.

Relevant international resources were identified as per the protocol and additionally from an ongoing search of COVID-19 related public health guidance,\(^4\) a summary of international policy measures compiled by the International Long Term Care Policy Network,\(^5\) and in consultation with subject matter experts to identify relevant agencies with guidance that is used widely by RCFs. Government websites were also searched for public health guidance relating to permission to reopen RCFs.

The focus of the review is on guidance for when RCFs reopen and the easing of measures for RCFs.
Results

Guidance for when RCFs reopen, identified for inclusion in this review, are summarised below by country.

The United States of America

The Centers for Medicaid and Medicare Services (CMS) have published recommendations for reopening RCFs.(6) This outlines criteria that can be used to determine when RCFs could relax restrictions on visitation, group activities and when such restrictions should be re-implemented. RCFs are advised to consider the current situation in their facility and community when making decisions about relaxing restrictions. Factors that should inform decisions about relaxing restrictions include: case status in the community, case status within the RCF (no new cases), adequate staffing, access to adequate testing, implementation of universal source control (where all residents and visitors wear a cloth face covering or facemask), access to adequate PPE for staff and local hospital capacity to accept transfers from RCFs.

The recommendations include a three phase plan with criteria for implementation, and guidance on visitation and service considerations (e.g. testing, communal dining, group activities and medical trips outside the facility) and recommendations for surveys to be performed at each phase. The CMS recommends that an RCF should spend a minimum of 14 days in a given phase, with no new RCF onset of COVID-19 cases, prior to advancing to the next phase.

Phase 1 refers to the highest level of vigilance, as detailed in Appendix A. Phase 2 allows the entry of non-essential healthcare workers and group activities for residents without symptoms, limited to 10 people. Phase 3 allows for visitation, group activities including outings for residents without symptoms and entry of volunteers. Physical distancing, use of facemasks for all, 100% screening of all entrants, daily monitoring of residents and weekly testing of staff, continue through all phases. The CMS recommends that during reopening, staff are tested weekly and that residents are tested upon identification of a suspected or confirmed case within the RCF.

The Centers for Disease Control and Prevention (CDC)(7) guidance for RCFs points to the CMS reopening guidance and details measures, for when communal activities and visitation resume. For the purposes of reopening, the CDC recommends baseline (or initial) testing of all residents and staff, followed by weekly testing of all staff.(8, 9) The CDC advises that the interval for re-testing can be adjusted based on local prevalence. However, individuals should not be tested more than once in a 24-hour period.(8) In addition to testing for COVID-19, the CDC recommends that clinicians should consider testing symptomatic residents for other causes of respiratory illness, such as influenza.
The CDC, as part of their guidance, have published a number of core practices that should remain in place as RCFs resume normal activities.(7) These core practices are: assign one or more individuals with training in infection control to on-site management of the IPC Program; report cases, facility staffing and information on supplies weekly to the National Healthcare Safety Network Long-term Care Facility COVID-19 Module; educate residents, healthcare personnel and visitors about COVID-19, precautions being taken in the facilities and actions they should take to protect themselves; implement source control measures including facemasks for staff at all times when in the facility, cloth face coverings for residents when they leave their room, cloth face coverings for visitors; have plans for visitor restrictions, testing residents and staff, admissions of residents, and staff shortages and monitoring; identify space in the facility dedicated to monitor and care for cases; actively monitoring residents upon admission and at least daily for fever and symptoms; and implement full IPC recommendations for patients with suspected or confirmed COVID-19 in healthcare settings(10), if a case is suspected.

As RCFs in the US begin to relax measures the CDC(7) recommend keeping an inventory of all volunteers and staff to determine who is non-essential and who can be excluded from providing care if the re-introduction of restrictions is necessary. Where communal dining, group activities and outdoor excursions are resumed, physical distancing and cloth face coverings for residents and PPE for staff should be implemented, depending on the transmission status in the community. When visits are allowed, they should be limited to select hours with no more than two visitors at a time, depending on the transmission status in the community. These visits should take place in the resident's room or a designated area.

New Zealand

New Zealand have transitioned down their alert level as a nation. New Zealand moved to alert level 1 on the 8 June. At alert level 1, there is no physical distancing requirement for anyone, including those in RCFs.(11) RCFs can operate as normal with visiting policies as they were before the COVID-19 alert level system.(12) A record of where people have been should be kept for contact tracing purposes, in particular where visitors are not routine (i.e. not direct family or regular visitors). All RCFs are to continue strict adherence to IPC protocols and screening at the point of entry to services for recent travel overseas, contact with anyone who has been overseas recently and contact with anyone with potential recent exposure to COVID-19. On 17 June, the Ministry of Health issued updated guidance for aged RCFs at Alert Level 1 in which it recommended that public health measures and PPE guidance should be adhered to, while testing for COVID-19 should be conducted in accordance with the national case definition.(13) At Alert Level 1, RCFs can operate at their full scope.
Canada

The Public Health Agency of Canada has published guidance for a strategic five step pan-Canada approach to lifting restrictive public health measures. This offers guidance as to what should open in each step, and can be applied by provinces in accordance with the nature and phase of the COVID-19 pandemic within the province. It is recommended that visitation to RCFs does not recommence until Step 3 and when it does, that restrictions and protective measures (unspecified) continue. Prince Edward Island is at Level 4 (lowest regional risk level). At Level 4 residents in RCFs are permitted to accept up to two designated visitors at one time, in outdoor spaces and since 15 July indoor visits are also permitted. Designated visitors lists, listing up to six designated visitors, should remain consistent and not change regularly. Residents may identify a temporary replacement designated visitor for approval if one of the originally designated visitors is unable to perform their role for a period of time. Visits are limited to one hour. The British Columbia Centre for Disease Control has announced that residents can have a single designated visitor in a specified indoor or outdoor visiting area or in RCFs where there is no active outbreak of COVID-19. This approach will be monitored through July with an aim to expand this in August. Visits in RCFs can commence from 1 July, once the RCF has a written safety plan in place. All visitors must bring and wear a face mask, maintain physical distance and be screened for signs and symptoms of illness. Visits must also be booked in advance. In addition, personal service providers, including hairdressers, will be allowed entry. The Government of Québec have announced that visitation to RCFs without a COVID-19 outbreak can resume.

Ireland

Ireland has allowed visits to RCFs to begin in a phased manner in facilities with no cases of COVID-19, from 15 June. The Health Protection Surveillance Centre (HPSC) has published guidance on facilitating visits for RCFs with no ongoing COVID-19 outbreak. This advises that visits are at the discretion of the RCF. Each resident can have a maximum of two named visitors and only one of those visitors can be present at any one time. Visits should be arranged in advance and scheduled to avoid heavy footfall. A separate entrance and exit area for visitors is encouraged. Visitors should be asked if they have had COVID-19 or close contact with a suspected or known case within the time period as determined in the national guidance. Visitors should declare that they have no symptoms and undergo a temperature check before entering. Visitors should sign in on entry to the facility and use their own pen or be signed in. Unplanned visits should not be facilitated. Visitors should be guided in performing hand hygiene when they arrive. Surgical masks are to be provided for visitors who cannot maintain physical distancing during the visit. Visits should occur in the resident’s room if the room is a single room or in a room away from other people in the case of a multi-occupancy facility, or in an outdoor area. Visits are limited to 30 minutes, with each visitor allowed a maximum of one visit per week. Visits should take place during the day with the main cohort of staff
on duty and away from mealtimes. Food and refreshments are not permitted. The use of the resident’s or visitors’ bathroom is discouraged. Children under 16 years are not permitted to visit. The resident’s right to decline a visitor shall be respected.

The HPSC has also published guidance specifically for visitors.\(^{(19)}\) This includes not visiting if you have any symptoms of COVID-19 infection or have symptoms of any other infection for example gastroenteritis; you should not visit until at least two days after your symptoms have gone away; and you should not visit if you have been told you are a COVID-19 contact, instead wait until the 14 days of self-isolation have passed before visiting. If you are tested for COVID-19, do not visit until you are told it is safe to do so. As of 21 July, there is no limit on the number of visitors that a resident may have. Only one nominated visitor may be present at one time; however, flexibility on this is advised for visits on compassionate grounds and involving children. Visitors must check in advance that it is OK to visit and keep to any time slots allocated. Contact details of nominated visitors should be provided to the RCF. Visitors should maintain 2 metres distance from the resident and everybody else in the RCF. Visitors must wear a face covering or a surgical mask, with some flexibility in relation to the needs of the resident and visitor for situations where physical distancing can be maintained. Gloves and aprons are not generally needed but a visitor may be asked to wear these by a member of staff. Visitors are asked to wash their hands properly and often and not touch their eyes, nose or mouth if their hands are not clean. Visitors should perform hand hygiene before they enter the residents’ areas and when leaving. Visitors may bring a gift or other things the resident needs when they visit. Visitors are further advised that if there is an outbreak, visiting will stop with the exception of on compassionate grounds for end of life situations.

The existing guidance and restrictions on visitation, as detailed in the Visitation section of this review, still apply in RCFs in Ireland where there is an outbreak of COVID-19.\(^{(20)}\)

**Hong Kong**

The Centre for Health Protection Hong Kong (CHP) has updated its guidance for RCFs to include a number of recommendations that apply as protective measures are eased, although they don’t explicitly state that the protective measures are no longer in effect.\(^{(21)}\) In relation to visitation, they recommend that people who have travelled in the past 14 days, those who have been in contact with a confirmed case in the past 28 days and those under medical surveillance are not permitted to visit. For those allowed to visit, visitor numbers should be limited at any one time, the duration of visits should be minimised, physical distancing should be maintained and a record of visitors should be maintained. Measures including temperature screening, hand hygiene, wearing of masks and a ban on children, are still in effect. If a resident, staff member or visitor becomes a confirmed case, all visits are to stop. Hong Kong has also provided advice for residents and staff who travel outside of Hong Kong, although they recommend that all non-essential travel should still be
avoided. All returning people should quarantine for 14 days. Staff who are in quarantine are not allowed to enter the RCF. Residents who leave the RCF temporarily for home leave or an excursion should wear a surgical mask when taking public transport, avoid crowded places and shower and change clothes as soon as possible after returning to the RCF. Although the Hong Kong guidance does not explicitly say whether communal activities can be resumed they recommend that for essential group activities and during meals, social distancing between residents is achieved by positioning residents 1 metre apart and or facing the same direction. They recommend that partitions are installed on dining tables to segregate residents, where feasible. The recommendation for the use of facemasks by all residents has been eased and now only applies to certain circumstances for example communal activities and when symptomatic. Residents should avoid leaving the institution unless deemed necessary; this includes going on home leave. In addition, RCFs should avoid, in so far as possible, the deploying of staff to work in different residential care homes.

On 8 July, the guidance was updated to explicitly state that visitors are only allowed under compassionate grounds.\(^{(21)}\) For visits under compassionate grounds, only one visitor should be allowed for each resident at a time and visits should be arranged at a designated space with proper segregation and hand sanitiser. People who are symptomatic, have been abroad in the previous 14 days, in contact with a confirmed case in the past 28 days or whose household members are under home quarantine are not permitted to visit, even under compassionate grounds.

**Australia**

Australia is beginning to ease restrictions. As of 25 June, RCFs can have gatherings of residents in communal or outdoor areas while implementing physical distancing and jurisdictional requirements for gathering sizes.\(^{(22)}\) Residents can leave the facility to attend small family gatherings. No new residents with symptoms compatible with COVID-19 are permitted to enter the facility. Some restrictions on visits and the cancellation of large group visits and external excursions are still in effect. Spouses, other close relatives and social supports can visit residents with no limitation on the number of hours they spend. Children of all ages can visit. Visiting service providers including hairdressers and therapists can also visit, if they cannot provide their services via telehealth or other models of care and the resident cannot attend an external facility to receive their services.

The **Australian Government Department of Health** has issued guidance for allowed visits, as described above.\(^{(22)}\) Visits are limited to two visitors at any one time, per resident. They must be facilitated in the resident’s room, outdoors or in a specified area in the facility. Visitors should be screened on their current health status before entry. Visitors should keep 1.5 metres from the resident where possible. Visitors who are unwell, have returned from overseas in the past 14 days, have had contact with someone confirmed to have COVID-19 in the past 14 days or have not had an influenza vaccine in 2020 are not permitted to enter. The
recommendation that all visitors have an influenza vaccination has been extended to include children.

Council on the Ageing (COTA), Australia, have developed an industry code for visiting RCFs during COVID-19.\(^{(23)}\) This takes a human rights based approach to care that both protects and respects residents and their visitors. It is recommended that RCFs, where there are no suspected or confirmed cases, facilitate visits in a restricted manner and supplement visits with additional ways to connect, such as window and courtyard visits and or utilising technology. RCFs should regulate the overall number of visitors, allow only short visits (30 minutes), use booking systems and limit visits to designated areas. Visits should occur unsupervised and with a maximum of two visitors per resident at any one time. All visitors should be educated about physical distancing and hygiene measures during their visit and should provide evidence of vaccination for influenza. Where there is a suspected or confirmed case within an RCF, exclusion of visitors should be considered. They have also outlined three scenarios where longer (up to two hours), more frequent and in room visits may occur, end of life situations, where a visitor has a clearly established pattern of involvement in a resident’s care and where visitors have travelled a substantial distance in order to visit. Spouses or other close relatives or social supports should not be limited in the number of hours they spend with relatives and children under 16 should once again be allowed to visit. It is recommended that additional IPC training and use of PPE are considered for these types of visitors. COTA also recommends that RCFs allow residents to leave to attend small family gatherings (with providers undertaking a risk assessment prior to the outing and a screening process post outing). However, in the event of an outbreak of COVID-19 in the RCF or a local cluster in the community, increased restrictions, including supervised visits and suspension of external excursions, can be reintroduced.

**New South Wales Health (NSW)** has updated the guidance for RCFs on restrictions on entry into the facility and for visitation.\(^{(24, 25)}\) Staff and visitors should not be permitted to enter if they have returned or arrived from overseas in the last 14 days, if they have travelled to Victoria or Melbourne (considered hotspots for COVID-19 transmission) in the last 14 days, if they have had contact with a confirmed case in the last 14 days, if they have not been vaccinated against influenza and if displaying symptoms. Visits should be limited to a short duration, limited to a maximum of two visitors at any one time and be conducted in the resident’s room, outdoors or in a specific designated area. No large group visits or gatherings, including social activities or entertainment should occur. External excursions should continue to be prohibited for residents. NSW also refer to COTA’s industry code for visiting RCFs during the COVID-19 pandemic, 11 May.\(^{(23)}\) Since 23 July, NSW recommends disability support providers who reside in South West Sydney to wear face masks when providing care or support to residents, this includes in RCFs.\(^{(26)}\) Previously, it was recommended that all staff wear face masks when within 1 to 2 metres of confirmed or suspected cases.
NSW published a protocol on the 10 July to support joint management of COVID-19 outbreaks in a Commonwealth funded residential aged care facility. A single positive COVID-19 case (resident or staff member) within an RCF will trigger the use of the protocol which includes a responsibility by the RCF to restrict visitors and community (including health workers) to the minimal essential requirements. Where the protocol is applied, non-essential visitors are precluded from face-to-face visits with residents and a log is to be maintained of all visitors entering the RCF, including areas and residents visited.\(^{(27)}\)

**The United Kingdom**

Since 19 March 2020, the UK prohibited all non-essential visits.\(^{(28)}\) On 22 July, the Department of Health and Social Care updated the *visitor guidance* for all RCFs in England.\(^{(29)}\) A local approach is recommended for allowing visits where the local directors of public health will, with local authorities, lead the decision-making process. A thorough risk assessment for individual RCFs taking into account the community context, should be undertaken before allowing visits. In making their judgment, the director of public health should consider as a minimum local testing data and any national oversight taking place in an area due to transmission risks.\(^{(29)}\) Where there is an outbreak of COVID-19 in the RCF or evidence of community hotspots or outbreaks leading to a local lockdown, RCFs should rapidly re-impose visiting restrictions.

Where visits do go ahead, a single constant visitor per resident is advised, wherever possible. Visitors should book in advance and RCFs should maintain a record of visitors as well those they interact with. Visitors should have no contact with other residents, minimal contact with staff (less than 15 minutes, maintaining 2 metre distance) and need to be informed of appropriate hand hygiene moments and the use of tissues for coughs and sneezes. Visitors should be encouraged to keep personal interaction with the resident to a minimum, for example avoid skin-to-skin contact (handshake, hug) and follow the latest social-distancing advice for as much of the visit as possible. The RCF should support the wearing of face coverings and provide appropriate PPE if a visitor is making close personal contact with a resident, and when the resident has COVID-19 and physical distancing is difficult maintain. In exceptional circumstances, it is acknowledged that a very small number of people may have great difficulty in accepting staff or visitors wearing masks or face coverings. The severity, intensity and or frequency of the behaviours of concern may place the resident, visitors or the supporting staff at risk of harm. In which case, a comprehensive risk assessment identifying the specific risks for them and others should be undertaken for the person’s care, and this same risk assessment should be applied for people visiting the resident. If visors or clear face coverings are available, they can be considered as part of the risk assessment. It is strongly stated that this assessment should not be applied to a whole care setting. All visitors should be screened for symptoms of acute respiratory infection before entering: no one who is currently experiencing, or first experienced, coronavirus symptoms in the last
seven days, should be allowed to enter the premises, nor should anyone who is a
household contact of a case or who has been advised to self-isolate by NHS Test and
Trace. Screening questions to ask visitors on arrival are provided.

A communal garden or outdoor area, which can be accessed without anyone going
through a shared building, are preferred for visits. While visits can take place in a
resident’s room, visitors should go directly to the resident’s room upon arrival and
leave immediately after. RCFs should encourage visitors to avoid public transport
and provide transport assistance to enable vulnerable visitors, if necessary. In
addition, RCFs are asked to consider additional precautions, which include plastic or
glass separation screens and assigning designated visiting rooms for the use of one
resident at a time.

The Scottish Government has issued guidance on a **four-stage, phased
reintroduction of visitors** to RCFs. This applies to RCFs that have not had any
COVID-19 cases and to RCFs where cases have been fully recovered from last
symptoms for 28 days. On 3 July, Scotland moved from stage one, where only
essential visitors were allowed, to stage two, where one designated visitor is allowed
to visit outdoors. This also includes visits to residents who are shielding. At stage
three, multiple visitors are allowed to visit outdoors and one designated visitor to
visit indoors. At stage four, a controlled programme of outdoor and indoor visits can
resume. At all stages, PPE must be worn by visitors and staff.\(^{(30)}\)

On 16 July, Northern Ireland **updated guidance for RCFs.** This details different levels
of visitor restrictions according the current regional surge level and the relevant RCF
outbreak status.\(^{(31)}\) When the regional surge is at high/extreme surge, no face-to-
face visits can occur. For medium surge level, only end of life visits can occur. At
pre/low surge level, visiting and accompanying of visitors can occur with a limit of no
more than two people at any one time and physical distancing should be maintained.
In addition to the surge level being at pre/low status, RCFs must have no outbreak
of infection and terminal clean must have been completed. Individual RCFs are
responsible for conducting a risk assessment prior to allowing visits. Depending on
the outcome of the risk assessment, visits may have to be limited to a maximum
number per week per resident. Other options include, restricting the number of
indoor visitors to one (or two when a care assistant is required), arranging visits in a
designated space that can facilitate physical distancing and only allowing residents
to receive visitors in their own rooms. For outdoor visits, when environmentallly
possible, visitors should be limited to up to six people. Visitors must wear face
coverings, visits must be booked in advance, and can last no more than an hour.
Screening questions may be asked of visitors, if the RCT deem it necessary. In
addition the guidance recommends when RCFs are proposing to take a bespoke
approach to a specific resident, it should seek to engage family and other likely
visitors, as well as the resident where appropriate, in this decision.
Conclusion

A number of countries are reopening RCFs or relaxing certain protective measures for these facilities. Guidance for when RCFs reopen has been published by the CMS and adopted by the CDC. This outlines a three phase plan with criteria for implementing and service provision guidance, including for testing, visitation, communal dining, group activities and medical trips outside the facility, at each phase. Scotland has issued guidance on a four-stage phased reintroduction of visitors. This applies to RCFs that are free of COVID-19 cases and RCFs where cases have been fully recovered from last symptoms for 28 days. England has issued guidance for when to allow visitors. This is based on the principles of taking a local approach and undertaking dynamic risk assessment of both the circumstances of the individual RCF and its local risk level.

Some countries are relaxing the protective measures they previously put in place. New Zealand has relaxed their guidance on visitation, isolation, admissions, outings and have removed the physical distancing requirement for everyone, including those in RCFs. The Centre for Health Protection Hong Kong has also relaxed their guidance on communal activities, the wearing of facemasks by residents and on outings for RCFs. (On 8 July, the Centre for Health Protection Hong Kong reintroduced restrictions and now only allows visitors on compassionate grounds.) Ireland has allowed visits from 15 June for RCFs with no cases of COVID-19 and from 21 July has removed the restriction on the number of nominated visitors. Australia has relaxed measures for visits, communal gatherings and external excursions. Some Canadian territories are allowing visits. As of 3 July, Scotland are allowing one designated visitor to visit outdoors, this includes visits to residents who are shielding. Since 22 July, England is allowing one nominated visitor per resident in RCFs where visits are allowed.

The Australian Government, British Columbia, Canada, Hong Kong, Ireland, New Zealand, Northern Ireland, NSW, and Scotland have issued guidance for visits during reopening of RCFs. This generally recommends to limit visitor numbers, maintain visitor logs, screen visitors for symptoms and potential contact with COVID-19, maintain physical distancing (except New Zealand), implement strict hand hygiene measures and to stop visits again if a case of COVID-19 is confirmed within the RCF. England, Ireland, Scotland and Northern Ireland additionally recommend or require face coverings for visitors. Due to local outbreaks, NSW recommends disability support providers who reside in South West Sydney wear face masks when providing care or support.

The findings from this rapid review were accurate as of 23 July 16.00 GMT, however, it is important to note that the guidance identified above may change as the situation and response to COVID-19 evolves.
References


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Rapid review of public health guidance for residential care facilities

Health Information and Quality Authority


Appendix A: Summary of interim guidance for RCFs on the prevention and management of COVID-19 cases and outbreaks.

Last updated 25 June 2020

Background

Ministries of health and other agencies have published interim guidance for RCFs on the prevention and management of COVID-19 cases and outbreaks. This guidance has been updated frequently due to the novel nature of the virus and the scale of mortality and morbidity in RCFs.

To inform guidance development by the Health Protection Surveillance Centre (HPSC) and decision-making by the National Public Health Emergency Team (NPHET), the Health Information and Quality Authority (HIQA) undertook an ongoing rapid review of guidance for RCFs in the context of COVID-19. The review was first undertaken on 30 March 2020 and was updated regularly until 25 June 2020. The review summarises recommendations that have been issued internationally to limit the spread of COVID-19 and protect healthcare workers and residents. The focus is on the highest level of public health guidance protective measures for RCFs put in place during the pandemic.

Methods

Relevant international resources were identified as per the protocol for the identification and review of new and updated relevant public health guidance - COVID-19, available on www.hiqa.ie and additionally from an ongoing search of COVID-19 related public health guidance undertaken by HIQA,(34) a summary of international policy measures compiled by the International Long Term Care Policy Network,(5) and in consultation with subject matter experts to identify relevant agencies with guidance that is used widely by RCFs.

Guidance documents were generally adapted from general infectious disease guidance for RCFs or guidance for RCFs on managing influenza. This review is limited to guidance documents explicitly related to COVID-19. If the document made reference to another document then it was only included if it was also explicitly related to COVID-19.

Results

Guidance documents for RCFs during the COVID-19 pandemic were identified for inclusion in this review from 17 agencies. Many guidance documents are interlinked and some are used in a hierarchical manner within a country. Furthermore, as the guidance is being updated frequently across the world, more recently updated guidance documents can partly replace other linked guidance documents. The agencies and the guidance documents included in this review and how they are interlinked are described below:
Australia: The Australian Government Department of Health primarily uses guidance developed by an Infection Control Expert Group (ICEG), to inform their RCFs on infection prevention and control (IPC) for COVID-19, published 2 April, updated 16 May. They also use guidance from the Communicable Disease Network Australia (CDNA), which was updated on 10 June and 30 April. The Australian Government Department of Health have issued guidance for people in RCFs in the context of easing measures, 25 June. Health Protection New South Wales (NSW) published brief COVID-19 guidance for RCFs, last updated 13 April. This guidance refers to the Australian ICEG guidance. Australia have published an industry code for visiting RCFs during the COVID-19 pandemic, 11 May.

Canada: The Public Health Agency of Canada published interim COVID-19 guidance for RCFs, last updated on 8 April.

The United States of America: Centers for Disease Control and Prevention (CDC) published COVID-19 guidance for RCFs, last updated on 19 May. The CDC published ‘Key Strategies to prepare for COVID-19 in Long-Term Care Facilities’, updated on 12 June and 21 May, ‘Preparing for COVID-19 in Nursing Homes’ updated 22 June and guidance for memory care units within RCFs, published 12 May. The CDC also published two documents on testing in RCFs, An update on ‘Testing Guidelines for Nursing Homes’ was provided on 13 June; the latest update on ‘Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes’ was provided on 19 May. CDC has separately published a preparedness checklist for RCFs and an ‘Infection prevention and Control Assessment Tool for Nursing Homes preparing for COVID-19’. The Society of Post-Acute and Long Term Medicine (PALTC) issued ‘Interim Recommendations for Post-Acute & Long-Term Care Facilities’ for COVID-19, last updated 5 March. The Centers for Medicaid and Medicare Services (CMS) published IPC guidance for COVID-19 in nursing homes, last updated 13 March.

The European Centre for Disease Prevention and Control (ECDC) published its third update of IPC guidance in health care settings on 13 May. This includes guidance for RCFs. The ECDC also published guidance on surveillance strategies in RCFs on 19 May.

Hong Kong: The Centre for Health Protection Hong Kong last updated its interim guidance for ‘Residential Care Homes for the Elderly or Persons with Disabilities for the Prevention of Coronavirus disease’ on 5 June.

Ireland: Guidance on transfer of residence was first provided on 10 March. More general guidance was first provided on 13 March and has been updated several times since by the Health Protection Surveillance Centre (HPSC). The HPSC guidance was last updated on 19 June. The HPSC also
published guidance on repeat testing in RCFs on 20 May\(^{(48)}\) and national guidance for management of contacts of cases, last updated 20 May.\(^{(48, 49)}\)

- **The United Kingdom:** The Department of Health and Social Care published guidance on admission and care of RCF residents on 2 April, and updated it on 19 June.\(^{(50)}\) Parts of this, such as testing and outbreak management guidance were replaced by the ‘Coronavirus (COVID-19): adult social care action plan’, last updated 16 April.\(^{(28)}\) The 19 June updated guidance on admissions and care of RCF residents is for periods of sustained community transmission and includes updated testing and outbreak management advice.\(^{(50)}\) Public Health England (PHE) has separately published guidance on the use of personal protective equipment (PPE) in RCFs.\(^{(51)}\) This PPE guidance was published 17 April and updated on 27 April and 15 June.

- **Scotland:** Health Protection Scotland (HPS) published COVID-19 guidance for RCFs on 26 April, updated on 15 June.\(^{(32)}\) HPS separately published an outbreak management tool on 17 April, updated on 20 May.\(^{(52)}\) HPS published a guidance document on testing in RCFs on 10 May, updated on 16 May.\(^{(53)}\) HPS has published guidance for discharging COVID-19 patients from hospital to residential settings, including to RCFs, last updated 4 June.\(^{(54)}\) The Scottish Government published Clinical and Practice Guidance on 13 March, updated on 15 May.\(^{(55)}\) HPS frequently refers to the UK Department of Health and Social Care\(^{(28, 50)}\) and PHE\(^{(51)}\) guidance, particularly in relation to PPE.

- **Northern Ireland:** Public Health Authority Northern Ireland (PHA) published their COVID-19 guidance for RCFs\(^{(56)}\) on 26 April, updated 7 May. PHA frequently refer to the UK Department of Health and Social Care \(^{(28, 50)}\) and PHE\(^{(51)}\) guidance, particularly in relation to PPE.

- **New Zealand:** The New Zealand Ministry of Health has published several documents on guidance for RCFs on COVID-19. Guidance on admissions was updated 22 May.\(^{(57, 58)}\) A screening questionnaire was published 20 May.\(^{(33)}\) Guidance on managing confirmed cases of COVID-19 in RCFs was updated 26 April.\(^{(59)}\) The Health Quality and Safety Commission New Zealand (HQSCNZ) separately published guidance on preventing and managing outbreaks of COVID-19 on 29 April\(^{(60)}\) which was partly informed by the CDNA guidance described above for Australia. The Ministry of Health issued updated guidance for aged RCFs (residential care facilities for older persons) on 17 June to accompany the country’s move to Level 1 (where the risk of community exposure to COVID-19 is very low) of its four-level Alert system.\(^{(13)}\)

- **The World Health Organisation (WHO):** The WHO published interim COVID-19 guidance for RCFs on 21 March.\(^{(61)}\)
The guidance, broadly covered the following themes: testing, screening, monitoring, isolation, cohorting, physical distancing, visitation, PPE, environmental cleaning and disinfection, immunisation, providing care for non-COVID-19 cases, caring for the recently deceased and governance and leadership.

The findings of the review are summarised below under these themes. Protective measures recommended are summarised by country or agency in Appendix Table 1.

**Testing**

There is variation in the recommendations for testing of residents and staff in RCFs for COVID-19 in the guidance included in this review.

Ireland, Northern Ireland, Scotland and the UK Department of Health and Social Care have extensive testing recommendations. A comprehensive testing sweep was implemented in Ireland on 18 April. In RCFs where there were current outbreaks, all residents and staff who had not yet been tested, were also tested. In RCFs where there were currently no cases, all staff were tested. It was recommended that after the testing sweep, all suspected cases should be tested, no matter what their testing history. The HPSC recommends testing close contacts of confirmed cases on day 0 and day 7 after last exposure to the confirmed case and testing all admissions to an RCF. The UK Department of Health and Social Care has offered tests to all symptomatic staff since 8 April. On 15 April, they committed to offering tests to anyone displaying symptoms of COVID-19 and to test all residents prior to their admission to care homes, including on discharge from hospital. As of 28 April, testing was expanded to include both symptomatic and asymptomatic RCF staff and residents. As of 11 May, RCF managers of particularly vulnerable RCFs could request tests for all staff and residents through the care home portal, this is known as ‘whole home testing’. Eligibility to request ‘whole home testing’ was expanded to all RCFs on 7 June.

PHA recommends testing all new admissions, residents with symptoms, and in the event of an outbreak, all staff and residents. Staff with symptoms are also ‘eligible for testing’. HPS recommends several strategies for testing in RCFs and prioritises these strategies based on available resources. HPS recommends that the primary strategy should be to test all residents and staff in RCFs with newly identified outbreaks. Secondly, HPS recommends testing all residents and staff in linked RCFs. A linked RCF is one where an outbreak has not occurred but a member of staff works in an RCF where an outbreak has occurred. If the staff member has worked in the linked RCF within 72 hours of the outbreak occurring, then all staff and residents in the linked RCF should be tested. With priority given to RCFs where the linked worker is symptomatic or has tested positive. As a third priority, HPS recommends that consideration be given to testing staff and or residents from RCFs with no confirmed or suspected cases. HPS recommend that if widespread testing of any kind is planned for an RCF, then there should be assurances sought that enhanced IPC practice and increased staffing can be implemented if cases are discovered. In
relation to re-testing, HPS recommends that RCF staff should be tested every time they develop symptoms, regardless of previous COVID-19 status. HPS also recommends testing all new RCF staff ‘prior to starting work at the affected care home’.

The CDC recommends testing all staff and residents who display symptoms and recommends testing all residents and staff if there is a new confirmed case in a staff member or a suspected or confirmed case in a resident. After testing all residents and staff in RCFs with a confirmed or suspected case, repeat testing of all residents and staff who tested negative is advised until no new cases are identified for a period of 14 days. It is recommended that the same individual is not tested more than once in a 24-hour period and that in addition symptomatic residents are tested for other causes of respiratory illness, for example, influenza. The CDC advises that if testing is limited then it should be directed towards the unit, floor or ward where the suspected or confirmed case works or resides, or only those who are symptomatic or are close contacts on the relevant unit, floor or ward. For repeat testing, the CDC advises giving priority to close contacts and those who leave the facility (for example, for a medical appointment or work in other facilities). At a system level, the CDC advises prioritising testing in RCFs with higher numbers of cases or in areas with higher community prevalence.

Other agencies have adopted less comprehensive testing approaches. The ECDC has made testing recommendations based on the number of cases in an RCF. If there are no cases, then testing random samples of residents and weekly or biweekly testing of all staff is recommended. If there is one or more possible cases, then it is advised to test all residents who are possible cases and test all staff. If there is one or more confirmed cases, then it is advised to test all staff weekly or biweekly and all residents including the deceased. The ECDC also advises to consider testing of regular visitors. The CDNA recommends testing residents with any new respiratory symptom and asymptomatic contacts of known cases. The NSW Government recommends that anyone with respiratory symptoms or an unexplained fever should be tested for COVID-19; this recommendation also applies to those living in RCFs. HQSCNZ recommends that residents with any new respiratory symptom should be tested and that staff who are suspected cases should be tested in the community, as they are a priority group for testing.

Some agencies have not included guidance on testing for RCFs, including the CMS, Canada, Hong Kong and the WHO. However, the CMS has published guidance on testing during reopening, detailed in the reopening section.

Screening

The Australian ICEG, Canada, the CDC, the CDNA, the CMS, Hong Kong, Ireland, NSW and the WHO recommend screening people entering an RCF. Various approaches to screening are outlined, including requiring temperature checks for staff before beginning work (Hong Kong, Ireland, the
CDC\(^{(7)}\), requiring staff to declare that they do not have symptoms (Ireland\(^{(47)}\)) or had potential exposure (Canada\(^{(37)}\)) before beginning work and screening everyone at the point of entry to the RCF (the Australian ICEG,\(^{(35)}\) Canada,\(^{(37)}\) the CDC,\(^{(38)}\) the CMS,\(^{(44)}\) NSW\(^{(24)}\)). The CDNA\(^{(36)}\) recommends self-screening by all people entering the facility and screening resident admissions. Hong Kong also recommend screening visitors.\(^{(21)}\) Some agencies recommend including temperature checks as part of screening (Ireland,\(^{(47)}\) the CDC,\(^{(38)}\) the CMS,\(^{(44)}\) NSW\(^{(24)}\), Hong Kong\(^{(21)}\)) while others limit screening to questions about symptoms, travel and or contact with cases of COVID-19 (the Australian ICEG,\(^{(35)}\) Canada,\(^{(37)}\) the CDNA\(^{(36)}\)). The WHO\(^{(61)}\) recommends screening visitors for symptoms and risk and temperature checks for staff at the point of entry.

**Monitoring**

A number of agencies recommend active monitoring of staff and residents for symptoms of COVID-19 (Canada,\(^{(37)}\) Hong Kong,\(^{(21)}\) HPS,\(^{(52)}\) Ireland,\(^{(47)}\) the Australian ICEG,\(^{(35)}\) CMS,\(^{(44)}\) the HQSCNZ,\(^{(60)}\) The UK Department of Health and Social Care,\(^{(50)}\) PHA,\(^{(56)}\) the CDC,\(^{(38)}\) WHO\(^{(61)}\), ECDC\(^{(45)}\)).

Recommendations on monitoring of residents vary from once a day (Canada,\(^{(37)}\) Hong Kong,\(^{(21)}\) HPS,\(^{(52)}\) the HQSCNZ,\(^{(60)}\) the CDC\(^{(38)}\), ECDC\(^{(45)}\)) to twice a day (the HPSC,\(^{(47)}\) the UK Department of Health and Social Care,\(^{(50)}\) PHA,\(^{(56)}\) WHO\(^{(61)}\)). The CMS\(^{(44)}\) recommends frequent monitoring but does not specify how often. The Australian ICEG\(^{(35)}\) recommends at least daily monitoring for residents who were close contacts with a confirmed case. The UK Department of Health and Social Care also recommend weekly monitoring of residents with symptoms by the clinical lead using the RESTORE2 and NEWS2 scoring systems.\(^{(50)}\)

Ireland,\(^{(47)}\) the CMS,\(^{(44)}\) the HQSCNZ,\(^{(60)}\) the UK Department of Health and Social Care,\(^{(50)}\) PHA\(^{(56)}\) and the CDC\(^{(7)}\) also recommends the monitoring of staff throughout the day. Canada\(^{(37)}\) recommends monitoring staff who have been exposed to COVID-19 but who are not unwell, twice a day.

Mostly, monitoring includes assessment for fever, cough or shortness of breath. Some countries and agencies (Canada,\(^{(37)}\) the CDC,\(^{(38)}\) HPS,\(^{(52)}\) Ireland,\(^{(47)}\) the UK Department of Health and Social Care,\(^{(50)}\) PHA\(^{(56)}\)) highlight that symptoms in elderly residents may be subtle and atypical, which may include new or worsening malaise, new dizziness, diarrhoea, falls, or loss of appetite and that staff should be sensitive to the detection of changes in a resident’s condition. PHA also notes that some residents, for example, those with dementia may be less able to report symptoms and highlights the importance of the close monitoring of these residents.\(^{(56)}\) The WHO recommends monitoring employees and their contact with residents and using the WHO risk assessment tool to identify employees who have been at a high risk of exposure to COVID-19.\(^{(61)}\)
Isolation

Isolation of Confirmed and Suspected Cases

The most common guidance on isolation is for confirmed and suspected cases. A suspected case is usually someone displaying symptoms of COVID-19 such as fever, shortness of breath or a new onset of persistent cough. Unless otherwise stated, a single room with a dedicated bathroom is recommended for isolation and isolation means the resident should not leave their room except for essential medical care.

The UK Department of Health and Social Care (50) and PHA(56) recommend an isolation period of 14 days from onset of symptoms. The UK Department of Health and Social Care recommends that if symptoms worsen during isolation or are no better after 7 days that further medical advice around escalation should be sought.(50) The HPSC(47) recommends that residents with confirmed COVID-19 infection should be isolated for 14 days from onset of symptoms and that the resident has been free of fever for the last five days in order to cease isolation. HPS(32) recommends that ‘symptomatic residents’ are isolated for 14 days from the onset of symptoms (or from date of positive test if date of symptom onset is unknown). The CDNA(36) and the HQSCNZ(60) recommend the isolation of ‘cases’ with faecal incontinence or diarrhoea until 48 hours after these symptoms resolve. The WHO(61) recommends that confirmed cases should be isolated until they have two negative tests, 24 hours apart or if testing is not available, until two weeks after symptoms resolve.

A number of agencies recommend isolating residents with suspected or confirmed COVID-19 but do not include guidance on an end point. The CDNA(36) also recommends isolating confirmed and suspected cases but does not provide a recommended point to end isolation. HQSCNZ(60) recommends isolating residents who meet the case definition for COVID-19 but does not provide a recommended point to end isolation. The Australian ICEG(35) recommends that suspected and confirmed cases should be isolated ‘while they remain infectious as determined by the public health unit’. Similarly, New Zealand(59) guidance recommends that all residents with suspected, probable or confirmed COVID-19 infection, should be isolated immediately and responsibility for determining the point of release lies with the resident’s health practitioner. The CMS(44) advises that potentially infectious residents should be isolated immediately. The CDC(7, 38) recommends the ‘prompt isolation’ of residents who present with atypical symptoms such as diarrhoea or new dizziness and of residents who develop symptoms consistent with COVID-19, pending results of testing.

Canadian guidance(37) does not give recommendations on isolating confirmed or suspected cases. The CDC(38) also does not give recommendations on isolating confirmed or suspected cases with typical symptoms, however, they recommend restricting all residents to their rooms if there are cases in the facility.
The Australian ICEG\(^{(35)}\) advises that residents with dementia need special consideration and should be isolated on a case-by-case basis. The HQSCNZ\(^{(60)}\) also advises that people with dementia should be isolated ‘if possible’.

**Close contacts**

The Australian ICEG\(^{(35)}\) recommends that residents who are close contacts of confirmed cases should be isolated in a single room for 14 days. Canadian guidance\(^{(37)}\) advises that roommates of symptomatic residents should be isolated, although the period of isolation is not specified. The CDC\(^{(38)}\) recommends that roommates of confirmed cases are not placed with another roommate for 14 days from the time of contact (assuming they do not develop symptoms or test positive). Hong Kong\(^{(21)}\) and Ireland\(^{(47)}\) recommends the isolation of close contacts of confirmed or possible cases for 14 days from the time of contact. The UK Department of Health and Social Care\(^{(50)}\) advise the isolation of contacts of suspected and confirmed cases for 14 days from the time of contact. HPS\(^{(32)}\) recommend isolation of contacts for 14 days from last exposure to a confirmed or suspected case.

**Transfers and admissions**

Many agencies have issued specific guidance on isolation for resident transfers and admissions to RCFs. The UK Department of Health and Social Care,\(^{(50)}\) PHA,\(^{(56)}\) HPS,\(^{(52)}\) NZ,\(^{(57)}\) Ireland,\(^{(47)}\) Canada,\(^{(37)}\) the CDC,\(^{(38)}\) and the CMS\(^{(44)}\) recommend isolating admissions for 14 days. The CDC\(^{(38)}\) advises that it is an ‘option’.

Some agencies caveat this advice. The HPSC\(^{(47)}\) recommends that confirmed cases should not be transferred until 14 days after symptom onset and after they are five days fever free. NZ\(^{(57)}\) recommends against admitting those who have travelled abroad or been in close contact with a confirmed or suspected case in the last 14 days or have any acute respiratory symptoms, although they advise that confirmed cases can be admitted. NZ has developed a screening questionnaire for assessment of admissions.\(^{(33)}\) It is recommended that potential admissions who meet any of the criteria in the questionnaire are offered a test for COVID-19 and not admitted until they have received a negative result. NZ also recommends that people being discharged from hospital who have tested positive, should not be admitted to an RCF until their isolation period is completed, and those that have tested negative should be admitted and isolated for 14 days.\(^{(58)}\) The Scottish Government\(^{(55)}\) and the HPS\(^{(54)}\) recommend that confirmed cases should have two negative tests 24 hours apart before being discharged from hospital. HPS recommends that testing can commence on day 8. Both agencies also recommend that those in hospital who do not have COVID-19 should have a negative test within 48 hours of discharge.\(^{(55)}\) HPS\(^{(52)}\) also advises that in the case of an outbreak, RCFs can close to admissions if it would be ‘beneficial’. PHA\(^{(56)}\) recommends conducting a risk assessment for those being admitted from their own homes.
The Australian ICEG\textsuperscript{(35)} advises that admissions should be restricted if an outbreak occurs, but those who have been transferred to a hospital from the RCF should be readmitted. New Zealand\textsuperscript{(57)} advises cancelling admissions for respite care, except in emergencies.

**Cohorting**

*Resident cohorting*

Several agencies have issued guidance to place residents together in a room, based on diagnosis (confirmed case of COVID-19) or having symptoms of COVID-19, in scenarios where there is not the capacity to put every resident in a single room with a dedicated bathroom. This is referred to as resident cohorting.

The Australian ICEG\textsuperscript{(35)} recommend that residents with the same diagnosed virus, can be cohorted in the same room together, if necessary. The Australian ICEG\textsuperscript{(35)} advises that close contacts can also be cohorted in the same room together, if necessary, but not in the same room as confirmed and or suspected cases. Canadian guidance\textsuperscript{(37)} advises the consideration of cohorting of residents confirmed to have COVID-19. The CDC recommends that confirmed cases should be in a ‘dedicated’ unit and highlights that cohorting residents on the same unit based on symptoms alone, could result in the unintentional mixing of infected and non-infected residents.\textsuperscript{(38)} The CDNA\textsuperscript{(36)} and the HSCQNZ\textsuperscript{(60)} recommend the cohorting of suspected or confirmed cases, if necessary. The CDNA\textsuperscript{(36)} and the HSCQNZ\textsuperscript{(60)} specify that those with the same diagnosis should be cohorted together, and if diagnosis is not known, then those with the same signs and symptoms of an infectious disease should be cohorted.

The HPSC\textsuperscript{(47)} guidance advises that if there are multiple suspected and or confirmed cases then they should be placed in single rooms near each other. Cohorting of confirmed cases is recommended by the HPSC\textsuperscript{(47)}, if necessary. The same advice is given for suspected cases, although this is cautioned by highlighting that it is a higher risk strategy.\textsuperscript{(47)} The HPSC\textsuperscript{(47)} also advises that cohorting of close contacts is acceptable, if necessary. The HPSC\textsuperscript{(47)} advises that confirmed cases and probable cases should be cohorted in mutually exclusive groups.

The UK Department of Health and Social Care\textsuperscript{(50)} and the WHO\textsuperscript{(61)} advise that the cohorting of residents can be implemented, if necessary. The UK Department of Health and Social Care\textsuperscript{(28)} and the WHO\textsuperscript{(61)} advise that suspected cases, confirmed cases and immunocompromised residents should be cohorted in mutually exclusive groups. The UK Department of Health and Social Care\textsuperscript{(50)} also discusses cohorting of close contacts, protective cohorting of unexposed residents and recommends that those who are clinically extremely vulnerable should be in a single room and not share bathrooms with other residents or staff. HPS\textsuperscript{(32)} advises that suspected cases and confirmed cases should be cohorted in mutually exclusive groups. HPS\textsuperscript{(32)} also advise that those who are extremely medically vulnerable and are being shielded
(similar to cocooning) should not be cohorted. HPS\(^{(32)}\) advise that consideration can be given to cohorting contacts of cases if necessary. PHA recommends cohorting symptomatic residents, if single occupancy rooms are not available, not cohorting suspected or confirmed cases with immunocompromised residents and suggests consideration of protective cohorting of unexposed residents.\(^{(56)}\)

The CDC notes to carefully manage any resident from a memory care unit that moves for cohorting, as this may cause disorientation.\(^{(4)}\)

**Staff cohorting**

Most agencies have some advice that healthcare workers should work with certain groups of residents only, such as confirmed cases. The Australian ICEG,\(^{(35)}\) HPS,\(^{(32)}\) PHA,\(^{(56)}\) the CDC\(^{(38)}\) and the ECDC\(^{(45)}\) advise the cohorting of staff that are caring for confirmed cases. The CDC also recommends the cohorting of staff to memory care units.\(^{(4)}\) The HPSC\(^{(47)}\) has the same advice, except refers to COVID-19 cohort areas and non-COVID-19 areas. The CDNA\(^{(36)}\) recommends that RCFs should ‘allocate specific RCF staff to the care of residents in isolation’. Canadian guidance\(^{(37)}\) recommends the cohorting of staff to ‘work only with suspected or confirmed’ cases. Hong Kong guidance\(^{(21)}\) recommends that staff should work within the same room(s), zone, or floor for care of the same group of residents.

The HQSCNZ\(^{(60)}\) advises that staff should be allocated to the care of residents in isolation and should not move from allocated patients. The UK Department of Health and Social Care\(^{(50)}\) and PHA\(^{(56)}\) advise that staff working with symptomatic residents should be ‘cohorted away from other care home residents and other staff’. The UK\(^{(50)}\) and PHA also advises that ‘staff should only work with symptomatic or asymptomatic residents’. The UK Department of Health and Social Care\(^{(50)}\) and PHA advises that staff who have had COVID-19 and have recovered, should care for patients with COVID-19 where possible. PHA\(^{(56)}\) also mentions being supportive of staff sleeping in RCFs and the UK Department of Health and Social Care\(^{(50)}\) recommends that RCFs consider providing accommodation for staff that proactively choose to stay separate from their families in order to limit social interaction outside of work. The UK Department of Health and Social Care also recommends that RCFs restrict staff movement wherever feasible and that members of staff only work in one RCF where possible.\(^{(50)}\)

**Physical distancing**

Physical distancing is recommended for everyone in the countries included in this review and should be applied where possible within RCFs, although it is acknowledged that this may be difficult to achieve. Nonetheless, some agencies have provided guidance on physical distancing for residents and staff and recommendations to avoid communal activities.

**Residents**
PALTC\(^{(43)}\) recommends the introduction of physical distancing but does not specify a distance or who this should apply to. The CDC\(^{(38)}\) and the CMS\(^{(44)}\) advise residents to practice physical distancing by maintaining at least 6 feet from others. The HPSC\(^{(47)}\) guidance recommends a distance of 1-2 metres from other residents and staff as well as avoiding touching. The HPSC\(^{(47)}\) provides for exceptions in the case of couples. The HQSCNZ\(^{(60)}\) and CDNA\(^{(36)}\) guidance advises that a distance of 2 metres and 1.5 metres, respectively, should be maintained between confirmed and suspected cases and others. The WHO\(^{(61)}\) recommends enforcing a distance of 1 metre between residents. The WHO\(^{(61)}\) also advises that residents should not touch. HPS\(^{(32)}\) and the UK Department of Health and Social Care\(^{(28, 50)}\) advise adherence to social distancing measures (2 metres distance from others), stressing that this is more important for those who are in high risk groups and that support should be given to residents who are shielding (also known as cocooning). Canadian guidance recommends a distance of two metres between all residents.\(^{(37)}\)

**Staff**

Canadian\(^{(37)}\) and the CDC\(^{(38)}\) guidance recommend that staff should maintain a distance of 2 metres from each other. Hong Kong guidance\(^{(21)}\) advises staff to ‘maintain a distance’ from each other when having meals. HPSC guidance\(^{(47)}\) advises staff to maintain physical distancing during breaks. HPS\(^{(32)}\) advises adherence to social distancing measures (2 metres distance from others), stressing that this is more important for those who are in high risk groups.

**Group activities**

Many agencies recommended restrictions on activities within RCFs.

The CDC\(^{(38)}\), the CMS\(^{(44)}\) and PALTC\(^{(43)}\) recommend the cancellation of communal dining. The WHO\(^{(61)}\), Canada\(^{(37)}\), and Hong Kong\(^{(21)}\) recommend that communal dining be staggered. Canada\(^{(37)}\) recommends the cancellation of communal dining if there are suspected or confirmed cases in the RCF. The HPSC\(^{(47)}\) and the WHO\(^{(61)}\) recommend that meals should be provided in rooms if social distancing rules cannot be adhered to. PHA\(^{(56)}\) recommends that social distancing should be maintained during dining and dining in residents’ rooms could be considered.

The Australian ICEG\(^{(35)}\), the HQSCNZ\(^{(60)}\), the Scottish Government\(^{(55)}\) and the CDNA\(^{(36)}\) recommend the cancellation of communal activities if there is a COVID-19 outbreak in the RCF. Ireland\(^{(47)}\), Canada\(^{(37)}\), Hong Kong\(^{(21)}\) and the UK Department of Health and Social Care\(^{(50)}\) recommend that group activities should be cancelled if physical distancing rules cannot be adhered to. The CDC\(^{(39)}\) also recommends cancelling all group activities to prevent the spread of COVID-19 in RCFs, in addition to enforcing physical distancing among residents. PALTC\(^{(43)}\) recommends that group activities be cancelled. PHA\(^{(56)}\) recommends that the use of communal areas should be strictly limited.
In contrast, the CDC recommends continuing to provide activities for residents in memory care units and to consider staggering in order to facilitate social distancing.\(^{(4)}\)

Some countries are beginning to allow group activities in RCFs, these are detailed in the *Reopening* section of this review.

**Visitation**

All agencies included in this review have recommended some restrictions on visitation, including limiting visits to essential visits and or barring visitors who are unwell. No agency has banned visits on compassionate grounds, for example end-of-life situations, however, most have recommended restrictions such as one visitor at a time (Australia,\(^{(35)}\) Canada,\(^{(37)}\) the HQSCNZ,\(^{(60)}\) PHA,\(^{(56)}\) the WHO\(^{(61)}\)) and visits in the resident’s room or other designated area only (the Scottish Government,\(^{(55)}\) Australia,\(^{(35)}\) Canada,\(^{(37)}\) the CDC,\(^{(38)}\) the CDNA,\(^{(36)}\) the CMS,\(^{(44)}\) HPS,\(^{(32)}\) NSW,\(^{(24)}\) NZ,\(^{(60)}\) the UK Department of Health and Social Care,\(^{(50)}\) the WHO\(^{(61)}\)). The Australian ICEG,\(^{(35)}\) NSW,\(^{(24)}\) the HQSCNZ,\(^{(60)}\) PHA\(^{(56)}\) and Hong Kong\(^{(21)}\) have a ban on visits from children in all circumstances and Canada\(^{(37)}\) has stated that people who cannot comply with the precautions in place in the RCF, cannot enter. NSW,\(^{(24)}\) the UK Department of Health and Social Care\(^{(50)}\), PHA\(^{(56)}\) and Australia\(^{(23)}\) recommend limiting essential visits to a short duration. Canada\(^{(37)}\) and CMS\(^{(44)}\) recommend that visitors wear face masks while in the RCF. The CMS\(^{(44)}\) additionally recommends disinfecting rooms after each resident-visitor meeting. The Scottish Government recommends that where visitors are permitted, visits should be staggered across the day so that there are not many visitors in the RCF at one time.\(^{(55)}\) The ECDC recommends physical distancing for essential visitors.\(^{(45)}\)

Australia has developed an industry code for visiting RCFs during COVID-19.\(^{(23)}\) This takes a human rights based approach to care that both protects and respects residents and their visitors. It is recommended that RCFs, where there are no suspected or confirmed cases, facilitate visits in a restricted manner and supplement visits with additional ways to connect, such as window and courtyard visits and or utilising technology. RCFs should regulate the overall number of visitors, allow only short visits (30 minutes), use booking systems and limit visits to designated areas. Where there is a suspected or confirmed case within an RCF, exclusion of visitors should be considered. They have also outlined three scenarios where longer (up to two hours), more frequent and in room visits may occur, end of life situations, where a visitor has a clearly established pattern of involvement in a resident’s care and where visitors have travelled a substantial distance in order to visit. It is recommended that additional IPC training and use of PPE are considered for these types of visitors.

Some agencies recommend the screening of visitors for temperature, respiratory symptoms, recent travel and or contact with a case (The Australian ICEG,\(^{(35)}\) Canada,\(^{(37)}\) the CDC,\(^{(38)}\) the CMS,\(^{(44)}\) Hong Kong,\(^{(21)}\) NSW,\(^{(24)}\) PALTC,\(^{(43)}\) the WHO\(^{(61)}\)).
These recommendations are detailed in the Screening section of this review. The CDNA,\textsuperscript{36} Canada,\textsuperscript{37} Hong Kong,\textsuperscript{21} HPS\textsuperscript{62} and the New Zealand Government\textsuperscript{60} advise RCFs to maintain registers of all visitors.

Some countries are beginning to relax their restrictions on visitations. This is detailed in the Reopening section of this review.

Personal Protective Equipment (PPE)

Healthcare workers when caring for confirmed and suspected cases

The most common PPE guidance is to employ contact and droplet precautions when within 1-2 metres of confirmed and or suspected cases. In the context of PPE this usually means wearing disposable gloves, surgical mask, apron/gown, and eye protection such as goggles or a face shield. This advice is given by the following agencies: Hong Kong,\textsuperscript{21} Australian ICEG,\textsuperscript{35} Government of Canada,\textsuperscript{37} the WHO,\textsuperscript{61} Ireland,\textsuperscript{47} New Zealand,\textsuperscript{63} and the UK Department of Health and Social Care.\textsuperscript{50}

There are some exceptions, for example, the Australian ICEG\textsuperscript{50} advises that eye protection is optional for asymptomatic close contacts. The HQSCNZ\textsuperscript{60} does not recommend the use of full PPE when caring for residents who are contacts of confirmed or suspected cases but does advise asking the patient to wear a mask during care.

The UK Department of Health and Social Care\textsuperscript{50} also gives guidance on breaches of PPE, which includes undertaking a risk assessment considering the severity of the symptoms of the resident, the length of exposure, the proximity to the resident, the activities undertaken (e.g. aerosol generating procedures, monitoring, personal care). They recommend that if the risk assessment concludes that there has been a significant breach, the worker should remain off work and self-isolate for 14 days.

Wider use of PPE by healthcare workers

Many agencies and countries recommend PPE outside of caring for confirmed and suspected cases of COVID-19. The CDC\textsuperscript{38} advises RCFs to consider having all healthcare workers wear facemasks while in the RCF, even if there are no confirmed cases. This is also advised in Hong Kong\textsuperscript{21} and Canada.\textsuperscript{37} Guidance from the HPSC\textsuperscript{47} advises healthcare workers to wear a surgical mask when within two metres of a patient or another healthcare worker regardless of COVID-19 status. Canadian guidance\textsuperscript{37} advises that face shields should be considered for entire shifts if an outbreak occurs in a facility. PHE\textsuperscript{51} advises that disposable gloves, disposable apron and a fluid resistant surgical mask are recommended for healthcare workers when providing close personal care in direct contact with a resident (for example, touching) or within two metres of any resident who is coughing. The advice applies to the personal care of all residents regardless of symptoms, including those in the ‘extremely vulnerable group’ undergoing shielding and those diagnosed with COVID-19.\textsuperscript{51} When healthcare workers are within two metres of a resident, but not
delivering personal care or needing to touch them, and there is no one within two metres who has a cough, PHE advises that only a type II surgical mask should be worn by staff. PHA(56) and HPS(32) advise that PHE’s PPE guidance(51) should be followed. The ECDC(45) recommends a surgical mask, a respirator where available, eye protection, a gown and gloves when in contact with residents with respiratory infections. The HPSC also recommends the wearing of masks for encounters between staff if the encounter is expected to last longer than 15 minutes.(47)

Also, the CDC(38) recommends the universal use of all recommended PPE (facemask or respirator, eye protection, gloves, gown) in a facility or unit when ‘even a single case among residents or HCP is identified in the facility’. CDC also advises the consideration of the universal use of all recommended PPE in the scenario of sustained community transmission(38) and the use of eye protection and respirators for staff working in memory care units to address the potential for encountering a wandering resident with COVID-19.(4) The Australian ICEG(35) mentions that if the number of cases and or contacts increase in the facility or the area then there may be a need for wider use of PPE, but no specifics are provided.

Other staff

Several documents also provide guidance on the use of PPE for other staff, particularly cleaners. Hong Kong(21) advises cleaners that full PPE is necessary when cleaning, after evidence of a confirmed or suspected case or if cleaning bodily fluids. The CDNA(36) advises the use of appropriate PPE when handling soiled linen. The Australian government(64) recommends gloves, facemask and eye protection for general cleaning and full PPE if cleaning respiratory secretions or bodily fluid or terminal cleaning. Full PPE is advised by the HQSCNZ(60) when handling ‘heavily soiled linen of an infected resident’. Canadian guidance(37) is not completely clear, advising that environmental services staff should wear the same PPE ‘as other staff’ when cleaning a resident’s room. HPSC guidance(47) advises all staff handling waste wear appropriate PPE. PHA advises that cleaners and other staff should be trained in the correct use of PPE, but does not specify what should be worn.(56) The WHO(61) advises that those cleaning surfaces, soiled bedding or laundry should wear full PPE as well as boots or closed toe shoes. The ECDC advises that staff involved in waste management wear PPE.(45)

Canadian guidance(37) is the only guidance to advise on PPE for screeners. Screening is recommended at the point of entry for all people entering the RCF in Canada.(37) Screeners should wear full PPE if there are no physical barriers between those being screened and the screener.(37)

Monitoring

Several agencies advise that compliance with PPE guidance should be monitored including Canada,(37) the CDC(38) and the HQSCNZ.(60)
Residents

Guidance for residents’ use of PPE varies between agencies and countries. Hong Kong\(^{(21)}\) recommends the universal use of surgical masks by residents.

The CDNA\(^{(36)}\), Australian ICEG\(^{(35)}\), and HQSCNZ\(^{(60)}\) advise that symptomatic residents should wear a facemask or cloth face covering if they leave their room. The CDC\(^{(38)}\) recommends that all residents wear a facemask if they leave their room. The WHO\(^{(61)}\) advises that confirmed and or suspected cases should wear a medical mask and if others are staying in the same room they should also wear a medical mask. Guidance from the HPSC\(^{(47)}\) advises that confirmed and or suspected cases should wear a surgical mask (or cover their mouth and nose with a tissue) if entering an occupied shared space. Canada\(^{(37)}\) advises that all residents should be given a mask during transfer between healthcare facilities. The CMS\(^{(44)}\) advises that confirmed and or suspected cases should be given a mask during transfer. The UK Department of Health and Social Care\(^{(50)}\) advises that all residents should be given a mask during transfer between rooms. PHA advises that residents with possible or confirmed COVID-19 should wear a surgical face mask in clinical areas, communal waiting areas and during transportation.\(^{(56)}\)

For the wearing of masks by residents it is often cautioned by saying ‘if tolerated’ (the Australian ICEG\(^{(35)}\), Hong Kong\(^{(21)}\), the CDC\(^{(38)}\), the HQSCNZ\(^{(60)}\), Ireland\(^{(47)}\), PHA\(^{(56)}\)). The CDC also recommends special consideration for cloth face coverings for residents in memory care units and advises not to give a covering to those with trouble breathing, or who are incapacitated or unable to remove the covering independently.\(^{(4)}\)

Visitors

As discussed above in the section on Visitation, most agencies have several restrictions on visitors. For visitors that are permitted, the following guidance on PPE is given.

The CDC\(^{(38)}\) recommends cloth face covering or facemasks for visitors. Hong Kong\(^{(21)}\) recommends visitors wear surgical masks. Canadian guidance\(^{(37)}\) recommends that visitors should be required to put on a mask when entering the RCF. CMS\(^{(44)}\) advises facilities that visitors entering in end-of-life situations should be required to wear PPE (‘such as facemasks’). The CMS\(^{(44)}\) also advises that facemasks should be worn by visitors ‘while in the building’.

The Australian ICEG\(^{(35)}\) advises that visitors should wear a surgical mask in the room of confirmed and or suspected cases. Canadian guidance\(^{(37)}\) recommends that visitors wear full PPE when in the room of confirmed and or suspected cases. Guidance from the HPSC\(^{(47)}\) recommends that for visiting confirmed and or suspected cases at end of life, a surgical mask and apron are worn, but not gloves.
Other agencies were less clear. The HQSCNZ, the CDNA and PHA advise that visitors should wear appropriate PPE or, as directed by staff. HPS advises RCFs to conduct a local risk assessment to determine whether visitors should wear PPE. COTA (Australia) recommends that PPE is considered for visitors who are allowed longer visits (up to 2 hours). The UK Department of Health and Social Care recommends that PPE is worn by visitors during an outbreak.

**Environmental cleaning and disinfection**

Most agencies, including Canada, Hong Kong, the WHO, HPS, the HPSC and the CDNA advise that frequently touched surfaces should be cleaned twice daily. HQSCNZ advises the cleaning of frequently touched surfaces twice daily in the case of an outbreak in the RCF. PALTC advises that it is done daily, Australian ICEG advises at least daily, the CDC advises regularly and PHA say it should be done.

*Terminal cleaning*

Some agencies also recommend terminal cleaning in certain scenarios. This usually involves a deep clean including removable objects such as curtains, as well as ventilators, light fittings and hard to reach areas.

Hong Kong recommends the terminal disinfection of a facility when a case is confirmed. Australian guidance recommends terminal cleaning of a patient's room following recovery from an infectious illness (not specifically COVID-19) or transfer or discharge of a resident with an infectious illness, this applies to COVID-19. CDNA advises that a room should be terminally cleaned if an ill resident is discharged or moved. Canada advises some elements of terminal cleaning after discharge, transfer or discontinuation of confirmed and or suspected cases including laundering curtains, disposing of unused toilet paper and toilet brushes. They also recommend that personal items be removed and cleaned and not handled for five days. The HPSC recommends that terminal cleaning should be conducted if a resident vacates their room and is not expected to return. PHA recommends terminal cleaning once the room is vacated after a resident death.

*Bundling of cleaning with care*

The CDC recommends that clinical staff clean frequently touched surfaces when in rooms to carry out care. Ireland and the UK Department of Health and Social Care provide the same guidance for isolation rooms. The UK Department of Health and Social Care and HPS advise that if cleaning is to be done by other staff then resident rooms should be done last.

*Ventilation and drainage*

Hong Kong guidance advises to clean air conditioners’ dust filters regularly and to clean drainage pipes once a week. They recommend that windows should be opened
and fans are switched on to provide better ventilation and enhance air flow. HPS\(^{(32)}\) advises the removal of portable cooling fans from RCFs during an outbreak as they may spread the virus.

**Management of waste**

The UK Department of Health and Social Care\(^{(50)}\) has published guidance on the management of waste. They recommend that personal contact waste, including PPE from routine care of all residents, and offensive waste (waste contaminated with body fluids) from all residents, should be placed in the usual bag, secured with zip tie or tape and disposed of as per usual. Where a resident is suspected of or confirmed as having COVID-19, respiratory intervention waste and personal contact waste should, in addition, be stored for at least 72 hours before being disposed of as usual. Written records to demonstrate that the waste has been held for 72 hours should be maintained. If the waste cannot be stored for 72 hours, it should be disposed of as infectious clinical waste. It is also advised that waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system.

The HPS also recommends storing waste ‘belonging to affected individuals’ for 72 hours before disposal, where a clinical waste contract is not in place.\(^{(32)}\)

**Immunisation**

In Australia, from 1 May 2020, all staff, visiting workers and visitors to RCFs must be vaccinated against influenza.\(^{(65)}\) Providers should seek appropriate evidence of immunisation status from individuals seeking to enter the RCF.\(^{(65)}\)

Ireland,\(^{(66)}\) the CDNA,\(^{(36)}\) HQSCNZ\(^{(60)}\) and NSW\(^{(24)}\) recommend vaccination of all residents and staff against influenza and the WHO\(^{(61)}\) advises RCFs to ensure annual influenza and pneumococcal conjugate vaccines for employees and staff. The UK Department of Health and Social Care recommends that residents should be up to date with their routine vaccinations, such as annual influenza and pneumococcal vaccination.\(^{(50)}\)

**Providing care to residents who are not known or suspected cases**

**Nebulisers**

The Australian ICEG has stated that nebulisers have been associated with a risk of transmission of respiratory viruses and their use should be avoided in RCFs and a spacer or puffer should be used instead.\(^{(35)}\) The CDNA\(^{(36)}\) also advises to cease using nebulisers and use spacers as an alternative wherever possible. The HQSCNZ\(^{(60)}\) recommends avoiding the use of nebulisers in the setting. HPS however, notes that the administration of medication via nebulisation is not considered to represent a significant infection risk and does not require aerosol generating procedure PPE.\(^{(32)}\)
PHA similarly stated that use of nebulisers is not considered an aerosol generating procedure.\(^{(56)}\)

**Appointments**

The UK Department of Health and Social Care has recommended that RCFs review and postpone all non-essential appointments (medical and non-medical) that would involve residents visiting a hospital or other health care facility.\(^{(50)}\)

**Reuse of equipment**

The CDNA,\(^{(36)}\) the HPSC\(^{(47)}\) PHA\(^{(56)}\) and HPS\(^{(32)}\) recommend dedicating equipment and supplies to patients with suspected or confirmed COVID-19 and not sharing with other uninfected residents. If it is not possible to dedicate pieces of equipment to the individual, such as commodes or moving aides, these must be decontaminated immediately after use and before use by any other individual.

**Extremely clinically vulnerable residents**

The UK Department of Health and Social Care\(^{(50)}\) and PHA\(^{(56)}\) recommend that organisations identify residents in the clinically extremely vulnerable group that require shielding (also known as cocooning). As a minimum, these residents should be separated from others, for example, reside in a single room.

**Other**

Hong Kong\(^{(21)}\) has recommended that staff should help new residents and residents newly discharged from hospitals to wash their hair, bathe and change their clothes as soon as possible.

**Caring for the recently deceased**

The Australian ICEG,\(^{(35)}\) Canada,\(^{(37)}\) HPS,\(^{(32)}\) PHE,\(^{(67)}\) PHA,\(^{(56)}\) Ireland\(^{(47)}\) and the UK Department of Health and Social Care\(^{(50)}\) have issued guidance for caring for the recently deceased in the context of COVID-19. It is recommended that routine practice for dealing with a death in the setting is followed, that the same IPC precautions as when caring for the resident during life are continued and that PPE including gowns, gloves and surgical masks, should be used when handling deceased bodies.

Some agencies have additional guidance for this situation. The Australian ICEG\(^{(35)}\) recommends that deceased bodies are placed in a leak-proof bag. HPS\(^{(32)}\) advises that where the deceased was a known or suspected COVID-19 case, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted. PHE recommends that if a resident dies of suspected COVID-19 in an RCF, residents should maintain a distance of at least 2 metres from the deceased person and all non-essential staff contact with the deceased person should be avoided.\(^{(67)}\) If a member of staff does need to provide care for the
deceased person, this should be kept to a minimum. PHA defers to PHE’s advice and additionally adds that all visits should stop, ‘no entry’ signs should be placed on the door, a surgical mask should be placed on the deceased resident and terminal cleaning should be undertaken.

Additional recommendations are included in the HPSC guidance. It is advised that washing or preparing the body for religious reasons is acceptable if those carrying out the task wear long-sleeved gowns, gloves, a surgical face mask and eye protection. An inner lining is not required in terms of COVID-19 risk but may be required for other practical reasons. A surgical face mask or similar should be placed over the mouth of the deceased before lifting the remains into the inner lining. The family should be advised not to kiss the deceased and should clean their hands with alcohol hand rub or soap and water after touching the deceased.

**Governance and Leadership**

Almost all agencies have provided guidance on governance and leadership. This can take many forms, including a checklist for outbreak management, having a point of contact for IPC or ensuring staff are adequately trained. Hong Kong guidance does not advise on aspects of governance and leadership.

**Point of contact**

Several agencies advise having a single focal point for outbreaks or COVID-19 outbreaks. The WHO advises having an IPC focal point with responsibilities for leading and coordinating IPC activities. This focal point should be supported by an IPC team with delegated responsibilities and advised by a multidisciplinary committee. The HPSC and the ECDC advise RCFs to identify a lead for COVID-19 preparedness and response in the RCF. The lead’s responsibility is to oversee development, implementation and review of policies and procedures. The CDC also recommends delegating this responsibility to a named individual. The CDNA recommends allocating a named staff member the responsibility for planning, the coordination and management of logistics during an outbreak, along with acting as a point of contact for relevant health departments. HQSCNZ guidance on governance and leadership is based on CDNA guidance and is the same throughout with slight context specific adaptations.

**Outbreak management**

Outbreak management is a core part of the governance process of many agencies’ RCF guidance. The CDNA advises that an outbreak management plan should be developed. The CDNA also provides checklists for the development of outbreak preparedness and management plans. In the scenario of an outbreak occurring the CDNA recommends assembling an outbreak management team. The CDNA also provides advice on managing the outbreak, declaring it over and conducting a review of how the outbreak was managed. A link to a tool to audit outbreak management is provided.
The CDC\(^{41}\) recommends developing a COVID-19 response plan and have also developed a preparedness checklist to be used by RCFs to do so. They also recommend assigning one or more individuals with training in infection control to provide on-site management of the IPC programme.\(^7\)

The Australian ICEG\(^{35}\) recommends that an RCF should have an ‘outbreak management team’ and an ‘outbreak management plan’.

HPS\(^{32, 52}\) advises contacting the RCF’s health protection team if an outbreak occurs. HPS\(^{52}\) has developed a checklist for managing an outbreak (enhanced IPC practices). HPS\(^{52}\) specifies the roles of different staff members in handling an outbreak. HPS\(^{52}\) also advises how to declare an outbreak ‘closed’.

The UK Department of Health and Social Care\(^{50}\) advises that if there is an outbreak in an RCF that a local health protection team is notified. In the scenario of a COVID-19 outbreak, the guidance advises RCFs to follow guidance for influenza outbreaks.\(^{50}\)

The HPSC\(^{47}\) advises that there should be an outbreak management plan prepared. The HPSC\(^{47}\) also advises that if there is an outbreak, then there should be a local incident management meeting with staff from various areas of the RCF such as cleaning, medical, nursing and so on. The HPSC\(^{47}\) provides a series of IPC actions for this team to take. It is also recommended that an outbreak control team should be convened in the case of an outbreak, with a mix of external experts (public health, GP and so on) and internal staff.\(^{47}\) The HPSC\(^{47}\) provides a list of information to be gathered for the outbreak control team, and has a checklist for the outbreak management team. The HPSC\(^{47}\) provides information on when to declare an outbreak as ‘over’.

PALTC\(^{43}\) recommends that RCFs develop plans to respond to outbreaks. These plans consist of enhanced IPC and increased staff using agency workers.\(^{43}\)

PHA\(^{56}\) advise RCFs that PHA has a team of IPC nurses who can provide ‘advice and guidance’ if an outbreak occurs. PHA\(^{56}\) also advises RCFs to use advice previously used for influenza outbreaks.

**Staff shortages**

Few agencies provide guidance on managing staffing shortages. The CDC,\(^{38}\) CDNA\(^{36}\) and PALTC\(^{43}\) all recommend making a plan for managing staffing shortages. The CDC\(^{38}\) and HPSC\(^{47}\) recommend planning for and establishing surge capacity for dealing with an outbreak of COVID-19 in an RCF. PHA\(^{56}\) recommends that RCFs develop contingency plans in the case of staff absences. The Scottish Government\(^{55}\) guidance recommends planning for staff absences of 30-50%. The UK Department of Health and Social Care recommends developing a business continuity policy that includes a plan for surge capacity for staffing.\(^{50}\)
Supplies

Several guidelines advise that RCFs should ensure adequate supplies of important stocks. The CDNA, Australian ICEG, Canadian guidance, and HPSC recommend ensuring there are adequate stocks of PPE, hygiene, clinical and cleaning supplies. The CMS advises RCFs to take steps to mitigate supply shortages. PHA advises to have contingency plans for long-term supplies of essential supplies such as food and pharmaceuticals. The CDC recommends making a plan to ensure supplies, as part of an outbreak management plan. The HPSC recommends that in the case of an outbreak, RCFs should have sufficient supplies of PPE.

Monitoring compliance

Some agencies advise to monitor compliance with important IPC practices. The CDC advises to ensure competency and adherence in IPC practice, especially in PPE use. Canadian guidance advises to ensure IPC practices are monitored, tracked and recorded. The HPS outbreak management checklist includes advice to ensure staff and residents are aware of and are adhering to best practice in IPC and PPE use. The WHO recommends that the IPC focal point should audit IPC practices regularly and ensure hand and respiratory hygiene.

Sick leave

Several agencies advise developing sick leave policies for people who have respiratory symptoms or COVID-19. CDC guidance places emphasis on implementing and informing staff about non-punitive sick leave policies. The CDNA advises RCFs to develop leave policies for staff who are suspected or confirmed cases. PALTC advises RCFs to develop policies to facilitate sick leave. The UK Department of Health and Social Care recommends a revision of sick leave policies for staff to stay home, as per the guidance for household isolation.

Ensure training

Ensuring adequate IPC training is common advice across agencies and countries. Re-training on IPC and PPE measures and training on new measures in the context of COVID-19 is emphasised across guidance documents. The CDC advises educating staff about new IPC practices. The CDC highlights the importance of educating a wide range of staff, especially those who work across multiple facilities. The CDNA and the HPSC advise that RCFs should ensure staff are educated in IPC practices. The Australian ICEG advises to ensure IPC training of staff when managing an outbreak. Canadian and HPS guidance advises that there should be ongoing training for staff in IPC practices. PALTC and PHA recommends re-educating staff on IPC and PPE. The ECDC advises providing training for staff on hand hygiene measures. The UK Department of Health and Social Care advises that RCF managers provide staff with appropriate training.
Communications

The CDC\(^{(38)}\) emphasises the need to plan for communications with residents and family. NSW\(^{(24)}\) advises developing a plan for rapid notification for staff, families, and carers. Canadian guidance\(^{(37)}\) advises the development of policies on communication with residents and family. The CDNA\(^{(36)}\) recommends informing families and staff of an outbreak. The HPSC\(^{(47)}\) advises that the outbreak management team should identify and communicate with those who require notification of the outbreak, such as the family of confirmed or suspected cases and various healthcare workers and providers.

Other

Some agencies have issued guidance in areas that are not common across guidance documents. These are summarised below.

Resident transfer

The CDNA\(^{(36)}\) has stated that in some circumstances, it may be feasible to transfer residents who are not symptomatic to other settings (e.g. family care) for the duration of the outbreak. Where a transfer is undertaken, a risk assessment should be completed to understand the family circumstance and health status prior to transferring residents. The family or receiving facility should be made aware that the resident may have been exposed and is at risk of developing the disease. They should be provided with information regarding the symptoms of COVID-19 and the use of appropriate personal protective measures. Security of tenure provisions should also be considered.

The PHA\(^{(56)}\) has advised that family or friends may wish to take residents to live with them away from the RCF for a period. This should be discussed by the RCF, resident, family and friends and the resident’s preference facilitated as far as possible. RCFs will need to discuss the care regime with any proposed carers and the resident to provide assurance that the resident’s needs are capable of being met out of the RCF. RCFs should not permanently reallocate these places, without agreement from the Trust and individual affected.

Temporary and external staff

Some agencies have issued guidance specific to agency and temporary staff, due to the risk of them working across multiple facilities.

HPS\(^{(32)}\) advises that contractors on site and the use of agency staff should be minimised. In addition, HPS\(^{(32)}\) and the UK Department of Health and Social Care\(^{(50)}\) advise that if agency staff are used then they should only work for one facility where possible. Similarly, the Australian ICEG\(^{(35)}\) advises that staff movement between RCFs should be limited. PHA\(^{(56)}\) recommends limiting the turnover of staff and to
limit the number of staff moving between homes. The HPSC recommends that staff should only work in one RCF and not move across settings.\(^{(47)}\)

The CDC\(^{(38)}\) advises that staff who work in ‘multiple locations’ should be encouraged to tell facilities if any of the facilities they work in have recognised cases. The CMS\(^{(44)}\) advises RCFs to identify staff that work at multiple facilities and actively screen them. The CDNA\(^{(36)}\) and PALTC\(^{(43)}\) consider agency staff necessary if a surge occurs. The CDNA\(^{(36)}\) advises that they should not work in multiple facilities.

**Deliveries**

Some agencies have also issued guidance for those conducting deliveries and external providers. Canadian\(^{(37)}\) and CMS\(^{(44)}\) guidance advise that deliveries should be made through a single access point. Many agencies have restricted visitation, this applies to non-essential service providers and is detailed under the *Visitation* section of this review.

**System-wide measures**

The NHS have established the Capacity Tracker\(^{(68)}\) as a single mechanism for use across the country, to report bed vacancies and help manage demand during the COVID-19 outbreak. Capacity Tracker is managed by the NHS North of England Commissioning Support and provides the opportunity to easily track occupancy and vacancies to support system-wide bed and discharge planning. RCFs must keep Capacity Tracker up to date on a daily basis. The CDC have established a system for monitoring cases, staff and supplies in RCFs. RCFs in the US are advised to report relevant data weekly.\(^{(7)}\)

**Signage and communications**

Although many guidance documents make reference to signage and communication in various contexts, the UK Department of Health and Social Care makes specific recommendations. They recommend displaying signs to inform of the outbreak and infection controls and providing ‘warn and inform’ letters to residents, visitors and staff if there is a possible case in the RCF.

**Return to work**

The UK Department of Health and Social Care\(^{(50)}\) provide detailed guidance for staff on returning to work after experiencing symptoms or being confirmed as a case. It is recommended that in most cases they can return to work no earlier than 7 days from symptom onset, provided clinical improvement has occurred and they have been afebrile (not feverish) without medication for 48 hours and they are medically fit to return.
Conclusion

A range of guidance has been issued internationally to protect residents and staff of RCFs in the context of COVID-19. The guidance for the most part, includes recommendations on testing, screening, monitoring, isolation, cohorting, social distancing, visitation, environmental cleaning, immunisation, providing care for non-cases, caring for the recently deceased and governance and leadership.

Many similarities exist between guidance documents, including recommendations to screen people entering facilities, to monitor staff and residents for new symptoms, to restrict visitation except on compassionate grounds, to isolate suspected and confirmed cases, to cohort symptomatic residents, to regularly clean frequently touched surfaces and to develop outbreak management plans.

There are some areas of guidance that differ between guidance documents, including recommendations to screen people entering facilities, to monitor staff and residents for new symptoms, to restrict visitation except on compassionate grounds, to isolate suspected and confirmed cases, to cohort symptomatic residents, to regularly clean frequently touched surfaces and to develop outbreak management plans.

Some differences in guidance is to be expected, particularly where one recommendation can have a knock-on effect on another, for example, the cohorting of residents and cancellation of communal activities can mean guidance on physical distancing is less relevant. Differences also exist between guidance depending on the setting, for example, the CDC recommends eye protection and respirators at all times while in a memory care unit. However, this recommendation is to address the potential for encountering a wandering resident who might have COVID-19 and is not as relevant to other settings.

Some recommendations were not common and were issued by only one or two agencies, such as the guidance on temporary resident transfer to the homes of family or friends, using a single country wide mechanism for reporting bed vacancies, ventilation and returning to work after self-isolation. Guidance on limiting staff movement between facilities and managing deliveries was also limited.

Not all guidance documents reviewed included detail on all of the themes identified. For example, the WHO does not give advice on the cohorting of staff, even though the cohorting of staff is recommended by most agencies reviewed. In instances where an agency has not provided guidance on a theme included in this review, it is possible that this area is covered in other guidance documents not specific to COVID-19 and RCFs and thus not captured in this review.

The findings from this rapid review were accurate as of 25 June 9.00 GMT; however, it is important to note that the guidance identified above may change as the situation and response to COVID-19 evolves.
Appendix Table 1 Highest level of public health guidance protective measures for RCFs by country or agency*

<table>
<thead>
<tr>
<th>Testing</th>
<th>Australia, ICEG(35) (includes CDNA(36))</th>
<th>Canada(37)</th>
<th>United States of America, CDC(38, 39, 41)</th>
<th>Ireland, HPSC(47, 66)</th>
<th>Scotland, HPS(32)</th>
<th>Hong Kong(21)</th>
<th>UK(28, 50) (includes PHE(51))</th>
<th>New Zealand(57, 59, 63) (includes HQSCNZ(60))</th>
<th>The WHO(61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents with new respiratory symptoms and asymptomatic contacts</td>
<td>No guidance</td>
<td>All staff and residents with symptoms. All staff and residents where a staff case is confirmed or a resident case is suspected or confirmed</td>
<td>All suspected cases, contacts of cases and on admission. A comprehensive testing sweep conducted in April.</td>
<td>All residents and staff where there is an outbreak (plus additional scenario based testing strategies)</td>
<td>No guidance</td>
<td>All symptomatic residents and staff. “Whole home” testing can be requested.</td>
<td>Residents with new respiratory symptoms, staff should be tested in the community as a high priority group</td>
<td>No guidance</td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td>All entrants</td>
<td>All entrants</td>
<td>All entrants</td>
<td>Staff</td>
<td>No guidance</td>
<td>Staff and visitors</td>
<td>No guidance</td>
<td>No guidance</td>
<td>No guidance</td>
</tr>
<tr>
<td>Screening checks</td>
<td>Contact, travel, symptoms</td>
<td>Contact and symptoms</td>
<td>Temperature and symptoms</td>
<td>Temperature and symptoms</td>
<td>No guidance</td>
<td>Temperature</td>
<td>No guidance</td>
<td>No guidance</td>
<td>Temperature (staff), symptoms and risk (visitors)</td>
</tr>
<tr>
<td>Monitoring of residents</td>
<td>Daily (close contacts only)</td>
<td>Daily</td>
<td>Twice daily</td>
<td>Daily</td>
<td>Daily (twice daily for new admissions)</td>
<td>Twice daily</td>
<td>Daily</td>
<td>Twice daily</td>
<td>Twice daily</td>
</tr>
<tr>
<td>Monitoring of staff</td>
<td>No guidance</td>
<td>Twice daily for exposed staff who are not unwell</td>
<td>Throughout the day</td>
<td>Twice daily</td>
<td>No guidance</td>
<td>No guidance</td>
<td>Daily</td>
<td>Daily</td>
<td>No guidance</td>
</tr>
<tr>
<td></td>
<td>Australia, ICEG(35) (includes CDNA(36))</td>
<td>Canada(37)</td>
<td>United States of America, CDC(38, 39, 41)</td>
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<td>Scotland, HPS(32)</td>
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<td>The WHO(61)</td>
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</tr>
<tr>
<td><strong>14 day isolation of confirmed and suspected cases</strong></td>
<td>✓</td>
<td>No guidance</td>
<td>✓</td>
<td>✓</td>
<td>No guidance</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Cohorting of residents</strong></td>
<td>Same diagnosed virus</td>
<td>Confirmed cases</td>
<td>Confirmed cases</td>
<td>Suspected or confirmed cases</td>
<td>Suspected or confirmed cases</td>
<td>No guidance</td>
<td>Suspected or confirmed cases</td>
<td>Suspected or confirmed cases</td>
<td>Suspected or confirmed cases</td>
</tr>
<tr>
<td><strong>Cohorting of staff</strong></td>
<td>Care for confirmed cases</td>
<td>Care for suspected or confirmed cases</td>
<td>Care for confirmed cases</td>
<td>COVID-19 cohort areas and non- COVID-19 areas</td>
<td>Care for confirmed cases</td>
<td>Work with ‘same group of residents’</td>
<td>Care for ‘symptomatic or asymptomatic residents and restrict movement within the facility for all staff’</td>
<td>‘residents in isolation’</td>
<td>No guidance</td>
</tr>
<tr>
<td><strong>Communal dining</strong></td>
<td>No guidance</td>
<td>Cancel if suspected or confirmed cases in RCF</td>
<td>Cancel if social distancing not possible</td>
<td>Cancel if social distancing not possible</td>
<td>No guidance</td>
<td>Stagger</td>
<td>No guidance</td>
<td>No guidance</td>
<td>Stagger, cancel if social distancing not possible</td>
</tr>
<tr>
<td><strong>Group activities</strong></td>
<td>Cancel if outbreak occurs in RCF</td>
<td>Cancel if social distancing not possible</td>
<td>Restricted but some may be conducted with social distancing</td>
<td>Cancel if social distancing not possible</td>
<td>Cancel if outbreak occurs in RCF</td>
<td>Cancel if social distancing not possible</td>
<td>Cancel if social distancing not possible</td>
<td>Cancel if outbreak occurs in RCF</td>
<td>No guidance</td>
</tr>
<tr>
<td><strong>Visitation restrictions</strong></td>
<td>Visits only on compassionate grounds</td>
<td>Visits only on compassionate grounds</td>
<td>Visits only on compassionate grounds</td>
<td>Visits only on compassionate grounds</td>
<td>Visits only on compassionate grounds</td>
<td>Visits only on compassionate grounds</td>
<td>Visits only on compassionate grounds</td>
<td>Family only</td>
<td>Visits only on compassionate grounds</td>
</tr>
<tr>
<td><strong>Facemasks for staff</strong></td>
<td>Within 1-2m of confirmed or suspected cases</td>
<td>While in the RCF</td>
<td>While in the RCF</td>
<td>Within 1-2m of residents or other staff or if the staff</td>
<td>Within two metres of residents</td>
<td>While in the RCF</td>
<td>Within two metres of residents</td>
<td>Within 1-2m of confirmed or suspected cases</td>
<td>Within 1-2m of confirmed or suspected cases</td>
</tr>
<tr>
<td></td>
<td>Australia, ICEC(25) (includes CDNA(26))</td>
<td>Canada(37)</td>
<td>United States of America, CDC(38, 39, 41)</td>
<td>Ireland, HPSC(47, 66)</td>
<td>Scotland, HPS(32)</td>
<td>Hong Kong(21)</td>
<td>UK(28, 50) (includes PHE(51))</td>
<td>New Zealand(57, 59, 63) (includes HQSCNZ(60))</td>
<td>The WHO(61)</td>
</tr>
<tr>
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<tr>
<td><strong>Facemasks for residents</strong></td>
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<tr>
<td>If symptomatic resident leaves room</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Symptomatic residents during transfer between rooms</td>
<td>If symptomatic resident leaves room</td>
<td>Confirmed and suspected cases</td>
</tr>
<tr>
<td>During transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>During an outbreak</td>
<td>As directed by staff</td>
<td>No guidance provided</td>
</tr>
<tr>
<td>If resident leaves room</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Local risk assessment’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmed and suspected cases in shared spaces</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No guidance</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All residents</td>
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<tr>
<td></td>
<td>encounter is &gt;15 minutes</td>
<td></td>
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<tr>
<td><strong>Facemasks for visitors</strong></td>
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<td></td>
</tr>
<tr>
<td>Room of suspected or confirmed cases</td>
<td>✓</td>
<td>✓</td>
<td>Room of suspected or confirmed cases</td>
<td>✓</td>
<td></td>
<td>Local risk assessment’</td>
<td>During an outbreak</td>
<td>As directed by staff</td>
<td>No guidance provided</td>
</tr>
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<tr>
<td>Cleaning of frequently touched surfaces</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Twice daily</td>
<td>Twice daily</td>
<td>Regularly</td>
<td>Twice daily</td>
<td>Twice daily</td>
<td>Twice daily</td>
<td>Twice daily (if an outbreak occurs)</td>
<td></td>
<td>Twice daily</td>
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<tr>
<td><strong>Immunisation</strong></td>
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<tr>
<td>Influenza for staff, visitors and residents</td>
<td>No guidance</td>
<td>No guidance</td>
<td>Influenza for residents and staff</td>
<td>No guidance</td>
<td>No guidance</td>
<td>No guidance</td>
<td>Influenza and pneumococcal vaccination for residents</td>
<td>Influenza for all staff and residents</td>
<td>Influenza and pneumococcal for employees and staff</td>
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<tr>
<td>Use of nebulisers for non-cases</td>
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<tr>
<td></td>
<td>Avoid</td>
<td>No guidance</td>
<td>No guidance</td>
<td>No guidance</td>
<td>No guidance</td>
<td>No guidance</td>
<td>No guidance</td>
<td>Avoid</td>
<td>No guidance</td>
</tr>
<tr>
<td><strong>Care of recently deceased</strong></td>
<td>Routine practice, continue IPC precautions, use leak-proof bag</td>
<td>Routine practice, continue IPC precautions</td>
<td>No guidance</td>
<td>Routine practice, continue IPC precautions, inner lining not needed, face mask for deceased resident, family advised</td>
<td>Routine practice, continue IPC precautions, no requirement for a body bag</td>
<td>No guidance</td>
<td>Routine practice, continue IPC precautions, non-essential contact should be avoided</td>
<td>No guidance</td>
<td>No guidance</td>
</tr>
</tbody>
</table>

**Page 48 of 50**
<table>
<thead>
<tr>
<th>Australia, ICEG(35) (includes CDNA(36))</th>
<th>Canada(37)</th>
<th>United States of America, CDC(38, 39, 41)</th>
<th>Ireland, HPSC(47, 66)</th>
<th>Scotland, HPS(32)</th>
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<th>New Zealand(57, 59, 63) (includes HQSCNZ(60))</th>
<th>The WHO(61)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develop policies and plans</strong></td>
<td></td>
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</tr>
<tr>
<td>Outbreak management, staff shortages, supplies, sick leave, point of contact</td>
<td>Supplies, communication</td>
<td>Outbreak management, staff shortages, supplies, compliance, sick leave, communication, point of contact</td>
<td>Outbreak management, supplies, communication</td>
<td>Outbreak management, staff shortages</td>
<td>No guidance</td>
<td>Staff shortages, sick leave, otherwise follow influenza outbreak management plans</td>
<td>Outbreak management, staff shortages, supplies, sick leave, point of contact</td>
<td>Compliance, point of contact</td>
</tr>
<tr>
<td><strong>Provide training for staff</strong></td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>No guidance</td>
<td>No guidance</td>
<td>☑</td>
</tr>
</tbody>
</table>

*Excludes PALTC as it is a non-governmental agency, PHA as their guidance is primarily based on PHE and UK guidance, CMS as the CDC guidance is considered the primary guidance for the United States, NSW guidance because the Australian Government Department of Health guidance is considered the primary guidance for Australia and the ECDC guidance as only select elements are applicable to RCFs.

As some de-escalation of measures have begun, protective measures introduced by countries have been detailed at the highest level of restriction.